Adams County ~ Early Childhood Coordinated Referral Roadmap

All children are valued, healthy, and thriving

The community will use a coordinated identification and referral system to increase young children’s access to comprehensive health care – medical, developmental, oral, and mental health

*Cultural and linguistically sensitive practice is recommended throughout the process

**Families have ultimate decision making in the options provided to them

***Education and support is provided to families throughout the process

Phases Defined

Specific Phases/Who

Recommended Best Practices

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**S U R V E I L L A N C E / O B S E R V A T I O N**
(all individuals who provide any type of care for young children, women, or parents)

1. Stay informed and up-to-date on the latest research and information pertaining to the health and development of young children and maternal wellness
2. Keep a watchful eye on children’s health and development/maternal wellness, closely monitor any concerns, and identify both risk and protective factors – keeping observational records if appropriate
3. Know and perform recommended activities with children that promote health and development
4. Do not wait too long to identify concerns – early intervention is key if there is problem

**I D E N T I F I C A T I O N / D E T E C T I O N**
(determine if:
1. Child/woman has a Medical Home
   - If yes – see #2
   - If no – refer and support family/woman to find Medical Home per information in packet
2. Child/woman has already been formally screened
   - If yes – request copy from screener with parent/woman’s permission
   - If no – provide formal screening or refer to Medical Home per Referral to Specialist (see phase #4) steps and provide family/woman with needed information on the process per Talking Points and Family Roadmap
3. If no formal screening tool exists refer per Referral to Specialist (see phase #4) steps and notify Medical Home and other involved parties with family permission
4. Family/woman needs anticipatory guidance – provide as needed (see examples in packet)

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**S C R E E N I N G**
(entities include: health clinics, home visitation programs, Head Start, other professionals trained in standardized screening tools)

**T r a i n e d S c r e e n i n g E n t i t y w i l l:**
1. Explain purpose of screening to family/woman
2. Use standardized tool within appropriate timelines
3. Provide outcome of screening (positive and concerning results) to family/woman within the same visit
4. Obtain necessary Releases of Information to share results with appropriate support people in families’ lives
5. If concern is present – follow Referral to Specialist (see phase #4) steps
6. Track all screenings and referrals made

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Adams County strives to have all individuals who touch the lives of young children and pregnant/post-partum women to have the knowledge of child health and development and maternal wellness needed to ensure the promotion of wellness for both women and children

Through “surveillance,” child/woman is identified as having a potential health need by a caregiver or community professional through informal methods – i.e.: developmental checklist or observation

Children and women (pregnancy-related depression) receive a formal screening for identified health need by a trained professional using a standardized tool
### Phases Defined

1. **Children/women who have an identified concern are referred to a specialist to determine next steps**

2. **Child/woman receives a formal evaluation or assessment by a specialist to determine eligibility for services**

3. **Comprehensive community-based programs are available to children/women to support health and child development**

### Specific Phases/Who

**REFERRAL TO SPECIALIST**
- Referring entities include: health clinics, home visitation programs, early childhood education programs, others noted in the Identification/Detection and Screening Phases.

**FORMAL EVALUATION/ASSESSMENT**
- Entities include: health clinics, North Metro, school districts, Community Reach Center, home visitation programs, oral health providers.

### Recommended Best Practices

**Referring Entity will:**
1. Explain reason for referral and expected next steps to the family/woman per *Talking Points* and *Family Roadmap*.
2. Identify and problem solve any barriers or needed support.
3. Send correct referral form in its entirety with full screening document to referral agency.
4. Contact the referral agency within 1 month if no update has been provided.
5. Follow up with the family/woman to determine any needed support.
6. Track all referrals made.

**Agency Receiving Referral will:**
1. Contact the family within 48 hours of referral to answer any questions, gather more information, and/or schedule an appointment as needed.
2. Address families’ barriers and needed support.
3. Ensure any additional screening completed follows standards set by the profession.
4. If child/woman do not need an evaluation or if family chooses not to have an evaluation done, determine if other community programs or supports would be helpful per *information in packet*.
5. If child/woman requires further evaluation, schedule appointment within guidelines (7 days).
6. Provide status update to the referring entity.
7. Track all referrals received.

**Evaluation Specialist will:**
2. Obtain needed Releases of Information for quality care coordination.
3. Provide status update to referral source as well as other identified entities.
4. Explain outcome of evaluation to family/woman in culturally responsive manner and address any identified needs or barriers.
5. If child/woman qualifies, provide services.
6. If child/woman does not qualify, refer to community programs and supports per *information in packet* if appropriate.

**Programs Receiving Referral will:**
1. Contact family/woman to explain program options and provide support as needed.
2. Refer to other programs as needed.
3. Provide status update to referring entity.

**Service-Providing Entity will:**
1. Coordinate care regularly with all involved parties as parent/woman permit.
2. Provide referrals for additional evaluations for services as needed and support family in following through.
3. Transition plan with families to other community programs or supports.

**Child/woman receives indicated services to address treatment needs and is re-assessed on an on-going basis to determine needed level-of-care.**

**Comprehensive community-based programs are available to children/women to support health and child development.**

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