



Change Package for Community Health Centers: Integrating the Early Childhood Development Continuum of Care in Clinical Practice



Early Childhood
Developmental
Health Systems

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INTRODUCTION

Early childhood development (ECD) lays the foundation of lifelong health, learning, well-being, and success. The earliest years of life are a critical window for supporting healthy brain development, strong relationships, and positive health outcomes.

Community health centers play an essential role in helping children and families thrive. By providing comprehensive, family-centered care, health centers support children's physical health, development, and social-emotional well-being while helping families connect to the services they need.

This change package provides an evidence-informed collection of actionable ideas to help health centers integrate the [ECD Continuum of Care](#), focusing on strengthening promotion and prevention, surveillance and screening, care coordination and linkage, and early intervention services. Together, these approaches support coordinated, family-driven care for children from conception to age 5, connecting health care with education and social services when families need them.

This introduction includes several sections to help your health center or practice use the change package:

- The Important Role of Community Health Centers in Supporting ECD
- About the Change Package
- Key Driver Diagram for Integrating the ECD Continuum of Care
- How to Use the Change Package as Part of a Continuous Quality Improvement Project
- How to Select and Test Change Ideas
- Quality Improvement Readiness Checklist and Prioritization Table for ECD Change Ideas

You can also go directly to the change ideas and tools, which are organized into the four parts of the ECD Continuum of Care:

- [Part 1: Promotion and Prevention](#)
- [Part 2: Surveillance and Screening](#)
- [Part 3: Care Coordination and Linkage](#)
- [Part 4: Early Intervention](#)

The Important Role of Community Health Centers in Supporting ECD

During the first 5 years of life, children experience rapid brain, emotional, and physical development that shapes future health and success.

Community health centers are uniquely positioned to reach the needs of all families early and consistently. Because they serve families across generations and communities, health centers

can identify developmental concerns early, provide guidance to caregivers, and connect families to services that strengthen their children's health and development.

When ECD support is embedded into routine pediatric care, community health centers can:

- Identify developmental concerns earlier
- Strengthen relationships with families more
- Connect families to timely supports and services
- Promote healthy development for all children

This change package helps community health centers turn those priorities into practice.

About the Change Package

This change package was developed as a practical resource for community health centers working to improve ECD outcomes. It includes the following components:

- **Key driver diagram:** A visual tool used in quality improvement to map the pathway toward achieving a specific goal.
- **Aims:** Desired outcomes that are specific, measurable, achievable, relevant, and time-bound.
- **Primary drivers:** High-level system components that influence progress toward the aim.
- **Change ideas:** Evidence-based actions, promising practices, or innovative approaches that help improve each driver.
- **Sample tools:** Practical resources such as workflows, checklists, templates, and examples that support test change ideas.

The key driver diagram helps teams understand how different parts of the system work together to improve outcomes. Each change idea outlines practical steps that teams can test and adapt in their own settings to strengthen promotion and prevention, surveillance and screening, care coordination and linkage, and early intervention.

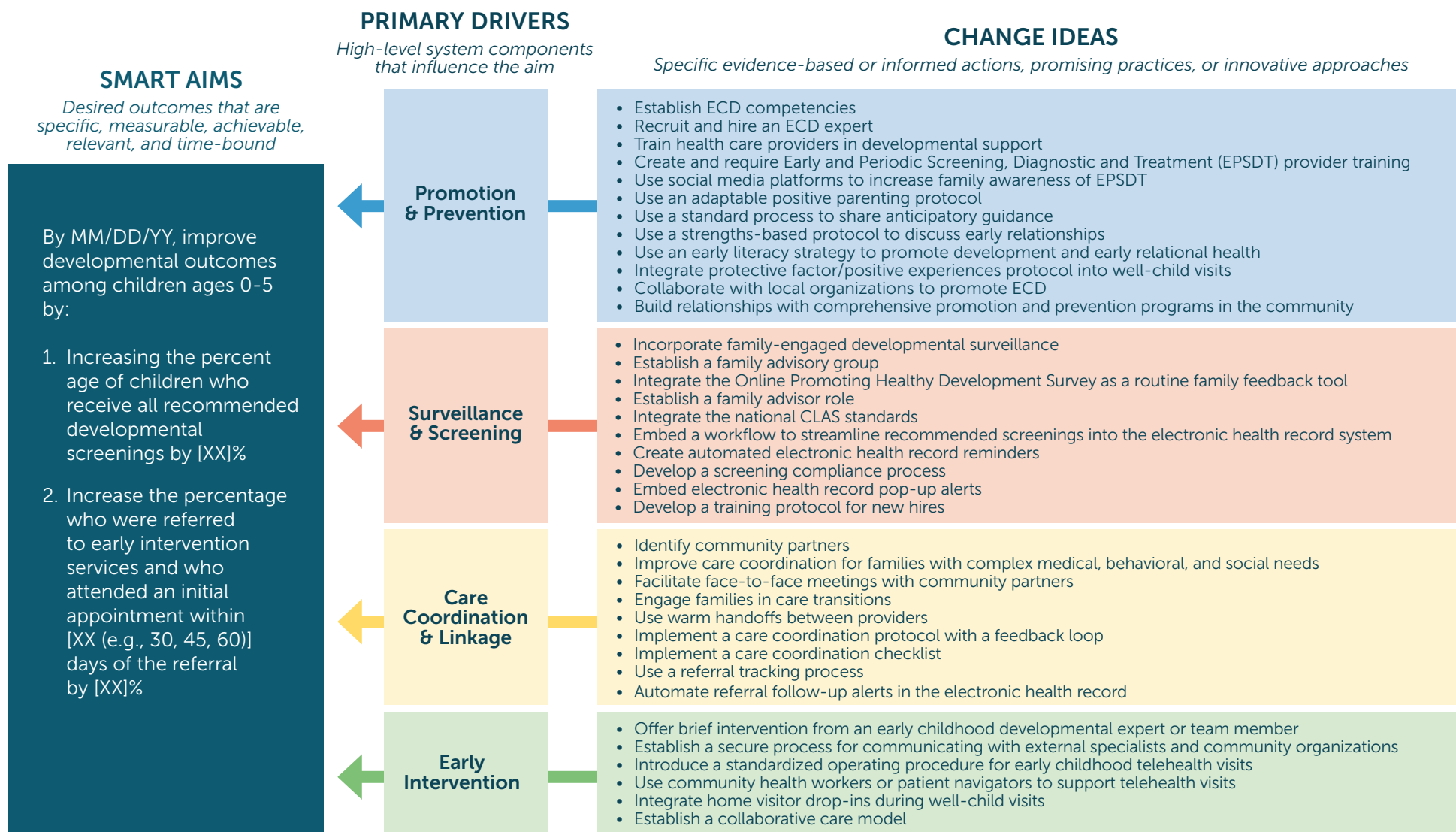
The change package also includes adaptable sample scripts, checklists, planning guides, and curated training resources designed to support busy health centers in implementing and testing improvements.

Teams are encouraged to test small changes, learn from the results, and adapt approaches to meet the needs of the families and communities they serve

***Note on Adaptation:** All examples provided throughout the change package are illustrative. Health centers should adapt these ideas to align with their local context, ethical guidelines, and organizational policies.*



Key Driver Diagram for Integrating the Early Childhood Development Continuum of Care in Clinical Practice



How to Use the Change Package as Part of a Quality Improvement Project

This change package is designed to support practical, ongoing improvement efforts in ECD care. Health centers can test and adopt these ideas using quality improvement (QI) methods that fit into everyday clinical practice.

QI is a structured way to improve health outcomes by testing changes, learning from results, and refining approaches over time. Using a QI approach allows community health centers to adapt change ideas to the needs of their communities while aligning with best practices in pediatric primary care.

Teams can begin by selecting one change idea and testing it on a small scale – for example, with one provider, one well-child visit, or a small group of families. Based on feedback and results, teams can refine the process before expanding successful changes across providers, clinics, or patient populations.

Each change idea in this package includes step-by-step guidance organized into five improvement stages.

STEP 1: GET READY

In this step, the health center identifies a specific area for improvement, such as strengthening development surveillance, improving referral follow-up, or enhancing family engagement.

A cross-functional team is formed, including clinical staff, administrative staff, and community and family representatives. The team gathers baseline information and ensures alignment with organizational priorities and family needs.

Key Actions:

- Define the quality improvement focus (e.g., family-engaged developmental surveillance, identifying community partners for care coordination, introducing brief interventions with an integrated early childhood expert).
- Form an improvement team with staff and community voices.
- Collect baseline information to understand the current workflow.
- Confirm leadership support and alignment with health center priorities.

STEP 2: PLAN AND PRACTICE

Once a focus area is identified, the team designs a small test of change. The goal is to try a new approach in a controlled way before expanding it more broadly. For example, a team might test a new script for introducing referrals, pilot a developmental guidance tool, or test a new screening workflow with one provider.

Key Actions:

- Generate change ideas based on data, staff input, and family feedback.
- Select a change to test in a small setting (e.g., one provider, 1 week).
- Outline a simple plan describing who will do what and when.

- Run the test and gather feedback or basic data.

STEP 3: REVIEW AND REFINE

After the test, the team reviews what happened and reflects on the results. Did the change improve the process? What worked well? What barriers were encountered? Teams analyze data, gather staff and family feedback, and determine whether the change should be modified, tested again, or expanded.

Key Actions:

- Review what happened during the test.
- Examine data, observations, and team experiences.
- Identify successes and barriers.
- Modify the plan for further testing or improvement.

STEP 4: EXPAND

If the change proves successful, the health center can expand it to other providers, departments, or clinics. This step focuses on training others, adjusting for different settings, and maintaining quality as the effort grows.

Key Actions:

- Develop a plan to roll out the change more broadly.
- Providing training and support for new staff involved in the process.
- Monitor implementation to ensure consistency and effectiveness.
- Adapt workflows for new settings while preserving core elements.

STEP 5: SUSTAIN

To ensure improvements last, the team integrates successful changes into standard policies, workflows, and training processes. Ongoing data monitoring and team check-ins help maintain progress and allow the health center to continue improving care over time.

Key Actions:

- Update protocols, workflows, and documentation.
- Establish routine monitoring to track long-term impact.
- Celebrate successes and recognize team contributions.
- Foster a culture of continuous improvement and learning.

This change package is designed to help community health centers strengthen ECD outcomes through structured, team-based efforts. When used as part of a quality improvement initiative, the package can guide teams in testing practical changes that improve care for children and families.

How to Select and Test Change Ideas

Health centers may begin their improvement work in different places. Some may already conduct developmental screenings but want to strengthen follow-up and referrals. Others may be working to expand family engagement or hire early childhood experts.

The key is to start with a change idea that fits your health center's current priorities, capacity, and community needs.

When selecting a change idea:

- Start with an area where improvement is needed or requested by staff or families.
- Choose a change that is small enough to test quickly (e.g., one provider, one age group, one clinic).
- Involve a cross-functional team to design and evaluate the test.
- Include family voices whenever possible as partners in improvement.
- Use short learning cycles to gather feedback and refine the approach.

Community health centers can use the **QI Readiness Checklist and Prioritization Table for ECD Change Ideas** to help determine where to begin.



Quality Improvement Readiness Checklist and Prioritization Table for Early Childhood Development (ECD) Change Ideas

This checklist helps community health centers identify where to begin testing QI strategies across ECD topic areas. Use this table to assess current practices, prioritize opportunities, and plan small tests of change.

PRIMARY DRIVER	CHANGE IDEA	Do We Already Do This? (Y/N/Partial)	Are Staff Trained? (Y/N/Partial)	Is It Documented in Workflow or EHR? (Y/N)	Are There Clear Measures? (Y/N)	Priority to Start QI? (High, Med, Low)	NOTES & NEXT STEPS
Promotion & Prevention	Establish ECD competencies						
	Recruit and hire an ECD expert						
	Train health care providers in developmental support						
	Create and require Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provider training						
	Use social media platforms to increase family awareness of EPSDT						
	Use an adaptable positive parenting protocol						
	Use a standard process to share anticipatory guidance						
	Use a strengths-based protocol to discuss early relationships						



PRIMARY DRIVER	CHANGE IDEA	Do We Already Do This? (Y/N/Partial)	Are Staff Trained? (Y/N/Partial)	Is It Documented in Workflow or EHR? (Y/N)	Are There Clear Measures? (Y/N)	Priority to Start QI? (High, Med, Low)	NOTES & NEXT STEPS
Promotion & Prevention	Use an early literacy strategy to promote development and early relational health						
	Integrate protective factor/positive experiences protocol into well-child visits						
	Collaborate with local organizations to promote ECD						
	Build relationships with comprehensive promotion and prevention programs in the community						
Surveillance & Screening	Incorporate family-engaged developmental surveillance						
	Establish a family advisory group						
	Integrate the Online Promoting Healthy Development Survey as a routine family feedback tool						
	Establish a family advisory role						
	Integrate the national CLAS standards						



PRIMARY DRIVER	CHANGE IDEA	Do We Already Do This? (Y/N/ Partial)	Are Staff Trained? (Y/N/ Partial)	Is It Documented in Workflow or EHR? (Y/N)	Are There Clear Measures? (Y/N)	Priority to Start QI? (High, Med, Low)	NOTES & NEXT STEPS
Surveillance & Screening	Embed a workflow to streamline recommended screenings into the electronic health record system						
	Create automated electronic health record reminders						
	Develop a screening compliance process						
	Embed electronic health record pop-up alerts						
	Develop a training protocol for new hires						
Care Coordination & Linkage	Identify community partners						
	Improve care coordination for families with complex medical, behavioral, and social needs						
	Facilitate face-to-face meetings with community partners						
	Engage families in care transitions						
	Use warm handoffs between providers						



PRIMARY DRIVER	CHANGE IDEA	Do We Already Do This? (Y/N/Partial)	Are Staff Trained? (Y/N/Partial)	Is It Documented in Workflow or EHR? (Y/N)	Are There Clear Measures? (Y/N)	Priority to Start QI? (High, Med, Low)	NOTES & NEXT STEPS
Care Coordination & Linkage	Implement a care coordination protocol with a feedback loop						
	Implement a care coordination checklist						
	Use a referral tracking process						
	Automate referral follow-up alerts in the electronic health record						
Early Intervention	Offer brief intervention from an early childhood developmental expert or team member						
	Establish a secure process for communicating with external specialists and community organizations						
	Introduce a standardized procedure for early childhood telehealth visits						
	Use community health workers or patient navigators to support telehealth visits						
	Integrate home visitor drop-ins during well-child visits						
	Establish a collaborative care model						



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Part One

Promotion and Prevention Change Ideas



CHANGE IDEA: Establish early childhood development (ECD) competencies to guide appropriate care for all families.

STEP 1: GET READY (TASKS)

- A. Schedule regular practice meetings to plan the test of change.
- B. Clarify the purpose (e.g., improve developmental outcomes, ensure consistent care, reduce risk).
- C. Choose one or more ECD frameworks to implement (e.g., HealthySteps, Care for Child Development, Bright Futures).
- D. Select a target population (e.g., well-child visits for 6 months).
- E. Schedule team training on selected frameworks.
- F. Identify key components to integrate (e.g., Bright Futures risk assessment questions).
- G. Identify where these components currently occur in your workflow, if at all.
- H. Assign responsibilities at each workflow step.

STEP 2: PLAN AND PRACTICE

In this example, the team aims to improve developmental outcomes during well-child visits for children ages 0-5 by implementing Bright Futures development screening guidelines, including risk assessment questions.

SAMPLE PROCESS:

- A. Integrate Bright Futures checklists and prompts into pre-visit planning or electronic health record (EHR) templates.
 - a. Add age-specific (e.g., 1-week, 2-month, 9-month) templates or smart phrases to the EHR.
 - b. Include prompts for:
 - i. Screenings (e.g., maternal depression, lead risk)
 - ii. Immunizations
 - iii. Anticipatory guidance
 - iv. Parent concerns
 - v. Workflow details (time, roles, challenges)
- B. Assign a staff member (e.g., pediatric nurse, care coordinator) to review the child's chart 24-48 hours before the visit using a [preplanning checklist](#) or EHR template.
 - a. Print or load parent handouts and guidance sheets.
 - b. Pre-enter needed orders (e.g., labs, screenings) in the EHR.
- C. Define measures:
 - a. Percentage of well-child visits using Bright Futures prompts
 - b. Provider satisfaction and usability
 - c. Parent satisfaction
- D. Test the workflow with one provider or age group in 1 day.

- E. Hold a brief huddle or lunch-and-learn to review the Bright Futures content, new process, and tools (e.g., PDFs, EHR templates, website) on testing day.
- F. Track data:
 - a. Number of visits using the process
 - b. Family feedback at the end of the visit: (1) How was your experience today?; and (2) Is there anything we could have done better?
- G. Have the team rate their satisfaction and ease of the process on a scale of 1-5. Note needed changes.

STEP 3: REVIEW AND REFINE

Participants in Step 2 huddle to review measures, guidance prompts, workflow timing, role clarity, and challenges. Adapt process steps as warranted.

STEP 4: EXPAND

After refining the process, scale implementation with additional families. Continue brief huddles to ensure the process works across a variety of circumstances and families.

STEP 5: SUSTAIN

Once the process has been tested and is ready to be adopted by your health center, integrate the process into your day-to-day workflow. Ensure staff understand their roles and receive orientation.



CHANGE IDEA: Recruit and hire an early childhood developmental (ECD) expert aligned with clinic and community needs.

STEP 1: GET READY (TASKS)

- A. Hold team meetings to define the ECD expert's role, expectations, and impact.
- B. Clarify the purpose of the role (e.g., responsive developmental care, improved family engagement, reduced differences in developmental outcomes).
- C. Identify gaps in developmental support and needs within the patient population.
- D. Review funding streams and budget capacity (e.g., grants, partnerships, existing program dollars).
- E. Identify potential recruitment pipelines or networks (e.g., local universities, early childhood coalitions, fellowship programs).
- F. Define the reporting structure and integration plan with the care team.
- G. Assemble a hiring panel including clinical staff and family and community representative(s).

STEP 2: PLAN AND PRACTICE

In this example, the team aims to improve developmental care and family engagement through the ECD expert hiring and recruitment.

SAMPLE PROCESS:

- A. Draft and post a [job description](#) emphasizing key qualifications (e.g., language skills, experience with population served, community knowledge).
- B. Develop [interview questions](#) that assess alignment with population needs and collaborative practices.
- C. Schedule interviews with qualified candidates.
- D. Define success metrics:
 - a. Number and quality of applicants
 - b. Panel feedback on candidate fit, especially family and community alignment
 - c. Alignment of the hiring process with practice principles.
- E. Test the recruitment and interviewing process using developed questions and a [scoring rubric](#).
- F. Complete first-round interviews with at least three qualified candidates.
- G. Hold team huddles to review feedback and identify challenges.

STEP 3: REVIEW AND REFINE

Hold a hiring team huddle to review:

- Number and quality of applicants
- Panel feedback on candidate fit
- Alignment with original role objectives

Once the team reviews first-round interview outcomes, proceed with next steps or adjust the process (e.g., modify the job description, repost the position, expand recruitment).

STEP 4: EXPAND

After a successful hire, document lessons learned to inform future hires.

STEP 5: SUSTAIN

Develop an onboarding and integration plan for the ECD expert. Pilot integration with one care team to clarify role expectations and collaboration. Align [onboarding practices](#) with the existing health center processes.



CHANGE IDEA: Train health care providers in developmental support tailored to the population served.

STEP 1: GET READY (TASKS)

- A. Hold planning meetings with pediatric staff, care coordinators, and clinic leadership to clarify the purpose (e.g., enhance developmental outcomes through relationship-based care, tailor communication and support, strengthen trust, increase screening efficacy, improve well-child visit quality).
- B. Select training curricula.
- C. Define the target population (e.g., children 0-3 years during well-child visits).
- D. Schedule provider/staff training (e.g., [Keystones of Development](#), [Bright Futures](#) modules) and conduct in-clinic workshops to review new scripts ([sample for 9 months](#)) and family engagement tools.
- E. Identify key components to integrate (e.g., coaching strategies, consistent developmental conversation prompts, and family-tailored scripts).
- F. Map current practices: When do developmental conversations occur? Are parent concerns elicited using structured tools? Are all families considered?
- G. Assign roles (e.g., primary care providers/nurse practitioners lead developmental conversations, nurses administer developmental tools and prep charts, care coordinators follow up and monitor parent satisfaction).

STEP 2: PLAN AND PRACTICE

For this example, the team aims to engage all parents more meaningfully during well-child visits and enhance developmentally supportive relationships through reflective practices. They will use the Bright Futures Parent Project framework's talking points and coaching prompts, as well as the Keystones of Development developmental reflections.

SAMPLE PROCESS:

- A. Add Parent Project talking points, coaching prompts, and developmental reflections to the electronic health record (EHR) and visit checklists.
- B. Load sample family scripts that reflect all families.
- C. Complete pre-visit planning:
 - Review developmental history, due screens, and parent concerns.
 - Identify coaching opportunities (e.g., sleep, play, attachment).
- D. Preload:
 - Provider talking points
 - Parent handouts by developmental stage
 - Scripts adapted for language and literacy
- E. Define measures:
 - Percentage of visits using developmental coaching
 - Provider confidence and usability
 - Parent feedback: Did they feel heard, supported, and informed?

- F. Conduct a 1-day test with 1-2 providers seeing families with infants/toddlers.
- G. Hold brief pre- and post-test huddles:
 - Pre-test: review tools and goals
 - Post-test: debrief on what worked and what did not

STEP 3: REVIEW AND REFINE

Hold a team huddle to review the workflow and feedback:

- Was chart preparation efficient?
- Did tools/scripts support or hinder communication?
- Was there variation across families?
- What did parents say?
- Were providers comfortable with new coaching methods?

Adapt as needed (e.g., revise scripts or templates, identify additional training, adjust workflow roles).

STEP 4: EXPAND

Scale the process to include all providers and age groups under 5, and integrate training into onboarding for new hires. Host quarterly refreshers on Bright Futures and Keystones of Development principles. Collect quarterly feedback and adapt for all family populations.

STEP 5: SUSTAIN

Incorporate coaching tools, scripts, and templates into routine visit workflows and embed training into annual competencies and orientation. Ensure staff:

- Know their roles
- Are trained on tools and scripts
- Understand the purpose of the change

Monitor key metrics over time (e.g., provider comfort level, parent satisfaction, documentation completeness).



CHANGE IDEA: Create and require web-based Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provider training.

STEP 1: GET READY (TASKS)

- A. Identify key stakeholders (e.g., clinical leads, training coordinators, IT staff, pediatric providers).
- B. Review current EPSDT compliance rates and provider knowledge gaps, referencing [SHO # 24-005 RE: Best Practices for Adhering to EPSDT Requirements](#).
- C. Identify web-based training platforms aligned with current Medicaid guidelines.
- D. Collaborate with state Medicaid or health department experts to tailor training content to local community needs and state requirements.
- E. Develop or customize the EPSDT training module to ensure accessibility and interactivity.
- F. Establish [data tracking mechanisms](#) for completion rates, pre and post scores, and provider feedback.
- G. Create staff communication materials explaining the new training requirement and [rationale](#).

STEP 2: PLAN AND PRACTICE

SAMPLE PROCESS:

- A. Pilot the training with five team members over 1 week.
- B. Administer [pre- and post-training assessments](#) to measure knowledge of core EPSDT elements, with a defined passing score (e.g., $\geq 80\%$).
- C. Conduct follow-up interviews or [surveys](#) to gather qualitative feedback on training content, length, accessibility, and usefulness.
- D. Observe changes in documentation and discussion of EPSDT components during patient visits.

STEP 3: REVIEW AND REFINE

- A. Analyze assessment results to evaluate knowledge improvements.
- B. Review feedback to identify challenges (e.g., time constraints, technical difficulties).
- C. Assess improvements in provider confidence and accuracy in delivering EPSDT services.
- D. Identify any necessary revisions to training content or platform usability.
- E. Discuss results with stakeholders to determine readiness for expansion.

STEP 4: EXPAND

- A. Refine training content based on pilot feedback.
- B. Launch training for all providers.
- C. Set flexible completion deadlines and integrate training into onboarding.
- D. Integrate training into existing workflows (e.g., staff meetings).

- E. Incorporate EPSDT training completion as a metric in provider performance evaluations.
- F. Provide office hours or tech support for staff during rollout.

STEP 5: SUSTAIN

- A. Schedule annual EPSDT refresher trainings with updates on guidelines or community needs.
- B. Maintain an internal dashboard tracking completion and compliance.
- C. Collect ongoing feedback to enhance training over time.
- D. Include EPSDT metrics in quality improvement reports and leadership dashboards.
- E. Continue collaboration with early childhood development experts to align training with updated resources.



CHANGE IDEA: Use social media platforms geared to community preferences to increase family awareness of Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

STEP 1: GET READY (TASKS)

- A. Identify key patient populations served by your health center.
- B. Survey parents or guardians about the social media platforms they use and trust.
- C. Form a planning team that includes community health workers, pediatric providers, and parent representatives.
- D. Create tailored EPSDT awareness content (e.g., bilingual versions, visuals, short videos).
- E. Set measurable goals (e.g., inquiry increases, scheduled appointments, social media engagement rates).
- F. Train the outreach team and parent volunteers on EPSDT and family engagement strategies

STEP 2: PLAN AND PRACTICE

- A. Choose a social media platform (e.g., Facebook for Spanish-speaking families, Instagram).
- B. Obtain required permissions and approvals for social media posts.
- C. Post three EPSDT [awareness messages](#) over 2 weeks using parent-approved messaging.
- D. Include interactive elements (e.g., polls, Q&A, parent stories) to boost engagement.
- E. Track views, likes, shares, comments, and EPSDT appointment requests [linked to social media](#). Consider using [Linktree](#) or a similar tool to track analytics.
- F. Have two parent representatives review posts before publishing to ensure clarity and relevance.
- G. Hold a follow-up focus group with parents who viewed the content.

STEP 3: REVIEW AND REFINE

- A. Collect data on:
 - o Social media analytics (e.g., engagement, reach)
 - o Appointment increases linked to the campaign
 - o Parent feedback on clarity and usefulness
- B. Hold a debrief meeting with the parent representatives and outreach team.
- C. Identify effective content and areas for improvement (e.g., translation, platform choice).

STEP 4: EXPAND

- A. Expand the campaign to a second platform (e.g., WhatsApp, Instagram, or TikTok, depending on community preferences).
- B. Partner with local parent influencers or ambassadors to co-create content.

- C. Involve additional families from different backgrounds.
- D. Share materials with related programs (e.g., Women, Infants, and Children [WIC], behavioral health) for cross-promotion.

STEP 5: SUSTAIN

- A. Incorporate EPSDT social media messaging into the health center's regular communication calendar.
- B. Continue engaging parent representatives to co-design and approve content.
- C. Monitor engagement monthly and adjust based on analytics and parent feedback.
- D. Train new staff and parent volunteers in social media strategy for EPSDT promotion.
- E. Apply for ongoing funding or grants to support family-centered digital outreach.



CHANGE IDEA: Use an adaptable positive parenting protocol to meet family needs and backgrounds.

STEP 1: GET READY (TASKS)

- A. Select a parenting resource appropriate for your population and assign one individual to access and manage the resource, including its use guidelines. This example uses the Centers for Disease Control and Prevention's (CDC) Positive Parenting Resources.
- B. Decide whether to embed messages into the electronic health record (EHR) or link directly to the resource.
- C. Orient 1-2 care teams of provider and staff (e.g., care coordinator/early childhood specialist [ECS]/lead nurse) to the resource or messages within the EHR.
- D. Create a [script for introducing the resource to families](#).
- E. Identify 1-2 families for each care team to test the change idea with.

STEP 2: PLAN AND PRACTICE

After completing Step 1, test your process on a small scale with one family, one well-child visit, in 1 day.

SAMPLE PROCESS:

- A. The care coordinator/ECS/nurse introduces the resource and helps the family access it as needed.
- B. The care team follows the protocol to streamline the use of materials at the next well-child visit. (Not all resources will require on-site handouts or materials.)
- C. The provider asks for the caregiver's priority topic at the beginning of the well-child visit, integrates resource content or EHR messages into the visit, and encourages use of the resource as supplemental guidance.
- D. The provider models positive strategies and highlights family strengths observed during the visit.
- E. At the end of the visit, the care coordinator/ECS/nurse asks the family: How was it hearing about your child's anticipated development? Did you feel heard by the provider as the expert on your child's development?
- F. On follow-up visits, the team may ask: Did you use the parent resource since your last well-child visit? Was it helpful?
- G. The provider rates their comfort with the process on a scale of 1-5 and notes needed changes.

STEP 3: REVIEW AND REFINE

Hold a brief huddle to review results and adapt the process as warranted.

STEP 4: EXPAND

Once the review is complete and any adaptations are made, scale implementation with additional families and provider teams. Continue brief huddles to ensure the process works across different circumstances and families.

STEP 5: SUSTAIN

Once the process has been tested and is ready to be adopted by your health center, ensure it is part of your routine workflow. Ensure staff understand their roles and receive regular refresher trainings. Share data and celebrate success stories.



CHANGE IDEA: Use a standard process to share anticipatory guidance during well-child visits using clear, multilingual print and multimedia materials.

STEP 1: GET READY (TASKS)

- A. Select the anticipatory guidance that the practice will use with families.
- B. Create a [script](#) for introducing resources and sharing guidance with families.
- C. Develop a [protocol for introducing scripts and resources](#) to staff.
- D. Identify one staff member to test the process with 1-2 families.

STEP 2: PLAN AND PRACTICE

After completing Step 1, test the process on a small scale, with one family, one visit, in 1 day. This example uses the Centers for Disease Control and Prevention's (CDC) Learn the Signs. Act Early. developmental milestones resources.

SAMPLE PROCESS:

- A. The care coordinator/nurse adds CDC milestone strategies to the patient's file for provider review.
- B. The provider reviews the milestones and strategy page prior to entering the patient's room.
- C. The provider shares anticipatory guidance using prepared scripts.
- D. At the end of the visit, the care coordinator/nurse or Early Childhood Development (ECD) Champion asks the family: How was it hearing about your child's anticipated development? Did you feel heard by the provider as the expert on your child's development? Is there anything we could improve?
- E. The provider rates their comfort with the process on a scale of 1-5 and notes needed changes.

STEP 3: REVIEW AND REFINE

Hold a brief team huddle to review results and adapt the process as warranted.

STEP 4: EXPAND

After refining the process with one or two families and gathering feedback, gradually introduce the standardized anticipatory guidance to more families. Train additional providers and ensure materials and scripts are available in commonly used languages. Continue regular team huddles and feedback loops to monitor effectiveness and make ongoing adjustments. As confidence and consistency grow, scale the approach to all well-child visits, ensuring guidance is delivered reliably and respectfully across the patient population.

STEP 5: SUSTAIN

Once the process has been tested and is ready to be adopted by your health center, ensure it is part of your routine workflow. Ensure staff understand the process and their roles.



CHANGE IDEA: Use a strengths-based protocol to discuss early relationships with families.

STEP 1: GET READY (TASKS)

- A. Watch the short Small Moments, Big Impact (SMBI) [introductory video](#) to understand its purpose, how to use it, and how it supports family engagement.
- B. Review the [Watch & Talk videos](#) aligned with well-child visits (newborn, 1, 2, 4, and 6 months).
- C. Create a [protocol for introducing videos to families](#).
- D. Identify one team member to test the process with 1-2 families.
- E. Select one Watch & Talk video for the relevant visit.

STEP 2: PLAN AND PRACTICE

After completing Step 1 are completed, test the process on a small scale, with one family, one visit, in 1 day.

SAMPLE PROCESS:

- A. The care coordinator/nurse cues up the relevant SMBI video in the exam room.
- B. The provider reviews the video and guiding questions before entering the room.
- C. The provider plays the video at the start of the visit while logging into the electronic medical record (EMR).
- D. The provider uses the prompt to start a conversation and get to know the family.
- E. At the end of the visit, the care coordinator/nurse asks the family: How was it to watch the video and talk about your relationship with your child? Did you feel heard by the provider when discussing your relationship with your child? Is there anything we could improve?
- F. The provider rates their comfort with the process on a scale of 1-5 and notes needed changes.

STEP 3: REVIEW AND REFINE

Hold a brief team huddle to review the results and adapt the process as warranted.

STEP 4: EXPAND

Once the review is complete and any adaptations are made, begin to scale implementation with additional families. Continue brief team huddles to ensure the process works across different circumstances and families.

STEP 5: SUSTAIN

Once the process has been tested and is ready to be adopted by your health center, ensure it is part of your routine workflow. Ensure staff understand the process and their roles.



CHANGE IDEA: Use an early literacy strategy to promote development and early relational health.

STEP 1: GET READY (TASKS)

- A. Determine leadership roles for implementation. This example uses Reach Out and Read (ROR) and would include an ROR Medical Champion and Site Coordinator.
- B. Complete the [application to start an ROR site](#).
- C. Use the [Site Coordinator Manual](#), which includes a Start-Up Checklist for New Programs, to design processes and protocols that work for your practice.
- D. Establish a training plan and timeline for providers to complete the online CME course. See the Start-Up Checklist for detailed instructions.
- E. Obtain an initial supply of books and establish a tracking system (e.g., written tally sheet, inventory process, electronic medical record documentation).
- F. Develop a data collection plan for biannual progress reporting and assign reporting roles.

STEP 2: PLAN AND PRACTICE

Conduct a one-month pilot during well-child visits for children ages 6 months to 5 years.

SAMPLE PROCESS:

- A. During the visit, the provider gives the child a new, developmentally appropriate book.
- B. The provider models how to read with the child and explains the importance of daily book-sharing for brain development and connection.
- C. Staff document book distribution in the child's chart for tracking and evaluation.
- D. Invite caregivers to share reactions or interest in additional literacy support.

STEP 3: REVIEW AND REFINE

Gather feedback from providers and families. Track the number of books distributed and staff confidence in delivering the literacy message. Reflect on how the experience influenced parent-child interaction during the visit.

STEP 4: EXPAND

If successful, expand the ROR model to additional providers or age groups. Explore partnerships with local libraries or literacy nonprofits to increase book access. Continue to review implementation data, family engagement, and provider feedback to assess integration into existing workflows and identify needed supports.

STEP 5: SUSTAIN

Integrate ROR into routine well-child visit protocols. Allocate ongoing funding for books, include literacy messaging in staff onboarding, and highlight outcomes to leadership and funders.



CHANGE IDEA: Integrate a protective factor/positive experiences protocol into well-child visits.

STEP 1: GET READY (TASKS)

- A. Identify a protocol. This example uses the Center for the Study of Social Policy's [Strengthening Families Framework](#).
- B. Select 1-2 [Protective Factor Action Sheets](#) (e.g., parental resilience, knowledge of parenting and child development, social-emotional competence of children).
- C. Orient pediatric and care coordination staff to the framework and action sheets.
- D. Adapt the sheets for clinic use (e.g., simplified language, translations, visual aids).
- E. Define the target population (e.g., caregivers of children under 3) and well-child visit intervals for testing.

STEP 2: PLAN AND PRACTICE

Pilot the Social-Emotional Competence of Children Action Sheet during well-child visits for a defined age group over a 1-month period (e.g., caregivers of children 18-36 months).

SAMPLE PROCESS:

- A. The provider or care coordinator introduces the action sheet at the end of the appointment.
- B. Staff highlight key points (e.g., recognizing feelings, building trust, managing emotions).
- C. Caregivers reflect on their child's emotional development and discuss questions.
- D. Staff offer follow-up resources if needed.
- E. Staff document whether the sheet was shared and any caregiver responses.

STEP 3: REVIEW AND REFINE

Gather provider and caregiver feedback on the usefulness and clarity of the action sheets. Assess workflow feasibility and the perceived value in strengthening family engagement.

STEP 4: EXPAND

If successful, introduce additional action sheets and expand use across more well-child visits or patient populations.

STEP 5: SUSTAIN

Integrate Protective Factor Action Sheets into the standard well-child visit toolkit. Establish a rotation schedule and staff training to ensure consistent use.

Periodically review use with staff and family advisors to assess relevance, ease of implementation, and caregiver engagement. Consider minor adaptations for improved accessibility.



CHANGE IDEA: Collaborate with local organizations to promote early childhood development using family-centered approaches.

STEP 1: GET READY (TASKS)

- A. Identify and map local organizations focused on early childhood development (e.g., libraries, parenting groups, child care, home visiting).
- B. Contact organization leaders to assess interest and current programming.
- C. Assemble a multidisciplinary team from the health center (e.g., providers, community health workers, social workers).
- D. Develop shared goals for collaboration focused on family-centered practices and early relational health.
- E. Select a platform for collecting data (e.g., electronic health record, RedCap, Excel, Qualtrics)
- F. Gather baseline data on current referrals, family engagement, and demographics.

STEP 2: PLAN AND PRACTICE

SAMPLE PROCESS:

- A. Start with one pilot partner (e.g., a local early literacy program).
- B. Co-develop a biweekly parent workshop on parent-child bonding, developmental milestones, and responsive parenting.
- C. Invite families identified during well-child visits using personalized outreach and trusted messengers (e.g., community health workers, home visitors) or existing community coalitions (e.g., Help Me Grow).
- D. Provide language-accessible materials and interpreters as needed.
- E. Collect feedback from families and partners after each session on relevance, clarity, and co-facilitation.
- F. Track engagement data, such as:
 - Number of referrals to community services (e.g., parenting classes, mental health)
 - Referral follow-up rate (if available)
 - Staff comfort discussing early relational health
 - Ease of integrating invitations into visits
 - Parent confidence in bonding, managing behavior, or understanding development
 - Changes in family engagement with services over time

STEP 3: REVIEW AND REFINE

- A. Analyze participation rates and demographics, family satisfaction and perceived value, and partner feedback on the collaboration process.
- B. Assess whether the intervention reached families typically unable to access such programs.

- C. Hold a reflection session with internal staff and community partners.

STEP 4: EXPAND

- A. Formalize referral workflows with additional partners (e.g., maternal mental health services; Women, Infants, and Children [WIC] offices).
- B. Develop co-branded educational materials that reflect community values and languages.
- C. Train additional staff in early relational health-informed engagement practices.
- D. Share results and successes in internal meetings, newsletters, and community forums.

STEP 5: SUSTAIN

- A. Establish ongoing community advisory input to ensure programming reflects family needs and preferences.
- B. Integrate partnership activities into routine well-child care (e.g., add discussions into electronic health records, set follow-up reminders).
- C. Secure funding through grants or shared resource agreements with community partners.
- D. Include evaluation in annual quality improvement processes.



CHANGE IDEA: Build relationships with comprehensive promotion and prevention programs in the community.

STEP 1: GET READY (TASKS)

- A. Identify early childhood promotion programs using local directories, public health networks, or early childhood coalitions. Example programs include Head Start, food banks, home visiting, and Women, Infants, and Children (WIC).
- B. Assign a staff liaison or small team to lead the outreach and relationship-building process.
- C. Review program materials to understand goals, structures, and overlap with health center services.
- D. Create a contact list of potential program partners and develop an information packet describing your health center's services and populations.

STEP 2: PLAN AND PRACTICE

Pilot outreach to two organizations from different program types (e.g., home visiting and early literacy).

SAMPLE PROCESS:

- A. Schedule introductory meetings to learn about each other's programs and explore shared goals. See [a sample email to partner organizations](#).
- B. Identify a small joint activity or information exchange (e.g., cross-referrals, staff training, shared screening protocols).
- C. Document meeting notes, partnership opportunities, and staff impressions.
- D. Discuss next steps, including communication preferences and a follow-up timeline.

STEP 3: REVIEW AND REFINE

Reflect as a team on the engagement process. Identify successful collaboration strategies, barriers encountered, and alignment with the health center's mission and strategic goals.

STEP 4: EXPAND

If initial relationships are successful, engage additional partners or deepen collaboration through joint grants, co-location of services, or cross-training opportunities.

STEP 5: SUSTAIN

Hold follow-up meetings with each partner organization to review outcomes, gather feedback, and refine the engagement process as needed. Begin drafting formal partnership agreements or [memoranda of understanding \(MOUs\)](#).

Develop a long-term partnership plan with regular check-ins, shared evaluation goals, and defined roles. Examples may include:

- A. Defining shared community health priorities
- B. Developing an MOU outlining roles and responsibilities
- C. Scheduling regular meetings for progress updates and strategy adjustments
- D. Co-creating evaluation metrics and using shared tracking tools
- E. Including community representatives to ensure comprehensive input

Consider establishing a family and community advisory group to inform future partnership development.



Early Childhood
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EVIDENCE TO
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Part Two

Surveillance and Screening Change Ideas



CHANGE IDEA: Incorporate family-engaged developmental surveillance into well-child visits.

STEP 1: GET READY (TASKS)

- A. Engage senior leadership to support staff time and resources toward quality improvement efforts.
- B. Convene a planning team (e.g., providers, nurses, care coordinators, administrative staff) to align on goals and logistics.
- C. Align on the value of family engagement in surveillance (e.g., improved child outcomes, early identification of delays, continued support of children with identified delays, enhanced family-provider relationships).
- D. Select a family-engaged surveillance tool aligned with Bright Futures guidelines. This example uses the [Cycle of Engagement – Well Visit Planner®](#). Allow time for your health center's approval of third-party tools, or choose resources that can be integrated into the electronic health record (EHR).
- E. Define the target population (e.g., children ages 0-5 during well-child visits). Discuss necessary adaptation processes (e.g., for children and families with known disabilities, ensure families feel seen when they receive a tool that may not apply to their child).
- F. Define team roles (e.g., who distributes, reviews, and responds to reports). Schedule [staff training](#) on the Well Visit Planner, including how to interpret family reports and incorporate them into developmental conversations.

STEP 2: PLAN AND PRACTICE

The planning team develops a workflow that integrates the Well Visit Planner into the pre-visit preparation and well-child visits.

SAMPLE PROCESS:

- A. Send families a digital or paper Well Visit Planner 3-5 days before the visit. Encourage completion via [phone/email reminders or text messages](#).
- B. Assign a pediatric nurse or care coordinator to review submitted Well Visit Planners 24-48 hours before the visit and highlight developmental concerns, risk factors, or family priorities.
- C. Prepare the provider with a summary of family responses in the EHR or printed form. Include Bright Futures prompts to support conversations about development and anticipatory guidance. See a [sample summary for a 9-month visit](#). Review this information during the morning team huddle if applicable.
- D. During the visit, providers use the Well Visit Planner report to start the developmental surveillance conversation, addressing family observations, concerns, and developmental milestones, including social-emotional health.
- E. At the end of the visit, share a summary of key takeaways and any referrals or follow-ups discussed.

- F. Pilot the full process with one provider and one age group for 1 week to observe the workflow in action.

STEP 3: REVIEW AND REFINE

Create a [huddle flow](#) and hold a review huddle with participating staff to assess:

- Frequency of Well Visit Planner use
- Time required for pre-visit review and in-visit conversation
- Provider and family satisfaction
- Workflow challenges or training needs

Use findings to adapt the workflow, tools, or training before expansion.

STEP 4: EXPAND

After refining the process, gradually expand implementation to additional providers and age groups. Continue regular huddles to identify challenges and adapt for different populations. Celebrate early wins to maintain momentum and foster staff buy-in.

STEP 5: SUSTAIN

Integrate family-engaged developmental surveillance into routine operations by:

- Including Well Visit Planner steps in job descriptions, [onboarding](#), and [staff training](#)
- Establishing standard operating procedures
- Periodically reviewing process and outcome metrics
- Sharing success stories and lessons learned

Maintain a continuous improvement loop to adapt as family needs, technology, or developmental guidelines evolve. If your organization has a formal quality improvement plan, ensure this change is included.

As more staff engage with the process, review data and user feedback to refine how the Well Visit Planner is integrated into workflows. Make needed updates to [EHR templates](#), communication scripts, and training.



CHANGE IDEA: Establish a family advisory group to guide developmental surveillance and screening procedures.

STEP 1: GET READY (TASKS)

- A. Identify health center stakeholders who will champion the family advisory initiative.
- B. Review the [Family Engagement in Systems Assessment Tool](#) to understand core principles and best practices.
- C. Develop an [invitation](#) to recruit family members from the community served by the health center.
- D. Provide orientation for staff and family members on shared decision-making and family engagement.
- E. Include one or more family members on the practice transformation team alongside the clinicians, nursing staff, and front office staff.

STEP 2: PLAN AND PRACTICE

Pilot the advisory group by reviewing current surveillance and screening procedures and gathering family feedback on relevance. Co-develop the group's [agenda](#) and [charter](#).

SAMPLE PROCESS:

- A. Conduct a kickoff meeting to introduce the goals of the advisory group.
- B. Facilitate structured feedback sessions using the Family Engagement in Systems Assessment Tool.
- C. Document recommendations and select two areas of screening and surveillance to pilot based on feedback.
- D. Establish communication channels between the advisory group and clinical leadership.

STEP 3: REVIEW AND REFINE

Review pilot outcomes, including family satisfaction, feasibility of recommendations, and staff reflections. Use feedback from discussions and surveys to assess effectiveness and adjust group structure or processes as needed.

STEP 4: EXPAND

Expand the family advisory group's role to advise on additional procedures and participate in standing committees. Consider including family representatives in broader health center decision-making bodies.

STEP 5: SUSTAIN

Embed family engagement in the health center's strategic plan. Allocate resources (e.g., staff time, stipends, training) to support the advisory group. Celebrate contributions to demonstrate the impact of family voice on health system improvements.

Review group functioning, participation levels, and impact on health center policies quarterly. Share updates with staff and families and identify opportunities to strengthen engagement.



CHANGE IDEA: Integrate the Online Promoting Healthy Development Survey (PHDS) as a routine family feedback tool to improve developmental screenings.

STEP 1: GET READY (TASKS)

- A. Identify screening workflows that can benefit from family feedback (e.g., developmental screening during well-child visits).
- B. Explore the [Online PHDS platform](#) and determine how to integrate it into post-visit digital or paper workflows.
- C. Train front desk and clinical staff on introducing the PHDS to families and its purpose in improving care. See a [sample presentation](#).
- D. Develop a simple process to collect and review responses weekly during the test period. See this [sample implementation checklist](#) and [data collection template](#).

STEP 2: PLAN AND PRACTICE

Test integration of the Online PHDS for well-child screening feedback with families of children ages 0-5 over a 2-week period.

SAMPLE PROCESS:

- A. Provide caregivers with a [QR code or printed link](#) to the PHDS at the end of well-child visit.
- B. Encourage completion of the survey within 48 hours and offer support where needed (e.g., tablets in the clinic).
- C. Review responses weekly to identify themes related to screening experiences and improvement opportunities. Survey summaries may be uploaded to the [Well Visit Planner](#) portal or documented in the electronic medical record (EMR) if integrated. Integration with the EMR may require coordination with the vendor and data-sharing agreements.
- D. Share summary findings with the quality team to identify improvements to workflows or communication.

STEP 3: REVIEW AND REFINE

Evaluate response rates, caregiver feedback quality, and feasibility. Meet with staff and family partners to review insights and identify improvements to implementation.

STEP 4: EXPAND

If promising, extend PHDS feedback collection to additional visit types or age groups. Adjust the distribution method to optimize participation (e.g., integrate with text reminders).

STEP 5: SUSTAIN

Hold a review meeting with leadership, clinical teams, and any family advisors to assess how feedback has improved screening processes and plan long-term integration.

Embed PHDS feedback into quality improvement cycles. Assign staff to review responses regularly, summarize insights, and ensure families are aware of changes made in response to their feedback.



CHANGE IDEA: Establish a family advisor role to inform and co-design developmental surveillance and screening processes.

STEP 1: GET READY (TASKS)

- A. Consider a current board member with lived family experience who represents the community and could serve as the initial family advisor.
- B. Define a [scope of work](#) focused on reviewing and providing input on current surveillance and screening protocols.
- C. Include the family advisor on the practice transformation team if applicable.
- D. Orient the advisor to the health center's systems, priorities, and expectations for engagement.
- E. Provide training on the [Family Engagement in Systems Assessment Tool](#) to guide their feedback process.

STEP 2: PLAN AND PRACTICE

Pilot the role by involving the family advisor in one screening improvement effort (e.g., developmental or maternal depression screening).

SAMPLE PROCESS:

- A. Schedule monthly meetings between the advisor, clinical staff, and quality team.
- B. Use structured questions from the engagement tool to gather insights on challenges and family needs.
- C. Collaboratively identify one or two changes to make the screening process more family-centered.
- D. Document recommendations and implement changes on a small scale.

STEP 3: REVIEW AND REFINE

Assess the impact of the family advisor's input using staff feedback, advisor reflections, and brief family satisfaction surveys.

STEP 4: EXPAND

If successful, recruit additional family advisors to participate in other quality improvement initiatives.

STEP 5: SUSTAIN

Conduct a review with staff and family participants to refine and strengthen the family advisor role.

Institutionalize the role by embedding family advisors in quality improvement teams and advisory councils. Provide stipends or other recognition to honor contributions.



CHANGE IDEA: Integrate the National CLAS Standards into screening and surveillance processes to ensure responsiveness for all families.

STEP 1: GET READY (TASKS)

- A. Include family advisors who represent the communities served by your health center.
- B. Review the [National CLAS Standards](#) and identify those most relevant to screening and surveillance workflows.
- C. Select one CLAS standard to focus on during the test (e.g., communication and language assistance).
- D. Conduct a [brief baseline assessment](#) of current practices related to responsive screening.
- E. Prepare materials for implementation (e.g., translated screening tools, interpreter workflows).

STEP 2: PLAN AND PRACTICE

Pilot the integration of the selected CLAS standard into screening and surveillance workflows for a defined population. For this example, the team chose CLAS Standard 6: Inform all individuals, in writing and orally, of the availability of language assistance services in English and other languages that serve their linguistic needs.

SAMPLE PROCESS:

First,

- A. Identify Spanish-speaking families scheduled for well-child visits in a 1-month pilot period.
- B. Use professionally translated, validated screening tools (e.g., Ages & Stages Questionnaires, Promoting Healthy Development Survey).
- C. Ensure signage, handouts, and language assistance instructions are available in Spanish.
- D. Provide brief training for front-desk and clinical staff on introducing interpreter services and translated materials.

Next,

- A. Select one pediatric provider and care team for the pilot.
- B. During patient check-in and screening, confirm language preference and offer interpreter services.
- C. Provide verbal notice and written information about free language assistance services in Spanish.
- D. Document language service offers in the electronic health record.

STEP 3: REVIEW AND REFINE

- A. At the end of the pilot, collect data on:
 - a. Number of families offered language assistance

- b. Number who accepted services
 - c. Feedback from families and staff
- B. Conduct a brief team debrief to identify challenges and improvement opportunities.

STEP 4: EXPAND

Refine workflows based on pilot feedback and expand implementation to additional providers and age groups. Incorporate language assistance indicators into routine visit preparation and population health workflows.

STEP 5: SUSTAIN

Develop standard operating procedures for language access during screenings. Monitor screening completion rates among Spanish- and English-speaking families and continue staff training on CLAS Standard 6.

Share results and improvements with the broader care team and leadership and integrate CLAS-informed practices into ongoing training, workflows, and quality improvement efforts.



CHANGE IDEA: Embed a workflow to streamline recommended screenings into the electronic health record (EHR) to support comprehensive care planning and documentation.

STEP 1: GET READY (TASKS)

- A. Convene a multidisciplinary team (e.g., clinical, IT, behavioral health, social work) to assess current screening workflows.
- B. Discuss the pros and cons of EHR-based versus paper screening workflows. Consider a hybrid approach to meet families' literacy and digital access needs.
- C. Select validated tools for each screening domain (e.g., Ages & Stages Questionnaires, Third Edition; M-CHAT-R/F [Modified Checklist for Autism in Toddlers, Revised with Follow-up]; Edinburgh Postnatal Depression Scale).
- D. Assess current EHR capabilities and identify gaps in screening documentation and data capture.
- E. Review resources like the Early Childhood Developmental Health Systems: Evidence to Impact Center's [Getting Started Guide: Implementing a Screening Process](#) to inform your team's screening workflow. Existing EHR tools or internal resources may also support this test of change.

STEP 2: PLAN AND PRACTICE

Pilot integrated screening workflows within a single age group (e.g., 18- or 24-month visits), focusing on streamlined data entry and team workflow.

SAMPLE PROCESS:

- A. Identify eligible patients in advance using visit scheduling reports.
- B. Assign pre-visit screening tasks to front-desk staff or care coordinators using the patient portal or paper forms.
- C. Embed key screenings (e.g., developmental, social-emotional, autism, perinatal depression) into the EHR using discrete fields and auto-scoring where possible.
- D. Create a workflow for clinicians to review results in real-time and provide referrals or interventions as needed.

STEP 3: REVIEW AND REFINE

Collect data on screening completion rates, referrals, and staff and family feedback. Identify technical or workflow issues and refine EHR templates and staff roles as needed.

STEP 4: EXPAND

Gradually expand the pilot to additional well-child visit age groups. Tailor screening tools by age. Train additional staff and integrate screening data with population health dashboards when available.

STEP 5: SUSTAIN

Conduct periodic reviews of the expanded workflow using Plan-Do-Study-Act (PDSA) cycles and evaluate outcomes such as early identification and connection to services.

Establish policies for routine screening documentation and EHR maintenance. Provide ongoing staff training and integrate screening metrics into quality improvement goals and reporting when appropriate.



CHANGE IDEA: Create automated electronic health record (EHR) reminders that alert staff when screenings are due at specific well-child visits to improve timely completion and follow-up.

STEP 1: GET READY (TASKS)

- A. Assemble a quality improvement (QI) team including pediatricians, nursing staff, IT personnel, and administrative staff.
- B. Identify key screening timepoints based on Bright Futures guidelines (e.g., developmental, social-emotional, perinatal depression).
- C. Review existing EHR capabilities for generating automated alerts or tasks.
- D. Define which screenings will trigger reminders (e.g., developmental, autism spectrum disorder, social-emotional, perinatal depression).

STEP 2: PLAN AND PRACTICE

Configure an automated EHR alert that flags due screenings at scheduling or check-in and appears on the provider dashboard and/or as a pre-visit task for support staff.

SAMPLE PROCESS:

- A. Use patient age data to trigger EHR logic for upcoming or overdue screenings.
- B. Display reminders in patient charts or workflow task lists.
- C. Train staff to respond to reminders and complete screenings during eligible visits.
- D. Pilot the system with 18- and 24-month well-child visits for 2 months.

STEP 3: REVIEW AND REFINE

Compare screening completion rates before and after implementation. Use staff feedback to assess alert usefulness, clarity, and burden. Adjust reminder frequency or visibility as needed.

STEP 4: EXPAND

Expand the automated reminders to all well-child age groups and, if available, integrate with population health dashboards to track outcomes and streamline documentation.

STEP 5: SUSTAIN

Establish a protocol for maintaining EHR reminders. Continue staff training and integrate screening alerts into routine workflows. Monitor for accuracy and periodic updates based on guideline changes.

Assess long-term trends in screening compliance and early intervention referrals, and hold periodic meetings to address workflow issues.



CHANGE IDEA: Develop a screening compliance process using retrospective chart reviews, real-time electronic health record (EHR) alerts, and clinical decision support (CDS) to improve completion of required screenings during well-child visits.

STEP 1: GET READY (TASKS)

- A. Form a multidisciplinary team including clinical, quality improvement, and IT staff.
- B. Identify screening domains to monitor (e.g., development, autism spectrum disorder, maternal depression, social-emotional).
- C. Determine appropriate ages for each screening using Bright Futures guidelines.
- D. Assess EHR capabilities and gaps related to alerts and prompts.
- E. Establish a screening compliance baseline via a retrospective chart review (e.g., screening completed, at-risk score flagged, caregiver discussion documented, referral documented when indicated, referral completion when available).

STEP 2: PLAN AND PRACTICE

Pilot a screening compliance protocol at selected well-child visits (e.g., 18- and 24-month visits) using a multi-layered approach with EHR alerts and CDS prompts.

SAMPLE PROCESS:

- A. Conduct chart reviews to identify missed screenings and common gaps.
- B. Configure age-based EHR alerts to appear on patient summary dashboards.
- C. Build CDS prompts that recommend provider actions for due or overdue screenings.
- D. Train staff and providers on how to respond to alerts and CDS prompts.

STEP 3: REVIEW AND REFINE

Analyze pilot data (e.g., screening completion, alert follow-through). Gather provider feedback on CDS usefulness and alert fatigue, and identify EHR or workflow limitations.

STEP 4: EXPAND

Refine alerts, CDS logic, and workflows based on findings. Expand the protocol to additional well-child visit intervals.

STEP 5: SUSTAIN

Develop a standard operating procedure for ongoing screening compliance monitoring. Maintain EHR alerts and CDS tools, integrate performance metrics into quality reporting, and reassess screening compliance rates and provider engagement periodically to refine engagement.



CHANGE IDEA: Embed electronic health record (EHR) pop-up alerts to notify providers and staff of previously missed screenings during well-child visits.

STEP 1: GET READY (TASKS)

- A. Assemble a team of clinical, quality, and IT staff to define the scope of missed screenings.
- B. Review screening schedules to identify commonly missed screenings (e.g., developmental, autism, social-emotional, perinatal depression).
- C. Assess current EHR capabilities for generating custom pop-up alerts.
- D. Establish baseline data on missed screening rates.

STEP 2: PLAN AND PRACTICE

Pilot the pop-up alert at 18- and 24-month visits, where screening completion often varies. Configure alerts to trigger when a required screening was not completed at a prior visit.

SAMPLE PROCESS:

- A. Configure EHR logic to flag missed screenings using patient visit and documentation history.
- B. Create a pop-up alert that appears when the provider opens the patient chart.
- C. Train providers and support staff on how to respond to alerts and document completion.
- D. Track alert effectiveness and impact on screening rates during a 2-month pilot.

STEP 3: REVIEW AND REFINE

Evaluate alert usefulness through chart audits, completion rates, and provider feedback. Identify any workflow disruptions or technical issues.

STEP 4: EXPAND

Refine alert language and logic based on pilot feedback. Expand to other well-child visit intervals and include additional screenings as needed.

STEP 5: SUSTAIN

Establish a process for maintaining and updating alert logic. Integrate alert response tracking into provider dashboards and provide ongoing training for new staff.

Monitor screening completion rates after expansion and evaluate improvements in early identification and timely referrals. Continue collecting provider feedback.



CHANGE IDEA: Develop a training protocol for new hires to ensure consistent implementation of early childhood screening and referral workflows.

STEP 1: GET READY (TASKS)

- A. Identify staff roles involved in development screening and referral (e.g., medical assistants, providers, front-desk staff, care coordinators). This example uses the Centers for Disease Control and Prevention's (CDC) "Learn the Signs. Act Early." materials to support early identification and referral follow-through.
- B. Review existing onboarding materials to identify training gaps.
- C. Select relevant "Learn the Signs. Act Early." materials for inclusion.
- D. Assign a lead trainer or team to develop and implement the protocol.

STEP 2: PLAN AND PRACTICE

Develop a structured training module for new hire orientation. Include developmental milestone tracking, screening tools (e.g., Ages & Stages Questionnaires), and referral workflows. Pilot the training with a small group of new hires.

SAMPLE PROCESS:

- A. Develop a training checklist and PowerPoint or online module.
- B. Provide printed and digital milestone checklists and parent-facing materials.
- C. Demonstrate the electronic health record (EHR) developmental screening template and referral documentation process.
- D. Assess staff knowledge and confidence using brief pre- and post-training surveys.

STEP 3: REVIEW AND REFINE

Collect feedback from new hires and trainers. Monitor early screening completion rates for newly onboarded staff. Adjust training content and delivery as needed.

STEP 4: EXPAND

Integrate the training into all new hire orientation processes. Offer refresher training for existing staff during meetings or professional development sessions.

STEP 5: SUSTAIN

Maintain an accessible training library (e.g., intranet, learning management system) and incorporate training completion into onboarding documentation. Assign a staff champion to update and deliver the training periodically.

Monitor screening and referral metrics across the care team and update training materials as guidelines or EHR workflows change.



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Part Three

Care Coordination and Linkage Change Ideas



CHANGE IDEA: Identify community partners for care coordination and linkage through community asset mapping.

STEP 1: GET READY (TASKS)

- A. Convene a health center planning team, including health care providers, family members, care coordinators, social workers, and administrative staff. See this [sample invitation](#) for a letter or email. It may be helpful to note that this is a multi-step process that may take several months.
- B. Explore existing community assets (e.g., 311 lines, Family Resource Centers, Help Me Grow) as opportunities to strengthen gap areas.
- C. Select 1-3 initial goals for enhancing care coordination through community asset mapping (e.g., improve access to health services, reduce roadblocks to behavioral health care).
- D. Use data to identify high-need areas that require additional resources (e.g., mental health services, substance use treatment, nutrition programs).
- E. Select a Geographic Information System (GIS) community asset mapping tool, such as [QGIS](#), that will allow easy access, updating, and sharing among care coordinators and patients.
- F. Assign roles and responsibilities to manage the asset mapping process and ensure data accuracy.
- G. Provide [training on the asset mapping tool](#).

STEP 2: PLAN AND PRACTICE

Use Geographic Information System (GIS) mapping to identify community partners.

- A. **Identify Relevant Data Sources:** Collect up-to-date data on local services related to mental health, early intervention, housing, nutrition, and transportation. Include recent needs assessments or landscape analyses if available.
- B. **Dialogue With Key Partners:** Meet with key partners to understand services, referral processes, and communication standards to optimize possible “warm handoffs” and reduce missed referrals and follow-up.
- C. **Map Resources:** Use GIS to create a map that includes the following services:
 - Mental health (e.g., counseling, therapy centers, home-based infant mental health)
 - Early intervention (e.g., developmental screening programs, early childhood education programs)
 - Housing assistance (e.g., public housing, housing vouchers, shelters)
- D. **GIS Mapping:** Enter the collected data into the GIS and create separate layers for each service type. Geocode each resource to its geographic location for easy reference.

- E. **Pilot Test:** Test the GIS mapping with a small group of families over a short period of time to evaluate the process of connecting families to community resources.

Evaluation:

- **Data Review:** Evaluate the accuracy of the GIS map by comparing it with existing resource directories. Check for missing services or outdated information.
- **Feedback Collection:** Gather feedback from care coordinators, families, and community partners on usability and effectiveness.
- **Measure Success:** Use key performance indicators to measure:
 - ✓ Number of families connected to services
 - ✓ Referral timeliness and accuracy
 - ✓ Family satisfaction
 - ✓ Stakeholder feedback on GIS usability

Key Questions:

- Were families able to identify available services easily?
- Did the GIS mapping tool accurately reflect available resources?
- Did the tool streamline the referral process?
- Were there any significant gaps in services?
- What language issues arose?

STEP 3: REVIEW AND REFINE

- A. **Evaluate the mapping tool's effectiveness:** Assess how well the community asset map supports care coordination by monitoring patient satisfaction, timely access, and health outcome improvements.
- B. **Gather feedback:** Collect input from care coordinators, families, and staff. Identify areas for improvement, such as missing resources or gaps in the referral process.
- C. **Adjust workflows and tools:** Based on the feedback, refine workflows and update the community resource map to include additional assets or remove outdated information.

STEP 4: EXPAND

- A. **Expand asset mapping to all care coordinators:** Once the mapping tool is refined, expand its use to all care coordinators at the health center. Ensure that every care coordinator is trained and has access to the map.
- B. **Integrate asset mapping into patient intake:** Incorporate questions about needs (e.g., housing, nutrition, transportation) into the patient intake process to ensure care coordinators are aware of these factors from the beginning.
- C. **Develop partnerships with community organizations:** Foster relationships with local organizations and service providers to keep the map current and ensure patients are referred to appropriate resources.

STEP 5: SUSTAIN

- A. **Embed the process into daily operations:** Integrate the asset mapping process into standard operating procedures so care coordination remains a routine.
- B. **Monitor long-term outcomes:** Track long-term outcomes for referred patients, including improvements in health and access to care.

- C. **Share success stories:** Share patient stories with staff and community partners to reinforce the impact of the asset mapping process and build momentum.
- D. **Continuously monitor the effectiveness:** Regularly review the impact of asset mapping on care coordination, focusing on patient access to resources, satisfaction, and health outcomes.
- E. **Make improvements to the map:** Continue adding new community resources and remove outdated ones to keep the map current and user-friendly.
- F. **Gather ongoing feedback:** Solicit regular feedback from care coordinators and patients about how the community asset map is functioning to further refine the process.



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



CHANGE IDEA: Facilitate face-to-face meetings with community partners to build relationships.

STEP 1: GET READY (TASKS)

- A. Identify community health center staff to serve as spokespeople and determine roles for community-building activities.
- B. Clarify the potential benefits that the health system can bring to community partners and how meetings will benefit partners and families.
- C. Explore existing community partnerships (e.g., community referral networks, young child coalitions, early childhood service councils) and request to join. If no groups exist:
 - a. Invite one or more key community partners to a face-to-face meeting for focused relationship-building.
 - b. Conduct broad outreach to many formal and informal community partners (e.g., host an open house to introduce your practice and assess interest in strengthening relationships, invite potential partners to an all-staff meeting).
 - c. Use both focused and wide-ranging approaches.
- D. Plan for staff time and related costs in organizing and participating in extra meetings.
- E. Determine short-term objectives for the initial meeting and plan an agenda and group activities aligned with those goals. Reserve long-term objectives for shared planning with partners.

STEP 2: PLAN AND PRACTICE

Identify your implementation process and test it. Consider starting small. If joining an existing network, attend one meeting to introduce your practice and assess interest and partnership “fit.” If establishing a new meeting, begin with the partner most likely to improve support for families in your practice.

SAMPLE PROCESS:

- A. Reach out to designated community partners. Choose accessible meeting times and locations. Include clear messaging about the mutual benefits of strengthening relationships and complementary expertise.
- B. Hold the initial meeting. Include a brief “getting to know you” icebreaker. Review short-term objectives and invite participant additions to the agenda.
- C. Identify the key decision-makers and champions needed to maximize the partnership.
- D. Schedule follow-up communications and/or meetings to clarify shared objectives, each partner’s roles and responsibilities, communication processes, procedures for cross-referrals and, if appropriate, shared service plans. Explore cross-training opportunities and shared, systematic feedback from families.
- E. Use a low-burden method to gather partner feedback (e.g., time during regular meetings to quickly assess how each participant is feeling using emojis, standardized poll following each meeting, feedback loop to ensure partners receive information as intended).

STEP 3: REVIEW AND REFINE

Participants in Step 2 huddle, look at the results, and adapt process steps as warranted.

STEP 4: EXPAND

Once the review is complete and any adaptations are made, the team can begin to scale implementation with additional community partners. Continue brief huddles to ensure the process works across formal and informal partners and benefits families.

STEP 5: SUSTAIN

Once the process has been tested and is ready to be adopted by your community health center, ensure relationships are maintained and remain beneficial to the practice, families, and community partners. Ensure staff understand the partnership-building processes and agreements (e.g., referral pathways, joint service plan agreements). Consider using the [Partnership Assessment Tool for Health \(PATH\)](#) to self-assess partnership quality and opportunities for ongoing improvements. PATH's service delivery and workflow section includes service alignment, workflow processes, service delivery capacity, and engaging the community. The data and outcomes section includes data collection, data usage, and demonstrating outcomes.

Key Partnerships:

Identify formal and informal resource partners that support family well-being and healthy development, including services related to parent behavioral health, substance misuse, family trauma, early relational health, and other community factors. Start with the partnerships that are most critical for your patient population.

Sample Lists:

- **Physical development:** Early intervention, sub-specialty care, neighborhood/county parks and recreation, home visiting, congregational activities, early care and education, school-based family resource centers and/or early childhood, and nutrition programs
- **Language development:** Early intervention, sub-specialty care, home visiting, early care and education, school-based family resource centers and/or early childhood (including Child Find partners), HealthySteps, Reach Out and Read, other early literacy initiatives like Dolly Parton Imagination Libraries, and local library programs
- **Academic skills/cognitive development:** Early care and education, school-based family resource centers and/or early childhood, early intervention, sub-specialty care, home visiting, and early literacy programs
- **Adaptive behavior and family strengthening:** Infant early childhood mental health (IECMH), child welfare, parent support groups, sub-specialty assessment, early care and education, school-based family resource centers and/or early childhood, and family/neighborhood group programs
- **Social and emotional development:** Caregiver behavioral health, substance misuse, parent support groups, child-focused early intervention, autism services for early interventions, IECMH, sub-specialty care, and school, neighborhood, and congregational programs specific to your patient population



CHANGE IDEA: Engage families in care transitions by creating a family care transition plan for services outside of the health center.

STEP 1: GET READY (TASKS)

- A. Review your current practice for transition planning with families. Note strengths and gaps in your protocols.
- B. Define roles and responsibilities for engaging families in care transitions based on your practice's staffing patterns.

STEP 2: PLAN AND PRACTICE

Identify your implementation process and test it. Consider starting small, with one family and one provider team (as defined by your practice staffing).

SAMPLE PROCESS:

- A. Create a [family care transition plan template](#) that includes:
 - The family's short- and long-term goals
 - Action steps for each goal
 - Space for clear documentation of the family's preferences
 - Formal supports (e.g., key professional contacts)
 - Informal supports (e.g., family, parent peers)
- B. [Gather feedback](#) from several families on the template to ensure content is appropriate, clear, and reflects the populations served by your practice. Note and respond to any suggestions for improvement.
- C. Design and monitor a workflow to ensure all eligible families receive a family care transition plan.
- D. [Train one medical team](#) (e.g., a provider and a care coordinator, or an early childhood specialist) on the drafted protocol, including training on the Teach-Back Method if needed.
- E. Identify one or two families to test your practice protocol by completing an individualized family care transition plan. Consider choosing families with a need for distinct types of services that require a transition plan.
- F. Use the Teach-Back Method to facilitate family understanding of goals and action steps.
- G. Follow up with families to assess completion of action steps and goals.
- H. Gather family feedback on their involvement in goal setting, whether their preferences were respected, and whether they completed the plan's goals.

STEP 3: REVIEW AND REFINE

Participants in Step 2 huddle to review the results and adapt process steps as warranted.

STEP 4: EXPAND

Once the review is complete and any adaptations are made, the team can begin to scale implementation with additional families and provider teams. Hold periodic huddles to ensure the process works across circumstances and families.

STEP 5: SUSTAIN

Once the process has been tested and is ready to be adopted by your community health center, ensure the process becomes part of your day-to-day workflow. Ensure all staff understand their roles. Standardize the transition planning protocol and review it periodically. Gather family feedback on the quality of the transition planning and respect for their preferences in the process. Use data reviews and/or case studies to identify further improvements.



CHANGE IDEA: Use warm handoffs between providers.

STEP 1: GET READY (TASKS)

- A. Review your current process for referring families to external resources and internal team members. Explore strengths and gaps, including whether referral protocols include standardized warm handoffs.
- B. Consider creating a process map of your current referral flow. Identify who informs the family of referral resources, who solicits the family's reaction to the referral(s), who completes the referral call or electronic health record (EHR) request, and how referrals are tracked and followed up. Warm handoffs increase the amount of time allotted to a scheduled visit. Consider options that are effective and efficient, while remaining family-centered.
- C. List the referral resources most often used to enhance child development and early relational health. Identify a key person within each resource or organization to help determine the warm handoff protocol and create a smooth referral pathway. Create and maintain a list that includes the referral resource, key contact information, and referral information needed by the referral resource.

STEP 2: PLAN AND PRACTICE

Identify your implementation process and test it. Consider starting small, with one provider team and one family receiving a referral.

SAMPLE PROCESS:

- A. Define roles and responsibilities for each medical team member involved in the warm handoff. Warm handoffs can also be used between the nursing staff and provider after rooming a patient, especially for new families. Decide how broadly your practice will use warm handoffs.
- B. Create a [warm handoff protocol](#).
- C. Train one team (e.g., provider and nurse, provider and care coordinator, provider and early childhood specialist, or care coordinator/liaison) to meet with the family and test the warm handoff protocol.
- D. Identify one family needing a referral and warm handoff to test your referral protocol.
- E. Create a script or handout for the team to use with the family to explain the warm handoff process and receive family feedback on the process. Include the reason for the referral, why the chosen referral provider is a good fit for the family, and a request for family consent. Consider what conversation prompts your team might use if the family declines the referral and/or warm handoff process.
- F. Determine if a warm handoff is feasible before the family leaves the office. If so, proceed with the agreed-upon connection process with the referral resource and family. Prioritize a face-to-face connection if the referral resource is an internal member of your practice or co-located with your practice. Use phone or video conference if a face-to-face handoff is not possible.

- G. Engage the family as an active participant in the referral process, including the conversation with the referral resource and the care plan.
- H. Solicit family feedback on the process after the referral connection is completed and the family accesses the referral.
- I. Gather data from your existing referral follow-up process to see if the resource was accessed.

STEP 3: REVIEW AND REFINE

Participants in Step 2 review the results and adapt process steps as warranted. What worked well? How did the family respond? How did the referral resource respond? What needs additional thought?

STEP 4: EXPAND

Once the review is complete and any adaptations are made, the team can begin to scale implementation with additional families and referral resources. Continue to huddle to ensure the process is working across circumstances, referral resources, and families.

STEP 5: SUSTAIN

Once the process has been tested and is ready to be adopted by your community health center, ensure the process becomes part of your day-to-day workflow. Ensure all staff are oriented to the change idea and clear on their roles. Review the process periodically (e.g., quarterly) to support sustainability. Gather EHR data to track referral completion and obtain family feedback on whether the warm handoff helped connect them to the resource.



CHANGE IDEA: Implement a care coordination protocol with a feedback loop.

STEP 1: GET READY (TASKS)

- A. Convene a planning team including providers, care coordinators, and administrative staff to review the [care coordination protocol](#).
- B. Identify ways to reduce manual entry and improve consistency using the pre-built early intervention [referral template](#) in the electronic health record (EHR).
- C. Consider meeting with other health centers with the same EHR to understand template functionality.
- D. Define the target population: children ages 0-5 referred for early intervention (Parts C and B).
- E. Assign roles: who completes the referral in the EHR, confirms receipt with early intervention partners, and documents follow-up. Consider assigning a community liaison or care coordinator.
- F. Train staff on the EHR template and reinforce documentation in care coordination logs.
- G. Define key metrics: number of referrals made, percentage with follow-up confirmation, and staff feedback.

STEP 2: PLAN AND PRACTICE

- A. Pilot the EHR referral template with one care coordinator and one provider for 2 weeks.
- B. Use the pre-populated template for all early intervention referrals during the pilot.
- C. Log all follow-up contacts with the early intervention agency in the EHR notes.
- D. Use the protocol's feedback loop to review family experiences and identify issues or delays.
- E. Observe the workflow and identify friction points.

STEP 3: REVIEW AND REFINE

- A. Conduct a review huddle with the pilot team.
- B. Evaluate how many referrals were made using the EHR template.
- C. Assess whether manual data entry decreased and documentation quality improved.
- D. Gather staff feedback about usability and communication outcomes.
- E. Identify training gaps or suggestions for modifying the referral form.

STEP 4: EXPAND

- A. If the pilot is successful, expand the use of the template to additional care coordinators and providers.
- B. Host quick check-ins to support new users and troubleshoot issues.
- C. Continue tracking referrals, follow-ups, and satisfaction using existing documentation tools or EHR metrics.

STEP 5: SUSTAIN

- A. Integrate the referral template and protocol into standard operations for pediatric visits and care coordination.
- B. Monitor early intervention referral quarterly and address workflow issues.
- C. Celebrate improvements in coordination, follow-up, and family engagement.
- D. Share success stories and include the protocol in new staff training.
- E. Maintain regular contact with early intervention partners to sustain strong referral pathways.
- F. Based on feedback, refine the template content or workflow (e.g., add dropdowns or reminders).
- G. Update job aids or standard operating procedures to reflect best practices.
- H. Reinforce updated workflows in staff meetings and ongoing training.



CHANGE IDEA: Implement a care coordination checklist with early intervention programs.

STEP 1: GET READY (TASKS)

- A. Convene a planning team including providers, care coordinators, administrative staff, and Part C and Part B leadership.
- B. Review the need for timely communication and coordination with early intervention programs.
- C. Introduce a [care coordination checklist](#) to improve referrals and follow-up. Include or develop a standardized referral form (Part C or Part B) and [feedback form](#) for the practice.
- D. Obtain agreement on a two-way release of information form signed by the family at the visit.
- E. Define the target population: children ages 0-5 referred to early intervention Part C or B.
- F. Develop communication pathways to confirm service availability for families (e.g., waitlists).
- G. Assign roles: who completes the checklist, communicates with early intervention partners, and documents in the electronic health record (EHR).
- H. Schedule a brief training for relevant staff on using the checklist.

STEP 2: PLAN AND PRACTICE

- A. Pilot the checklist with one care coordinator and one early intervention program partner for 1 week.
- B. During the pilot, complete the checklist for each new referral to early intervention.
- C. Communicate with the early intervention partner to confirm receipt and follow-up.
- D. Log referrals and checklist completion in a tracking system.
- E. Collect feedback from staff and the early intervention partner.

STEP 3: REVIEW AND REFINE

- A. Hold a brief review huddle with staff involved in the pilot.
- B. Assess how many checklists were completed and whether follow-up improved.
- C. Discuss time burden, usability, and staff feedback.
- D. Identify any workflow issues or points of confusion.

STEP 4: EXPAND

- A. Update the checklist or process based on feedback.
- B. Expand to additional care coordinators and, if feasible, another early intervention partner.
- C. Continue regular check-ins to track use and troubleshoot.

STEP 5: SUSTAIN

- A. Integrate the checklist into standard care coordination operations.

- B. Include in new staff onboarding.
- C. Share metrics and success stories.
- D. Review the process annually to ensure relevance and effectiveness.
- E. Use data from expanded use to refine checklist content or documentation workflows.
- F. Incorporate checklist steps into care coordination protocols or EHR templates.
- G. Provide ongoing support or refresher training.



CHANGE IDEA: Use a referral tracking process.

STEP 1: GET READY (TASKS)

- A. Assemble a planning team of providers, care coordinators, administrative staff, and IT personnel.
- B. Review the need to track early intervention referrals to ensure timely follow-up and family engagement.
- C. Develop a [referral tracking system protocol](#) and define key data fields in the electronic health record (EHR).
- D. Define the focus population: all children referred to Part C or Part B services.
- E. Clarify staff roles for entering, updating, and monitoring referral information.
- F. Schedule training on EHR tracking features and referral workflow for pilot staff.

STEP 2: PLAN AND PRACTICE

- A. Pilot the referral tracking process with one provider and one care coordinator for 2 weeks.
- B. Use standardized EHR fields to log and follow up on all early intervention referrals.
- C. Enter information such as referral date, agency name, acknowledgment received, and service outcome.
- D. Set reminders to follow up on referrals without confirmation after 5 business days.
- E. Document all follow-up actions in the EHR tracking notes.

STEP 3: REVIEW AND REFINE

- A. Conduct a review huddle with participating staff at the end of the pilot.
- B. Evaluate the number of referrals entered, tracked, and documented with follow-up.
- C. Review usability of EHR fields, time required, and any breakdowns in workflow.
- D. Gather staff feedback on effectiveness and burden.
- E. Identify any modifications needed to the workflow or training materials.

STEP 4: EXPAND

- A. Based on feedback, expand referral tracking to additional providers and care coordinators.
- B. Provide refresher training and technical support to new users.
- C. Run weekly referral status reports to ensure follow-through.

STEP 5: SUSTAIN

- A. Embed referral tracking into routine pediatric and care coordination workflows.
- B. Incorporate responsibilities into job descriptions and onboarding materials.
- C. Monitor referral follow-up rates monthly and share updates in team meetings.
- D. Maintain a feedback loop with early intervention partners to address system-level issues.

- E. Celebrate progress and share success stories to maintain staff engagement.
- F. Analyze data from the expanded rollout to identify trends (e.g., delays in acknowledgment).
- G. Refine the tracking template or EHR workflow (e.g., add dropdowns or defaults) to reduce burden.
- H. Integrate improvements into care team huddles and quality checklists.



CHANGE IDEA: Automate referral follow-up alerts in the electronic health record (EHR).

STEP 1: GET READY (TASKS)

- A. Obtain senior leadership approval to prioritize this task.
- B. Convene a planning team including providers, care coordinators, IT staff, and administrative leads.
- C. Assess EHR capabilities and learn from peer clinics using the same system.
- D. Review current gaps in referral follow-up for early intervention and specialty care.
- E. Confirm the benefits of automated alerts (e.g., fewer missed referrals, improved patient outcomes).
- F. Define the target population: all pediatric patients referred for external services.
- G. Assign roles: who configures alerts, monitors tasks, and follows up.
- H. Define process steps for your referral follow-up and alert system. See an [example process](#).
- I. Schedule training on the referral alert system.

STEP 2: PLAN AND PRACTICE

- A. Configure alert logic: Trigger a task if 'Acknowledgment Received' is missing after 5 days and if 'Outcome' is missing after 14 days. See a sample [tip sheet](#).
- B. Pilot the process with one care coordinator and one provider over 2 weeks.
- C. Use the dashboard or task queue to track follow-up alerts.
- D. Log all actions taken in the EHR referral tracking notes.
- E. Collect staff feedback on alert usability and workload impact.

STEP 3: REVIEW AND REFINE

- A. Conduct a review huddle at the end of the pilot period.
- B. Analyze how many referrals triggered alerts and whether follow-up was completed on time.
- C. Assess the accuracy of alert timing and task assignments.
- D. Discuss usability, barriers, and any unintended consequences.
- E. Identify needed changes to timing, messaging, or training.

STEP 4: EXPAND

- A. Roll out alert tracking to additional providers and referral types.
- B. Provide refresher training and workflow support to new users.
- C. Monitor key metrics (e.g., percentage of referrals followed up within 14 days).
- D. Hold monthly team check-ins to support implementation and problem-solving.

STEP 5: SUSTAIN

- A. Embed automated referral follow-up alerts into standard referral workflows.
- B. Include alert review and documentation as part of new staff onboarding.
- C. Monitor referral completion and alert resolution metrics quarterly.
- D. Share success stories and ongoing challenges during staff meetings.
- E. Maintain a feedback loop with IT and care coordination teams to support sustainability.
- F. Adjust alert timing, templates, or task routing based on user feedback and tracking data.
- G. Add default notes or checklists to reduce documentation burden.
- H. Update training guides and standard operating procedures.
- I. Incorporate staff improvement ideas into EHR design discussions.



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Part Four

Early Intervention Change Ideas



CHANGE IDEA: Offer brief intervention from an early childhood developmental expert or team member to provide immediate guidance and support.

STEP 1: GET READY (TASKS)

- A. Assess the need for brief intervention as an enhancement to current family services.
- B. Develop an operational definition for brief intervention (e.g., can be completed in 1-3 visits and not inclusive of tertiary interventions).
- C. Determine delivery mode (e.g., telephone, virtual, in-person).
- D. Select topic areas appropriate for brief intervention. This example uses safe sleep.
- E. Train the expert in [safe sleep guidelines](#), or your chosen topic, using reputable guidelines.
- F. Identify a brief intervention strategy. This example uses [motivational interviewing](#).
- G. Select print materials for all families. For this example, print the National Institutes of Health's [Safe Sleep for Your Baby: Reduce the Risk of Sudden Infant Death Syndrome \(SIDS\) and Other Sleep-Related Infant Death](#).
- H. Develop [clinic workflows](#) to identify eligible families. For this example, infants under 1 year.

STEP 2: PLAN AND PRACTICE

Test a brief intervention delivered by an integrated early childhood developmental expert or other team member during routine pediatric visits to promote safe sleep practices. Use motivational interviewing to explore and reinforce safe sleep behaviors.

SAMPLE PROCESS:

- A. The pediatric provider introduces the developmental expert during the visit.
- B. The expert uses motivational interviewing to assess caregiver knowledge, attitudes, and challenges.
- C. The expert provides guideline-aligned education and helps caregivers create a safe sleep plan.
- D. Document the interaction in the electronic health record (EHR) and review in team huddles for follow-up.

STEP 3: REVIEW AND REFINE

[Collect data](#) on the number of safe sleep conversations, family feedback, and caregiver-reported behavior changes. Hold team debriefs to assess what is working and what needs [adjustment](#).

STEP 4: EXPAND

Based on initial feedback, extend the intervention to more providers and visit types. Tailor materials and approach to meet families' linguistic needs.

STEP 5: SUSTAIN

Continue monitoring safe sleep knowledge and practices. Partner with community organizations for crib distribution or home safety support.

Formalize the developmental expert's role. Seek funding or reimbursement mechanisms. Provide ongoing training in motivational interviewing and brief intervention.

Test improvements to timing, delivery, documentation, visit flow, motivational interviewing, and handoff language based on staff and family feedback. Continue reviewing data on completion rates, family engagement, and EHR use.



CHANGE IDEA: Establish a secure process for communicating with external specialists and community-based organizations to improve care continuity and follow-up documentation.

STEP 1: GET READY (TASKS)

- A. Identify gaps in the current communication process with external partners.
- B. Choose a secure communication method, ideally with a feature already within your electronic health record (EHR). This example uses Epic's secure chat feature.
- C. Train clinical and care coordination staff on [Epic's Direct Messaging functionality](#).
- D. Create a contact list of partner specialists and community organizations (e.g., health centers, behavioral health providers, social services).
- E. Develop communication [protocols and message templates](#) for common referral scenarios.
- F. Confirm technical readiness, including message delivery validation and security configurations.
- G. Ensure information-sharing agreements are in place and follow HIPAA guidelines.

STEP 2: PLAN AND PRACTICE

Pilot Epic Direct Messaging for a specific use case, such as behavioral health referrals. Assign a care manager or medical assistant to send and track messages for a specific patient group.

SAMPLE PROCESS:

- A. The family is referred to a behavioral health provider.
- B. The care manager sends a Direct Message with the referral summary and contact information.
- C. The receiving provider acknowledges receipt and confirms appointment scheduling or next steps.
- D. Document the status in the EHR for care team visibility.

STEP 3: REVIEW AND REFINE

Review how many messages were successfully sent and received. Gather staff and partner feedback to refine the process. Identify workflow or technical challenges. See a [sample data collection template](#).

STEP 4: EXPAND

Broaden the pilot to additional referral scenarios (e.g., specialist follow-up, early intervention). Add more external partners to the approved messaging network.

STEP 5: SUSTAIN

Formalize the use of Direct Messaging in care workflows and staff onboarding. Keep partner lists updated and conduct routine audits of messaging success and referral completion.

Continue reviewing care coordination metrics (e.g., referral completion, follow-up rates, documentation time) and gathering staff and partner feedback.



CHANGE IDEA: Introduce a standardized operating procedure (SOP) for early childhood telehealth visits to improve consistency, efficiency, and developmental outcomes.

STEP 1: GET READY (TASKS)

- A. Assess the need for integrated telehealth options for well-child visits to enhance family services.
- B. Obtain senior leadership approval to prioritize this effort.
- C. Review current telehealth workflows and existing SOPs.
- D. Engage key stakeholders (e.g., providers, IT, parents, administrators) for input and feedback.
- E. Conduct a [needs assessment](#) to identify process gaps.
- F. Identify reimbursement pathways and processes.
- G. Select or draft an [SOP](#) for early childhood telehealth visits and developmental screenings.
- H. Ensure all team members understand their roles.

STEP 2: PLAN AND PRACTICE

Pilot the SOP. Start small with just a few early childhood telehealth visits and families in one topic area (e.g., safe sleep, diaper rash). Provide training and a practice session for all involved clinicians and support staff.

SAMPLE PROCESS:

- A. Schedule and confirm telehealth appointments with caregivers.
- B. Share preparation instructions with families (e.g., how to access the platform, [what to expect](#)).
- C. Conduct the visit using the SOP, including developmental milestone checklists, caregiver observations, and documentation practices.
- D. Gather feedback post-visit from caregivers and providers.

STEP 3: REVIEW AND REFINE

Collect and review feedback from staff and families. Analyze visit quality, satisfaction, and follow-through on care recommendations. Revise the SOP as needed.

STEP 4: EXPAND

Roll out the revised SOP across all early childhood telehealth visits. Provide refresher training to ensure consistent implementation.

STEP 5: SUSTAIN

Integrate SOP training into onboarding and continuing education. Review regularly to align the SOP with updated guidelines and technologies.

Continue monitoring SOP use and performance metrics (e.g., screening rates, caregiver satisfaction, follow-up compliance).



CHANGE IDEA: Use community health workers (CHWs) or patient navigators to support telehealth visits.

STEP 1: GET READY (TASKS)

- A. Identify trained CHWs or patient navigators with experience in early childhood support.
- B. Review [baseline telehealth participation data](#) for families with children ages 0-5.
- C. Create a [checklist and tip sheet](#) for early childhood telehealth preparation (e.g., setting up the space, having toys nearby).
- D. Select a small group of families to pilot CHW-supported early childhood telehealth visits.

STEP 2: PLAN AND PRACTICE

Prepare CHWs on how to engage families of young children, including basic developmental milestones, virtual visit preparation, and troubleshooting common video visit issues. Start with one family and one visit.

SAMPLE PROCESS:

- A. The CHW contacts the caregiver 24-48 hours before the visit to confirm the appointment and review expectations.
- B. The CHW reviews the telehealth platform, tests the link, and ensures device readiness.
- C. The CHW ensures the checklist is followed.
- D. The CHW provides tips to prepare the child (e.g., have snacks, books, and toys ready; ensure the child is fed and rested).
- E. After the visit, the CHW checks in to review the care plan, help with referrals, and answer any caregiver questions.

STEP 3: REVIEW AND REFINE

Review [metrics](#) (e.g., visit completion rates, caregiver satisfaction, completed screenings and referrals). Gather [feedback](#) from CHWs and families to improve the model.

STEP 4: EXPAND

Based on pilot outcomes, expand support to additional families, prioritizing those with prior no-shows or new to telehealth.

STEP 5: SUSTAIN

Embed telehealth support in CHW workflows. Collaborate with pediatric providers for coordinated follow-up and seek sustainable funding (e.g., grants, Medicaid). Use continuous quality improvement processes and metrics from Step 3 to ensure consistent implementation.

Conduct periodic reviews of CHW processes and caregiver outcomes. Update training and preparation materials based on family needs and platform changes.



CHANGE IDEA: Integrate home visitor drop-ins during well-child visits to strengthen coordination and personalized care.

STEP 1: GET READY (TASKS)

- A. Establish partnerships with local home visiting programs such as [maternal infant and early childhood home visiting](#).
- B. Hold a [kickoff meeting](#) with key stakeholders from the health center and home visiting programs to align on goals, responsibilities, and processes.
- C. Ensure shared understanding of program policies related to attending medical visits and discuss how clinical recommendations can be supported by home visitors.
- D. Create a [standardized family consent form](#) explaining the purpose and benefits of home visitor attendance.
- E. Develop a [referral process](#) to notify home visiting programs of upcoming well-child visits for enrolled families.
- F. Obtain consent language approval from the health center's legal team.
- G. Establish a communication process to confirm and schedule appointments.
- H. Ensure home visitors have access to necessary information, with family consent.

STEP 2: PLAN AND PRACTICE

- A. Select a small group of enrolled families for the pilot.
- B. Obtain consent from these families to allow home visitors to accompany them during their well-child visits.
- C. [Train home visitors](#) on collaborating with pediatric providers, focusing on roles, expectations, and communication.
- D. Ensure health center staff understand the home visitor's role and how to integrate them without disrupting clinical flow.
- E. Schedule well-child visits with home visitor attendance.
- F. Coordinate scheduling to ensure home visitors can attend visits within their scope of work.
- G. Develop a clear [plan for what the home visitor will do](#) during the visit (e.g., provide emotional support, reinforce educational content, help address family questions or concerns).

STEP 3: REVIEW AND REFINE

- A. Track participating families and note scheduling or attendance challenges.
- B. Record the number of successful visits where home visitors attended and any challenges encountered.
- C. Collect feedback from participating families on their satisfaction and perceived value of home visitor participation.

- D. Ask families how the home visitor addressed their questions or concerns and influenced their experience.
- E. Gather staff feedback, including from pediatricians and nurses, on working with home visitors during visits.
- F. Assess home visitor integration into the clinical workflow and contribution to social and emotional support.

STEP 4: EXPAND

- A. Use family and staff feedback to refine the process and further improve communication, scheduling, and role clarity.
- B. Adjust referral and scheduling processes to align with family and provider needs.
- C. If the pilot is successful, gradually expand to additional families.
- D. Monitor expansion closely to ensure the process is effective for a larger group of families and staff.

STEP 5: SUSTAIN

- A. Embed home visitor drop-in into regular well-child visit standard processes.
- B. Monitor outcomes such as family satisfaction, provider experience, and improved health indicators (e.g., adherence to care recommendations).
- C. Identify challenges and any necessary adjustments.
- D. Summarize outcomes and recommend clear next steps based on collected data.
- E. Share results with key stakeholders (e.g., community partners, home visiting programs, health center leadership) to highlight the successes and lessons learned.
- F. Seek funding and resource allocation to sustain collaboration.
- G. Establish ongoing feedback from families and providers to monitor long-term impacts and refine the process as needed over time.



CHANGE IDEA: Establish a collaborative care model to coordinate primary care and specialized child health and behavioral health services.

STEP 1: GET READY (TASKS)

- A. Define the focus population: families with children who need both primary care and behavioral health services (e.g., infant mental health, dental care).
- B. Identify primary care providers and behavioral health providers willing to participate (e.g., infant mental health professionals, dental providers).
- C. Establish [communication protocols](#) to ensure seamless and timely sharing of patient information and care plans.
- D. Develop a [standardized bidirectional referral process](#).
- E. [Train providers](#) on the benefits of the model and how to integrate their services effectively.
- F. Create a shared electronic health record (EHR) or case management system for coordinated communication and documentation.

STEP 2: PLAN AND PRACTICE

Test a care coordination plan that clearly defines provider roles and common goals for child health (e.g., developmental milestones, behavioral health, dental care).

- A. Test the model (communication, referral process, training, shared EHR/case management system) with a small group of families.
- B. Identify and address any challenges to collaboration (e.g., gaps in communication, coordination, appointment scheduling, service integration).
- C. Collect baseline data on behavioral health screenings, dental checkups, and developmental assessments.

STEP 3: REVIEW AND REFINE

- A. Monitor the pilot group to assess effectiveness of the collaborative care model.
- B. Gather feedback from providers and families on the coordination process.
- C. Evaluate if families experienced improved access to primary care and behavioral health services and whether coordination enhanced care delivery.
- D. Measure key health outcomes (e.g., developmental progress, mental health, dental health).

STEP 4: EXPAND

- A. If successful, expand the collaborative care model to additional families and providers (e.g., pediatric specialists, therapists, nutritionists).
- B. Refine the referral system, provider communication, and shared care planning based on lessons learned.

- C. Develop implementation tools (e.g., training materials, referral templates, care coordination workflows).
- D. Review results to identify further improvements.
- E. Assess whether the expanded model improved outcomes for child and behavioral health outcomes.
- F. Consider integrating additional services (e.g., early intervention, parent education) for a more holistic care model.

STEP 5: SUSTAIN

- A. Develop a long-term sustainability strategy, including securing funding, resources, and stakeholder buy-in.
- B. Train new providers to ensure they understand the value of collaboration and are prepared to integrate the model.
- C. Create a plan for regular program evaluation and feedback to ensure continuous and responsive improvements.



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Appendix: Sample Tools



Sample Newborn Pre-Planning and Well-Child Visit Checklists

SAMPLE NEWBORN PRE-PLANNING CHECKLIST

(Bright Futures-Based)

This checklist is for use by the assigned staff member (e.g., pediatric nurse, care coordinator) to review the newborn's chart 24–48 hours before the scheduled well-child visit.

Patient Information

Patient Name: _____ **Date of Birth:** _____

Date of Scheduled Visit: _____

1. Screenings Due

- ☐ Newborn metabolic screening completed?
- ☐ Hearing screening completed in hospital?
- ☐ Bilirubin screening completed or required?
- ☐ Maternal depression screening due?
- ☐ Any outstanding labs or follow-up from hospital discharge?

2. Past Visit Notes/Concerns

- ☐ Any concerns documented at birth or during hospital stay?
- ☐ Any feeding issues or weight concerns?
- ☐ Any family/social risk factors noted (e.g., housing, food security)?
- ☐ Any parental concerns documented in past notes?

3. Educational Materials to Prepare

- ☐ Safe sleep handout
- ☐ Feeding guide (breast/formula)
- ☐ Soothing techniques and normal newborn behavior
- ☐ Postpartum support or maternal mental health info
- ☐ Car seat safety info
- ☐ Women, Infants, and Children (WIC) or local community resources

Notes: _____

Reviewed by: _____ **Date:** _____

SAMPLE NEWBORN WELL-CHILD VISIT CHECKLIST

(Bright Futures-Based)

Patient Age: Newborn (Birth – 1 Week)

Visit Type: Initial well-child visit

Provider Name: _____

Date: _____

1. Physical Examination

- ☐ Weight, length, head circumference
- ☐ General appearance
- ☐ Skin (jaundice, rashes)
- ☐ Head (fontanelles, shape, sutures)
- ☐ Eyes (red reflex, symmetry)
- ☐ Ears (position, canal patency)
- ☐ Mouth (palate, tongue)
- ☐ Heart (murmurs, rhythm)
- ☐ Lungs (breath sounds, effort)
- ☐ Abdomen (masses, hernias)
- ☐ Genitalia (testes descended, anomalies)
- ☐ Hips (Ortolani/Barlow)
- ☐ Spine (dimples, sacral area)
- ☐ Extremities (tone, movement)

2. Developmental Surveillance

- ☐ Looks at caregiver's face
- ☐ Responds to sound
- ☐ Moves all limbs symmetrically
- ☐ Sucks/swallow coordinated

3. Risk Assessments

A. Maternal Depression Screening * (PHQ-2 or EPDS) *

- ☐ Over the past 2 weeks, have you felt down, depressed, or hopeless?
- ☐ Have you felt little interest or pleasure in doing things?

B. Family & Environmental Risk Factors

- ☐ Any concerns about safety at home or in relationships?
- ☐ Does anyone smoke or vape in the home?
- ☐ Is there enough food in the home for your family?
- ☐ Do you have the support you need in caring for the baby?

C. Newborn Screening Follow-Up



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- ☐ Confirm state newborn metabolic screening was completed
- ☐ Hearing screening completed in hospital?
- ☐ Bilirubin screening reviewed?

4. Anticipatory Guidance (Key Talking Points)

- ☐ Feeding (breast or formula; feeding on demand every 2–3 hours)
- ☐ Elimination (6–8 wet diapers/day by day 5; stool patterns)
- ☐ Sleep (back to sleep, safe sleep practices)
- ☐ Umbilical cord and circumcision care
- ☐ Normal newborn behaviors (sneezing, hiccups, startle reflex)
- ☐ Soothing strategies (swaddling, holding, white noise)
- ☐ When to call the doctor (fever >100.4°F, poor feeding, jaundice)

5. Referrals / Follow-Up

- ☐ Lactation consultant (if breastfeeding concerns)
- ☐ Social worker/case management (if social determinants of health or maternal health needs)
- ☐ Schedule for the next well-child visit (1 month)
- ☐ Additional follow-up needed: _____

Provider Signature: _____

Parent Questions/Concerns Addressed: _____

For Team Use Only:

- How long did this process take?
- Were roles clear?
- What if any workflow challenges came up during this process?





Sample Interview Questions for Early Childhood Expert – Community Health Center

Responsiveness and Community Alignment

1. Tell us about your experience working with families in the communities this community health center serves. How do you ensure your approach to developmental support is responsive to all families?
2. How do you build trust with families who may have had negative experiences with healthcare or early childhood systems?
3. What community-based organizations or resources are you familiar with that serve families with young children in our region?
4. Can you share an example of how you adapted your communication style to meet the needs of a caregiver?

Clinical Expertise and Developmental Knowledge

5. Describe your experience conducting developmental screenings. Which tools have you used, and how do you explain the results to families?
6. How do you incorporate family strengths when offering developmental guidance?
7. Tell us about a time when you identified a developmental delay or concern. What steps did you take, and how did you support the family?
8. What frameworks or models (e.g., Bright Futures, HealthySteps) are you trained in or familiar with? How have you used them in your work?

Team Collaboration and Integration

9. How do you see your role fitting into a multidisciplinary team that includes medical providers, behavioral health clinicians, and community health workers?
10. Describe a time you participated in a team huddle or case review. What was your contribution, and what was the outcome?
11. How do you handle situations where you and a provider may not agree on a developmental concern or approach to care?

Family Engagement

12. What strategies do you use to engage families who are hesitant to follow through with referrals or developmental services?

13. How do you approach conversations about sensitive topics (e.g., developmental delays, parenting practices, and trauma)?
14. In your view, what does meeting the needs of all families in early childhood development look like in a healthcare setting?

Systems Knowledge and Community Impact

15. How do you stay updated on local early intervention programs, Head Start, child care, home visiting, and other early childhood systems and services?
16. What is your process for helping a family navigate community referrals?
17. Have you ever created or maintained a resource map or referral guide for families or staff?

Scenario-Based Questions

18. Scenario: A 2-year-old child shows signs of language delay during a well-child visit, and the parent appears anxious and unsure. How would you approach this conversation and support the parent?
19. Scenario: You're scheduled to join a well-child visit with a provider who is running behind and feeling rushed. How do you ensure your developmental work is still effective without disrupting clinic flow?
20. Scenario: A family expresses strong beliefs that conflict with your standard developmental advice (e.g., beliefs about discipline or sleep routines). How do you balance respect with guidance?





Sample Interview Scoring Rubric for Early Childhood Expert – Community Health Center

Scoring Rubric

Competency	Excellent (4 pts)	Good (3 pts)	Adequate (2 pts)	Needs Improvement (1 pt)
Responsiveness & Community Alignment	Demonstrates deep understanding and consistent application of responsive practices; gives specific examples of community engagement	Shows clear understanding and some experience applying responsive practices	Acknowledges importance but provides vague or limited examples	Lacks awareness or experience with responsiveness or community alignment
Developmental Screening & Guidance Expertise	Extensive hands-on experience with screenings, frameworks, and anticipatory guidance; explains processes clearly and accurately	Solid experience with tools and frameworks; describes implementation with some depth	Limited experience or understanding of tools; responses are general or incomplete	Unfamiliar with tools/frameworks or provides unclear/inaccurate responses
Team Collaboration & Clinical Integration	Provides strong examples of interdisciplinary collaboration; understands care team dynamics and integration workflow	Describes past teamwork experience and shows willingness to collaborate	General understanding of team collaboration; limited direct experience	Prefers independent work or lacks clear understanding of integrated care

Competency	Excellent (4 pts)	Good (3 pts)	Adequate (2 pts)	Needs Improvement (1 pt)
Family Engagement	Demonstrates empathetic, family-driven approach; skilled in engaging families across barriers	Understands importance of helping all families and sharing thoughtful strategies for family engagement	Basic knowledge of family engagement; limited strategies for equitable care	Lacks understanding of family-centered approaches
Knowledge of Community Resources & Systems Navigation	Demonstrates deep familiarity with early childhood systems and has effectively connected families to services	Has moderate experience with referrals and community connections	Knows of some local resources but limited application	Unfamiliar with systems or struggles to navigate referrals
Communication & Interpersonal Skills	Communicates clearly, with warmth and professionalism; adjusts style to family and team needs	Effective communicator with appropriate tone and language	Adequate communication skills; may lack adaptability	Poor communication or difficulty connecting with others
Problem Solving & Scenario Responses	Offers insightful, strengths-based, and realistic responses to scenarios; anticipates challenges	Provides sound responses with some consideration of family or system dynamics	Responses are generic or miss key elements	Responses are unclear, inappropriate, or not feasible
Overall Fit for CHC Mission & Population Served	Deeply aligned with health center values, population needs, and health mission	Shows alignment with health center work and understanding of community needs	Basic understanding of health center environment; may need more orientation	Limited understanding or fit for health center mission or population

Scoring Guide

- ✓ **28–32:** Strong candidate – highly recommended for next steps
- ✓ **21–27:** Solid candidate – consider with team discussion
- ✓ **15–20:** Moderate fit – may need further screening or support
- Below 15: Not recommended at this time





Sample Job Description for Early Childhood Expert

Role Title: Early Childhood Development (ECD) Expert

Department: [Insert Department]

Reports To: [Insert Supervisor]

Location: [Insert Community Health Center Location]

Full-Time / Part-Time: [Specify]

Position Summary: The Early Childhood Development (ECD) Expert plays a key role in supporting families with young children (ages 0-5) through responsive, developmentally informed care integrated into primary care services. This role is responsible for providing early childhood expertise to the care team, promoting optimal developmental outcomes, and engaging families with tools, guidance, and referrals. The ECD Expert will work directly with families and providers, ensuring developmental supports are aligned with the needs of the population served by the community health center.

Key Responsibilities:

- Collaborate with medical providers, behavioral health clinicians, care coordinators, and community health workers to support the developmental needs of children during well-child and other pediatric visits.
- Conduct responsive developmental screenings and provide anticipatory guidance to families.
- Help families navigate referrals to early intervention programs, early education providers, behavioral supports, and other community-based resources.
- Build trusting relationships with families that honor their practices, beliefs, and parenting values.
- Support the care team in identifying health factors that impact child development and coordinate appropriate interventions.
- Participate in case reviews and team huddles to plan developmental supports tailored to the family's goals and strengths.
- Develop and maintain a community asset map of early childhood resources that reflect all families.
- Educate health center staff on early childhood development practices, including trauma-informed and strengths-based approaches.
- Assist with onboarding and staff training related to early childhood development frameworks (e.g., Bright Futures, HealthySteps, Care for Child Development).

Required Qualifications:

- Specific knowledge/experience in child development, early childhood education, psychology, social work, or a related field and/or minimum 3 years of experience working with children ages 0-5 and their caregivers, preferably in a community-based or healthcare setting.
- Demonstrated commitment to serving the needs of all families.
- Fluency in [insert relevant language(s), e.g., Spanish, Mandarin, Haitian Creole, etc] strongly preferred.
- Knowledge of local early childhood systems and community-based organizations that serve young children and families.
- Strong communication and collaboration skills; ability to work within interdisciplinary teams.
- Experience conducting developmental screenings and using evidence-based guidance tools.
- Familiarity with trauma-informed and family-centered care principles.

Preferred Qualifications:

- Certification or training in early childhood development frameworks (e.g., HealthySteps, Bright Futures, Care for Child Development).
- Experience working in Federally Qualified Health Centers (FQHCs) or other safety-net settings.
- Experience in motivational interviewing or other family engagement techniques.

Working Conditions & Physical Demands:

- Work is typically performed in a clinical setting, with occasional home or community-based visits depending on community health center practices.
- May require occasional evening or weekend hours for outreach or parent workshops.





Sample Reporting Structure and Integration Plan for Early Childhood Development Expert

Position: Early Childhood Development (ECD) Expert

Department: Pediatrics /Family Health / Behavioral Health Integration (depending on community health center structure)

Reports To: Director of Integrated Services or Clinical Director

Collaborates Closely With:

- Pediatric Medical Providers (MDs, DOs, NPs, PAs)
- Behavioral Health Providers (LCSWs, psychologists)
- Care Coordinators / Case Managers
- Community Health Workers (CHWs)
- Nurses / Medical Assistants
- Front Desk and Scheduling Teams
- Health Educators / Family Navigators

Phase 1: Orientation and Role Definition (Weeks 1-4)

- Meet with leadership to understand clinical goals, priorities, and patient demographics.
- Shadow pediatric well-child visits to understand existing workflows.
- Review current use of developmental tools (e.g., Ages & Stages Questionnaires, Bright Futures).
- Define scope of responsibilities with input from the care team (e.g., whether the ECD Expert will support all visits, targeted age ranges, or high-risk families).
- Develop a shared understanding with providers about when and how to involve the ECD Expert during visits.

Phase 2: Pilot Integration (Month 2-3)

- Start small: Embed the ECD Expert into one pediatric provider's well-child visit schedule (e.g., 0-3 age range).
- ECD Expert participates in pre-visit planning huddles, reviewing charts and identifying opportunities for engagement (e.g., screening needs, developmental red flags).
- During visits, ECD Expert can:
 - Conduct or interpret developmental screenings.
 - Offer anticipatory guidance (e.g., sleep, language, behavior).
 - Provide parent handouts in preferred languages.
 - Refer to community resources as needed.

- Post-visit, ECD Expert documents interactions in the electronic health record (EHR) and updates relevant care plans.

Phase 3: Feedback and Workflow Adjustment (Month 3-4)

- Hold bi-weekly huddles with the pilot provider and care team to:
 - Review patient/family feedback.
 - Evaluate handoffs, documentation process, and integration flow.
 - Troubleshoot barriers (e.g., time constraints, role clarity).
- Adjust responsibilities as needed (e.g., expanding ECD involvement in behavioral health consultations or group visits).

Phase 4: Scale Up (Month 5-6)

- Expand ECD Expert support to additional providers or care teams, focusing on:
 - High-risk families (e.g., preterm birth, housing insecurity, parental mental health needs).
 - Specific age groups (e.g., 9-month and 18-month visits tied to key milestones).
- ECD Expert may begin co-leading parent workshops or developmental education groups with health educators or CHWs.

Phase 5: Sustain & Evolve

- Include the ECD Expert in:
 - Quality improvement efforts related to child development.
 - Staff training and onboarding of new team members.
 - Community partnership meetings (e.g., early intervention agencies, Head Start).
- Establish a formal evaluation plan tracking outcome such as:
 - Developmental screening rates.
 - Referral follow-through.
 - Family satisfaction with care.
 - Provider feedback on ECD expert support.





Sample 9-Month Well-Child Visit Checklist Incorporating Parent Project, Coaching Prompts, and Keystones of Development

During the Visit: Relationship-Based Engagement

1. Warm Welcome & Parent Validation (Keystones)

- Greet the family warmly, acknowledge the caregiver's role
Example: "It's great to see you both — these early months are such a big journey for families."
- Ask open-ended questions about daily routines
Example: "What's a typical day like with [Child's Name] right now?"

2. Developmental Surveillance (Bright Futures)

- Ask about and observe:
 - a. Sitting without support
 - b. Crawling or scooting
 - c. Babbling ("mama," "baba")
 - d. Finger feeding or using pincer grasp
 - e. Stranger anxiety or showing preferences
- Document parent responses and observations

Developmental Coaching & Reflection

1. Coaching Prompts (The PARENT Project)

- Reinforce what parents are doing well
Example: "You're already doing a lot to support [Child's Name] just by playing and talking with them every day."
- Suggest responsive activities:
 - a. Peek-a-boo and mirror games
 - b. Naming objects during diapering or meals
 - c. Reading board books with pointing and labeling
 - d. Encouraging safe exploration of space

2. Tailored Reflection (Keystones)

- Ask:
 - a. "What brings [Child's Name] the most joy lately?"
 - b. "Are there family traditions or languages you're sharing with them?"
- Reflect back:

- a. “It’s beautiful how you’re nurturing connection — that’s one of the most powerful supports for brain development.”

Guidance & Anticipatory Topics (Bright Futures)

- Safety: choking hazards, car seats, babyproofing
- Sleep routines, separation anxiety
- Nutrition: introduce more textures, iron-rich foods
- Language development and screen-free interaction
- Monitor for developmental concerns

Family Questions & Shared Decision-Making

- Ask:
 - a. “Do you have any concerns about how [Child’s Name] is growing, learning, or behaving?”
 - b. “Are there any questions we didn’t cover today?”

Post-Visit Follow-Up

- Provide milestone checklist and activity suggestions
- Offer contact info for developmental resources if any concerns
- Note any referrals or follow-ups in chart
- Document coaching moment and family strengths observed





Sample 9-Month Well-Child Visit Checklist Incorporating Parent Project, Coaching Prompts, and Keystones of Development

During the Visit: Relationship-Based Engagement

1. Warm Welcome & Parent Validation (Keystones)

- Greet the family warmly, acknowledge the caregiver's role
Example: "It's great to see you both — these early months are such a big journey for families."
- Ask open-ended questions about daily routines
Example: "What's a typical day like with [Child's Name] right now?"

2. Developmental Surveillance (Bright Futures)

- Ask about and observe:
 - a. Sitting without support
 - b. Crawling or scooting
 - c. Babbling ("mama," "baba")
 - d. Finger feeding or using pincer grasp
 - e. Stranger anxiety or showing preferences
- Document parent responses and observations

Developmental Coaching & Reflection

1. Coaching Prompts (The PARENT Project)

- Reinforce what parents are doing well
Example: "You're already doing a lot to support [Child's Name] just by playing and talking with them every day."
- Suggest responsive activities:
 - a. Peek-a-boo and mirror games
 - b. Naming objects during diapering or meals
 - c. Reading board books with pointing and labeling
 - d. Encouraging safe exploration of space

2. Tailored Reflection (Keystones)

- Ask:
 - a. "What brings [Child's Name] the most joy lately?"
 - b. "Are there family traditions or languages you're sharing with them?"
- Reflect back:

- a. “It’s beautiful how you’re nurturing connection — that’s one of the most powerful supports for brain development.”

Guidance & Anticipatory Topics (Bright Futures)

- Safety: choking hazards, car seats, babyproofing
- Sleep routines, separation anxiety
- Nutrition: introduce more textures, iron-rich foods
- Language development and screen-free interaction
- Monitor for developmental concerns

Family Questions & Shared Decision-Making

- Ask:
 - a. “Do you have any concerns about how [Child’s Name] is growing, learning, or behaving?”
 - b. “Are there any questions we didn’t cover today?”

Post-Visit Follow-Up

- Provide milestone checklist and activity suggestions
- Offer contact info for developmental resources if any concerns
- Note any referrals or follow-ups in chart
- Document coaching moment and family strengths observed





Sample EPSDT Training Assessment for Community Health Center Staff

A. Pre-Training Assessment

Instructions: Choose the best answer(s) for each question.

1. EPSDT is a Medicaid program aimed to ensure children receive:
 - a) Emergency care only when needed
 - b) Preventive and medically necessary health care from birth through age 20
 - c) One-time immunizations
 - d) Services based only on parental request
2. Which of the following best describes the purpose of the periodicity schedule in EPSDT?
 - a) It is used for billing purposes only
 - b) It outlines mandatory immunization requirements
 - c) It provides a timeline for screenings based on age and development
 - d) It determines Medicaid eligibility
3. True or False: EPSDT includes both physical and mental health screenings.
☐ True
☐ False
4. What are the required components of an initial or periodic EPSDT screen? (Select all that apply)
☐ Comprehensive health and developmental history
☐ Unstructured observation
☐ Vision and hearing screening
☐ Laboratory tests and immunizations
☐ Documentation of school attendance
5. Why is accurate documentation critical in EPSDT services?
 - a) It helps complete the patient's record for internal office use
 - b) It ensures services are tracked, billed appropriately, and can be reviewed for compliance
 - c) It fulfills HIPAA training requirements
 - d) It reduces staff time on each visit

6. Which type of service is NOT typically covered under EPSDT unless medically necessary?
- a) Dental care
 - b) Hearing aids
 - c) Cosmetic surgery
 - d) Vision exams

A. Post-Training Assessment

Instructions: Choose the best answer(s) for each question.

1. Which of the following are essential elements to include when documenting an EPSDT visit? (Select all that apply)
- ☐ Date and time of visit
 - ☐ Components of the screening (e.g., hearing, vision, developmental)
 - ☐ Referrals provided
 - ☐ Provider initials only
2. EPSDT billing requires which of the following to be accurate and complete?
- a) Patient demographics only
 - b) Procedure codes, diagnosis codes, and appropriate modifiers
 - c) Medicaid eligibility report
 - d) Referral logs only
3. Which of the following best illustrates the role of the provider in delivering EPSDT services?
- a) Perform a basic exam and refer all children to a specialist
 - b) Conduct a comprehensive screening, document all components, educate families, and provide or coordinate follow-up
 - c) Focus on immunizations only
 - d) Collect forms and provide optional services
4. True or False: A provider may skip vision or hear screenings if they are short on time.
- ☐ True
 - ☐ False
5. A child receives a comprehensive EPSDT screen and is found to have a suspected developmental delay. What should be done next?
- a) Inform the parent but take no further action
 - b) Schedule another screen in 6 months
 - c) Refer for appropriate follow-up services and document the referral
 - d) Wait until symptoms worsen



6. EPSDT services must be provided:
- a) Only upon parental request
 - b) Based on the provider's availability
 - c) In accordance with the state's periodicity schedule and federal guidelines
 - d) Only when a child enters school

Answer Key

Pre-Training Assessment Answers

- 1. b
- 2. c
- 3. True
- 4. a, c, d
- 5. b
- 6. c

Post-Training Assessment Answers

- 1. a, b, c
- 2. b
- 3. b
- 4. False
- 5. c
- 6. c





Sample EPSDT Training Follow-Up Survey

Purpose: To gather feedback that will help us improve future trainings and ensure staff feel supported and informed.

Instructions: Please respond honestly based on your experience. All responses are confidential.

1. What is your role at the health center?
2. How would you rate the overall quality of the EPSDT training?
 - ☐ Excellent
 - ☐ Good
 - ☐ Fair
 - ☐ PoorPlease explain your rating:
3. Was the length of the training appropriate for the amount of content provided?
 - ☐ Too long
 - ☐ Just right
 - ☐ PoorPlease explain your answer:
4. Was the training content easy to understand and clearly presented?
 - ☐ Yes
 - ☐ Somewhat
 - ☐ NoPlease provide any suggestions for improvement:
5. Did the training improve your understanding of the EPSDT program and your role in it?
 - ☐ Yes
 - ☐ Somewhat
 - ☐ NoPlease explain:
6. Was the training platform or method of delivery (e.g., online module, in-person, slides) accessible and easy to use?

- ☐ Yes
- ☐ Somewhat
- ☐ No

If not, please describe any issues you experienced:

7. What part of the training did you find most useful?
8. What part of the training was least useful, or could it be improved?
9. Do you feel more confident documenting and billing for EPSDT services after this training?
 - ☐ Yes
 - ☐ Somewhat
 - ☐ NoPlease explain:
10. How meaningful was this training in terms of the care you provide to patients?
 - ☐ Very meaningful – it connects directly to patient care
 - ☐ Somewhat meaningful – some connection, but not always clear
 - ☐ Not very meaningful – did not feel directly relevantPlease share why you selected your response:
11. Does the current workflow in your department support consistent delivery of EPSDT services?
 - ☐ Yes
 - ☐ Somewhat
 - ☐ NoPlease explain what's working or where there are challenges:
12. What additional resources, support, or workflow changes would help you apply what you learned in the training?
13. Any additional comments or suggestions?





Sample EPSDT Training Tracker

[illegible]



Sample Internal EPSDT Training Memorandum

To: *All Clinical and Support Staff*

From: *[Your Name], [Your Title]*

Date: *[Insert Date]*

Subject: *Mandatory EPSDT Training Requirement for All Staff*

Dear Team,

As part of our ongoing efforts to improve the quality of care we provide to our pediatric patients, [Your Health Center Name] is implementing a mandatory training on EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) for all clinical and support staff who are involved in providing or documenting services for children and adolescents under Medicaid. Training is required and to be completed virtually by [XX date].

Why This Training Is Important

EPSDT is a critical component of the Medicaid program that ensures children and youth under age 21 receive appropriate preventive, dental, mental health, and developmental services. As a federally mandated benefit, EPSDT is essential in:

- Identifying and addressing health issues early
- Promoting healthy development and timely treatment
- Ensuring we are in full compliance with Medicaid regulations
- Improving documentation and billing accuracy

Training Details

- **Who is required:** All providers, nurses, medical assistants, case managers, early childhood experts, and billing/documentation staff
- **Format:** Online module + knowledge check, 90 minutes
- **Due Date:** [Insert deadline for completion]
- **How to Access:** [Insert training link or instructions]

What You Will Learn

- Overview of EPSDT guidelines and requirements
- Screening timelines and documentation standards
- Billing and coding for EPSDT services
- How to ensure compliance and improve care outcomes

We appreciate your commitment to high-quality care. This training will help ensure we're meeting our mission to provide comprehensive services to all members of our community, especially our youngest patients.

If you have any questions or need assistance accessing the training, please contact [Training Coordinator/HR Name] at [Email] or [Phone Number].

Thank you for your dedication and continued service.

Sincerely,

[Your Name]

[Your Title]

[Your Health Center Name]



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Sample EPSDT Awareness Facebook Posts (English and Spanish)

Post #1: “Is Your Child Covered for Checkups?” / “¿Tu hijo tiene sus chequeos al día?”

English:

EPSDT means FREE regular health checkups for kids on Medicaid!

From birth through age 21, your child can get:

- ✓ Vision & hearing screenings
- ✓ Dental care
- ✓ Developmental checks
- ✓ Mental health support
- ✓ Immunizations

Stay on track with well-child visits. It's your child's right — and it's covered!
Call us at [Health Center Number] or message us here to schedule.

[Health Center Name] | We're here for your family

#EPSDT #Medicaid #ChildHealth #FreeCheckups

Español:

EPSDT significa ¡chequeos médicos GRATIS para niños con Medicaid!

Desde el nacimiento hasta los 21 años, tu hijo puede recibir:

- ✓ Exámenes de visión y audición
- ✓ Cuidado dental
- ✓ Evaluaciones del desarrollo
- ✓ Apoyo de salud mental
- ✓ Vacunas al día

¡No te saltes los chequeos! Es un derecho de tu hijo — ¡y está cubierto!
Llámanos al [Número del Centro de Salud] o envíanos un mensaje para hacer una cita.

[Nombre del Centro de Salud] | Estamos aquí para tu familia

#EPSDT #SaludInfantil #ChequeosGratis #Medicaid

Post #2: “Did You Know?” / “¿Lo Sabías?”

English:

!! Many families don’t know their child’s Medicaid includes dental, mental health, AND hearing/vision care — all for FREE.

That’s the power of EPSDT:

- ✓ Early — catching problems early
- ✓ Periodic — regular check-ups
- ✓ Screening — tests to check your child’s health
- ✓ Diagnostic — finding out what’s wrong if there is a concern
- ✓ Treatment — getting the care they need

If your child seems behind on speech, struggles in school, or needs glasses — you can get help now. No referrals needed.

Comment “INFO” below or message us to learn more!

#EPSDTMatters #HealthyKidsHappyFamilies #MedicaidBenefits

Español:

!! Muchas familias no saben que Medicaid incluye cuidado dental, salud mental, exámenes de audición y visión — ¡todo sin costo!

Eso es EPSDT:

- ✓ Exámenes Tempranos
- ✓ y Periódicos
- ✓ con Diagnóstico
- ✓ y Tratamiento

Si tu hijo necesita lentes, terapia del habla o apoyo en la escuela — puedes obtener ayuda ahora mismo. No se necesita referencia.

Comenta “INFO” abajo o mándanos un mensaje para saber más.

#EPSDTImporta #NiñosSanosFamiliasFelices #BeneficiosDeMedicaid

Post #3: Parent Video/Testimonial / Testimonio de una madre



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English:

"When my son needed speech therapy, I had no idea it was fully covered by Medicaid. He's thriving now!" – Maria, local mom 💬

EPSDT gives families access to the care kids need to grow strong — and it's already included in your Medicaid plan.

Let us help you check what services your child qualifies for.
Message us or call [Number] to talk with a family care coordinator.

#ParentVoices #EPSDTWorks #SupportOurKids

Español:

"Cuando mi hijo necesitó terapia del habla, no sabía que estaba cubierta por Medicaid. ¡ahora le va muy bien!" – María, mamá local 💬

EPSDT da acceso a cuidados esenciales para que nuestros niños crezcan fuertes — y ¡ya está incluido en tu plan de Medicaid!

Déjanos ayudarte a revisar los servicios disponibles para tu hijo.
Mándanos un mensaje o llama al [Número] para hablar con nuestro equipo.

#VocesDePadres #EPSDTFunciona #ApoyoFamiliar



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Sample Script for Introducing Centers for Disease Control and Prevention (CDC) Positive Parenting Resources

Hello! I'm so glad we have a moment to talk today. I want to share a wonderful, free resource that many parents and caregivers have found helpful. It's called the CDC's Positive Parenting Tips. These tips come from the Centers for Disease Control and Prevention (CDC), and they're designed to support families in raising healthy, happy children. The great thing is that the tips are grouped by age – so whether your child is a baby, toddler, preschooler, or even a teenager, you'll find guidance that's tailored to your child's developmental stage.

The tips include:

- What to expect at different ages, and how to support your child's physical, emotional, and social development
- Ways to encourage positive behavior and healthy routines
- Signs to watch for that might suggest your child needs extra support

They are quick to read, written in plain language, and based on research about child development and family well-being.

You can explore the resources by visiting: https://www.cdc.gov/child-development/positive-parenting-tips/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/index.html

Feel free to take a look when you have time, and if you'd like, we can talk through any tips or ideas you find helpful!



Sample 6-Month Well-Child Visit: Parent-Driven Developmental Guidance Script (English and Spanish)

English: Provider-Family Script

Provider:

“Hi [Parent’s Name], it’s wonderful to see you and [Baby’s Name] today! At 6 months, babies are learning so much every day. I’d love to hear from you — what changes have you noticed lately in how [Baby’s Name] is growing or interacting?”

Explore Developmental Areas Using CDC Milestones:

“Thanks for sharing! Let’s walk through some key areas of development and hear what you’ve been seeing at home. Every baby develops at their own pace, so this is just a conversation to learn more.”

1. Social & Emotional:

“How does [Baby’s Name] respond to you or familiar faces? Do you see smiles or excitement when you come into the room?”

2. Communication:

“What kinds of sounds is [Baby’s Name] making lately? Are they babbling, or making new noises?”

3. Movement & Physical Development:

“Is [Baby’s Name] rolling over yet?” Sitting up with help?”

“What’s tummy time like these days — how often do you try it, and how do they respond?”

4. Cognitive & Play:

“Have they started reaching for toys or putting things in their mouth to explore?”

Parent-Led Guidance and Ideas:

“You’re doing such a great job — and I’d love to know: what kinds of things do you and [Baby’s Name] enjoy doing together right now?”

“Based on what you’re doing and what we’re seeing today, here are a few playful ways to support their development at this age:”

- Talk and sing to them often — even when you’re just doing chores.
- Offer colorful, safe toys they can grab or explore with their hands and mouth.

- Play simple games like peek-a-boo or ‘Where’s your nose?’ — these teach a lot!
- If they’re showing signs of readiness, you might begin offering soft, mashed foods, while continuing formula or breastfeeding.

Wrap-Up and Parent Partnership:

“What questions do you have about [Baby’s Name]’s growth, sleep, feeding, or anything else?”

“We’ll print your ASQ results and give you some fun take-home activities you can do together.

You’re doing amazing — and I’m here for you every step of the way.”

Español: Guion para el proveedor y la familia

Proveedor:

“Hola [Nombre del padre/madre], ¡qué gusto verlos a ti y a [Nombre del bebé] hoy! A los 6 meses, los bebés están aprendiendo muchísimo cada día. Me encantaría saber de ti — ¿qué cambios has notado últimamente en cómo crece o interactúa [Nombre del bebé]?”

Explorando áreas del desarrollo con las pautas de los CDC:

“Gracias por compartirlo. Vamos a repasar algunas áreas clave del desarrollo y me cuentas qué has notado en casa. Cada bebé se desarrolla a su propio ritmo, así que esta es solo una conversación para aprender más.”

1. Social y emocional:

“¿Cómo responde [Nombre del bebé] cuando ve a personas familiares? ¿Muestra sonrisas o emoción cuando te ve?”

2. Comunicación:

“¿Qué tipos de sonidos hace últimamente? ¿Balbucea o hace nuevos ruiditos?”

3. Movimiento y desarrollo físico:

“¿Ya se da vuelta? ¿Se sienta con apoyo?”

“¿Cómo le va con el tiempo boca abajo? ¿Con qué frecuencia lo hacen y cómo reacciona?”

4. Cognitivo y juego:

“¿Empieza a alcanzar objetos o se los lleva a la boca para explorar?”

Orientación y sugerencias centradas en la familia:

“Lo estás haciendo muy bien — y me encantaría saber: ¿qué cosas disfrutan hacer juntos tú y [Nombre del bebé] en este momento?”

“Con base en lo que haces y lo que vemos hoy, aquí tienes algunas ideas para apoyar su desarrollo:”

- Háblale y cántale seguido — incluso cuando estés haciendo tareas del hogar.
- Ofrecele juguetes coloridos y seguros que pueda agarrar o explorar con las manos y la boca.



- Jueguen a esconderse o a “¿Dónde está tu nariz?” — ¡estos juegos enseñan mucho!
- Si muestra señales de estar listo/a, puedes comenzar con alimentos suaves y triturados, además de seguir con leche materna o fórmula.

Cierre y colaboración con la familia:

“¿Qué preguntas tienes sobre el crecimiento, el sueño, la alimentación o cualquier otro tema relacionado con [Nombre del bebé]?”

“Vamos a darte una copia de los resultados del ASQ y algunas actividades divertidas para hacer en casa. Lo estás haciendo excelente — y estoy aquí para apoyarte en cada paso del camino.”





Sample Protocol for Introducing Scripts and Resources to the Team

1. Preparation Phase

- Leadership Buy-In
 - a. Present [the Centers for Medicare & Medicaid Services' \(CMS\) 2024 guidance on EPSDT](#) or other screening tool(s) and importance of proactive family engagement.
 - b. Sharing how integrating scripts and tools improves quality metrics, health outcomes, and patient satisfaction.
- Resource Distribution
 - a. Distribute printed or digital versions of the following:
 - 6-Month Well-Child Visit Script (English & Spanish)
 - CDC Developmental Milestone Checklists (6 months)
 - ASQ-3 Toolkit Summary

2. Training & Walkthrough Session

- Kickoff Training Agenda (60 mins)
 - a. Welcome & Purpose
 - Overview of EPSDT and anticipatory guidance
 - b. Why do parent-led conversations matter.
 - c. Script Demonstration
 - Role-play the 6-month visit using both English and Spanish scripts
 - Model the use of open-ended questions and affirming parent insights
 - d. Developmental Screening Integration (ASQ-3 or other screening tool)
 - Explain ASQ process and how to frame it as parent-empowering
 - Assign clear roles (e.g., medical assistant [MA] introduces ASQ, provider reviews it)
 - e. Techniques for Family-Centered Engagement
 - Using active listening
 - Encouraging storytelling
 - Responding to concerns without judgment

3. Implementation Workflow

Visit Step	Team Member	Action
Check-in	Front Desk / MA	Hand parent the ASQ-3 (paper or tablet)
Rooming	Provider	Review of ASQ responses & prep chart
Provider Visit	Provider	Use script to guide milestone conversation
Wrap-up	Provider / MA	Share results, give handouts, set next visit

Referral (if needed)	Care Coordinator	Connect family with early intervention services
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4. Reinforcement Tools

- Visual Reminders: Post laminated milestone checklists and conversation prompts in exam rooms
- Team Huddles: Quick milestone refreshers during morning huddles
- Monthly Spotlights: Feature one age group or milestone domain monthly (e.g., motor skills, language)





Sample Protocol for Introducing the “Newborn” Video From Small Moments, Big Impact

Objective: To introduce the [“Newborn” video](#) in a meaningful way that fosters reflection, builds empathy, and supports best practices in early relational health among community health center staff.

1. Preparation (Before the Session)

Audience:

Health center staff (medical providers, nurses, behavioral health clinicians, outreach workers, front desk staff, etc)

Materials Needed:

- The “Newborn” video (queued and tested)
- Projector or screen for video display
- Printed or digital reflection questions
- Notepads/pens for notes or journaling
- Flipchart or whiteboard for group discussion

Time Needed:

20–30 minutes

2. Introduction (5 minutes)

Facilitator Script:

“Thank you all for joining today. We're going to watch a brief video from the Small Moments, Big Impact series, which highlights the importance of everyday interactions between caregivers and newborns. These moments lay the foundation for lifelong emotional and physical health. This video helps us reflect on how our roles, no matter how small they may seem, can support families during a powerful and sensitive time.”

Optional Context:

Briefly introduce the series and its focus on early relational health (ERH).
Connect it to your center’s mission or work with families.

3. Viewing the Video (2–3 minutes)

Play the “Newborn” video.

4. Silent Reflection (3–5 minutes)

Invite participants to reflect silently or jot down thoughts:

- What stood out to you in this video?
- How did it make you feel?
- How does this relate to our work with families?

5. Group Discussion (10–15 minutes)

Break up into small groups of 2-3 and pair and share to allow time for active reflection. Share key takeaways as a large group.

Facilitator Prompts:

- What did this video make you think about in terms of supporting parents and newborns?
- Have you seen moments like these in your work? How did they impact the family?
- What can we do — as a team or as individuals — to help support early bonding and parent confidence?
- How do we already support these “small moments,” and how might we do more?

Optional Activity:

Write responses on a flipchart labeled:

- “What We’re Already Doing”
- “Opportunities to Grow”

6. Application and Wrap-Up (5 minutes)

Close the Session With:

“This video reminds us that even brief, kind, intentional interactions can shape a family's experience and their child’s development. Whether we’re giving a warm greeting, offering reassurance, or taking time to listen, these moments matter. Let’s keep this in mind as we support our patients and each other.”

Optional Next Steps:

- Incorporate the video into new staff orientation
- Share the video with patient-facing teams monthly
- Identify small changes that could support early relational health at your clinic





Sample Email to Partner Organization

Subject: *Exploring Collaboration to Support Early Childhood Development for All Families*

Dear [Leader's Name],

I hope this message finds you well.

My name is [Your Name], and I'm reaching out on behalf of [Your Organization/Health Center Name]. We're currently exploring opportunities to partner with organizations that are actively promoting birth to five early childhood development, especially those working to ensure approaches are tailored to the needs of all families.

Given your organization's impactful work in the community, we would love to learn more about your current programming, particularly any efforts related to early childhood development, family engagement, or health promotion in early years.

We're interested in identifying areas of alignment and exploring ways we might collaborate, whether that's through shared outreach, coordinated programming such as training, or mutual support in promoting developmentally appropriate services.

Would you be open to a brief conversation in the coming weeks to discuss your current work and potential synergies?

Thank you for all that you and your team do for families in our community. I look forward to the possibility of connecting.

Warm regards,
[Your Full Name]
[Your Title]
[Your Organization Name]
[Phone Number]
[Email Address]
[Website, if applicable]



Sample Memorandum of Understanding

This Memorandum of Understanding (MOU) is entered into by and between:

- Organization A: [Insert Name and Address]
- Organization B: [Insert Name and Address]

This MOU outlines the terms of collaboration to promote early childhood development and well-being through coordinated services, outreach, and support for families.

1. Purpose and Scope

- Define the shared vision and purpose of the partnership.
- Describe the target population and geographic or service area.

2. Roles and Responsibilities

- Outline each organization's roles in service delivery, outreach, and coordination.
- Specify responsibilities for referrals, resource sharing, or family support.

3. Services and Activities

- List joint activities (e.g., cross-referrals, family workshops, resource distribution).
- Describe collaborative services such as warm handoffs, co-location, or shared training.

4. Communication and Coordination

- Define primary points of contact for each organization.
- Specify frequency and format of communication (e.g., monthly check-ins, quarterly meetings).

5. Referral Process

- Outline protocols for making and tracking referrals between partners.
- Include consent and follow-up procedures.

6. Confidentiality and Information Sharing

- Address HIPAA, FERPA, or other applicable privacy regulations.
- Describe any agreed-upon data sharing practices or limitations.

7. Evaluation and Continuous Improvement

- Define shared outcomes or metrics to assess partnership success.
- Identify tools and frequency for reviewing partnership effectiveness.

8. Term and Review

- State the duration of the MOU and any renewal or termination clauses.

- Describe the process for reviewing and updating the agreement.

9. Signatures

This MOU is entered into on [Insert Date] and is effective for a period of [Insert Duration].

Organization A:

Name: _____

Title: _____

Signature: _____

Date: _____

Organization B:

Name: _____

Title: _____

Signature: _____

Date: _____



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Sample Completed Well Visit Planner – 9-Month-Old

Child's Name: *Emma Rivera*

Date of Birth: *06/15/2023*

Parent/Guardian Name: *Ana Rivera*

Upcoming Visit Date: *03/29/2024*

Developmental Milestones (Parent Responses):

Gross Motor:

- ☐ Sits without support – Yes
- ☐ Begins to crawl – Yes
- ☐ Pulls to stand – Not yet

Fine Motor:

- ☐ Transfers objects between hands – Yes
- ☐ Uses raking grasp to pick up small items – Yes

Communication:

- ☐ Responds to name – Yes
- ☐ Babbles with consonants (e.g., ba, da) – Yes
- ☐ Points or gestures – Not yet

Social/Emotional:

- ☐ Shows stranger anxiety – Yes
- ☐ Enjoys social games like peek-a-boo – Yes

Parental Concerns or Topics to Discuss:

- ☐ Concerned Emma isn't pulling to stand yet
- ☐ Would like to talk about feeding (introducing more solids)
- ☐ Has questions about safety now that she's crawling

Provider Summary and Bright Futures Prompts – 9-Month Visit

Patient: *Emma Rivera*

Age: *9 months*

Visit Type: *Well-Child Check*

Parent Priorities: *Development (gross motor), feeding, safety*

Summary:

Emma is meeting most 9-month developmental milestones. She is sitting without support, crawling, and transferring objects between hands. She is babbling and showing appropriate social behaviors. Parents report she has not yet started to pull to stand or use gestures like pointing.

Areas to monitor:

- Gross motor delay: Not pulling to stand yet (mild concern)
- Expressive communication: Not waving (watchful waiting)
- Discuss developmental surveillance plan and consider follow-up if concerns persist at 12-month visit

Feeding Discussion:

- Parent is ready to increase solids
- Discuss appropriate textures and self-feeding skills (pincer grasp emerging)

Safety Discussion:

- Child is crawling — discuss home safety, baby-proofing, and supervision
- Review choking hazards, car seat use, and water safety

Bright Futures Anticipatory Guidance Prompts:

- Development and Behavior: Encourage floor play, interactive games, and opportunities for pulling up with supervision.





Sample Cycle of Engagement Testing Huddle Flow (15-20 Minutes)

1. Quick Welcome & Focus Reminder (2 min)

Team Lead or Champion welcomes the team and reminds every one of the goal:

“We’re here to check in on how the Cycle of Engagement – Well Visit Planner (WVP) is going – especially to spot barriers and think about what specific families or populations might need more support.”

2. Snapshot of Progress (3-4 min)

Data Check-in (if available):

- Number of families invited to complete the WVP
- Percent completion rates by population (e.g., language, age group, insurance type)
- Common flagged priorities (development, behavior, food security)

Ask:

“Any quick wins or signs the tool is helping families engage more in the visit?”

3. Identify Emerging Barriers (5-6 min)

Prompt discussion:

- Are any families having trouble accessing or completing the WVP?
- Any technical issues (wrong emails, electronic health record integration, and printing)?
- Any staff uncertainty about roles or timing in the workflow?
- Are there populations we’re not reaching (e.g., non-English speakers, teen parents)?

Record themes quickly on a whiteboard, sticky notes, or shared doc.

4. Tailor Support for Specific Populations (4-5 min)

Choose 1-2 identified populations and brainstorm:

- What’s getting in the way for this group?
- What can we test or adjust this week?
- Translation?
- In-person WVP help during check-in?
- Family relevant examples or reminders?
- Staff script tweaks?

5. Decide on a Tiny Test or Next Step (2 min)

Use a Plan-Do-Study-Act mindset:

- What can we test before the next huddle?

“Let’s try offering printed WVPs in Spanish for walk-ins this week.”

Assign who’s tracking or following up.

6. Appreciation & Wrap-Up (1 min)

Quick gratitude round:

“Thanks to Maria for catching that email mismatch issue last week!”

Confirm next huddle time to update the plan.



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Sample Electronic Health Record Template: Well Visit Planner Well-Child Visit (0-5 Years)

1. Reason for Visit

Well-child visit – [Age]

- ☐ Preventive care
- ☐ Developmental surveillance
- ☐ Parental priorities from Cycle of Engagement – Well Visit Planner (COE-WVP)

2. Pre-Visit Summary

COE-WVP Completed: [Yes/No]

Date Completed: [MM/DD/YYYY]

Parent-Reported Priorities:

- [Insert top 1-3 priorities from WVP]

Developmental Concerns Identified by Parent:

- [Select: None | Speech | Behavior | Motor | Social | Other: _____]

Social Determinants / Family Context Noted:

- [Select: Food | Housing | Childcare | Mental Health | None | Other: _____]

3. Developmental Surveillance

Milestone Review (based on age):

- ☐ Motor
- ☐ Language
- ☐ Social-emotional
- ☐ Cognitive

Concerns raised by provider:

- [None | Area(s) of concern: _____]

Comparison with previous visits (if applicable):

- [Improved | Stable | Regression noted in: _____]

4. Anticipatory Guidance (Select Age-Specific Topics)

- ☐ Nutrition & feeding
- ☐ Sleep
- ☐ Language stimulation
- ☐ Behavior & routines
- ☐ Screen time
- ☐ Safety (home, car, water, etc.)

- ☐ Toilet training
- ☐ School readiness

Handouts Given: *[Yes/No]*

Referred to: *[e.g., HealthySteps, early intervention, care coordination]*

5. Screening Tools Completed

- **Edinburgh:** *[Yes/No]*
- **ASQ-3 / ASQ:SE:** *[Yes/No]*
- **MCHAT:** *[Yes/No]*
- **Maternal Depression (PHQ-2/9):** *[Yes/No]*
- **Lead Risk:** *[Yes/No]*
- **Vision/Hearing:** *[Yes/No]*
- **Immunizations Updated:** *[Yes/No]*

6. Plan / Next Steps

Key Takeaways for Family:

- *[Auto-populate from WVP Summary or note main messages]*

Referrals / Follow-up:

- ☐ Early Intervention
- ☐ Developmental Specialist
- ☐ Infant Early Childhood Mental Health
- ☐ Social Work
- ☐ Follow-up in *[timeframe]*

Visit Summary Reviewed with Family: *[Yes/No]*





Sample Email, Text, and Phone Script for Sending Well Visit Planner Reminders to Families

Sample Email Reminder

Subject: Help Us Prepare for Your Child's Upcoming Well-Child Visit

Dear [Parent/Guardian Name],

We're looking forward to seeing you and [Child's Name] for their upcoming well-child visit on [Appointment Date] at [Time].

To help us provide the best care possible, please take a few minutes to complete the Well Visit Planner ahead of your appointment. This helps us understand your child's development and your priorities for the visit.

Click here to get started: [Insert Well Visit Planner link]

It only takes about 10 minutes, and your input helps make the visit more personalized and meaningful.

If you have any questions or need help completing the form, please call us at [Clinic Phone Number].

Warmly,
[Your Name]
[Community Health Center Name]

Sample Text Message Reminder

[Community Health Center Name]: Hi [Parent First Name]! Please complete the Well Visit Planner before [Child's Name]'s appointment on [Date] at [Time]. It helps us prepare for your visit. [Insert link]

Need help? Call us at [Phone Number].

Sample Phone Call Script

Staff:

Hello, this is [Your Name] calling from [Community Health Center Name]. May I please speak with [Parent/Guardian Name]?

Parent responds.

We're calling to remind you of [Child's Name]'s upcoming well-child visit on [Date] at [Time]. To help us get ready and make the most of your visit, we encourage you to complete the **Well Visit Planner** before your appointment. It's a short questionnaire that helps us learn about your child's development and any questions or priorities you may have.

You can complete it online here: [Insert link]

Would you like us to text or email you the link right now? If you have any trouble accessing it, feel free to give us a call at [Phone Number], and we'd be happy to help. Thanks so much – we look forward to seeing you soon!



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Sample Well Visit Planner Onboarding Guide for Community Health Centers

What Is the Cycle of Engagement – Well Visit Planner?

The Cycle of Engagement-Well Visit Planner (COE-WVP) is a family-centered tool that helps parents and caregivers prepare for well-child visits by sharing their concerns, priorities, and observations ahead of time. It strengthens the partnership between providers and families and improves developmental care.

Why It Matters

- Puts families at the center of care
- Encourages early identification of developmental and social needs
- Supports more focused and efficient visits
- Aligns with Bright Futures guidelines and best practices

How It Works: The Cycle of Engagement

1. **Pre-Visit (3-5 days before):** Families receive a secure link to complete the WVP online (or in paper form if needed).
2. **Visit Preparation (1-2 days before):** Staff review the completed WVP and flag concerns, needs, or priorities using a checklist or summary.
3. **Well Visit Day:** Providers use the WVP summary to:
 - Start conversations about child development
 - Address family-identified priorities
 - Guide developmental surveillance and anticipatory guidance
4. **Post-Visit Follow-Up:** Reinforce key points and referrals; provide resources aligned with family goals.

Your Role (Depending on Staff Position)

- ✓ Front Desk/Administrative Staff
 - Send WVP links to families when scheduling visits
 - Remind families to complete WVP before the appointment
- ✓ Medical Assistants/Nurses
 - Print or upload the WVP summary to the electronic health record (EHR)
 - Flag any concerns and prep materials for the provider
- ✓ Providers
 - Review of the WVP summary
 - Use family input to guide the developmental conversation
 - Complete any screenings, referrals, or anticipatory guidance

- ✓ Care Coordinators
 - Support follow-up actions
 - Help connect families to resources for referrals or developmental supports

Key Tips for Success

- Encourage families to complete the WVP as early as possible
- Use the summary as a conversation starter, not a checklist
- Check the WVP portal or EHR for flagged concerns before entering the room
- Celebrate the family's role in their child's development!

Resources

- COE-WVP Website: <https://www.wellvisitplanner.org>
- Training Videos & FAQs: Available through your health center intranet or training coordinator
- Bright Futures Guidance: <https://brightfutures.aap.org>

Questions?

Ask your site champion or care coordination lead for support. We're all in this together to provide exceptional, family-centered care!



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Sample Family Advisory Group Agenda

Meeting Title: *Family Voices in Screening & Surveillance*

Date: *[Insert Date]*

Time: *[Insert Time]*

Location: *[Insert Location or Virtual Link]*

Meeting Objectives:

- Introducing the Family Advisory Group and its purpose
- Gather family input on developmental and social screening processes
- Discuss how the clinic can better support families in understanding and completing screenings

Agenda:

Time	Topic	Lead
10 Min	Welcome & Introductions	Facilitator / Family Engagement Lead
10 Min	Overview: Screening and Surveillance in Well-Child Visits	Pediatric Provider / Clinical Lead
20 Min	Family Experience Sharing: What Works, What's Confusing?	Group Discussion
20 Min	Brainstorm: How Can We Improve Communication and Support?	Breakout or Group Activity
10 Min	Wrap-Up & Next Steps	Facilitator



Sample Family Advisory Group Charter

Name: Family Advisory Group on Developmental Screening & Family-Centered Care

Purpose: To ensure that family voices help shape how the community health center delivers developmental, behavioral, and social needs screening. The group provides feedback, identifies barriers, and co-designs solutions that support comprehensive, respectful care for young children and their families.

Goals:

1. Increase family understanding and engagement in screening and surveillance processes.
2. Improve the design and delivery of screening workflows (e.g., Well Visit Planner, electronic health record alerts).
3. Ensure that materials and communication are family and linguistically appropriate.
4. Promote trust and partnership between families and providers.

Membership:

- 5-8 parent or caregiver representatives of children ages 0-5
- 2-3 clinic staff members (e.g., care coordinator, pediatrician, behavioral health)
- Family Engagement Coordinator (Facilitator)

Responsibilities:

- Attend monthly meetings (virtual or in-person)
- Share personal experiences and represent family perspectives
- Review and provide input on screening forms, reminders, workflows, and materials
- Collaborate on projects to improve communication and access

Meeting Schedule:

- Monthly, 60-minute meetings
- Additional ad-hoc working sessions as needed

Support Provided:

- Stipends or gift cards for family participation
- Child care or virtual participation options
- Translation and interpretation services if needed



Sample Invitation Letter to Recruit Family Advisory Members

Dear Parent or Caregiver,

We invite you to join our Family Advisory Group at [Community Health Center Name]! This group brings together parents and caregivers to help shape how we support families through developmental, behavioral, and socio-emotional screenings for children ages 0-5. Your voice and lived experience are powerful tools for improving the care we provide.

As a member of the Family Advisory Group, you will:

- Share your thoughts and ideas about the screening process during well-child visits.
- Help us improve communication, tools, and reminders for families.
- Collaborate with staff to ensure our services are respectful, helpful, and family-centered.

Sample Timeframe and Commitment:

- Monthly meetings (virtual or in-person) lasting 60 minutes.
- Opportunity to review materials or attend short working sessions between meetings.
- A 6-month term, with the option to continue or rotate off.
- Participation stipend or gift card in the amount of [XX] provided for your time and input.

We welcome family members with children of all abilities and backgrounds. No experience is needed, just a willingness to share your perspective and ideas!

If you are interested in joining or learning more, please contact [Name] at [Phone Number] or [Email Address]. We look forward to partnering with you to make a difference in our community.

With appreciation,

[Your Name]

[Your Title]

[Community Health Center Name]



Sample Guide for Embedding the Promoting Healthy Development Survey (PHDS) Into Post-Visit Workflows

Embedding PHDS in Paper-Based Workflows

When to Use:

- For clinics without a fully integrated electronic health record (EHR) or limited IT capacity.
- As part of check-out or follow-up packet.

How to Implement:

1. Distribute at Check-Out:

- Hand the survey to families as they leave a well-child visit.

2. Attach to Visit Summary:

- Include PHDS in printed after-visit summary materials.

3. Set Up Collection System:

- Provide drop-boxes at front desk or waiting room for anonymous return.

4. Staff Follow-Up:

- Call or text families after the visit to complete PHDS on paper or over the phone.

5. Translate Forms:

- Offer PHDS in the family's preferred language.

Embedding PHDS Into EHR Workflows (Post-Visit)

When to Use:

- EHRs with patient portal or survey delivery capabilities (e.g., Epic MyChart, Athenahealth, eClinicalWorks).

How to Implement:

1. Build into EHR Workflow:

- Add a smart phrase or trigger in the after-visit summary (AVS) to include a PHDS link or QR code.
- Include the PHDS link in appointment reminder follow-ups sent 1-3 days post-visit.

2. Use the Patient Portal:

- Send PHDS through secure messaging via the patient portal.
- Automate reminders for completion after specific well-visit types.

3. Integrate via API or Embed Code:

- If supported, embed a secure PHDS link or iframe in the post-visit dashboard.
- Work with IT or your EHR vendor to ensure data privacy.

4. Track Completion and Feedback:

- Set up a reporting system to monitor response rates.
- Review aggregated feedback regularly for quality improvement.

Best Practices for Integration

- Inform Families: Let caregivers know their feedback helps improve care.
- Limit Burden: Make the process simple with a link, QR code, or drop-off option.
- Incentivize Participation: Offer small incentives or raffle entries.
- Close the Loop: Share “You said, we did” summaries to build trust and engagement.





Sample Promoting Healthy Development Survey (PHDS) Implementation Checklist – Weekly Review Checklist (Pilot Period)

Use this checklist to guide the weekly collection and review of Promoting Healthy Development Survey (PHDS) responses during the test period. Help ensure a consistent, actionable approach to family feedback.

Set-Up Tasks

- ☐ Identify pilot dates (e.g., April 1-June 30)
- ☐ Determine eligible visit types (e.g., 9-, 18-, 24-, 30-month visits)
- ☐ Assign PHDS coordinator and reviewers
- ☐ Prepare printed surveys or digital links/QR codes
- ☐ Set up secure storage (locked box or HIPAA-compliant platform)

Daily Workflow

- ☐ Front desk/medical assistant distributes PHDS after eligible well-child visits
- ☐ Families complete paper or digital version at check-out or home
- ☐ Collect completed paper forms at end of day and log count

Weekly Review (e.g., every Friday)

- ☐ Tally surveys distributed vs. received
- ☐ Summarize key themes (family understanding, satisfaction, concerns)
- ☐ Identify any trends or red flags from open comments
- ☐ Hold 30-minute huddle with quality improvement lead, provider, and front desk rep

Tracking and Documentation

- ☐ Enter survey counts and findings into tracking log or spreadsheet
- ☐ Highlight suggestions or insights for workflow improvements
- ☐ Share summary with clinic team at weekly staff meeting

Follow-Up

- ☐ Adjust workflow, communication, or training based on feedback
- ☐ Identify family participants for additional input or advisory group



Sample Scope of Work: Family Advisory – Surveillance and Screening Co-Design

This scope of work outlines the responsibilities and expectations for a Family Advisor who will partner with the community health center to inform and co-design developmental surveillance and screening processes. The ideal candidate brings lived experience as a caregiver and strategic insight as a member of the Health Center's Board of Directors.

Role Purpose

The Family Advisor will help ensure that surveillance and screening processes reflect the needs, preferences, and experiences of families served by the health center. They will act as a bridge between leadership and the community, bringing insights from both perspectives to shape more comprehensive, family-centered systems.

Key Responsibilities

- Participate in planning meetings and working sessions related to early childhood screening and surveillance.
- Review and provide input on tools, workflows, forms, and family-facing materials (e.g., screening reminders, handouts).
- Serve as a liaison between families and health center leadership, sharing insights and lifting up community feedback.
- Co-design and help facilitate feedback mechanisms such as surveys or focus groups.
- Participate in Family Advisory Group meetings and support engagement of other family members.
- Help evaluate pilot projects and offer recommendations for refinement and sustainability.
- Maintain regular communication with staff and provide brief written or verbal summaries when needed.

Time Commitment

- Estimated 2-4 hours per month
- Monthly meetings (virtual or in-person), plus ad-hoc feedback sessions as needed
- Term: 6 months, with the option to renew or expand based on interest and project needs

Compensation

Family Advisors will receive a monthly stipend or gift card in the amount of [XX] as a token of appreciation for their time and contributions.

Qualifications

- Current recipient of pediatric services at the community health center.
- Parent, guardian, or primary caregiver of a child under age 6.
- Experience serving on the Health Center Board of Directors.
- Interest in improving family-centered care and early childhood development services.
- Ability to communicate ideas clearly and respectfully in group settings.





Sample Baseline Assessment of CLAS Standard #6 in Community Health Centers

This brief baseline assessment guides community health centers in evaluating current practices related to CLAS Standard 6: Informing all individuals of the availability of language assistance services clearly, in their preferred language, verbally and in writing.

Goal of the Assessment

Determine how consistently and effectively the health center informs patients about the availability of language assistance services, both verbally and in writing, and whether this is done in the patient's preferred language.

Step-by-Step Baseline Assessment Process

1. Define the Scope

Focus on front-desk, registration, and clinical intake processes, including all entry points where patients interact with staff or materials (in-person, phone, patient portal).

2. Review Written Materials

Check whether information about language services is:

- ☐ Clearly visible on signage, check-in desks, and waiting rooms
- ☐ Included in registration packets and after-visit summaries and available in the top 3-5 languages spoken by your patient population

Checklist:

- ☐ Signage posted about free language assistance written notice in top languages available at front desk
- ☐ Language services info included in the after-visit-summary/patient packet
- ☐ Taglines or nondiscrimination notices on key documents

3. Staff Interviews or Surveys

Ask staff:

- How do you inform patients of their right to free language assistance?
- Are you trained to offer interpreter services or translated materials?
- What do you say to a patient who may need language support?

Sample survey questions:

- Do you verbally inform patients of their right to an interpreter? (Always / Sometimes / Never)

- Do you provide this information in the patient’s preferred language? (Yes / No / Not Sure)
- Are materials about language assistance services visibly posted in your area? (Yes / No)

4. Review Electronic Health Record (EHR) Intake Process

Check how the EHR captures preferred spoken and written language and whether offers of language assistance are documented.

5. Summarize Findings

Use the table below to summarize results:

Assessment Area	Current Practice	Gaps	Notes
Verbal notice of LAS	Staff sometimes offer interpreters	Inconsistent across shifts	Needs scripting
Written materials	Present in English only	Limited translation	Prioritize top 3 languages
EHR language fields	Captured at intake	Not consistently updated	Staff training needed

6. Share and Plan Next Steps

Present findings to leadership and staff. Recommend training, improved signage, translated materials, or updated workflows. Integrate this process as part of an organization’s Language Access Plan if you have Limited English Proficient patients. Re-assess quarterly or biannually to track progress.





Sample Email to Partner Organization

Subject: *Exploring Collaboration to Support Early Childhood Development for All Families*

Dear [Leader's Name],

I hope this message finds you well.

My name is [Your Name], and I'm reaching out on behalf of [Your Organization/Health Center Name]. We're currently exploring opportunities to partner with organizations that are actively promoting birth to five early childhood development, especially those working to ensure approaches are tailored to the needs of all families.

Given your organization's impactful work in the community, we would love to learn more about your current programming, particularly any efforts related to early childhood development, family engagement, or health promotion in early years.

We're interested in identifying areas of alignment and exploring ways we might collaborate, whether that's through shared outreach, coordinated programming such as training, or mutual support in promoting developmentally appropriate services.

Would you be open to a brief conversation in the coming weeks to discuss your current work and potential synergies?

Thank you for all that you and your team do for families in our community. I look forward to the possibility of connecting.

Warm regards,
[Your Full Name]
[Your Title]
[Your Organization Name]
[Phone Number]
[Email Address]
[Website, if applicable]



Sample Invitation for Joining the Asset Mapping Team

Subject: Invitation to Join the Community Asset Mapping Team at [Health Center Name]

Dear [Stakeholder's Name],

I hope this message finds you well. At [Health Center Name], we are committed to improving the health and well-being of our community by enhancing our care coordination efforts. As part of our ongoing efforts to provide comprehensive and effective care, we are launching a Community Asset Mapping initiative. This initiative aims to identify and map existing resources within the community to improve patient outcomes and address critical needs.

We would like to extend an invitation for you to join our Community Asset Mapping Team. As a valued member of the community and a key stakeholder in [specific area, such as healthcare, housing, or education], your insights and expertise will be invaluable in helping us identify resources, services, and organizations that contribute to community well-being.

The goals of the Community Asset Mapping initiative include:

- Identifying existing resources and services that can support patients' social and healthcare needs
- Mapping community assets such as healthcare providers, food programs, housing services, and educational opportunities
- Strengthening collaboration among community organizations to improve care coordination and resource utilization
- Ensuring that patients and families are connected to the appropriate services to address their unique needs

We would love to have your participation in the process. We are planning a series of initial meetings where we will discuss the scope of the project, define roles, and begin the mapping process. Your input will be essential as we work together to build a comprehensive map of our community's assets.

Details of the first meeting:

- **Date:** [Proposed Date]
- **Time:** [Proposed Time]
- **Location:** [Meeting Location] / [Virtual Meeting Link]
- **Agenda:** Introduction to the Community Asset Mapping project, team roles, next steps

If you are interested in joining our team, please confirm your attendance by replying to this email or contacting me directly at [Your Contact Information].

We greatly appreciate your consideration and hope to work alongside you to make a lasting impact on our community's health and well-being.

Thank you for your time and commitment to improving the lives of our community members.

We look forward to your participation.

Warm regards,
[Your Full Name]
[Your Title]
[Health Center Name]
[Phone Number]
[Email Address]



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Sample Secure Email Template for Coordinated Referrals

Subject Line: *[Secure]* Referral Coordination Request – [Client Initials] – [Service Type]

Email Body Template:

Less

Copyedit

[SECURE EMAIL NOTICE: Please ensure this message is opened using secure, HIPAA-compliant systems.]

Dear [Partner Organization Name / Contact Person],

I am reaching out to coordinate care for a shared client who has complex needs across medical, behavioral health, and/or social domains. Below are the referral details:

- **Client Info (Initials or ID only):** [E.G., J.D. / #10123]
- **Date of Birth:** [MM/DD/YYYY]
- **Referral Date:** [MM/DD/YYYY]
- **Referring Organization:** [Your Agency Name]
- **Referral Contact:** [Your Name, Phone, Secure Email]
- **Referral Type:** [E.g., Behavioral Health / Housing Assistance / Developmental Screening]
- **Reason for Referral:** [Brief explanation of current needs and goals]
- **Urgency:** [Routine / Urgent / Crisis]

Requested Actions:

- Please confirm receipt of this referral.
- Contact the client (if appropriate) within [X] business days.
- Update us on appointment status or service access.

Additional Notes:

[Any relevant background info, care coordination points, or attachments.]

Thank you for your collaboration and commitment to whole-person care.

Sincerely,

[Your Name]

[Your Title]

[Organization]

[Secure Phone Number]

[Secure Email Address]

Security Tips:

- Use encrypted email platforms (e.g., Virtru, Paubox, Office365 Encrypted Mail).
- Limit identifiable info unless encryption is verified.
- Attach secure referral forms or signed releases when appropriate.



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Sample Shared Referral Tracking Spreadsheet (Google Sheets or Excel)

Title: Community Care Coordination & Referral Tracking Tool

Purpose: To create a centralized, easy-to-use referral log that helps community providers track client needs, referrals, follow-up actions, and outcomes across multiple sectors (health, behavioral, social services).

Suggested columns:

Client ID	Client Name	Date of Birth	Referral Date	Referred By	Referred To	Service Type	Reason for Referral	Status	Follow-Up Date	Outcome / Notes	Contact Person
-----------	-------------	---------------	---------------	-------------	-------------	--------------	---------------------	--------	----------------	-----------------	----------------

Instructions for Use:

- Each provider updates the spreadsheet when initiating or receiving a referral.
- Assign one column owner per row to follow up and complete notes.
- Use color codes (e.g., green = completed, yellow = pending, red = urgent).
- Protect client-identifying info if using shared platforms, and use codes if needed.
-

Access Recommendation:

- Use Google Sheets with restricted, invite-only access.
- Enable version control and change tracking.
- Optional: Add tabs for each service domain (health, mental Health, housing, etc).



Sample Family Care Transition Plan

Community Health Center: _____

Date Created: _____

Reviewed/Updated On: _____

Facilitator/Care Coordinator: _____

Family Name: _____

Child/Individual's Name: _____

Date of Birth: _____

I. Family's Goals

Goal Type	Specific Goal Description	Target Date

II. Action Steps to Achieve Each Goal

Goal Reference	Action Step	Person Responsible	Start Date	Due Date	Notes/Status

III. Family Preferences

Use this section to document linguistic, religious, scheduling, and caregiving preferences.

Preferred Language for Communication: _____

Religious Considerations: _____

Preferred Service Delivery Times/Days: _____

Preferred Providers or Settings: _____

Other Family Preferences (e.g., values, traditions, goals): _____

IV. Formal Supports (Professional Contacts)

Provider Name	Role/Service	Organization	Contact Info

V. Informal Supports

Name	Relationship to Family/Individual	Role in Support Plan	Contact Info

VI. Additional Notes or Special Considerations

Include anything not already captured above that is critical for smooth transition planning.

VII. Signatures

Parent/Guardian Name & Signature: _____

Date: _____

Transition Coordinator/Care Manager: _____

Date: _____

Other Relevant Team Member(s): _____

Date: _____





Sample Family Review Questions for the Transition Plan

- A. Does this plan give you a clear and comfortable way to share your values, goals, and what matters most to your family?
- B. Are there places in the plan where you can explain your hopes and concerns in your own words?
- C. Do the sections about short- and long-term goals feel meaningful and helpful to your family's current situation and future plans?
- D. Do you feel encouraged to set both medical and everyday life goals (like school, friendships, or independence)?
- E. Is the language in the plan easy for you to understand?
- F. Would it be helpful to have the plan in another language or with simpler wording?
- G. Does the plan help you include the people who support you, like extended family, friends, or community members?
- H. Are there enough places to write about these informal supports?
- I. Do the steps and responsibilities in the plan feel doable for your family?
- J. Are you given space to say what help you need to follow through with the plan?



Sample Training Module: Implementing Family Care Transition Planning

Audience: Providers, Care Coordinators, Early Childhood Specialists

Duration: 30-45 minutes

Format: Brief presentation + case discussion + Q&A

Learning Objectives:

1. Understand the purpose and principles of family-centered care transition planning.
2. Navigate and use the Family Care Transition Plan template effectively.
3. Facilitate meaningful family engagement in planning.
4. Coordinate formal and informal supports for successful transitions.

Part 1: Why Family Care Transition Planning Matters

Definition: A structured approach to supporting families through transitions (e.g., developmental stages, provider changes, program exits).

Why it's important:

- Prevents gaps in care
- Reduces family stress
- Builds independence and long-term stability

Who it's for: Children and families facing care shifts due to age, health, or setting changes.

Part 2: Overview of the Transition Plan Template

Key Sections:

- I. Family's Goals – Captures family-defined short- and long-term goals
- II. Action Steps – Identifies who will do what and by when
- III. Preferences – Ensures linguistic and scheduling needs are honored
- IV. Formal Supports – Names professional contacts and services
- V. Informal Supports – Acknowledges natural support networks (e.g., relatives, friends)
- VI.-VII. – Documents additional needs and signatures

Part 3: Protocol & Workflow

Step-by-Step Guide:

1. Identify Transition Point – Age-based or system change
2. Schedule a Transition Planning Meeting – Include all relevant participants
3. Facilitate Collaborative Completion of the Template – Start with goals, co-develop actions, document supports
4. Assign Follow-Up Roles – Define who checks on each action item
5. Store & Share the Plan – Save in electronic health record or system and share with family
6. Review & Update – Regularly review and update (e.g., every 6 months)

Part 4: Case Example & Practice

Scenario: A 3-year-old child transitioning from early intervention to a preschool special education program.

Discussion Points:

- What are short-term and long-term goals?
- What informal supports could be involved?
- What role will the care coordinator play?

Part 5: Q&A and Discussion

- Barriers to implementation?
- What support do teams need to integrate this into daily workflow?





Sample Warm Handoff Protocol for Community Health Center Referrals

Purpose: To ensure that families feel supported and informed when transitioning to services outside of the community health center (e.g., early intervention, infant mental health, preschool special education, sub-specialty care).

Team Roles & Responsibilities:

1. Primary Care Provider (PCP)

Role: Initiator of Referral

Responsibilities:

- Discuss the referral with the family using plain, respectful language
- Explain the purpose, benefit, and next steps
- Document the reason for referral in the electronic health record (EHR)
- Provide initial clinical documentation required by the referral agency
- Warmly introduce the care coordinator (in person or virtually)

2. Care Coordinator or Referral Specialist

Role: Central Point of Contact for Coordination

Responsibilities:

- Meet with the family to review referral details
- Confirm family understanding and answer questions
- Obtain consent for release of information and coordinate paperwork
- Contact the receiving agency/provider to confirm referral was received
- Schedule follow-up with the family to check on referral status (within 5 days and again by 14 days)
- Ensure outcomes are recorded in EHR

3. Medical Assistant or Front Desk Staff

Role: Administrative Support

Responsibilities:

- Provide the family with referral handouts or care instructions
- Assist with scheduling any appointments, transportation coordination, or interpreter needs
- Ensure the family leaves the visit with clear next steps and contact information

4. Behavioral Health or Early Childhood Specialist (if applicable)

Role: Supportive Services Connector

Responsibilities:

- Join the handoff if the referral is behavioral, developmental, or social-emotional
- Offer trauma-informed guidance and emotional support to the family
- Coordinate directly with the receiving mental health or early childhood provider as needed

5. Family Engagement Liaison or Peer Support (if available)

Role: Family Advocate

Responsibilities:

- Provide lived experience and emotional support during the handoff
- Help the family prepare questions for the new provider
- Follow up with the family after the first appointment to offer continued encouragement

Key Elements of a Warm Handoff:

- In-Person or Real-Time Introduction (phone, video, or live)
- Simple, Clear Language tailored to the family's literacy level
- Acknowledgment of Family Values and Concerns
- Documentation of All Steps in the EHR and referral tracking tool



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Sample Care Coordination Protocol: Early Intervention (Example Parts C and B)

This protocol outlines the standardized process for coordinating care between the community health center and early intervention (EI) programs under IDEA Parts C and B. It leverages pre-built referral templates within the electronic health record (EHR) to streamline communication, ensure accurate documentation, and support follow-up through a feedback loop.

1. Initiating the Referral

- Identify children ages 0-5 who demonstrate developmental concerns, delays, or diagnosed conditions.
- Discuss early intervention (EI) services with the family and obtain signed consent for information sharing.
- Access the pre-built EI referral template in the EHR under Referrals > Early Intervention.

2. Using Pre-Built EHR Referral Templates

- The EHR referral template auto-populates key patient information:
 - ✓ Child's name, date of birth, address, and insurance
 - ✓ Parent/guardian contact information
 - ✓ Primary care provider name and contact
 - ✓ Relevant diagnoses and visit notes
- Complete remaining required fields:
 - ✓ Reason for referral (select from dropdown or enter brief narrative)
 - ✓ Any developmental screening results (e.g., Ages & Stages Questionnaires)
 - ✓ Consent verification checkbox

3. Communication and Documentation

- Submit the referral electronically through the EHR or via secure fax/email if an external system is used.
- Log the referral and confirmation of receipt in the care coordination tracking tab of the EHR.
- Add the EI service coordinator's contact information to the patient's chart.
- Schedule internal case conference as needed for shared care planning.

4. Follow-Up and Transition Planning

- Set EHR task reminders for follow-up 2 weeks post-referral.
- Review and document outcomes from the Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP) when available.
- Coordinate regular check-ins with the family to monitor progress.
- Support transition planning (e.g., from Part C to Part B) before the child's third birthday.

5. Feedback Loop

- Collect feedback from families regarding the referral and coordination process during follow-up calls or visits.
- Hold quarterly check-ins with EI partners to review referral outcomes and identify system gaps.
- Use EHR data to track referral completion rates and timelines.
- Update templates and protocols based on staff and partner feedback.
- Share key metrics and success stories with the care team to reinforce quality improvement.





Sample Early Intervention Referral Template

This referral template can be adapted for use in major electronic health record systems (e.g., Epic, Cerner, NextGen, eClinicalWorks).

1. Auto-Populated Patient Information

- Patient Full Name: _____
- Date of Birth: _____
- Medical Record Number (MRN): _____
- Parent/Guardian Name: _____
- Preferred Language: _____
- Address: _____
- Phone Number: _____
- Insurance Type: _____
- Primary Care Provider: _____
- Provider Contact (email/phone): _____

2. Reason for Referral

- ☐ Developmental Delay
- ☐ Diagnosed Condition (e.g., Down syndrome, cerebral palsy)
- ☐ Failed Developmental Screening (Ages & Stages Questionnaires [ASQ], Survey of Well-being of Young Children, etc)
- ☐ Parental Concern
- ☐ Other (please specify): _____

3. Supporting Documentation

- ☐ Developmental Screening Attached (e.g., ASQ results)
- ☐ Visit Notes from Pediatric Evaluation
- ☐ Relevant Diagnostic Reports (e.g., audiology, genetics)
- ☐ Immunization Record (if applicable)

4. Consent Verification

- ☐ Consent to share information with early intervention provider is signed and attached.
 - ☐ Verbal consent documented in visit notes.
- Date of Consent: _____

5. Early Intervention Program Contact (Optional)

- Agency Name: _____

- Contact Person: _____
- Email: _____
- Phone: _____

6. Referring Provider Information

- Referring Provider Name: _____
- National Provider Identifier (NPI): _____
- Clinic Name: _____
- Clinic Address: _____
- Contact Email: _____
- Phone Number: _____





Sample Care Coordination Checklist for Early Intervention (Parts C and B)

1. Identification and Consent

- ☐ Confirm child is eligible for early intervention (EI) (Part C or B).
- ☐ Confirm that the family can access services in a timely manner if they meet eligibility. (For example, is there a waitlist or delay in access?)
- ☐ Obtain signed consent for release of information between community health center and EI program. Use two-way release of information signed by the family to facilitate communication between the practice and the early intervention program
- ☐ Document child's developmental concerns or diagnosis in the electronic health record (EHR).

2. Referral and Communication

- ☐ Share referral information with EI contact via secure method.
- ☐ Confirm EI receipt of referral and initial contact with family.
- ☐ Document EI service coordinator's name and contact information in EHR.
- ☐ Log referral communication in the EHR care coordination or referral tracking section.

3. Care Plan Coordination

- ☐ Schedule internal case conference if needed to align on care plan.
- ☐ Request copy of IFSP (Individualized Family Service Plan) or IEP (Individualized Education Plan), if available.
- ☐ Review IFSP/IEP goals and document relevant updates in the EHR.
- ☐ Coordinate follow-up visits to review child's developmental progress and document in visit notes.

4. Transition and Follow-Up

- ☐ Confirm transition plan is in place for children aging out of Part C (by third birthday).
- ☐ Track ongoing communication with EI partners in the care coordination log or EHR notes.
- ☐ Set reminders in the EHR for follow-up milestones or re-evaluations.
- ☐ Provide family with developmental resources and contact information for EI partners.

5. Feedback Loop

- ☐ Collect feedback from families on their experience with EI referrals and coordination.

- ☐ Schedule regular (e.g., quarterly) check-ins with EI partners to review referral outcomes and coordination process.
- ☐ Review care coordination notes and referral tracking data to identify patterns or issues.
- ☐ Use feedback and data to improve internal workflows and strengthen EI partnerships.





Sample Early Intervention/Special Education Feedback Form to Referring Practice

This form is intended to provide feedback to the referring community health center regarding a referral made to early intervention (Part C) or special education (Part B).

Child's Information

- Name: _____
- Date of Birth: _____
- Date of Referral Received: _____
- Referred By (Health Center Name): _____

Referral Outcome

- Contact made with family: ___ Yes ___ No
- Date of contact attempt(s): _____
- Evaluation completed: ___ Yes ___ No
- Date of evaluation: _____
- Child found eligible for services: ___ Yes ___ No ___ Pending
- Services initiated: ___ Yes ___ No
- Start date of services (if applicable): _____

Summary of Services Provided (if applicable)

- Type(s) of Services: _____
- Frequency/Intensity: _____

Follow-Up Recommendations for Community Health Center

- Additional referrals needed: _____
- Medical follow-up recommended: _____
- Other comments: _____

Feedback on Referral Process

- Was the referral form complete and helpful? ___ Yes ___ No
 - Suggestions for improving the referral process: _____
-

Contact Information of Completing Provider

- Name: _____
- Title: _____

- Agency/Program Name: _____
- Phone: _____
- Email: _____

Date Completed: _____



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Sample Referral Tracking System for Health Center's Electronic Health Record

This referral tracking system is designed to support community health centers in monitoring and managing referrals to early intervention (EI) programs and other external providers through their electronic health record (EHR). It standardizes referral entry, follow-up documentation, and communication status to improve care coordination and reduce missed referrals.

1. Required EHR Fields for Referral Entry

All EI referrals should include the following standardized fields, completed at the time of referral entry:

- Referral Date
- Referral Type (dropdown: EI Part C, EI Part B, Behavioral Health, etc)
- Referred To (agency name and contact person if known)
- Reason for Referral (from pre-set list or brief narrative)
- Consent Received (checkbox or dropdown: Yes/No)
- Method of Referral Submission (EHR, secure fax, email, other)

2. Referral Follow-Up and Status Tracking

Care coordinators or designated staff should update the referral record using these follow-up fields:

- Acknowledgment Received (Date the referral was confirmed by receiving agency)
- Family Contacted by EI Provider (Yes/No + Date)
- Appointment Scheduled (Yes/No + Date)
- Referral Outcome (dropdown: In progress, Declined, Not Eligible, Services Started, Other)
- Notes/Comments (free text area for documenting conversations or status updates)

3. Dashboard or Report for Tracking Referrals

IT or reporting teams should configure a dashboard or regular report to monitor referral data. Recommended metrics include:

- Total referrals by month and type
- % of referrals with acknowledgment within 5 business days
- % of referrals resulting in services started
- Referrals without follow-up after 14 days
- Top referral destinations (to support partnership development)

4. EHR Alerts and Reminders

Configure EHR task reminders or alert flags for referrals that need follow-up:

- Reminder to confirm referral acknowledgment if not received within 5 business days
- Alert if referral outcome has not been updated within 14 days
- Option to add referrals to provider or coordinator task list

5. Staff Roles and Responsibilities

- **Provider:** Initiates referral and confirms consent
- **Care Coordinator:** Tracks referral status, follows up with families and EI agency, updates referral record
- **Administrative Staff:** Supports documentation and communication where applicable
- **Supervisor/Manager:** Monitors reports and supports continuous quality improvement





Sample Automated Referral Follow-Up Alert Process in Electronic Health Record

Step 1: Define Referral Follow-Up Parameters

Establish the criteria for triggering follow-up alerts:

- Referral types to track (e.g., Early Intervention, Behavioral Health, Specialty Care)
- Timeframes for alerts (e.g., 5 business days for acknowledgment, 14 days for outcome)
- Responsible roles (e.g., care coordinators, nurses)

Step 2: Build Standardized Referral Templates

Develop electronic health record (EHR) referral templates that include:

- Auto-filled patient demographics (name, date of birth, provider, etc)
- Fields for 'Date Sent,' 'Acknowledgment Received,' and 'Outcome'
- Referral method (e.g., direct message, fax, email)

Step 3: Configure EHR Task Rules or Alerts

Create automated alert rules based on referral activity:

- **Alert 1:** Trigger a follow-up task if 'Acknowledgment Received' is blank after 5 days
- **Alert 2:** Flag for review if no 'Outcome' is recorded within 14 days
- **Alert 3 (Optional):** Notify the referring provider after 7 days if the referral remains pending

Step 4: Create Dashboard or Task Queue

Configure an EHR dashboard or task list that shows:

- Referrals by days since submission
- Referral status (e.g., pending, acknowledged, complete)
- Filters for referral type, date, or assigned staff
- Ability to sort overdue or at-risk referrals

Step 5: Implement Staff Workflow

Assign daily follow-up duties to care coordinators:

- Review alert dashboard daily
- Contact the referred agency or family as needed
- Update referral notes and status in the EHR
- Supervisors review referral completion rates weekly

Step 6: Pilot and Refine

Run a short pilot to test and improve the system:

- Choose 1-2 referral types for testing
- Monitor alert accuracy and staff response
- Collect data on follow-up completion
- Refine alert timing or workflow based on feedback

Step 7: Scale and Sustain

Expand the process to all relevant referral types:

- Include the alert process in standard operating procedures and onboarding
- Monitor performance monthly
- Share outcomes and celebrate improvements
- Revisit system logic quarterly to ensure relevance and effectiveness





Sample Tip Sheet: Setting Up Electronic Health Record Alert Logic for Referral Follow-Up

This tip sheet provides step-by-step guidance for setting up automated alerts in the electronic health record (EHR) system to support referral follow-up and ensure timely action by care teams.

Purpose

To automate task creation in the EHR when key referral-related fields are not completed within the appropriate timeframes:

- Trigger a task if 'Acknowledgment Received' is missing after 5 days
- Trigger a task if 'Outcome' is missing after 14 days

Step-by-Step Instructions

1. Navigate to your EHR's alert or workflow rules configuration area (often labelled Automation Rules, Custom Alerts, or Task Triggers).
2. Select 'Create New Rule' or 'Add New Workflow.'
3. Configure the first rule for Acknowledgment:
 - Condition: Referral entry exists
 - AND Field 'Acknowledgment Received' is empty
 - AND Referral date is more than 5 days ago
 - Action: Create task for assigned care coordinator or provider
4. Configure the second rule for Outcome:
 - Condition: Referral entry exists
 - AND Field 'Outcome' is empty
 - AND Referral date is more than 14 days ago
 - Action: Create task for care coordination follow-up
5. Assign notifications or task priority as needed to alert the appropriate team member.
6. Test the rules with sample referrals to ensure tasks are triggered as expected.

Tips

- Work with your IT or EHR support team to ensure logic aligns with system capabilities.
- Clearly define user roles responsible for completing 'Acknowledgment' and 'Outcome' fields.
- Periodically audit task completion to identify any delays or gaps.



Sample Clinic Workflow: Identifying Families With Infants Under 1 Year

This workflow outlines steps for identifying families with infants under 1 year of age in pediatric or family medicine settings. It supports targeted interventions such as safe sleep education, developmental screenings, and brief parenting guidance.

1. Intake & Registration

- Front desk staff confirms the child's date of birth during scheduling or check-in.
- Age under 12 months is flagged in the electronic health record (EHR) (automatically or manually).
- Family is given a brief newborn/infant screening form (optional, based on clinic goals).

2. Medical Assistant (MA) or Nurse Pre-Visit Prep

- MA/nurse verifies age in the EHR (e.g., "Patient is 6 months old today").
- MA/nurse checks a quick checklist:
 - ✓ Safe sleep discussion documented?
 - ✓ Developmental screening up to date?
 - ✓ Vaccinations current?
 - ✓ Breastfeeding or feeding concerns noted?
 - ✓ If any items are missing or due, a flag is placed in the chart or a note added for the provider.

3. Pediatrician/Provider Visit

- Provider confirms patient is under 1 year and engages in age-appropriate anticipatory guidance.
- If flagged: Provider or integrated team member (e.g., developmental expert, social worker) delivers a brief intervention (e.g., safe sleep conversation, motivational interviewing, and referral).

4. Integrated Team Brief Intervention (if applicable)

- Warm handoff to early childhood expert, behavioral health clinician, or community health worker. For example, "I want to introduce you to [Name], who's part of our care team. They're an expert in [child development / behavior / helping families with resources and support], and I think it would be really helpful for you to talk together. We work closely as a team, and I'll fill them in on what we've talked about."

- Then the provider would physically walk the team member into the room (or bring the family to their office if needed) and do a brief verbal summary: “This is Jordan and her son, Liam. We were talking about some challenges with sleep, and I thought it’d be great for you to chat more.”
- Short, structured interaction (5-10 minutes) focused on:
 - ✓ Safe sleep practices
 - ✓ Feeding and attachment
 - ✓ Parent stress or questions
- Interaction is documented in EHR using a dedicated template or visit note section.

5. Documentation & Data Collection

- Staff ensures proper EHR coding:
 - ✓ “Infant under 1” tag or encounter form
 - ✓ Brief intervention codes (if applicable)
 - ✓ Education and materials given
- Clinic dashboard tracks number of infants seen, interventions delivered, and referrals made.

6. Follow-Up Coordination

- Care team sets reminders for:
 - ✓ Next well-baby visit
 - ✓ Any referrals or services offered (e.g., WIC, early intervention)
 - ✓ Developmental follow-up or screenings

7. Optional Enhancements

- Monthly report of infants seen under 1 year and service gaps (screenings, education).
- Pop-up alerts in the EHR when a patient under 12 months checks in.
- Color-coded chart labels for quick ID (e.g., red for 0-3 months, yellow for 4-6, green for 7-12).





Sample Needs Assessment Tool for Telehealth Standard Operating Procedures – Early Childhood Development Visits

Objective:

To evaluate current practices, identify gaps, and determine areas for improvement in the clinic's telehealth process for early childhood developmental care.

Section 1: General Information

- Clinic Name:
- Date of Assessment:
- Assessor Name & Role:
- Participants (Names/Titles):

Section 2: Current Standard Operational Procedure (SOP) and Workflow

- Is there a written SOP for early childhood telehealth visits?
☐ Yes ☐ No ☐ In Development
- If yes, when was it last updated? [Date or N/A]
- Who is responsible for maintaining and updating the SOP? [Name/Role]
- Is the SOP readily accessible to clinical and support staff?
☐ Yes ☐ No

Section 3: Pre-Visit Process

- Are there procedures in place for:
 - Scheduling telehealth visits? ☐ Yes ☐ No
 - Sending consent forms and pre-visit materials? ☐ Yes ☐ No
 - Providing technical instructions to caregivers? ☐ Yes ☐ No
 - Gathering pre-visit developmental screening information? ☐ Yes ☐ No
- Are families given developmental checklists or preparation tools before the visit?
☐ Always ☐ Sometimes ☐ Never
- What challenges are staff facing in the pre-visit process? [Open text]

Section 4: During the Visit

- Is there a standard script or checklist used during the telehealth visit?
☐ Yes ☐ No
- Do providers consistently use validated screening tools (e.g., ASQ, PEDS)?
☐ Always ☐ Sometimes ☐ Rarely
- Is the provider trained in engaging young children via telehealth?
☐ Yes ☐ No
- What technical or engagement challenges are common during visits? [Open text]

Section 5: Post-Visit Process

- Are visit summaries shared with caregivers after appointments?
☐ Yes ☐ No
- Are referrals or follow-up steps documented and tracked?
☐ Yes ☐ No
- Is there a process for checking caregiver satisfaction or follow-up adherence?
☐ Yes ☐ No

Section 6: Staff Feedback and Training

- Have staff received formal training on telehealth protocols for early childhood?
☐ Yes ☐ No ☐ Partially
- Do staff feel confident in delivering developmental care via telehealth?
☐ Very Confident ☐ Somewhat Confident ☐ Not Confident
- What improvements or resources would help staff perform better? [Open text]

Section 7: Technology and Accessibility

- Are there frequent technical issues with the telehealth platform?
☐ Yes ☐ No
- Do all families have access to devices and internet for virtual visits?
☐ Yes ☐ No ☐ Unknown
- Are interpretation/language services available for telehealth visits?
☐ Yes ☐ No

Section 8: Final Notes & Recommendations

- Top 3 Identified Gaps:
 1. _____
 2. _____
 3. _____
- Suggested Actions or Next Steps:
[Open text]





Sample Motivating Interviewing Techniques for Discussing Safe Sleep With Families

Motivational interviewing is a collaborative, empathetic communication style that helps families explore and resolve ambivalence about behavior change. Below are practical motivational interviewing techniques that healthcare providers can use when discussing safe sleep practices.

Open-Ended Questions

Encourage dialogue and exploration of beliefs or concerns:

- “What do you know about safe sleep recommendations for babies?”
- “Can you tell me about how your baby usually sleeps?”
- “What are your thoughts on room-sharing versus bed-sharing?”

Affirmations

Recognize strengths, efforts, or intentions:

- “You really care about doing what’s best for your baby.”
- “It’s great that you’ve been thinking about ways to keep your baby safe.”
- “I appreciate how open you are in talking about your experience.”

Reflective Listening

Show understanding and encourage deeper discussion:

- Parent: “My baby sleeps better in my bed.”
- Provider: “You’ve noticed your baby seems to sleep more soundly when you’re nearby.”
- Parent: “I grew up with babies sleeping with parents.”
- Provider: “That’s something you’ve seen as a normal part of caring for a baby.”

Elicit-Provide-Elicit (EPE)

Ask permission to share, provide brief information, and then ask for the family’s reaction:

- Elicit: “Would it be okay if I shared some updated recommendations?”
- Provide: “They recommend babies sleep on a flat surface in the same room but not the same bed as their parents.”
- Elicit: “What do you think about that?”

Explore Ambivalence

Help caregivers weigh pros and cons of current practices vs. safer options:

- “On one hand, bed-sharing may feel more comforting. On the other, it increases the risk of sleep-related death. What are your thoughts on that?”

Develop Discrepancy

Highlight the gap between goals and current practices:

- “You mentioned you want to do everything possible to keep your baby safe. Using a crib without pillows or blankets is one way to help with that. What do you think?”

Motivational Interviewing Sample Script

“A lot of parents tell me they’ve heard different things about where and how babies should sleep. I’d love to hear your experience. What has sleep looked like for your baby so far?”

“There are new recommendations from pediatric experts that say the safest place for your baby is in your room, but in their own sleep space, like a bassinet or crib with a firm mattress. What are your thoughts on that idea?”





Sample Safe Sleep Brief Intervention Data Collection and Team Debrief Process

Purpose

This document is designed to support community health centers in collecting data on safe sleep education efforts and conducting team debriefs to improve delivery of brief interventions.

Data Collection Areas

1. Number of Safe Sleep Conversations

- Track the number of safe sleep conversations conducted by providers or developmental experts.
- Use electronic health record (EHR) flags, checkboxes, or custom forms to document delivery.

2. Family Feedback

- Use brief surveys or verbal feedback forms to assess family perceptions of the discussion.
- Suggested questions:
 - ✓ Did you find the safe sleep conversation helpful?
 - ✓ Was the information new or different from what you previously heard?
 - ✓ Did the provider answer your questions or concerns about sleep practices?

3. Changes in Caregiver-Reported Behaviors

- At follow-up visits, ask about any changes made since the previous conversation.
- Sample questions:
 - ✓ Are you currently placing your baby on their back to sleep?
 - ✓ Have you changed anything about where or how your baby sleeps?
 - ✓ Are there any challenges you've faced in following safe sleep guidelines?

4. Data Collection Tools

- EHR documentation
- Post-visit caregiver feedback form (paper or electronic)
- Monthly summary dashboard showing total conversations and reported changes



Sample Safe Sleep Data Collection Template

Date	Infant's Age (months)	Safe Sleep Conversation Completed (Yes/No)	Family Feedback (Helpful/Not Helpful/Other Notes)	Reported Behavior Change (Yes/No/Describe)	Follow-Up Needed (Yes/No)

Sample Team Debrief Flow

Conduct regular team huddles or monthly debriefs to assess progress, barriers, and success stories.

Debrief Agenda:

1. Review data on number of safe sleep conversations delivered.
2. Share highlights or quotes from family feedback.
3. Discuss any reported behavior changes or caregiver challenges.
4. Identify what aspects of the intervention are working well.
5. Highlight any barriers (e.g., time constraints, language needs).
6. Brainstorm improvements or workflow adjustments.
7. Assign follow-up tasks (e.g., update materials, add electronic health record prompts).



Sample Quick Guide for Clinic Staff: Using Direct Messaging in Epic

What is Direct Messaging?

Direct Messaging is a secure, HIPAA-compliant method for exchanging clinical information electronically between healthcare providers, specialists, and community partners. In Epic, this function helps streamline communication outside your organization, improving care coordination.

When Should You Use Direct Messaging?

- Referrals to external specialists or behavioral health providers
- Communicating with community-based organizations (e.g., housing, WIC, home visiting)
- Sharing discharge summaries or care plans with external care teams
- Confirming appointment follow-up or test results with partners

How to Send a Direct Message in Epic

1. Open the patient chart and navigate to the 'Communication' or 'Referral' section.
2. Select 'Send Direct Message' or use the SmartPhrase (.directmsg if configured).
3. Enter the recipient's direct address (example: clinic@directaddress.org).
4. Attach relevant documents (referral summary, visit notes, etc.).
5. Send the message securely through Epic's Direct Messaging interface.

How to Receive and View Direct Messages

- Messages from external providers appear in the 'In Basket' under 'Clinical Messages' or 'Referrals.'
- Staff can open and review the content, then update the patient's chart accordingly.
- Acknowledge the message or forward to the appropriate team member if follow-up is needed.

Best Practices

- Always confirm the recipient's direct address before sending messages.
- Keep messages concise, clear, and include all necessary patient identifiers.
- Use message templates when available to save time and maintain consistency.
- Log follow-up actions taken based on the received communication.

Troubleshooting Tips

- If a message fails to send, doublecheck the recipient's address and try again.
- Report technical issues to your clinic's electronic health record (EHR) support or IT team.
- Use test messages for new partners to verify receipt before sending clinical content.

Additional Training and Support

- For step-by-step training or help setting up Direct Messaging, contact your Epic Superuser or EHR lead.
- For questions about interoperability or privacy, speak to the clinic compliance officer or IT department.



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Sample Direct Messaging Data Collection Template

[illegible]



Sample Direct Messaging Protocols and Templates for Early Childhood Referrals

Purpose

These examples provide sample communication protocols and example message templates for clinic staff using Direct Messaging within Epic to coordinate care for infants and young children with external specialists and community-based partners.

Communication Protocols

- Confirm the recipient organization uses Direct Messaging and verify the correct direct address before sending.
- Use brief, clear messages with necessary identifiers: child's name, date of birth, and medical record number (MRN).
- Attach supporting documentation (visit notes, screenings, and referral forms).
- Clarify urgency and request a reply or acknowledgment if appropriate.
- Document message sent and expected follow-up in the patient's chart.

Message Templates for Common Early Childhood Referral Scenarios

1. Early Intervention Referral (If the program does not have their own required form)

Subject: Referral for Early Intervention Services – [Child's Name], DOB [MM/DD/YYYY]

Body:

Dear [Agency Name],

We are referring [Child's Name], age [X] months, for early intervention evaluation due to concerns regarding developmental delays noted during their recent well-child visit.

Please find attached the visit summary and Ages & Stages Questionnaires (ASQ) screening results. Parent/guardian contact: [Parent Name, Phone, Email].

Please confirm receipt and next steps.

Thank you,
[Provider/Clinic Name]

2. Behavioral Health Referral (Infant Mental Health)

Subject: Referral – Infant Mental Health Support for [Child's Name], DOB [MM/DD/YYYY]

Body:

Hello [Behavioral Health Provider],

We are referring [Child's Name], age [X] months, for early childhood behavioral health support due to caregiver concerns about bonding and regulation. This referral follows a recent pediatric screening and parental interview.

Relevant notes are attached. Please contact the family directly to coordinate services.

Thank you,
[Provider/Clinic Name]

3. Home Visiting Program Referral (unless the program has their own form)

Subject: Referral to Home Visiting Program – [Child's Name], DOB [MM/DD/YYYY]

Body:

To Whom It May Concern,

[Child's Name] and their caregiver were identified as eligible for home visiting services during their [X month] well-child visit. The family expressed interest in parenting support and early literacy resources.

Please see the attached visit summary and consent form. The caregiver's contact details are included. Kindly confirm enrollment steps.

Warm regards,
[Provider/Clinic Name]

4. Women, Infants, and Children (WIC)/Nutrition Referral

Subject: WIC/Nutrition Referral – [Child's Name], DOB [MM/DD/YYYY]

Body:

Hi [WIC/Nutrition Program Contact],

We are referring [Child's Name], age [X] months, to WIC for nutritional support and formula guidance. Growth concerns were noted during the last visit, and the family is interested in accessing resources.

Documentation is attached. Please notify us of next steps or if more information is needed.

Sincerely,
[Provider/Clinic Name]



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Sample Key Components to Consider for Telehealth Standard Operating Procedure From the American Telemedicine Association

For further guidance on the components below, see the American Telemedicine Association Operating Procedures for Pediatric Telehealth Guidance here: <https://www.aarc.org/wp-content/uploads/2017/09/pediatric-telehealth-procedures-guide.pdf>.

1. Informed Consent:

- Clearly explain the nature of telehealth services to caregivers, including potential benefits and limitations.
- Obtain documented consent before initiating services, ensuring compliance with state-specific regulations regarding minors' consent.

2. Patient Verification:

- Implement procedures to verify the identity of both the patient and caregiver at the start of each session.
- Confirm the physical location of the patient during the telehealth session to address any jurisdictional considerations.

3. Privacy and Confidentiality:

- Ensure that both provider and patient environments are conducive to maintaining confidentiality.
- Discuss and document any potential privacy concerns with caregivers prior to the session.

4. Emergency Protocols:

- Establish clear procedures for managing emergencies that may arise during a telehealth session, including identifying local emergency resources based on the patient's location.

5. Documentation:

- Maintain thorough records of each telehealth encounter, including assessments, interventions, and any technical issues experienced during the session.

6. Technical Standards:

- Utilize equipment and platforms that are appropriate for pediatric patients, considering factors such as age and developmental stage. <https://www.liebertpub.com/doi/10.1089/tmj.2017.0176>
- Ensure all technology complies with HIPAA and other relevant regulations to protect patient information. <https://www.aarc.org/wp-content/uploads/2017/09/pediatric-telehealth-procedures-guide.pdf>

7. Provider Training:

- Offer specialized training for providers on conducting telehealth visits with young children, focusing on engagement strategies and developmental considerations.





Sample Language for Families: Preparing for Your Child's Telehealth Visit

Thank you for scheduling a telehealth appointment for your child with our community health center. To help you prepare and ensure a smooth visit, please review the information below.

What to Expect During the Telehealth Visit

- The visit will be conducted through secure video with a pediatric healthcare provider.
- You will be asked questions about your child's health, development, and behavior.
- The provider will observe your child and guide you through activities to assess developmental milestones.
- You will have an opportunity to ask questions and discuss any concerns.
- The visit usually lasts 20-30 minutes.

How to Access the Telehealth Platform

- You will receive a secure link by email or text before your scheduled appointment.
- Click the link 5-10 minutes before your appointment time.
- The platform works best on a smartphone, tablet, or computer with a camera and microphone.
- Make sure your internet connection is stable.
- If you have trouble connecting, call us at [Clinic Phone Number] for help.

What You Need for the Visit

- Your child should be present for the full visit.
- Choose a quiet, well-lit space where your child can move around.
- Have a few toys or books nearby to help your child feel comfortable.
- A second adult is helpful but not required.
- If possible, have a recent weight and height measurement ready.

Before the Visit

- Complete any questionnaires or forms sent to you before the visit.
- Review your child's developmental milestones if provided.
- Write down any questions or concerns you want to share with the provider.

After the Visit

- You will receive a summary of the visit, including any recommendations.
- Follow-up appointments or referrals will be scheduled if needed.
- Contact the clinic if you have questions or need additional support.



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Sample Community Health Work Checklist and Tip Sheet – Early Childhood Telehealth Preparation

Use this tool to help families get ready for their child’s virtual healthcare visit.

Before the Visit – Community Health Work Checklist

Confirm appointment time and date with caregiver.

- ☐ Verify family has access to a working device (smartphone, tablet, and computer).
- ☐ Ensure family has the telehealth link and knows how to access it.
- ☐ Offer a tech test session or trial run if needed.
- ☐ Review family preparation tool with caregiver.
- ☐ Encourage caregiver to gather any questions or concerns.
- ☐ Confirm caregiver has recent weight/temperature (if available).

Tips for Setting Up the Space

- Recommend a quiet, well-lit space with minimal distractions.
- Ask caregiver to set up the device on a stable surface at the child’s eye level.
- Remind them to have good lighting (e.g., facing a window or lamp).
- Suggest muting other devices or background noise during the visit.

Suggested Items to Have Nearby

- A favorite toy, book, or stuffed animal to comfort and engage the child.
- Snacks or drink (if needed to keep the child calm).
- Items to support movement or play (e.g., blocks, ball, toy phone).
- A flashlight or phone light (to help provider observe throat or ears).
- Diaper and wipes (for infants, in case the provider needs info during visit).

During the Visit

- Remind caregiver to stay close to the child and help direct their attention.
- Help troubleshoot any tech issues if needed.
- Support caregiver with interpretation or clarification if appropriate.

After the Visit

- Follow up to confirm understanding of care plan.
- Assist with referrals, follow-up appointments, or accessing services.
- Document any barriers or concerns raised by the family.



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Sample Early Childhood Telehealth Metrics Tracking and Feedback Tool

This tool helps track key metrics and gather feedback to evaluate and improve early childhood telehealth services.

1. Telehealth Visit Metrics

- Tracking Period: _____
- Total Scheduled Telehealth Visits (0-5 years): _____
- Completed Visits: _____
- No-Shows: _____
- Rescheduled Visits: _____
- Canceled Visits: _____
- In-Person Visits (same age group): _____

Calculated Metrics:

- Visit Completion Rate = Completed ÷ Scheduled = _____ %
- No-Show Rate = No-Shows ÷ Scheduled = _____ %
- Reschedule Rate = Rescheduled ÷ Scheduled = _____ %

2. Caregiver Satisfaction Summary

- Number of post-visit surveys completed: _____
- Percentage reporting positive experience: _____ %
- Common themes from feedback:

3. Developmental Screenings and Referrals

- Screenings completed during telehealth visits: _____
- Referrals made (e.g., speech, audiology, early intervention): _____
- Follow-up appointments scheduled/completed: _____
- Missed or declined referrals: _____

4. Community Health Worker & Family Qualitative Feedback

Community Health Worker Observations:

- Challenges caregivers faced: _____
- What worked well: _____
- Suggestions for improvement: _____

Caregiver Feedback (open-ended):

- _____
- _____
- _____

4. Summary & Action Plan

- Key findings this review period:

- Adjustments to telehealth model or CHW process:





Sample Post-Telehealth Visit Survey for Caregivers

Thank you for participating in your child's telehealth visit. Please take a few minutes to complete this short survey. Your feedback helps us improve our services.

A. Support and Preparation

1. Did the community health worker (CHW) help confirm your appointment time and answer any questions?
☐ Yes ☐ No ☐ Not Sure
2. Did the CHW help you test your device or access the video link?
☐ Yes ☐ No ☐ Not Needed
3. Did the CHW give you tips to help prepare your child and space for the visit?
☐ Yes ☐ No

B. About the Visit

1. How easy was it to connect to the video visit?
☐ Very easy ☐ Somewhat easy ☐ Difficult ☐ Very difficult
2. Did the provider clearly explain your child's health/development?
☐ Yes ☐ Somewhat ☐ No
3. Were your concerns or questions addressed during the visit?
☐ Yes ☐ Somewhat ☐ No
4. How comfortable did your child seem during the visit?
☐ Very comfortable ☐ Somewhat comfortable ☐ Uncomfortable

C. Follow-Up

After the visit, did the CHW follow up with you to review the provider's instructions?

- ☐ Yes ☐ No ☐ Not Yet

D. Satisfaction

1. How helpful was the CHW's support overall?
☐ Very Helpful ☐ Somewhat Helpful ☐ Not Helpful ☐ Did Not Interact
2. Overall, how satisfied were you with the telehealth visit?
☐ Very Satisfied ☐ Satisfied ☐ Neutral ☐ Dissatisfied
3. Would you use telehealth again for your child's care?
☐ Yes ☐ Maybe ☐ No

E. Additional Comments

1. What went well during your child's telehealth visit?

2. What could we improve for next time?

F. CHW Support

Any feedback you'd like to share about the CHW or navigator?



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Sample Process for Reviewing Baseline Telehealth Participation Data

1. Define the Review Period

Choose a timeframe that gives you meaningful data (e.g., past 6-12 months).

2. Pull Relevant Data from the EHR or Scheduling System

Request or extract reports from your electronic health record (EHR) or appointment software that includes:

- Total number of scheduled telehealth visits for children 0-5
- Number of completed visits
- Number of no-shows or cancellations
- Number of rescheduled visits
- Number of in-person visits for same population (for comparison)

3. Segment by Key Demographics (if possible)

To understand patterns and gaps:

- Age ranges (e.g., <12 months, 1–2 years, 3–5 years)
- Insurance type (Medicaid vs private)
- Language spoken
- Zip code or neighborhood
- Visit type (sick, well child, developmental screening)

4. Identify and Calculate Key Metrics

Here are example metrics:

Metric	Calculation
Telehealth completion rate	Completed visits ÷ Scheduled telehealth visits
No-show rate	No-shows ÷ Scheduled telehealth visits
Telehealth vs. in-person visit ratio	Telehealth visits ÷ Total visits
Reschedule rate	Rescheduled visits ÷ Scheduled telehealth visits

5. Interview or Survey Staff and Families

Collect qualitative feedback on:

- Reasons for missed or canceled visits
- Comfort with technology
- Language or connectivity issues

- Perceptions of telehealth value

6. Summarize Baseline Insights

Create a short summary that includes:

- Participation trends (e.g., high/low age ranges)
- Challenge identified (technology, digital literacy, trust)
- Opportunities for community health worker/patient navigator support

Use This Review to Inform:

- Your quality improvement goals (e.g., reduce no-show rate by 20%)
- Community health worker outreach to focused populations
- Training needs or technology access support





Sample Training Outline for Home Visitors: Collaboration With Pediatric Providers During Well-Child Visits

Objective: To equip home visitors with the knowledge and skills necessary to effectively collaborate with pediatric providers during well-child visits. This training will focus on understanding roles, setting expectations, and improving communication to ensure that families receive coordinated and comprehensive care.

Training Outline

1. Introduction to the Collaboration

- **Objective:** To understand the importance of collaboration between home visitors and pediatrics
- Providers during well-child visits.
- **Duration:** 15 minutes
- **Content:**
 - ✓ Overview of the goals of the well-child visit and the role of pediatric providers.
 - ✓ The value of integrating home visiting services into pediatric care to address the whole family's needs (medical, emotional, social).
 - ✓ Importance of strengthening the relationship between home visiting staff and pediatric providers for improved family outcomes.

2. Roles and Responsibilities

- **Objective:** To clearly define the roles and responsibilities of home visitors during well-child visits.
- **Duration:** 25 minutes
- **Content:**
 - ✓ Pediatric Provider's Role:
 - i. Conduct the medical examination (physical growth, vaccinations, and developmental milestones).
 - ii. Discuss medical concerns, treatment plans, and address the child's health and well-being.
 - iii. Provide educational resources related to child health, safety, and development.
 - ✓ Home Visitor's Role:
 - i. Provide emotional support to families during the visit.

- ii. Help reinforce the pediatric provider's messages and ensure the family's understanding of recommendations.
- iii. Offer additional resources and follow-up support for non-medical needs such as housing, food security, and social services.

3. Setting Expectations

- **Objective:** To set clear expectations for the interaction between home visitors and pediatric providers during well-child visits.
- **Duration:** 20 minutes
- **Content:**
 - ✓ Communication Protocol:
 - i. Home visitors should introduce themselves to the pediatric provider at the start of the visit to establish a collaborative relationship.
 - ii. The home visitor should ask the pediatric provider if there are specific areas they would like to address or reinforce with the family (e.g., child development, health practices).
 - iii. Ensure that both the provider and home visitor understand their roles and responsibilities during the visit to prevent overlap or confusion.
 - b. Respecting Boundaries:
 - i. Home visitors should respect the provider's time and clinical responsibilities, avoiding interruptions during medical procedures.
 - ii. If the family has concerns requiring medical expertise, the home visitor should assist the family in addressing these concerns directly with the provider.

4. Effective Communication with Families

- **Objective:** To equip home visitors with strategies for improving communication with families during well-child visits.
- **Duration:** 30 minutes
- **Content:**
 - ✓ Active Listening:
 - i. Encourage home visitors to practice active listening when engaging with families, which helps to build trust and ensure that all concerns are addressed.
 - ii. Home visitors should give families ample time to express their concerns while being empathetic and non-judgmental.
 - ✓ Clarification and Reinforcement:
 - i. Home visitors should reinforce the pediatric provider's advice using simpler language to ensure the family fully understands.
 - ii. Provide practical examples and resources that can help the family apply medical advice (e.g., parenting tips, child development milestones).
 - ✓ Providing Additional Resources:



- i. Home visitors can offer resources for community programs, food assistance, parenting education, etc., that complement medical care.

5. Problem-Solving and Handling Challenge

- **Objective:** To help home visitors manage challenges that may arise during the well-child visit.
- **Duration:** 20 minutes
- **Content:**
 - ✓ Scenario 1: Family Hesitation or Concerns:
If a family is hesitant to follow medical advice, the home visitor can validate the family's concerns and gently encourage them to engage in a conversation with the pediatric provider to discuss alternatives.
 - ✓ Scenario 2: Communication Breakdown:
If there is a misunderstanding between the family and the pediatric provider, the home visitor should help clarify the information by rephrasing it in simpler terms.
 - ✓ Scenario 3: Emotional Challenges:
Families may be dealing with social or emotional challenges, such as financial insecurity or parenting stress, which may impact their care during the visit. The home visitor can offer emotional support and provide resources for community services.

6. Case Studies and Role-Playing

- **Objective:** To practice the learned skills through case studies and role-playing exercises.
- **Duration:** 30 minutes
- **Content:**
 - ✓ Home visitors will break into small groups and role-play different scenarios that could occur during well-child visits (e.g., reinforcing the pediatrician's advice, managing family anxiety, addressing unclear medical instructions).
 - ✓ Each group will present their role-play to the larger group, followed by a discussion of what worked well and areas for improvement.

7. Review and Q&A

- **Objective:** To review key takeaways from the training and address any questions or concerns.
- **Duration:** 10 minutes
- **Content:**
 - ✓ Recap of the key roles of home visitors and pediatric providers during well-child visits.
 - ✓ Open the floor for any questions or clarifications about specific challenges or scenarios that home visitors might encounter.
 - ✓ Provide additional resources for ongoing learning, such as articles, webinars, or peer support groups.



8. Evaluation and Certification

- **Objective:** To assess understanding and readiness of the home visitors to collaborate effectively with pediatric providers.
- **Duration:** 10 minutes
- **Content:**
 - ✓ Conduct a short quiz or survey to assess the home visitors' understanding of their role and the collaboration process.
 - ✓ Provide certification of completion for the training, acknowledging the home visitor's preparedness to work effectively with pediatric providers.

Key Takeaways from the Training:

- Clear communication and respect for each other's roles are essential for successful collaboration.
- Home visitors provide critical support by reinforcing the pediatric provider's messages and addressing emotional or social concerns.
- Collaborative care ensures that families receive the best possible outcomes from both medical and social support perspectives.





Sample Kickoff Meeting Agenda

Objective: Ensure a shared understanding of the goals, responsibilities, and processes for home visitors to accompany families to their well-child visits.

1. Welcome and Introductions (10 minutes)

- Facilitator: [Name]
- Brief introductions of all attendees.
- Overview of the meeting's objectives and desired outcomes.

2. Overview of the Initiative (15 minutes)

- Facilitator: [Health Center Representative/Home Visiting Program Lead]
- Content
 - ✓ Purpose and goals of linking home visiting programs to well-child visits to allow for more integrated care coordination and support for families.
 - ✓ Expected benefits for families, health centers, and home visiting programs.
 - ✓ Long-term vision for the collaboration between home visiting services and the health center.

3. Roles and Responsibilities (20 minutes)

- Facilitator: [Name]
- Content:
 - ✓ Health Center Responsibilities:
 - i. Identifying a team member for leading coordination.
 - ii. Referral process and identifying families for participation.
 - iii. Scheduling well-child visits and confirming home visitor attendance.
 - iv. Coordination of medical care, tracking and follow-up.
 - ✓ Home Visiting Program Responsibilities:
 - ✓ Family engagement and consent process.
 - i. Providing pre-visit information and educational materials.
 - ii. Attending well-child visits and supporting family needs.
 - ✓ Joint Responsibilities:
 - i. Communication and coordination between health center and home visiting staff.
 - ii. Addressing barriers to participation (e.g., scheduling conflicts, transportation).

4. Consent and Confidentiality (15 minutes)

- Facilitator: [Name]
- Content:
 - ✓ Review of consent process for families to allow home visitors to accompany them to well-child visits.
 - ✓ Ensuring confidentiality and data-sharing practices.
 - ✓ Discussing expectations and legal considerations regarding patient information.

5. Process Flow for Integration (25 minutes)

- Facilitator: [Name]
- Content:
 - ✓ Step-by-step process for scheduling, referral, and home visitor attendance:
 - i. Family Selection and Consent:
 - 1. Process for identifying eligible families and obtaining consent.
 - ii. Scheduling Coordination:
 - 1. How the health center and home visiting programs will coordinate visits.
 - iii. Role of the Home Visitor During the Visit:
 - 1. What the home visitor will do during the well-child visit (e.g., provide emotional support, help with follow-up, and reinforce education).
 - iv. Follow-up:
 - 1. How follow-up care will be coordinated after the visit.

6. Communication and Reporting (15 minutes)

- Facilitator: [Name]
- Content:
 - ✓ Establishing effective communication protocols between health center and home visiting staff.
 - ✓ Reporting mechanisms for sharing visit outcomes, family feedback, and any issues encountered during the visit.
 - ✓ Frequency and format of check-ins or follow-up meetings.

7. Timeline and Next Steps (10 minutes)

- Facilitator: [Name]
- Content:
 - ✓ Discuss the timeline for rolling out the process, including pilot phases.
 - ✓ Outline immediate next steps:
 - i. Finalizing consent forms.
 - ii. Scheduling training for home visitors and health center staff.
 - iii. Identifying families for initial participation.

8. Q&A and Open Discussion (10 minutes)

- Facilitator: [Name]



- Content:
 - ✓ Open the floor for any questions, concerns, or clarifications from attendees.
 - ✓ Discuss any challenges or potential barriers that may arise and brainstorm solutions.

9. Closing Remarks (5 minutes)

- Facilitator: [Name]
- Content:
 - ✓ Summarize key takeaways from the meeting.
 - ✓ Reiterate the importance of collaboration and ensuring smooth integration for better family outcomes.
 - ✓ Set the date for the next meeting or check-in.





Sample Plan for Home Visitor Role During Well-Child Visit Appointment

Objective: To provide home visitors with a clear and structured plan for their role during well-child visits, ensuring they effectively support the family by offering emotional support, reinforcing educational content, and addressing any family questions or concerns.

1. Preparation Before the Visit

- **Objective:** Ensure that the home visitor is fully prepared for the well-child visit, understands the child's needs, and knows what to expect during the appointment.
- **Actions:**
 - ✓ Review the Family's Information:
 - i. Familiarize yourself with the child's medical history, developmental milestones, and any specific needs or concerns that have been raised during previous home visits.
 - ii. Understand the goals of the upcoming well-child visit (e.g., vaccinations, developmental screenings, growth monitoring).
 - ✓ Prepare Emotional Support Tools:
 - i. Bring along any materials or tools that can help support the family emotionally (e.g., pamphlets about common developmental concerns, tips for managing childhood anxiety or behavior).
 - ii. Be prepared to offer reassurance, particularly if the child needs shots or other procedures that may cause distress.
 - ✓ Coordinate with Health Center Staff:
 - i. Confirm the appointment time and any specific needs or concerns to address during the visit.
 - ii. Establish clear communication with the healthcare provider to ensure alignment of roles and expectations.

2. Role During the Well-Child Visit

- **Objective:** Support the family in understanding and engaging with the visit, help manage emotions, and reinforce key health and developmental messages.
- **Actions:**
 - ✓ Provide Emotional Support
 - i. Greeting and Building Trust:
 - Arrive early and greet the family warmly, offering reassurance that you are there to support them.

- Establish a calm, friendly environment that encourages the family to feel comfortable sharing concerns.
- ii. Offer Reassurance:
 - During the visit, stay close to the family and provide emotional support, particularly when there is a need for vaccinations or other potentially stressful procedures.
 - If the child is anxious or upset, comfort them by explaining what will happen and offering words of encouragement.
- iii. Manage Anxiety:
 - If the family expresses anxiety about the visit or a specific procedure (e.g., vaccinations), validate their feelings and provide comforting words.
 - Offer strategies for coping, such as deep breathing exercises or distraction techniques for children.
- ✓ Reinforce Educational Content
 - i. Clarify Medical Information:
 - Listen carefully to the pediatrician's instructions and reinforce any important educational messages (e.g., child development, safety guidelines, nutrition).
 - Break down complex medical language into simpler terms so the family can better understand the information provided.
 - ii. Provide Practical Examples:
 - Help parents apply what they've learned in the visit to everyday scenarios by offering practical examples (e.g., tips on creating a sleep routine or managing picky eating).
 - For younger children, explain developmental milestones and give examples of what parents should look for at home.
 - iii. Highlight Key Health Messages:
 - Summarize key points from the visit, such as vaccination schedules, growth tracking, and developmental milestones.
 - Provide printed resources or referrals that reinforce the information shared during the visit.
- ✓ Address Family Questions and Concerns
 - i. Encourage Questions:
 - Encourage the family to ask the pediatric provider questions and ensure they feel comfortable discussing any concerns they may have about their child's health or behavior.
 - If they are hesitant, gently prompt them by asking, "Is there anything you are concerned about regarding your child's development or health?"
 - ii. Provide Clarification:



- If the family has any questions during the visit, ensure they are addressed promptly. If you are unsure of the answer, assist them in asking the pediatric provider for clarification.
- Help parents navigate healthcare systems, such as how to schedule follow-up appointments or access services like nutritional counseling or mental health support.
- iii. Offer Referrals and Resources:
 - If a concern is raised that is outside the scope of the well-child visit (e.g., behavioral issues, social support needs), provide referrals to appropriate services, such as early intervention programs, community resources, or therapy.
 - Ensure families have access to local resources, including community programs, support groups, or financial assistance.

3. After the Visit

- **Objective:** Ensure that the family understands the care plan, has all necessary resources, and feels supported moving forward.
- **Actions:**
 - ✓ Summarize the Visit
 - i. Review Key Points:
 - Once the visit is completed, summarize the most important aspects of the appointment, including any follow-up care or actions required (e.g., scheduling another visit, following up on lab results).
 - ii. Clarify Any Next Steps:
 - Ensure the family is clear on any next steps, such as referrals, upcoming vaccinations, or changes to the child's routine.
 - ✓ Check-in for Any Questions
 - Post-Visit Support:
 - After the visit, check in with the family to ensure they feel confident about what was discussed during the well-child visit.
 - Provide a contact number or email for further questions, offering the family the opportunity to reach out for additional support if needed.
 - ✓ Follow-Up Visit
 - Plan for Future Visits:
 - Discuss with the family the schedule for any follow-up appointments or home visits, ensuring continuity of care.
 - Reinforce that you are available for support in-between visits, whether they need help with navigating the healthcare system or understanding developmental concerns.



4. Documentation and Feedback

- **Objective:** Document the visit and gather feedback to improve future collaborations.
- **Actions:**
 - ✓ Record the Visit:
 - i. After the visit, document any key interactions, family concerns, and follow-up actions in the family's case file.
 - ii. Record any resources provided, referrals made, and feedback received from the family.
 - ✓ Solicit Family Feedback:
 - i. After the visit, ask the family for feedback on how helpful the visit was and whether they felt supported.
 - ii. Use their feedback to improve future visits and ensure that both the family's and the healthcare provider's needs are met.





Sample Referral System Process for Well-Child Visits and Home Visiting Program Notification

Objective: To establish a streamlined and efficient referral system that enables health center staff to notify home visiting programs about upcoming well-child visits for families enrolled in those programs. This process ensures better coordination of care, support, and the possibility for home visitors to accompany families to their well-child visits when consent is provided.

1. Identifying Eligible Families for Referral

- **Responsibility:** Health Center Reception Staff, Care Coordinators, or Medical Assistants
- **Process:**
 - ✓ At the time of scheduling or confirming the well-child visit, health center staff check if the family is enrolled in a home visiting program (e.g., maternal-infant home visiting, early intervention).
 - ✓ Health center staff should use the patient's electronic health record (EHR) or database to confirm enrollment in home visiting programs.
 - ✓ A checklist should be in place for staff to quickly identify these families during the scheduling process.

2. Referral Creation and Documentation

- **Responsibility:** Health Center Reception Staff, Care Coordinators, or Medical Assistants
- **Process:**
 - ✓ Once a family is identified as enrolled in a home visiting program, staff create a referral document (either through EHR or a standardized referral form) that includes the following information:
 - i. Family Information:
 - Parent/guardian name
 - Child's name and date of birth
 - Home visiting program(s) involved
 - ii. Well-Child Visit Information:
 - Date and time of the scheduled well-child visit
 - Type of visit (e.g., routine check-up, vaccination, growth monitoring)
 - iii. Consent:
 - Whether the family has consented to having a home visitor attend the well-child visit

- Details on any specific needs or preferences (e.g., language, family concerns)
- ✓ The referral document should be attached to the family's electronic health record (EHR) or, if not available, stored securely and shared with the home visiting program in a timely manner.

3. Sending the Referral to the Home Visiting Program

- **Responsibility:** Health Center Referral Coordinator, Medical Assistants, or Care Coordinators
- **Process:**
 - ✓ The completed referral form is sent electronically to the appropriate home visiting program(s) (e.g., via EHR or a secure email system).
 - ✓ If a paper-based system is used, the referral is printed and faxed to the home visiting program's office or securely mailed.
 - ✓ Include a follow-up reminder notification system to ensure that home visiting programs acknowledge receipt of the referral and confirm the home visitor's availability.
 - ✓ Notification Protocol:
 - If a family has given consent, the home visiting program should be notified at least 48-72 hours before the well-child visit to ensure that the home visitor can attend.
 - Include a note regarding the need for home visitor attendance if the family has agreed, and highlight any special needs or concerns.

4. Confirmation of Home Visitor Attendance

- **Responsibility:** Home Visiting Program Staff
- **Process:**
 - ✓ Home visiting program staff should confirm receipt of the referral and notify the health center (or referral coordinator) of the home visitor who will attend the well-child visit.
 - ✓ If the family has provided consent for the home visitor to attend, the home visiting program will reach out to the family to confirm details and ensure that the home visitor's attendance is coordinated.
 - ✓ A confirmation should be provided to the health center at least 24 hours before the well-child visit, confirming the attendance of the home visitor and providing any specific updates (e.g., changes to home visitor availability).

5. Communicating Any Issues or Changes

- **Responsibility:** Health Center Staff, Home Visiting Program Staff
- **Process:**
 - ✓ If there are any issues with the referral (e.g., scheduling conflicts, home visitor unavailability, or family refusal), the health center should be notified immediately by the home visiting program to address these concerns.



- ✓ The health center should communicate any scheduling changes, cancellations, or adjustments to the home visiting program as early as possible to ensure coordination.
- ✓ Regular communication between the health center staff and home visiting program staff is crucial to ensure the smooth execution of the process.

6. Documentation and Follow-Up

- **Responsibility:** Health Center Staff, Home Visiting Program Staff
- **Process:**
 - ✓ Both the health center and the home visiting program should document the interaction in their respective systems:
 - i. Health Center: Update the family's EHR to reflect the referral to the home visiting program and confirm the home visitor's attendance at the well-child visit.
 - ii. Home Visiting Program: Record the successful coordination and attendance of the home visitor during the well-child visit in the home visiting program's documentation system.
 - ✓ A follow-up call or email should be made within 1-2 days after the well-child visit to check on any additional support needed for the family and to address any questions or issues that arose during the visit.

7. Continuous Improvement and Feedback

- **Responsibility:** Health Center and Home Visiting Program Leadership
- **Process:**
 - ✓ Periodically evaluate the referral process by collecting feedback from health center staff, home visitors, and families.
 - ✓ Use feedback to address any issues, such as delays in referrals, lack of consent forms, or challenges in communication.
 - ✓ Regularly update and refine the referral process to improve efficiency and family satisfaction.

Sample Referral Form Template

- **Family Information:**
 - Parent/Guardian Name: _____
 - Child's Name: _____
 - Date of Birth: _____
 - Home Visiting Program(s) Involved: _____
- **Well-Child Visit Information:**
 - Date of Well-Child Visit: _____
 - Time of Well-Child Visit: _____
 - Type of Visit: _____
- **Consent:**
 - Has family consented to home visitor attendance? [] Yes [] No



- Special Family Concerns/Needs: _____
- Preferred Home Visitor Language: _____

Health Center Staff Signature: _____

Date: _____

This referral system process ensures that home visiting programs are effectively notified of upcoming well-child visits, which promotes better coordination of care, enables home visitors to provide support, and ensures families receive the comprehensive care they need.



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Sample Standardized Consent Form

Home Visitor Attendance at Well-Child Visits

1. Purpose of this Form:

This form is designed to provide you with information about the opportunity for a home visitor to accompany you and your child during your well-child visit at the community health center. The home visitor's role is to support both your family and your healthcare team to ensure that you and your child receive the best care and services possible. By signing this form, you are giving your consent to allow the home visitor to attend the well-child visit with you.

2. Purpose and Benefits of Home Visitor Attendance

The goal of having a home visitor accompany you to the well-child visit is to enhance the coordination of care, support, and resources available to you and your family. The benefits include:

- **Improved Communication:** The home visitor can help facilitate communication between you and the healthcare team, ensuring that all of your questions are answered.
- **Emotional and Practical Support:** The home visitor can provide emotional support, assist with understanding medical instructions, and help you address any concerns about your child's health or development.
- **Access to Additional Resources:** The home visitor can offer information about other services that may be helpful to your family, such as community programs, financial assistance, or early childhood services.
- **Ongoing Support:** The home visitor can help ensure that any recommendations or follow-up care from the well-child visit are understood and followed through. By having a home visitor accompany you, you will receive additional support to ensure that both the medical and social needs of your family are met.

3. Your Role and Consent

By signing this consent form, you agree to the following:

- You are willing to have a trained home visitor attend your well-child visit at the health center.
- You understand that the home visitor will be present to provide support and may assist with communication, understanding medical advice, and providing additional resources.

- You acknowledge that your participation in this process is voluntary and that you may withdraw your consent at any time without affecting the care you receive at the health center.
- You consent to the sharing of necessary health information between the healthcare team and the home visitor for the purpose of coordinating care and providing support during your visit.
- You understand that the home visitor will respect your privacy and confidentiality in accordance with health information privacy laws.

4. Confidentiality

All information shared during the well-child visit will be treated as confidential. The home visitor will maintain confidentiality of all personal health information shared, and no information will be disclosed without your explicit permission, except as required by law.

5. Voluntary Participation

Your participation in this process is voluntary, and you may choose not to have the home visitor accompany you to your well-child visit. If you choose not to have a home visitor attend the visit, this will not affect the care or services you and your child will receive at the health center.

6. Consent

Please review the information provided above and sign below to indicate your consent to allow a home visitor to accompany you to your well-child visit:

- Parent/Guardian Name: _____
- Child's Name: _____
- Home Visitor Name: _____
- Health Center Name: _____
- Well-Child Visit Date: _____

By signing below, I agree to allow the home visitor to accompany me and my child to the well-child visit and to assist with the coordination of care as outlined in this consent form.

- Parent/Guardian Signature: _____
- Date: _____
- Home Visitor Signature (optional): _____

7. Contact Information

If you have any questions or concerns about this consent form or the process, please feel free to contact:

- Community Health Center Contact: _____
- Phone: _____
- Email: _____





Sample Communication Protocol for Coordinating Between Primary Care Providers and Specialized Child Health and Behavioral Health Providers

Objective: To establish a clear and effective communication protocol that facilitates coordination between primary care providers (PCPs) and specialized child health and behavioral health providers, ensuring seamless integration of care for children. This protocol aims to enhance collaboration, improve service delivery, and ensure that all providers involved in a child's care are working towards common goals.

1. Roles and Responsibilities

- PCPs:
 - ✓ Lead the coordination of care, ensuring that children receive necessary medical, developmental, and behavioral health services.
 - ✓ Provide referrals to specialized providers as needed.
 - ✓ Share medical history, screening results, and any other relevant health information with specialists.
 - ✓ Communicate regularly with specialized providers regarding the child's health progress, concerns, and treatment plans.
- Specialized Providers (e.g., infant mental health services, dental providers, behavioral health services):
 - ✓ Provide specialized care according to their area of expertise, addressing the child's unique needs.
 - ✓ Share relevant information back with the PCP, including updates on the child's condition, treatment progress, and any concerns or recommendations.
 - ✓ Ensure that the child and family are engaged in treatment plans and follow-up care.
 - ✓ Alert the PCP of any emerging issues that may require medical intervention or additional support.

2. Communication Flow

- Initial Referral Process
 - ✓ PCP to Specialist Referral:

PCP identifies the need for specialized care (e.g., behavioral health, dental, or developmental support).

✓ Referral should include:

- i. Reason for referral (e.g., developmental concern, behavioral issue, dental need).
- ii. Relevant medical history and any previous treatments or screenings.
- iii. Contact information for the family and a request for follow-up.
- iv. Authorization/consent from the family to share relevant health information with the specialist.

✓ The referral should be made via:

- i. Email via a secure institute supported pathway (e.g., basket message in the electronic health record [EHR]);
- ii. Refer via standard referral workflow in EHR. Fax (if necessary) using secure systems; or
- iii. Electronically via a pager or secure messaging in addition to a direct phone call for consultation for urgent cases

✓ Specialist to PCP Communication:

Upon accepting the referral, specialists will:

- Acknowledge receipt of the referral within 72 hour or 3 business days for non-urgent emails or messages.
- Schedule an initial appointment with the family and inform the PCP.
- Send a confirmation or an assessment report after the initial evaluation, highlighting the treatment plan, recommendations, and follow-up needs.

○ Ongoing Communication

✓ Progress Updates:

Specialists should send periodic updates to the PCP, detailing:

- The child's progress in their care.
- Any adjustments made to the treatment plan.
- Outcomes of ongoing treatments (e.g., mental health therapy, dental treatments).
- Any concerns or issues identified that may need medical intervention or further referrals.

✓ Emergency or Urgent Care Situations:

- i. For urgent issues (e.g., acute behavioral crisis, sudden health complications), the provider initiating care (e.g., ER, urgent care, crisis behavioral health team) immediately contacts the child's PCP and/or care coordinator, if known via phone or secure messaging within 24 hours.
- ii. The PCP and specialist will establish a mutual plan for addressing the urgent issue and may communicate multiple times within a short period to ensure appropriate care.

○ Family Involvement

✓ Engagement in the Care Process:



- i.* Consult family for impact referral may have on insurance and schedule (in network, out of network, location, etc)
- ii.* The PCP should ensure that the family is actively involved in care coordination and kept informed about all referrals and treatment plans.
- iii.* The specialist should also keep the family informed about progress and seek family input when making decisions about care.
- iv.* Schedule regular family check-ins (phone, in-person, or online) to review treatment, progress, and challenges.





Sample Standardized Referral Process for Primary Care Providers to Refer Children to Behavioral Health Providers and Vice Versa

Objective: To provide a standardized referral process that allows primary care providers (PCPs) to refer children to behavioral health providers and vice versa. This process aims to ensure effective communication and coordination between providers, improving the overall care and outcomes for children requiring both medical and behavioral health services.

Referral Process for PCPs Referring Children to Behavioral Health Providers

1. Identification of Need

- PCPs identify children who may benefit from behavioral health services, based on clinical observations, parental concerns, or routine screening tools (e.g., developmental screenings, behavioral assessments, and mental health screenings).
- Common reasons for referral include:
 - ✓ Behavioral concerns (e.g., ADHD, anxiety, depression, aggression)
 - ✓ Emotional or mental health issues (e.g., trauma, grief, family stress)
 - ✓ Developmental delays requiring further intervention (e.g., speech or social delays)
 - ✓ Family-related issues impacting child development (e.g., domestic violence, substance abuse).

2. Referral Documentation

- The PCP should complete a standardized referral form that includes the following information:
 - ✓ Child's personal and medical information
 - ✓ Parent/guardian contact information
 - ✓ Reason for referral (e.g., specific concerns regarding behavior, mental health, or emotional development)
 - ✓ Relevant medical history (e.g., any diagnosed conditions, prior treatments, medications)
 - ✓ Previous assessments (e.g., mental health screening results, developmental screening outcomes)
 - ✓ Parent consent for referral and information sharing.
- The referral form should be shared with the behavioral health provider either through secure electronic health records (EHR), secure email, or fax.

3. Consent for Referral

- The PCP should obtain written consent from the parent/guardian before sending the referral. The consent form should explain the purpose of the referral, the benefits of seeking behavioral health services, and the information being shared between providers.
- Ensure that the consent form also allows for feedback from the behavioral health provider to be sent back to the PCP.

4. Follow-Up

- After the referral is made, the PCP should follow up with the family to ensure that the referral has been received and that the child has scheduled an appointment with the behavioral health provider.
- Ensure all parties are aware of the timing for appointment and have a plan on managing the situation until first available appointment has taken place.
- The PCP should receive confirmation from the behavioral health provider regarding the child's initial appointment and treatment plan.
- Regular follow-up should be scheduled between the PCP and behavioral health provider to ensure that the child's needs are being addressed comprehensively.

Referral Process for Behavioral Health Providers Referring Children to PCPs

1. Identification of Need

- Behavioral health providers identify children who require medical evaluations or treatment, such as:
 - ✓ Medical conditions that may be affecting mental health (e.g., ADHD, chronic illnesses)
 - ✓ Need for medications or adjustments to behavioral health treatments (e.g., psychotropic medications)
 - ✓ Concerns regarding nutrition, sleep, or physical health that may affect mental or behavioral development

2. Referral Documentation

- The behavioral health provider should complete a standardized referral form that includes the following information:
 - ✓ Child's personal and behavioral health information
 - ✓ Parent/guardian contact information
 - ✓ Reason for referral (e.g., need for medical evaluation, specific concerns regarding physical health, medication management)
 - ✓ Relevant behavioral health information (e.g., diagnoses, treatment progress, current therapy goals)
 - ✓ Any behavioral or psychological assessments performed.
- The referral form should be shared with the primary care provider (PCP) through secure electronic health record, email, or fax.



3. Consent for Referral

- The behavioral health provider should obtain consent from the parent/guardian before sending the referral. The consent form should outline the purpose of the referral, the benefits of medical evaluation, and the shared information between providers.
- The consent form should also allow the PCP to provide feedback on the child's treatment and progress.

4. Follow-Up

- After the referral is made, the behavioral health provider should check with the family to confirm that they've scheduled the medical appointment with the PCP.
- The behavioral health provider should request confirmation from the PCP regarding the medical evaluation and any recommendations for treatment.
- Regular communication should occur between the PCP and behavioral health provider to ensure the child's health and behavioral needs are fully met.





Sample Training Outline for Providers on the Benefits of the Collaborative Care Model and Integrating Health and Behavioral Health Services

Objective: To provide training to healthcare providers on the benefits of the collaborative care model and how to integrate their services to work more effectively with health and behavioral health providers. This training will focus on enhancing communication, building teamwork, and improving patient outcomes through collaborative care strategies.

Training Outline

1. Introduction to the Collaborative Care Model

- **Duration:** 20 minutes
- **Content:**
 - ✓ Overview of the collaborative care model and its goals: providing comprehensive, coordinated care that addresses both physical and behavioral health needs.
 - ✓ The importance of integrating physical health, mental health, and behavioral health services in a unified care approach.
 - ✓ Key principles of the collaborative care model: team-based care, shared responsibility, coordinated treatment, and patient-centered care.
 - ✓ Evidence supporting the effectiveness of the collaborative care model in improving patient outcomes, reducing costs, and enhancing provider satisfaction.
 - ✓ Benefits for patients: improved access to care, better management of complex conditions, and holistic treatment plans.

2. Benefits of the Collaborative Care Model

- **Duration:** 25 minutes
- **Content:**
 - ✓ Improved patient outcomes through integrated care for mental health and medical conditions (e.g., depression, chronic illness, substance use).
 - ✓ Reducing challenges to accessing mental health services by providing in-house behavioral health support within medical settings.

- ✓ Enhanced patient satisfaction through coordinated care and improved communication.
- ✓ Better health outcomes for patients with comorbid conditions (e.g., diabetes and depression) through coordinated care plans.
- ✓ Cost efficiency by addressing the root causes of mental health and behavioral health issues early, reducing emergency visits and hospitalizations.

3. How to Integrate Health and Behavioral Health Services

- Duration: 30 minutes
- Content:
 - ✓ Identifying opportunities for collaboration between primary care providers and behavioral health providers.
 - ✓ Roles and responsibilities of health and behavioral health providers within the collaborative care model.
 - ✓ How to share information effectively and ensure confidentiality while promoting collaboration.
 - ✓ Building trust and fostering strong working relationships between health and behavioral health teams.
 - ✓ Tools and systems for effective communication (e.g., electronic health records, care coordination meetings, patient tracking).
 - ✓ Case studies of successful integration in different healthcare settings (e.g., integrated care in pediatric practices, collaborative care in community health centers).

4. Communication and Coordination Strategies

- Duration: 25 minutes
- Content:
 - ✓ Effective communication techniques for building a collaborative relationship with behavioral health providers.
 - ✓ Establishing regular check-ins and care coordination meetings to discuss patient progress and adjust treatment plans as necessary.
 - ✓ Clear documentation practices to ensure all team members are informed and updated on patient care.
 - ✓ How to handle conflicts or challenges in collaboration and find common ground.
 - ✓ Creating shared goals and treatment plans that align with both medical and behavioral health perspectives.

5. Overcoming Challenges to Integration

- Duration: 20 minutes
- Content:
 - ✓ Identifying common challenges to integrating health and behavioral health services (e.g., siloed care, lack of training, inadequate resources).



- ✓ Addressing logistical challenges to collaboration between health and behavioral health providers.
- ✓ Overcoming resistance to change and promoting teamwork within healthcare settings.
- ✓ Strategies to streamline workflows and reduce administrative burdens to facilitate smoother integration.

6. Hands-On Application and Role-Playing

- **Duration:** 30 minutes
- **Content:**
 - ✓ Role-playing scenarios where healthcare providers practice integrating care for a patient with both physical and behavioral health needs.
 - ✓ Discussion of real-life cases to explore how different providers can collaborate effectively in managing complex patients.
 - ✓ Interactive exercises to identify challenges and come up with practical solutions for collaboration in real-world settings.
 - ✓ Feedback and discussion on strategies for improving communication and care coordination.

7. Review and Q&A

- **Duration:** 10 minutes
- **Content:**
 - ✓ Recap of the collaborative care model and its benefits.
 - ✓ Open the floor for questions and discussion to clarify any concepts or concerns.
 - ✓ Discuss next steps for providers to begin integrating collaborative care practices into their daily routines.
 - ✓ Provide additional resources and tools for ongoing education and skill development.

