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Screening and Referral Checklist and Strategies Part 2: *Strengthening Relationships With Referral Partners*

Well-child clinical guidance recommends the following screenings at specific well-child visits: developmental milestones, autism, social-emotional development, perinatal depression of the caregiver, and health-related social needs. Providers must have referral pathways to address all concerns raised through screenings.

State-level teams are uniquely positioned to bridge connections between local communities and state early childhood services and resources. This is especially valuable for pediatric practices working to strengthen their linkages with services beyond clinic walls. State-level teams can build statewide capacity and coach pediatric practices to implement best practices for referral processes.

Best Practices for Primary Care Referrals:

1. Meet in person with partners to build relationships and establish shared communication strategies.
2. Collect organization-specific feedback forms to ensure the proper information is shared.
3. Establish a standardized release of information (ROI) form and process to communicate with partners.
4. Create and refine referral feedback loops with partners to ensure patients' needs are met. Develop warm handoff processes whenever possible.
5. Elicit family feedback on referrals and incorporate it into continuous quality improvement efforts.
6. Meet regularly (can be virtually) to check in with referral partners for continuous quality improvement.
7. Document standardized procedures with partners to ensure sustainability.

Referral Pathways in Early Childhood

State-level teams are well-positioned to strengthen linkages between other state-level system partners to better support young children and their families. Assess the systems in place that may already be doing similar work, such as the local American Academy of Pediatrics (AAP) chapter, 211 Child Care Resource and Referral Network, early childhood coalitions, and/or state *Learn the Signs. Act Early*. Ambassadors.

Many states have centralized intake and referral systems, like a Help Me Grow Network, that offer comprehensive, coordinated services to families. If your state system does not have this, it may be an initiative that can be undertaken by state-level system partners (including you!).

Analyze and Define Relationships

Not all referral pathways will require the same level of partnership. State-level teams can support pediatric practices to map which referral sources require a close, coordinated partnership versus mutual awareness-building. The Cross-Sector Engagement Tool can be helpful in analyzing and categorizing partnerships.

Encourage practices to identify 5-7 key partners as priorities to start with. These partners should include organizations and specialists whom they often rely on and who require the greatest degree of monitoring to ensure families are connected. Some suggested partners may be early care and education, IDEA Part B and C, parent and infant and early childhood mental health (IECMH), and specialty care.

Once referral partners are identified, a team can support pediatric practices in codifying their relationships. This will look different between agencies and sectors and can change over time. A sample discussion guide is included on the next page.

Identifying Referral Partners

Use the following questions to support pediatric practices in identifying referral partners. Practice data can provide guidance.

- What are the practice's top referrals?
- What, if any, are the major social needs in this community?
- What are patients' language needs?
- Are there existing networks that could be leveraged to support this patient population?

Additionally, consider staff and family feedback on referral partners, along with logistical considerations (e.g., location and hours of operation, whether they are currently taking referrals, accepted insurance and payment types).

State-level teams are well-positioned to guide practices through the following checklist. Commonalities across practices may be appropriate to uplift as system-level facilitators or barriers that can be addressed more broadly than by individual practices.

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Sample Meeting Discussions for Practice and Community Referral Partners

This should be a two-way discussion, and pediatric practices should be prepared to answer the questions and provide resources.

Objective	Discussion Item	Supporting Resources
Get to know each other personally.	Welcome and relationship building	
Understand the referral partner's services.	What services do you offer? What insurance do you take?	
Communication agreements established.	What is your **preferred communication for our partnership** (e.g., frequency, types, method)? If we run into **communication issues**, how do you envision resolving them together?	For communication issues: • Gottman Repair Checklist • SCARF Model
Organization-specific feedback forms are collected to ensure the proper information is shared between partners.	What is your preferred communication and documentation to **initiate referrals** to you?	• Sample ROI • Generic early intervention referral document
Warm handoff processes are developed where possible.	Is it possible to **do a warm handoff** with your organization? What would that look like (e.g., call, in person, virtual)? What information do you need to be successful? Who should I ask for when I reach out?	

Objective	Discussion Item	Supporting Resources
Established updates on the referral by the receiving provider/organization.	What is your preferred communication and documentation to receive **follow up on patient** updates, outcomes, and additional needs for support and care management?	• CDSA and preschool feedback form • Primary care feedback form
Family feedback on referrals is elicited and incorporated into decision-making.	How can we **share family feedback** with each other to improve our support to families (e.g., things that work and do not work well for families, challenges and solutions to try)?	
Care coordination or management shared protocols.	Do you have established **care coordination/management protocols** internally that we can share to support each other? Are there areas of alignment, gaps, or places we do things differently that we can improve?	
Establish a culture of continuous quality improvement.	Can we check in periodically on our processes for **continuous improvement to help families**?	Help Me Grow provider report
Leave with an understanding of clear next steps, who is responsible, and when the action should be completed.	**Next steps**	

Checklist for Practice-Level Internal Processes for Referral Partnerships

Community Referral Partner (up to 5 per sector, where applicable)	Partner Name	Is there an ROI in place?*	Does the practice need partner-specific forms?**	Is the partner included in the patient panel?***	Does the practice have a process to follow up with the partner?	Does the practice have a process to follow up with the family?
Developmental needs (not early intervention) #1						
Developmental needs (not early intervention) #2						
Developmental needs (not early intervention) #3						
Developmental needs (not early intervention) #4						
Developmental needs (not early intervention) #5						
Individuals with Disabilities Education Act (IDEA) Part B						
IDEA Part C						
Specialty health care #1						

Community Referral Partner (up to 5 per sector, where applicable)	Partner Name	Is there an ROI in place?*	Does the practice need partner-specific forms?**	Is the partner included in the patient panel?***	Does the practice have a process to follow up with the partner?	Does the practice have a process to follow up with the family?
Specialty health care #2						
Specialty health care #3						
Specialty health care #4						
Specialty health care #5						
IECMH #1						
IECMH #2						
IECMH #3						
IECMH #4						
IECMH #5						
Home visiting #1						
Home visiting #2						
Home visiting #3						
Home visiting #4						
Home visiting #5						

Community Referral Partner (up to 5 per sector, where applicable)	Partner Name	Is there an ROI in place?*	Does the practice need partner-specific forms?**	Is the partner included in the patient panel?***	Does the practice have a process to follow up with the partner?	Does the practice have a process to follow up with the family?
Caregiver well-being support (e.g., Postpartum Support International, family support networks) #1						
Caregiver well-being support (e.g., Postpartum Support International, family support networks) #2						
Caregiver well-being support (e.g., Postpartum Support International, family support networks) #3						

Community Referral Partner (up to 5 per sector, where applicable)	Partner Name	Is there an ROI in place?*	Does the practice need partner-specific forms?**	Is the partner included in the patient panel?***	Does the practice have a process to follow up with the partner?	Does the practice have a process to follow up with the family?
Caregiver well-being support (e.g., Postpartum Support International, family support networks) #4						
Caregiver well-being support (e.g., Postpartum Support International, family support networks) #5						
Caregiver well-being treatment #1						
Caregiver well-being treatment #2						

Community Referral Partner (up to 5 per sector, where applicable)	Partner Name	Is there an ROI in place?*	Does the practice need partner-specific forms?**	Is the partner included in the patient panel?***	Does the practice have a process to follow up with the partner?	Does the practice have a process to follow up with the family?
Caregiver well-being treatment #3						
Caregiver well-being treatment #4						
Caregiver well-being treatment #5						
Social needs #1						
Social needs #2						
Social needs #3						
Social needs #4						
Social needs #5						
Early care and education #1						
Early care and education #2						
Early care and education #3						

Community Referral Partner (up to 5 per sector, where applicable)	Partner Name	Is there an ROI in place?*	Does the practice need partner-specific forms?**	Is the partner included in the patient panel?***	Does the practice have a process to follow up with the partner?	Does the practice have a process to follow up with the family?
Early care and education #4						
Early care and education #5						
Child and family services (e.g., foster care) #1						
Child and family services (e.g., foster care) #2						
Child and family services (e.g., foster care) #3						
Child and family services (e.g., foster care) #4						
Child and family services (e.g., foster care) #5						

Community Referral Partner (up to 5 per sector, where applicable)	Partner Name	Is there an ROI in place?*	Does the practice need partner-specific forms?**	Is the partner included in the patient panel?***	Does the practice have a process to follow up with the partner?	Does the practice have a process to follow up with the family?
Early Head Start/Head Start #1						
Early Head Start/Head Start #2						
Early Head Start/Head Start #3						
Early Head Start/Head Start #4						
Early Head Start/Head Start #5						
Other #1						
Other #2						
Other #3						
Other #4						
Other #5						

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*ROI. Release of information, preferably a two-way release. (Sample release of information)

**Partner specific forms needed. Standardized and simplified forms that are agreed on. (Sample feedback form from IDEA Part A and B)

***Patient panel. Use the How to Identify and Track Developmental Needs resource to create a simple registry of developmental needs using diagnosis codes. This allows for the creation of an electronic health record report or flowsheet to identify patients that need more frequent follow up.

For more support on internal screening and referral processes, review the Screening and Referral Checklist and Strategies Part 1: Processes for Pediatric Practices.

The Early Childhood Developmental Health Systems (ECDHS): Evidence to Impact Center was made possible through the support of the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $4,740,000 with 0% financed from non-governmental sources. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.