ECPAC
EARLY CHILDHOOD PARTNERSHIP
OF ADAMS COUNTY

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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
1 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	**SURVEILLANCE/OBSERVATION** (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
2 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	**IDENTIFICATION/DETECTION** (all individuals who touch the lives of young children with knowledge of typical child health and development or women with knowledge of signs of pregnancy-related depression – PRD)	**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** • 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 3. Family/woman needs anticipatory guidance – provide as needed (see examples in packet)
3 Children and women (pregnancy-related depression) receive a formal screening for identified health need by a trained professional using a standardized tool	**SCREENING** (entities include: health clinics, home visitation programs, Head Start, other professionals trained in standardized screening tools)	**Trained Screening Entity will:** 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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4 Children/women who have an identified concern are referred to a specialist to determine next steps	**REFERRAL TO SPECIALIST** (Referring entities include: health clinics, home visitation programs, early childhood education programs, others noted in the Identification/Detection and Screening Phases) (Receiving entities include: health clinics, North Metro, school districts, Community Reach Center, home visitation programs, oral health providers, others providing services/supports)	**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
5 Child/woman receives a formal evaluation or assessment by a specialist to determine eligibility for services	**FORMAL EVALUATION/ ASSESSMENT** (entities include: health clinics, North Metro, school districts, Community Reach Center, oral health providers)	**Evaluation Specialist will:** 1. Complete evaluation/assessment using best practices 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

AND/OR

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Comprehensive community-based programs are available to children/ women to support health and child development	**COMMUNITY PROGRAMS OR SUPPORTS** **Can be accessed throughout the process at all phases**	**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

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