Early Childhood Developmental Health Systems | EVIDENCE TO IMPACT CENTER

Best Practices for Promoting a Team-Based Care Environment

As part of the Transforming Pediatrics for Early Childhood (TPEC) project, state- and community-level teams in eight states, known as TPEC Resource Hubs, support pediatric practices in embedding early childhood development (ECD) experts into their teams. ECD experts work under a variety of titles depending on the practice's staffing needs and billing opportunities in alignment with the families they serve. Common roles include integrated mental/behavioral health providers, community health workers, and other positions that support parent education, community outreach, and system navigation.

The Early Childhood Developmental Health Systems (ECDHS): Evidence to Impact Center held focus groups with pediatric practice staff across the eight TPEC Resource Hubs to identify what worked and what hindered implementation of team-based care. This resource provides reflections and best practices for pediatric practices implementing team-based care, including strategies to build readiness prior to hiring.

Team-Based Care Structure

The Bright Futures program creates and shares clinical national guidelines for pediatric well-child visits. The guidelines help pediatric providers deliver preventive services to children and youths from birth to age 21.

As recommended by Bright Futures, pediatric providers should screen for developmental milestones, autism, social-emotional health, perinatal depression, and health-related social needs. During well-child visits, providers are expected to respond to numerous needs; however, no single provider meets all children's and families' needs alone.

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Team-based care ensures that young children and their families receive comprehensive support in primary care and breaks down silos that prevent families from accessing other needed services. To do this, pediatric practices may hire ECD experts to join their care teams. Oftentimes, ECD experts are family partners (such as community health workers or community navigators) or mental and behavioral health providers.

Pediatric practices implementing team-based care report building stronger relationships with families, which has contributed to families coming in more regularly for preventive care. Teams also report being better equipped to meet families' needs, which has contributed to the satisfaction and retention of clinical staff. The following best practices were emphasized during the ECDHS: Evidence to Impact Center's focus groups with pediatric practice teams.

Best Practices From Pediatric Practice Teams

Strategy	Why It Matters	Key Lessons	Practice Example
Maximize existing staff and flexibly define roles	Team-based care does not always require hiring new staff. Existing personnel often have untapped skills and relationships that can strengthen service delivery.	• Engage front-desk staff in pre-visit planning. • Identify positions that can partly support the navigation of community resources. • Leverage the existing knowledge and experiences of staff when strengthening relationships with external partners.	An administrative team developed a pediatric secretary role that is responsible for sending and tracking referrals between organizations.
Hire the right fit	The right person can make a significant difference for the team's culture and for families, so take time to hire someone who understands the value of team-based care.	• If hiring a family partner or resource navigator, prioritize someone with extensive knowledge of community resources.	A front-desk staff member was hired for a family partner position because of their existing relationship with families and knowledge of the electronic health record.

Strategy	Why It Matters	Key Lessons	Practice Example
Establish multiple communication channels	Team-based care requires near-constant communication and coordination to ensure everyone is on the same page.	• Use complementary communication channels for information sharing, triaged by urgency. • Lead with a "no wrong door" communication style to ensure staff feel comfortable asking questions about who to connect families to.	Family partners' offices were placed in the same space as the providers they work with, to allow for informal opportunities to check in and build rapport.
Use purposeful scheduling to match care to the family	Purposeful scheduling allows teams to prepare for patient complexity and improves workflow efficiency.	• Flag complex visits before appointment dates. • Schedule longer visits when additional needs are anticipated. • Coordinate schedules when multiple team members will need to participate.	Administrative staff identify families with higher support needs and communicate and adjust scheduling accordingly.
Leverage electronic health records (EHRs) and registries for care coordination	EHRs are an existing system that every staff member uses, so they can be leveraged to strengthen communication, tracking, and follow-up.	• Ensure that all staff can write notes in the EHR and require staff to update their notes after any communication. • Utilize the "delegate tasks" feature to remind other staff about follow-up activities or prepare questions to check in with families in upcoming visits.	Family partners were trained to facilitate care coordination and referral processes using EHRs shared across agencies (e.g., an Individualized Education Plan).

Strategy	Why It Matters	Key Lessons	Practice Example
Utilize a continuous quality improvement (CQI) approach	Team-based care processes take trial and error to identify what works best for every staff member.	• Expect short-term delays as staff get comfortable with new ways of working. • Start with testing small changes to build confidence in the CQI process. • Encourage questions and feedback from families and all staff to normalize experimentation and problem-solving. • Create opportunities for shared learning.	Informal and formal feedback was gathered from families (e.g., a family partner should attend all visits through 1 year), and test associated changes (e.g., services expanded after assessing caseloads).
Develop strong external partnerships	Strong care coordination goes beyond the clinic walls and requires practices to maintain relationships with referral partners.	• Ensure a staff member knows what the next steps look like after a family reaches out to a referral source, so this can be communicated proactively to families. • Standardize processes with the most common referral sources so that there is bidirectional feedback between partners.	A program manager began to meet biweekly with intake staff to maintain strong behavioral health care coordination processes.

Strategy	Why It Matters	Key Lessons	Practice Example
Create the space for reflective practice	Supporting families through complex challenges can bring up difficult emotions. Also, hiring new roles will create gray areas and uncertainty among staff. Reflective practice gives staff the opportunity to debrief and problem-solve.	• Build in one hour, twice a month, for staff to engage in reflective practice with a coach. • Ensure private spaces are reserved for reflective practice.	Family partners spent their reflective practice time with their coach going over complex cases, reflecting on their feelings, and refining their workplace skills.

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