

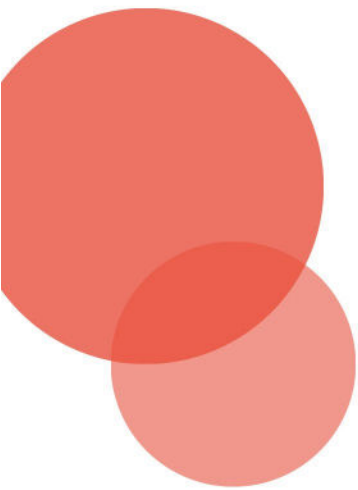
One Big Doable Thing! *Elevating Comprehensive Developmental Promotion and Preventive Services With the Family-Engaged Well Visit Planner Approach*

September 10, 2024



Early Childhood
Developmental
Health Systems

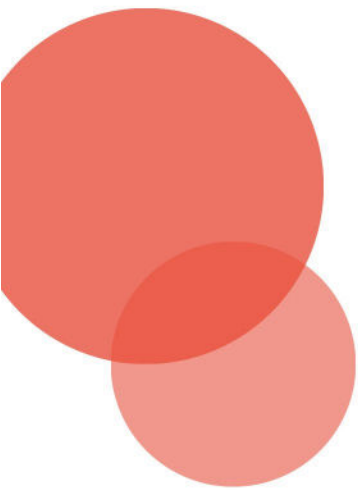
EVIDENCE TO
IMPACT CENTER



Housekeeping

- Attendees are muted for the duration of the event.
- Please submit questions through the Q&A feature.
- Today's slides are available under the Handouts tab on the eLearn event page.
- A recording will be available within 48 hours and sent through a post-event email within 1 week.
- CEUs are provided for this webinar (more details on how to receive credits will be shared at the end of the presentation).





About the Early Childhood Developmental Health Systems (ECDHS): Evidence to Impact Center

- We support states and communities to build early childhood systems that improve the health and well-being of young children and their families
- Our objectives:
 - Strengthen the evidence base of state ECD systems
 - Accelerate ECD systems development
 - Increase systems-building skills and the number of early childhood and health system leaders
 - Advance the delivery of high-quality ECD promotion and support services in pediatric settings
- Learn more about our mission and structure at earlychildhoodimpact.org/about-us/



Funding Acknowledgement

This program 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 \$5,300,000 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](https://www.hrsa.gov).



Early Childhood
Developmental
Health Systems

EVIDENCE TO
IMPACT CENTER

Poll #1. Which role best describes you? Select one only.



Today's Speakers



Christina Bethell, PhD, MBA, MPH
Director, Child and Adolescent
Health Measurement Initiative



Barbara Leach
Family Support Specialist, UNC
School of Social Work



Louis Appel, MD, MPH
Director of Pediatrics, People's
Community Clinic



One Big Doable Thing!

Elevating Comprehensive Developmental Promotion and Preventive Services With the Family-Engaged Well-Visit Planner Approach

Dr. Christina Bethell, PhD, MBA, Founding director of the Child and Adolescent Health Measurement Initiative

Barbara Leach, Family Support Specialist, University of North Carolina

Dr. Louis Appel, MD, MPH, FAAP,
Director of Pediatrics, People's Community Clinic

September 10, 2024

Early Childhood Developmental Health Systems(ECDHS)

Evidence to Impact Center Webinar



Our Aim: To translate the science of healthy development and flourishing into everyday practice, policy and culture for early and lifelong health

Hypothesis: Advances in the sciences of human development create unprecedented opportunities to proactively advance child well-being. Breakthrough findings across disciplines point to a new science of thriving that illuminate often untapped capacities for the promotion of healthy development and healing despite adversity. Given high rates of adversity, healing is prevention.

Key to this possibility are policies and practices that enable and support families and communities to recognize and learn to heal and flourish in the face of stress and adversity.



Objectives

We Seek to Inspire and Support You To.....

1. Identify mindsets and pathways for ***leveraging existing systems*** to improve access to comprehensive health promotion and preventive services that engage families in ways that effectively promote the early relational health required to ***foster whole child and family flourishing***.
2. Learn about how the ***family engaged Well Visit Planner*** approach addresses key requirements and challenges related to ***assuring high quality, personalized well child care services*** that put families at the center to foster early relational health and child flourishing.
3. Explore the ***application of the Well Visit Planner*** approach through a case example in a Community Health Center and consider how this approach ***addresses existing barriers*** to the comprehensive, family engaged, personalized care needed to effectively promote early relational health and child flourishing.

Our Agenda

Our One Big
Doable Thing!
Story (OneBDT!)

Deeper Dive:
The Essential
Shift to Real
Family
Engagement

Deeper Dive:
The Concrete
Approach and
Tools for
Transformation

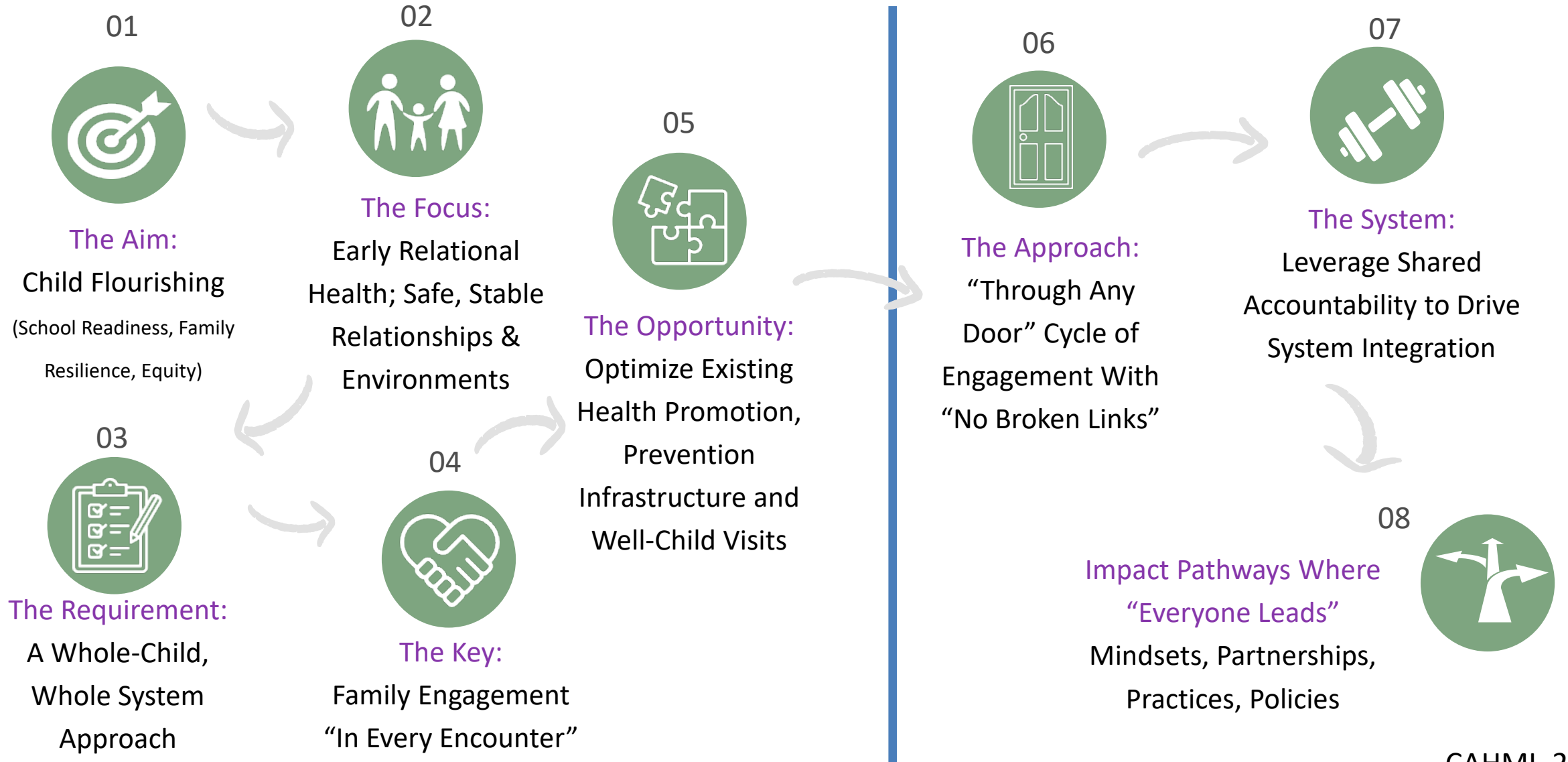
Embrace
Possibilities
Leverage Short
Term Actions to
Foster System
Transformation



The presenters have no financial relationships to disclose or conflicts of interest to resolve.



Meeting the Moment Where Our Science of Healthy Development, Lived Experiences and Practices Meet: Our “One Big Doable Thing” Story!





Start Where We
Want to End Up!

The Aim
Promote Child
Flourishing

The Flourishing Paradigm

Flipping the narrative to proactively promote early and lifelong flourishing



- The absence of the negative (risk, illness) is not the same as the presence of well-being and flourishing.
- Child flourishing measures assess positive health characteristics essential for healthy development like healthy attachment, resilience, engagement and learning and emotional openness, empathy and communication.
- Child Flourishing strongly predicts school readiness and engagement, social success and mental health and is negatively associated with ACEs, poverty and having a disability. Yet.....
- Family resilience and connection, caregiver-child connection and positive childhood experiences promote flourishing, even amid high adversity

**Four Components of the Child Flourishing Index: National Survey of Children's Health, 6 months-5 years
assessing markers of healthy attachment, emotional well-being, engagement and resilience**



Affectionate
and tender
with parent



Bounces back
quickly when
things don't go
their way



Show interest
and curiosity
in learning
new things



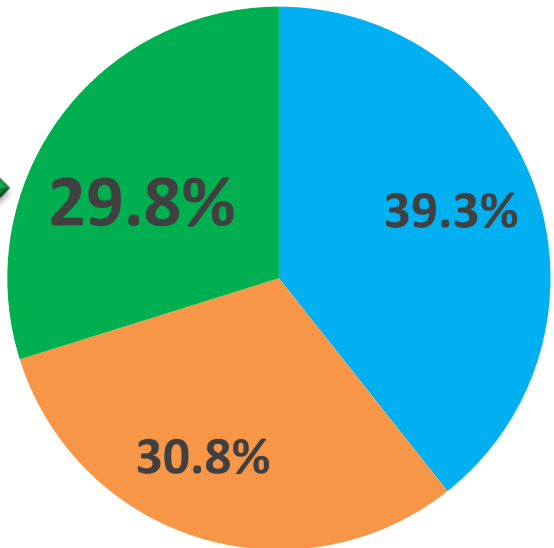
Smile and
laugh a lot

Interrelated attributes that reflect, contribute to or are precursors for flourishing of the
"living and relating self" & supporting living a meaningful and engaged life

Prevalence of Publicly Insured Children Aged 6 Months to 5 Years By Child Flourishing Index Score and Item Data: 2021-2022 National Survey of Children's Health

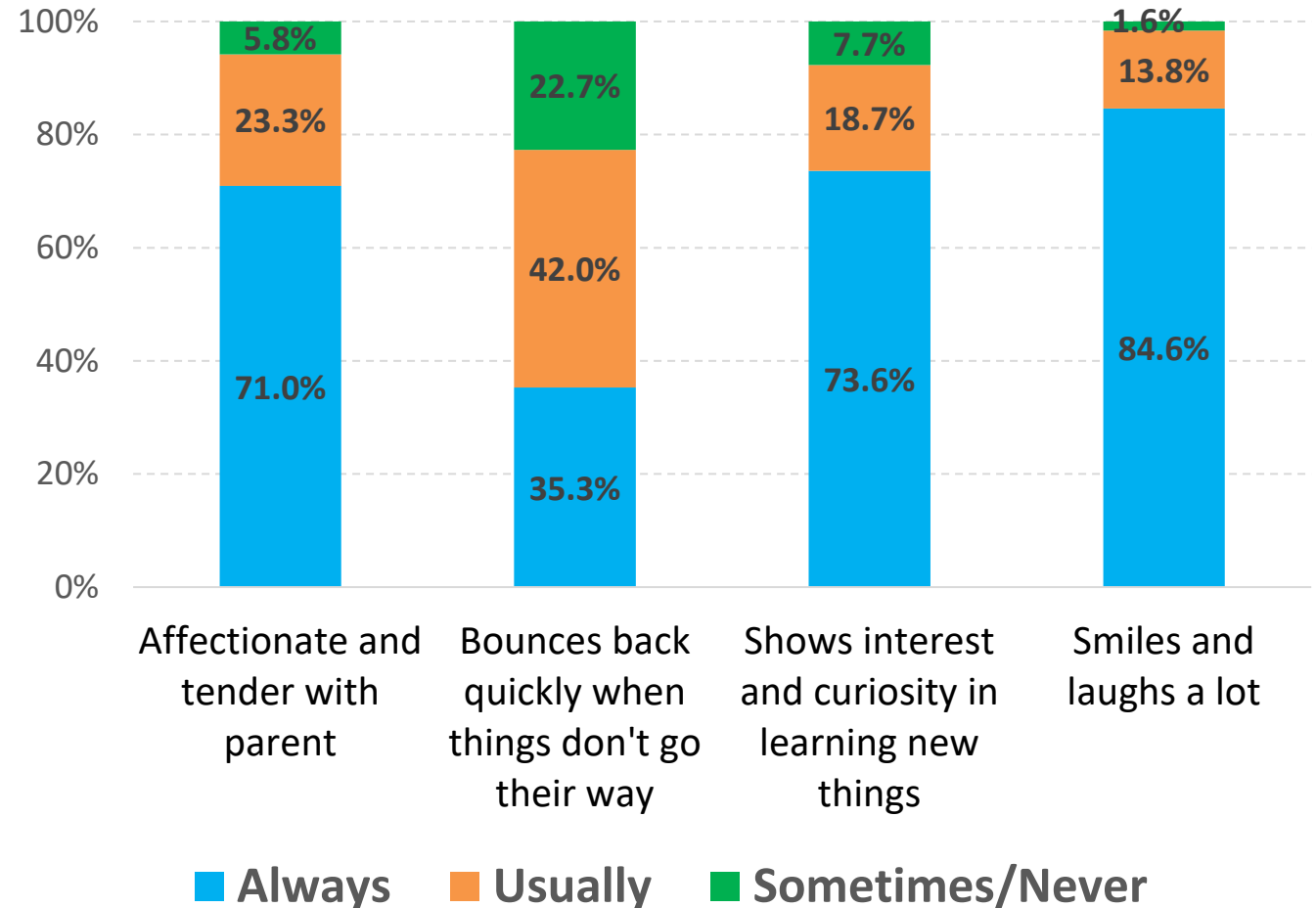
Publicly Insured Children, 6 months-5years

State Range:
18.9%-43.5%



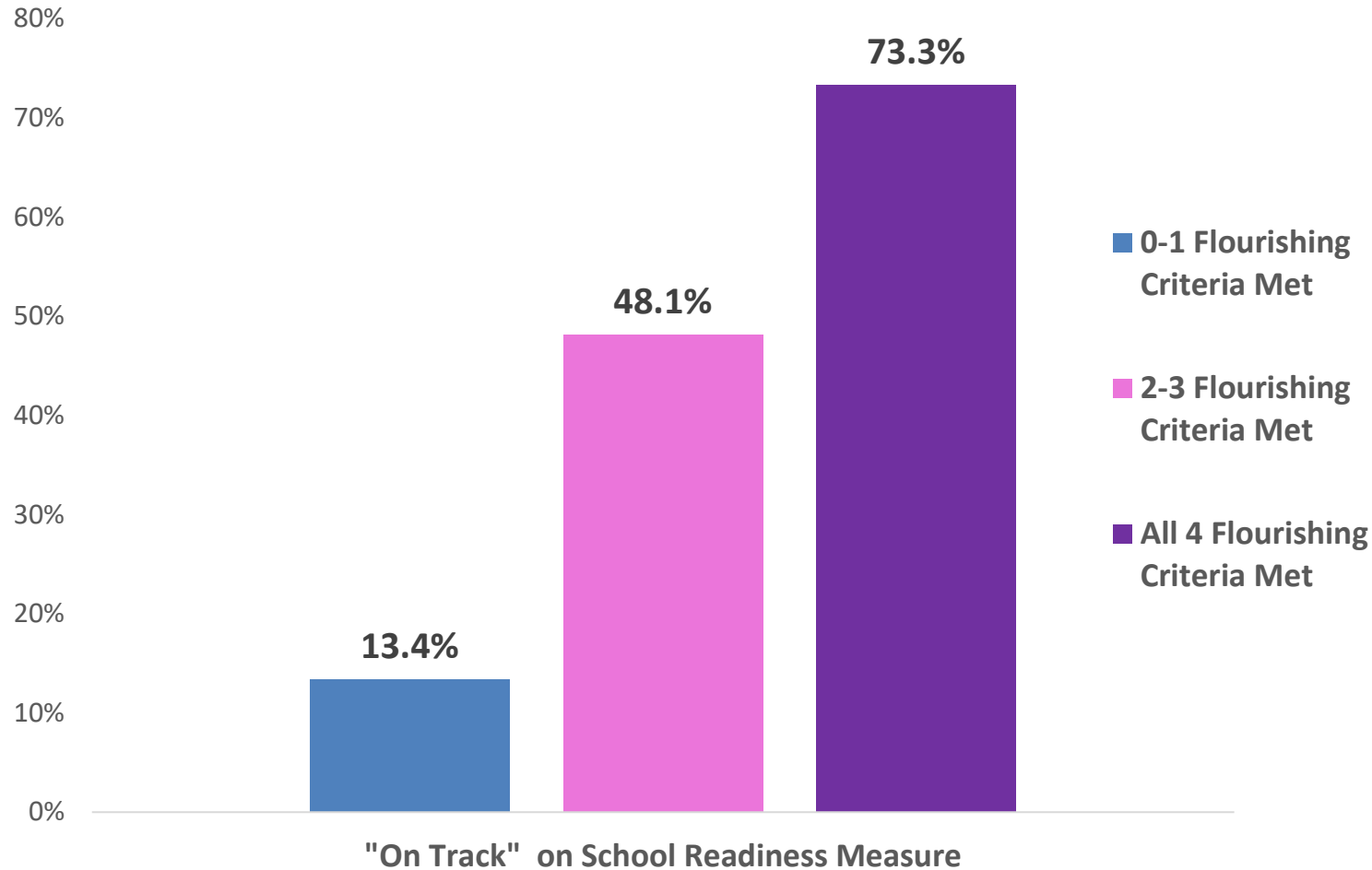
- Met 0-2 flourishing items
- Met 3 flourishing items
- Met 4 flourishing items

Prevalence by Individual Flourishing Items



School Readiness by Child Flourishing (age 3-5)*

2022 NSCH Data



The absence of flourishing is more strongly associated with school readiness than the presence of ACEs**

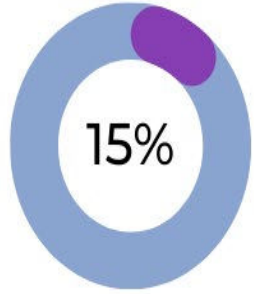
**Flourishing Items for Young Children (how often)*

- 1) is this child affectionate and tender?
- 2) does this child bounce back quickly when things do not go their way?
- 3) does this child show interest and curiosity in learning new things?
- 4) does this child smile and laugh a lot?

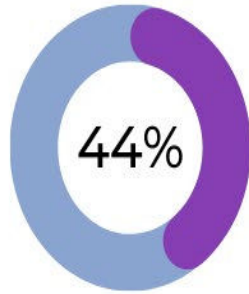
***School Readiness by ACEs Exposure:*

0 ACEs: 70% "On Track"
1 ACE: 50.9%
2+ ACEs: 47.2%

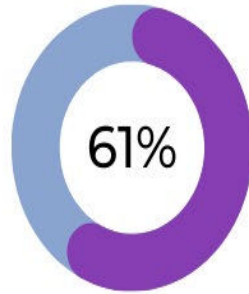
There is a four-fold difference in the prevalence of children's mental health conditions depending on the social and relational health risks they experience.
Optimize positive and relational health for children and families by acting now!



Those with 0 Relational or Social Health Risks



Those with 2 or more Relational Health Risks



Those with 2 or more Relational Health Risks and Social Health Risks

A Critical Focus

Promote early relational health to establish the safe, stable and nurturing relationships and environments children need to thrive

C. Bethell, Child Adolesc Psychiatr Clin N Am. 2022

By promoting positive childhood experiences and increasing flourishing for all children, **we have the power** to prevent poor mental health, even amid adversity!



HOW to Build Early Relational Health?

Three “Lenses” to Operationalize Relational Health

- **Two-Generational Approach**
 - Assess caregiver health and history that may impact parenting and partner with caregivers in order to help the children
- **Developmental Approach**
 - Affect regulation and relational health are moving targets. Requires ongoing relationships, learning and developmental assessment
- **An Integrated Services, Public Health Approach**
 - Layered efforts are needed across systems of care to address social, relational and special needs of children and families

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children



Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health

Andrew Garner, MD, PhD, FAAP^{a,b} Michael Yogman, MD, FAAP^{c,d}
COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, SECTION ON DEVELOPMENTAL AND BEHAVIORAL
PEDIATRICS, COUNCIL ON EARLY CHILDHOOD



Gaps in Child Flourishing Narrow with Family Resilience and Connection

Existing programs could increase thriving, even for children facing adversity, large study finds

Less than half of school-aged children in the U.S. are flourishing, according to a new study led by researchers at the Johns Hopkins Bloomberg School of Public Health. However, children living in families with higher levels of resilience and connection are much more likely to flourish. This is true for children across levels of household income, health status and exposure to adverse childhood experiences.

Family Resilience and Connection Index

- ☐ Know they have strengths to draw on
- ☐ Stay hopeful even in difficult times
- ☐ Share ideas and talk about things that really matter
- ☐ Parent coping well with parenting
- ☐ Family reaches out and talks with each other when they face problems
- ☐ Family works together to solve problems (vs. ignoring problems)

Citation: Bethell CD, Gombojav N, Whitaker RC. Family Resilience And Connection Promote Flourishing Among US Children, Even Amid Adversity. Health Aff (Millwood). 2019 May;38(5):729-737. doi: 10.1377/hlthaff.2018.05425. PMID: 31059374.

7 Positive Childhood Experiences (PCEs)



feeling able to talk to your family about feelings



feeling a sense of belonging in high school



feeling your family stood by you during difficult times



feeling safe and protected by an adult in your home



feeling supported by friends



enjoying participation in community traditions



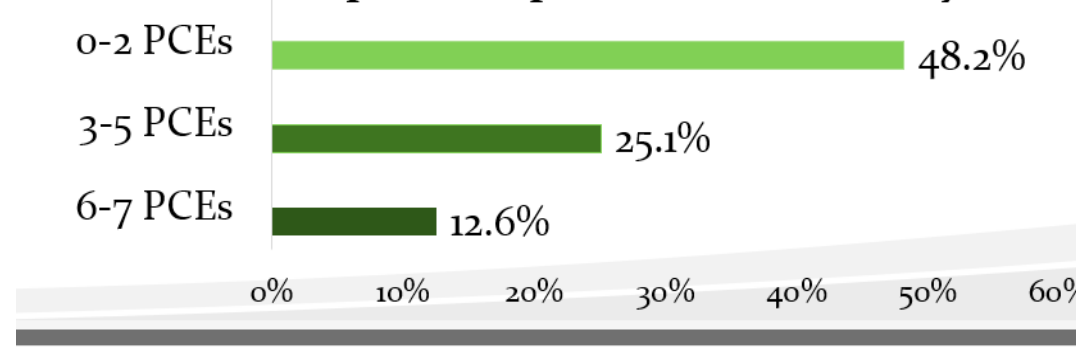
have at least two non-parent adults who took genuine interest in you



Positive Childhood Experiences (PCEs)

Our research demonstrates the lifelong impact of PCEs on health

Prevalence of depression/poor mental health by PCEs



JAMA Network
JAMA Pediatrics

Search All Enter Search Term

View Correction

This Issue Views 108,098 Citations 158 Altmetric 1149

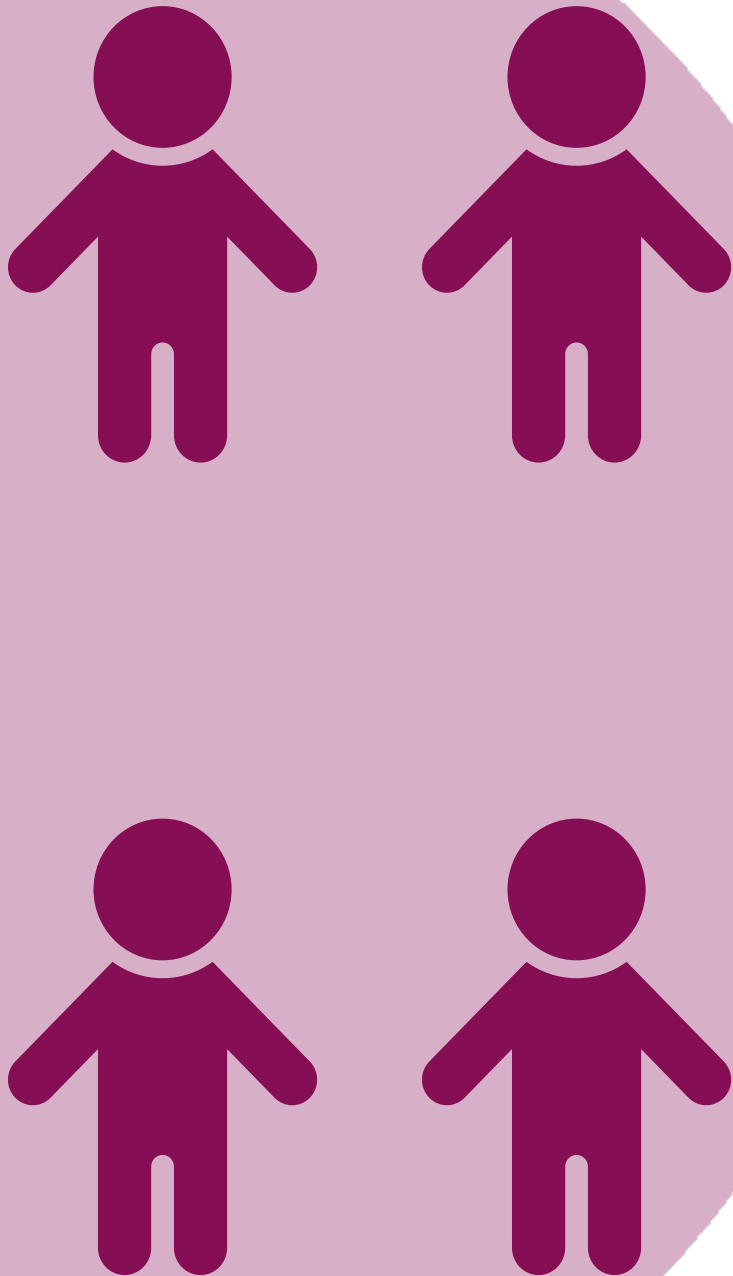
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Original Investigation
September 9, 2019

Positive Childhood Experiences and Adult Mental and Relational Health in a Statewide Sample
Associations Across Adverse Childhood Experiences Levels

Christina Bethell, PhD, MBA, MPH¹; Jennifer Jones, MSW²; Narangerel Gombojav, MD, PhD¹, et al
Author Affiliations | Article Information
JAMA Pediatr. 2019;173(11):e193007. doi:10.1001/jamapediatrics.2019.3007

Bethell C, Jones J, Gombojav N, Linkenbach J, Sege R. Positive Childhood Experiences and Adult Mental and Relational Health in a Statewide Sample: Associations Across Adverse Childhood Experiences Levels. *JAMA Pediatr.* 2019;173(11):e193007. doi:10.1001/jamapediatrics.2019.3007



The Requirement

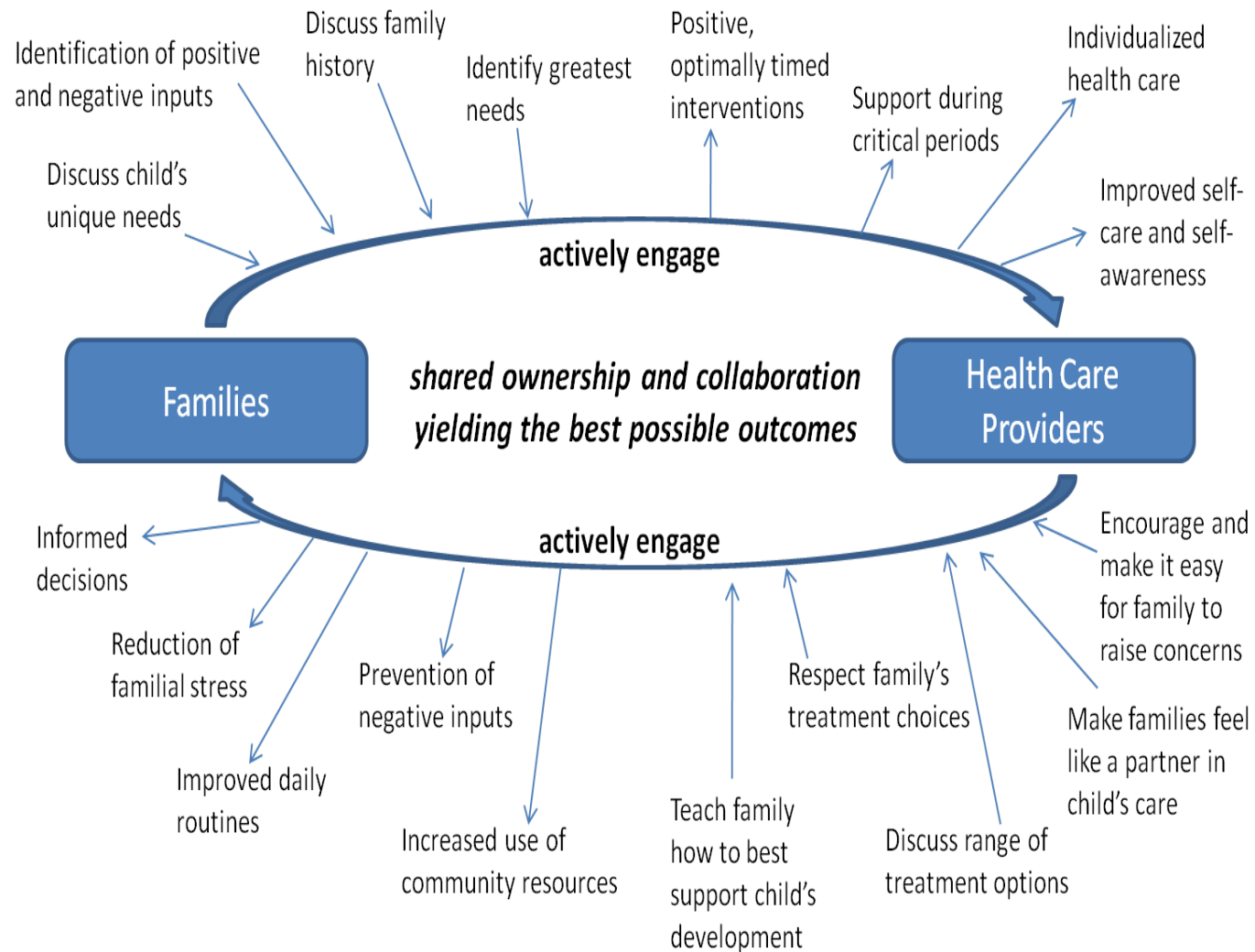
A whole child and family approach to assessment and the integration of services and supports to address needs and promote healthy development



The Key

Engage families “Through Any Door”, “In Every Encounter” with “No Broken Link” where “Everyone Leads”

Active Engagement and Time to Connect are Fundamental to Quality Care and Outcomes



Family often practices 4 qualities of resilience when facing problems	
How often providers spend enough time*	
Always	73.1%
Sometimes/Never	47.9%
How often providers listen carefully to parents*	
Always	71.0%
Sometimes/Never	46.1%
How often specific information needed is provided	
Always	70.7%
Sometimes/Never	45.9%

Bethell CD, Gombojav N, Whitaker RC. Family Resilience And Connection Promote Flourishing Among US Children, Even Amid Adversity. *Health Aff (Millwood)*. 2019 May;38(5):729-737. doi: 10.1377/hlthaff.2018.05425. PMID: 31059374.

The Opportunity

Optimize Existing
Developmental Promotion and
Prevention Well Child Visit
Infrastructure to Streamline
National Bright Futures
Comprehensive Developmental
Promotion and Screening

Bright Futures



HRSA's Bright Futures Program aims to improve health outcomes for the nation's infants, children, and adolescents by increasing the quality of primary and preventive care through maintenance and dissemination of age-specific, evidence-driven clinical guidelines. HRSA launched the Bright Futures program in 1990 to address a need for unified guidance on how to design the most modern, efficient, and comprehensive pediatric checkup.



**Bright
Futures™**

prevention and health promotion
for infants, children, adolescents,
and their families™

American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

Why are well visits important?

Well visits are an opportunity for families and health providers to connect and celebrate what's going well, meet family needs, and address child health concerns. These visits allow for age-specific:

Surveillance
& Screening



Anticipatory
Guidance

Disease
prevention



Health
Promotion

Bright Futures Guidelines recommend **15 well visits** in the first **six years** of life.



Children and families thrive when they stay on track with well visits!

A project of the Child & Adolescent Health Measurement Initiative

One Big Doable Thing: Equitable access to high-quality well-child care services for all young children and families-60 million encounters recommended; ½ occur; 90% missing core elements of guideline-based care. 15 age-specific visits in the first 6 years of life.



1wk



1m



2m



4m



6m



9m



12m



15m



18m



2y



30m



3y



4y



5y



6y



Closing the Gap! National Performance Measure Well Child Visit Rates (CMS Data)*

Proportion of publicly insured children **under 15 months** of age that had at least **6 of 9** recommended well visits

2022: 55.7%
Range Across States:
28.2%-77.5%
(1/2 visits occur)

Proportion of publicly insured children **15-30 months** of age that had at least **2 of 4** recommended well visits

2022: 64.9%
Range Across States:
36.5%-84.4%
(2/3 visits occur)

Nationally, nearly half of the estimated well child visits that should happen do not occur



*<https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html>

We Can Close the Gap!

Even today, only 1 in 3 young children receive the appropriate developmental screenings.



Publicly Insured: 28.7%
Range Across States:
8%-54.6%

National Performance Measure: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Data Source: 2021-2022 National Survey of Children's Health

Nationwide: 33.7% of children met indicator

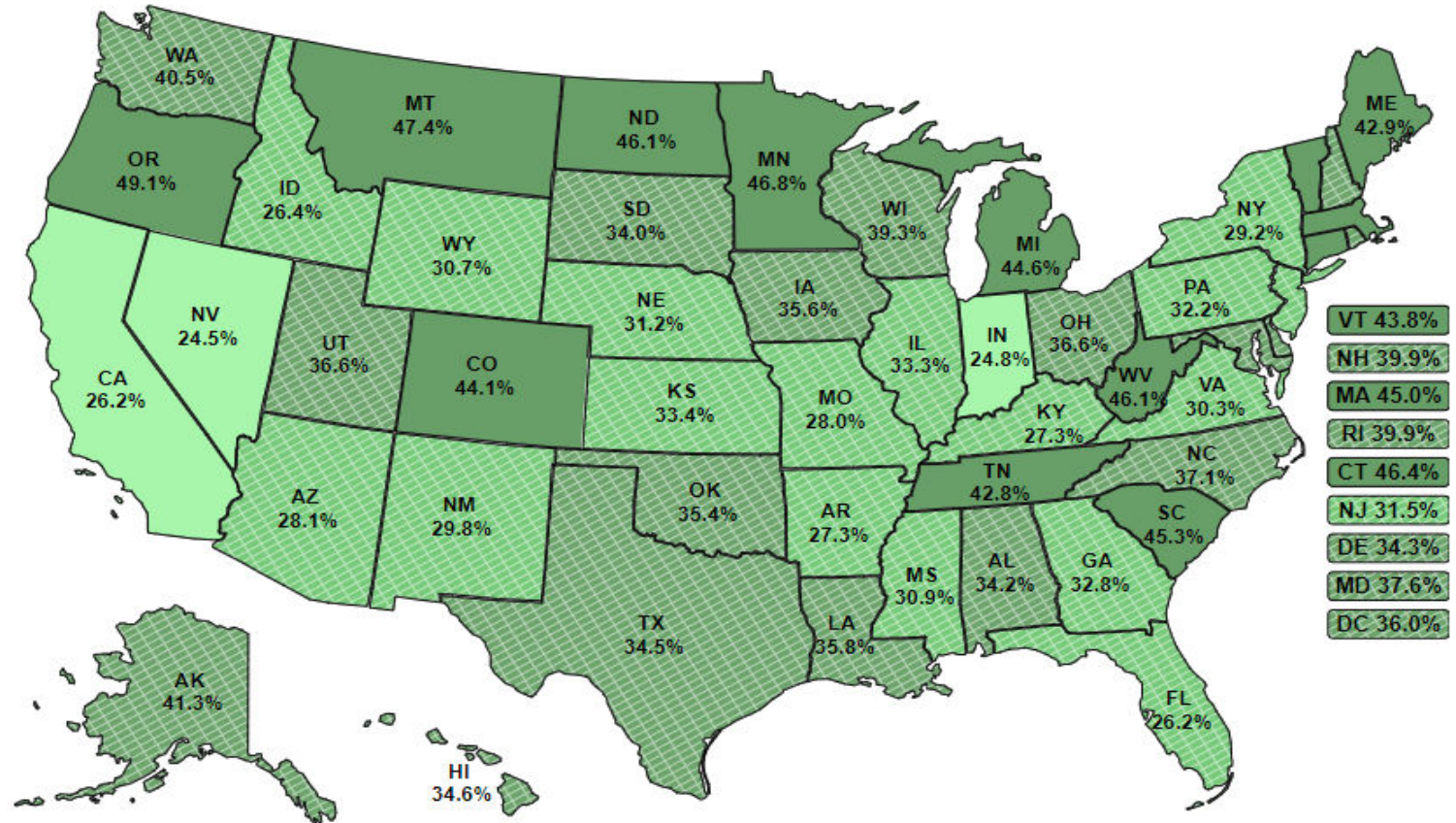
Range Across States: 24.5% to 49.1%

Note: Click on any state to compare national and state level data and to access subgroup level data (i.e. age, race, income, insurance type).

Higher=better performance



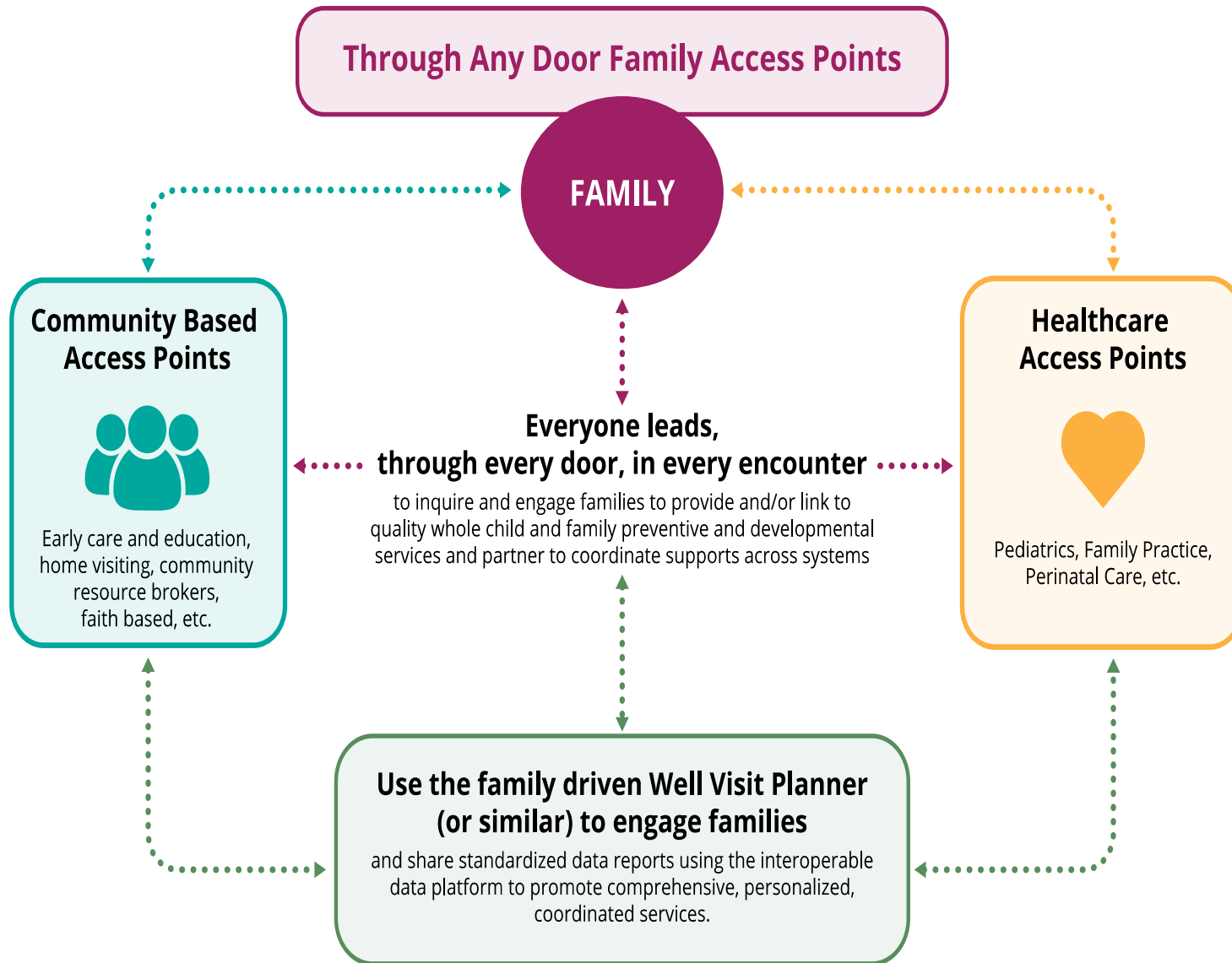
The significance of differences between state and national prevalence was assessed using a nested t-test at $p < 0.05$



Citation: Child and Adolescent Health Measurement Initiative. "National Performance Measure: Percent of children, ages 9

Poll #2. Which best describes your familiarity with the Bright Futures Guidelines? Select one only.



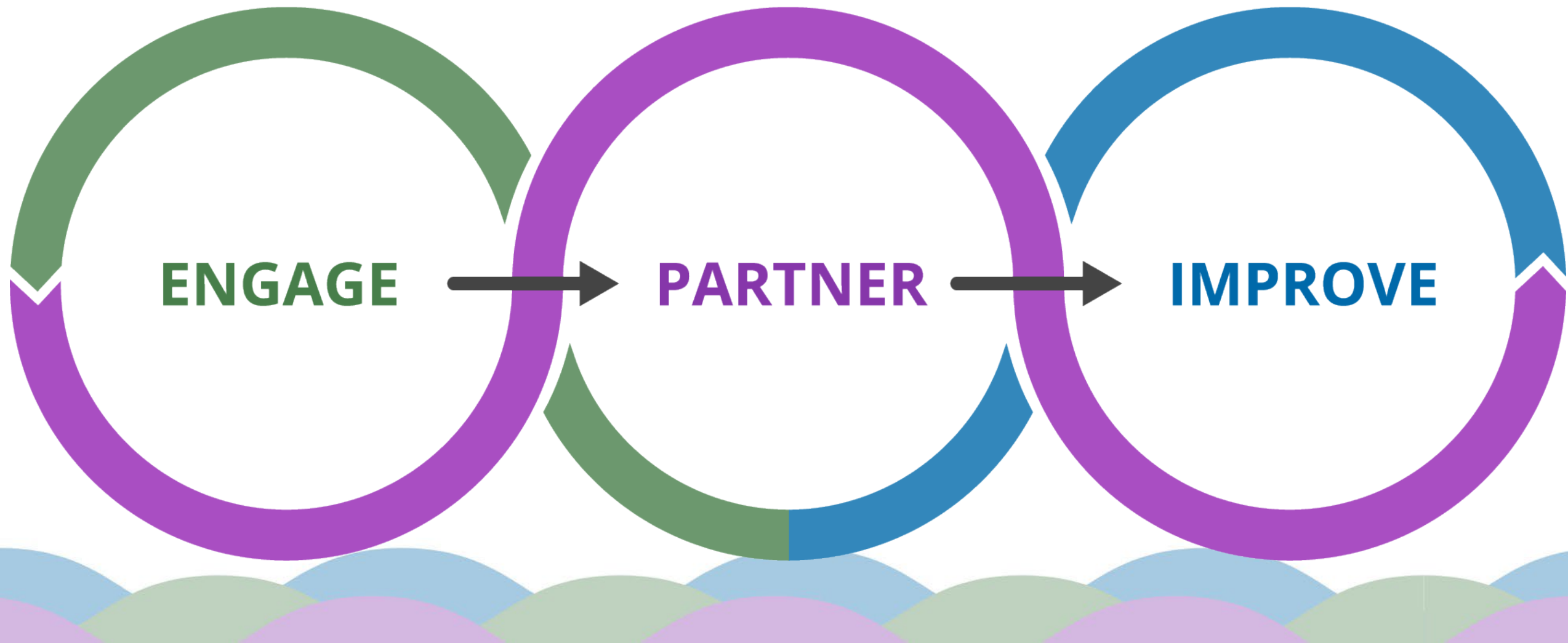


The Approach

Enabling a Through Any Door **G**uideline-Based, **P**ersonalized and **S**ystems Integrated (GPS) Interoperable Approach to Optimize Services

(4 criteria identified by cross-sector EC program teams)

The Cycle of Engagement Well Visit Planner Approach to Care



What is the Cycle of Engagement?



A personalized, relationship centered model of care



A whole child, integrated approach to assessment

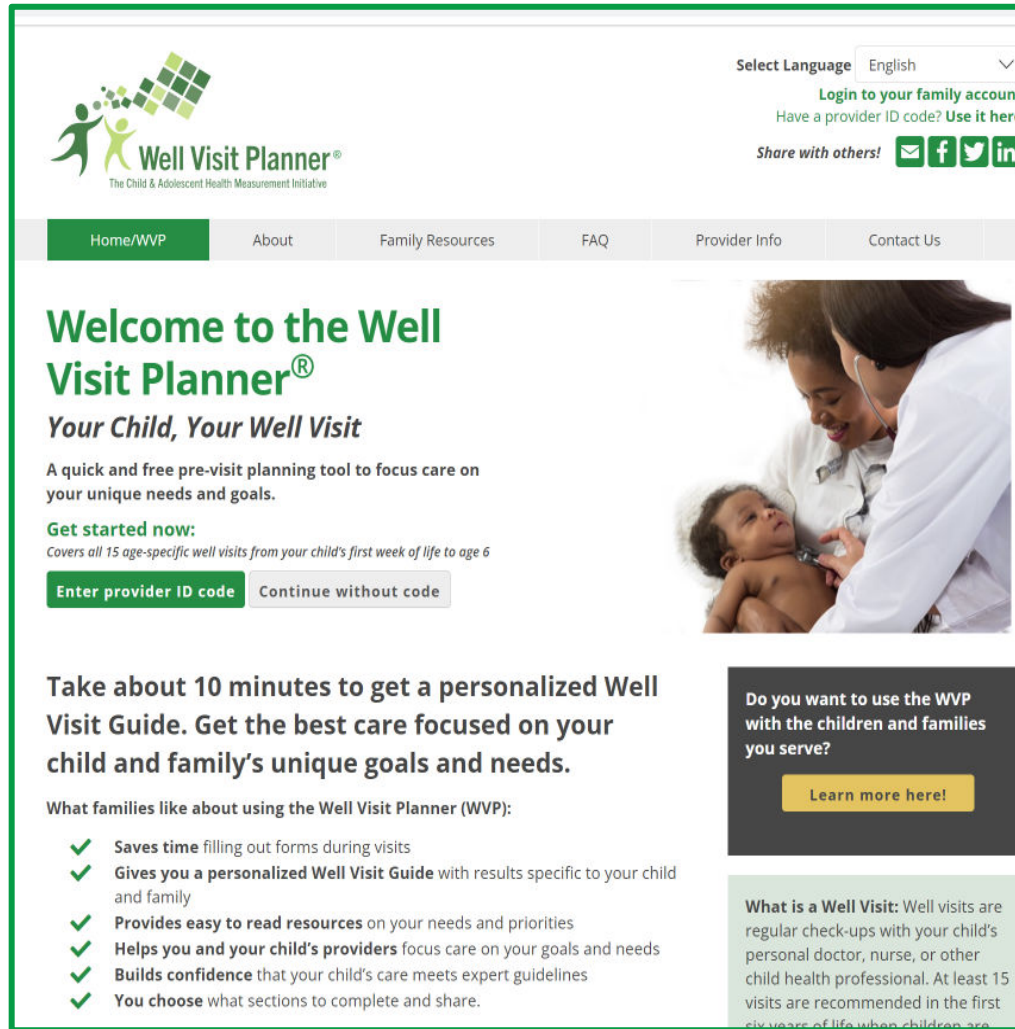


A feasible and standardized measurement process



A population health strategy aligned with Bright Futures

The Well Visit Planner



The screenshot shows the homepage of the Well Visit Planner. At the top, there is a logo with the text 'Well Visit Planner®' and 'The Child & Adolescent Health Measurement Initiative'. To the right, there is a language selector set to 'English', a login link, and social media sharing icons. A navigation bar includes links for 'Home/WVP', 'About', 'Family Resources', 'FAQ', 'Provider Info', and 'Contact Us'. The main content area features a large heading 'Welcome to the Well Visit Planner®' followed by the tagline 'Your Child, Your Well Visit'. Below this, it describes the tool as a quick and free pre-visit planning tool. A 'Get started now:' section mentions it covers 15 age-specific well visits and provides two buttons: 'Enter provider ID code' and 'Continue without code'. A section titled 'Take about 10 minutes to get a personalized Well Visit Guide...' is followed by a list of benefits. On the right, there is a photo of a doctor examining a baby and a sidebar with a 'Learn more here!' button and a definition of a well visit.

Select Language English

Login to your family account
Have a provider ID code? Use it here

Share with others!    

Home/WVP About Family Resources FAQ Provider Info Contact Us

Welcome to the Well Visit Planner®

Your Child, Your Well Visit

A quick and free pre-visit planning tool to focus care on your unique needs and goals.

Get started now:
Covers all 15 age-specific well visits from your child's first week of life to age 6

[Enter provider ID code](#) [Continue without code](#)

Take about 10 minutes to get a personalized Well Visit Guide. Get the best care focused on your child and family's unique goals and needs.

What families like about using the Well Visit Planner (WVP):

- ✓ Saves time filling out forms during visits
- ✓ Gives you a **personalized Well Visit Guide** with results specific to your child and family
- ✓ Provides **easy to read resources** on your needs and priorities
- ✓ Helps you and your child's providers focus care on your goals and needs
- ✓ Builds confidence that your child's care meets expert guidelines
- ✓ You choose what sections to complete and share.

Do you want to use the WVP with the children and families you serve?

[Learn more here!](#)

What is a Well Visit: Well visits are regular check-ups with your child's personal doctor, nurse, or other child health professional. At least 15 visits are recommended in the first six years of life when children are

1. Complete all **Bright Futures Guidelines-Based Screeners/ Assessments** (age specific)
2. Identify **Guidelines-Based priorities to discuss with provider** at the well visit (age specific)
3. Family and providers get the same **Well Visit Guide** and **Clinical Summary** (two views, same data)



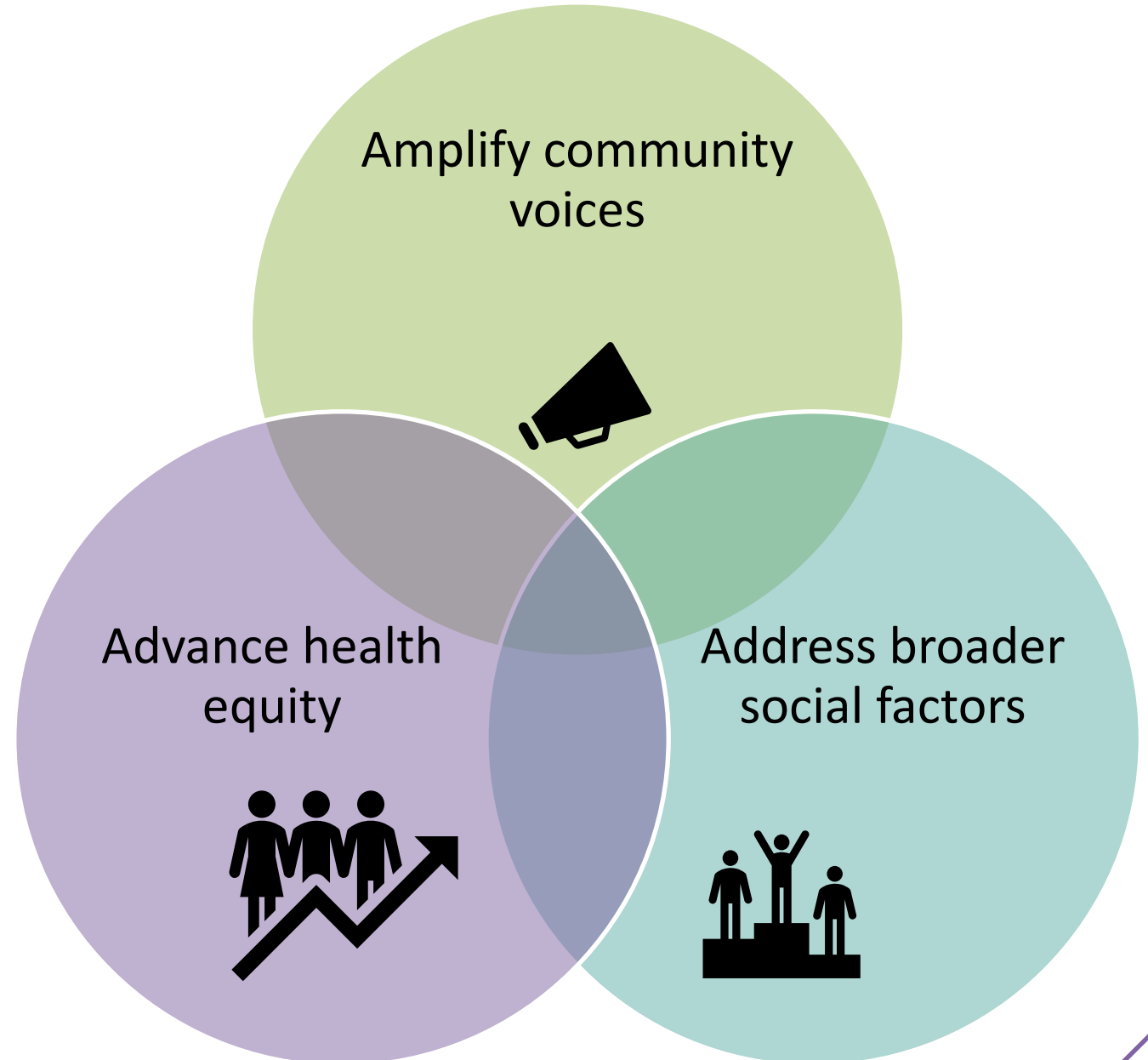
Designed to Work In Broader System of Supports!





Studies funded by HRSA and RWJF (2008-present) with over 20,000 children demonstrate that the **Well Visit Planner** tool improves quality, personalizes care, builds trust and makes more time for providers to focus on family priorities and connect to resources and supports.

A 2021 independent review by Mathematica confirmed value of the COE/WVP approach to lift family and community voice, improve care for all and address broader social factors



Building Bridges

The Essential Role of Real Family Engagement and Community-Based Supports in Child Flourishing and Family Well-Being

Exploring the WVP approach, overcoming barriers, and fostering trust for early relational health and family well-being

Who am I?



Professional and Family Member
Mom, Grandmother, Great Grandmother

My journey

30+ Years of Lived Experience

Real Family Engagement Is a Real Paradigm Shift!

It Means....



1. **Understanding that families ARE in the drivers-seat** when it comes to their child's health and are not passive recipients of care. Without engagement it is not clear WHAT care is actually being provided or its value!
2. **Building competencies to engage families so they are actively involved** in planning and decision-making processes regarding their children's health and well-being and are energized and feel supported to follow through with recommendations. This is a change—patience and new skills are required!
3. **Empowerment:** Families **FEEL empowered** to advocate for their children and contribute to their communities.

Real Family Engagement Is a Real Paradigm Shift!

It Means.... (cont'd)



4. **Facilitating strong collaboration and partnership** between families, healthcare providers, and community organizations and making sure there is “***No Broken Link***” as families move across the “system”
5. **Building trusting relationships that support** open, honest, and communication between families and providers “***In Every Encounter***” – having trust with one professional and not others is not good enough!
6. **Keeping a whole child and family focus** where families can share not only child development concerns, but also whole family priorities that impact child well being as set for the in Bright Futures Guidelines.

7. Supporting families to access a broad array of resources and services that support family needs and enhance their ability to care for their children *“Through Any Door”*



Current Barrier

Preparing Providers, Not Families

- Traditional focus has been on preparing providers for well visits (yet screening is still low and barriers are high for providers to know about and achieve guideline-based care)
- Need for families to be prepared and understand role in the visit (otherwise, there can be a sense that good care was provided even when quality was low and families left without seeing the value)

Current Barrier

Whose information?

- Providers are asked to collect information from families (vs. families choosing to share data knowing why and what it is used for)
- Families often do not understand what this is for and how it is being used (vs. informing them about the goals, guidelines and what to expect)
- This can lead to miscommunication and feelings of mistrust between families and the medical community (lack of response to screeners and sense that they are not for the family is common)

True or False – Myth Busting

Claim

True or false?

Families know what to expect and what information to talk about at their child's well visit

FALSE

Families don't schedule or come in to their child's well-visit because they don't see it as important

FALSE

Families want to know what quality care is and prefer a comprehensive tool with more information about their child and family's health & care

TRUE

It's sufficient to send families a text with a link to a screen with questions through a "My Chart" type system

FALSE

The **Well Visit Planner** empowers families with knowledge to effectively partner with their child's care team while ensuring Bright Futures guideline-based, personalized care is provided



Select Language English

Login to your family account
Have a provider ID code? Use it here

Share with others!    

Home/WVP About Family Resources FAQ Provider Info Contact Us

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Your Child, Your Well Visit

A quick and free pre-visit planning tool to focus care on your unique needs and goals.

Get started now:
Covers all 15 age-specific well visits from your child's first week of life to age 6

[Enter provider ID code](#) [Continue without code](#)

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What families like about using the Well Visit Planner (WVP):

- ✓ Saves time filling out forms during visits
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- ✓ Provides easy to read resources on your needs and priorities
- ✓ Helps you and your child's providers focus care on your goals and needs
- ✓ Builds confidence that your child's care meets expert guidelines
- ✓ You choose what sections to complete and share.

"I agree that the WVP can increase the value of my child's well visit because it is empowering to me to feel like I am a part of the health care team in a way that I can properly advocate for my child's needs..."

[I can] get additional information that I wouldn't normally know to discuss had it not been for this useful tool."

Parent





Select Language English
Do you have a family account? Log in here
Are you a provider? Log in to your COE account
Share with others!    

Home/WVP

About

Family Resources

FAQ

Contact Us

You are using the Well Visit Planner® on a website tailored for your child's provider or family support professional.
(wellvisitplanner.org/PCC)

Welcome to the Well Visit Planner®

Your Child, Your Well Visit

A quick and free pre-visit planning tool to focus care on your unique needs and goals.

Covers all 15 age-specific well visits from your child's first week of life to age 6

GET STARTED NOW

Learn more about creating a family account

People's Community Clinic invites you to take about **10 minutes to complete the Well Visit Planner and get a personalized Well Visit Guide.** You will use your Well Visit Guide to make sure you get the best care focused on your child and family's unique goals and needs.



What is a Well Visit?: Well visits are regular check-ups with your child's personal doctor, nurse, or other child health professional. At least 15 visits are recommended in the first six years of life when children are growing rapidly. Be sure to stay on track with well visits to help your child and family

*"The WVP helped me think about what's going well with my child and family. I have a **better relationship with my child's doctor now** that we focus on my concerns and priorities.*

*Our time together is **more productive and satisfying.**"*

Currently Available for each of the 15 early childhood well visits in both English and Spanish



Select Language Español
¿Tiene una cuenta familiar? Ingrese aquí
¿Es un proveedor de salud? Ingrese a su cuenta
¡Compártalo con otros!    

Inicio/WVP

Acerca del WVP

Recursos para familias

Preguntas frecuentes

Contáctenos

Usted está utilizando una versión del Well Visit Planner personalizada por su proveedor de salud infantil.
(wellvisitplanner.org/PCC)

Bienvenido/a al Well Visit Planner®

Su hijo/a, su visita de salud infantil

Una herramienta gratis y fácil de usar antes de la visita de salud infantil para enfocarla en sus necesidades y metas.

Cubre las 15 visitas específicas de salud infantil desde la primera semana de vida de su hijo/a hasta los 6 años

EMPIECE AHORA

Aprenda más sobre cómo crear una cuenta familiar

People's Community Clinic le invita a **tomar 10 minutos para completar el Well Visit Planner y obtener su guía personalizada.** Usted y utilizarán su guía personalizada para asegurarse de que obtenga la mejor atención centrada en las metas y necesidades únicas de su hijo/a y su familia.



¿Qué es una Visita de Salud?: Las visitas de salud son chequeos regulares con el médico, la enfermera u otro profesional de la salud infantil de su hijo/a. Se recomiendan al menos 15 visitas en los primeros seis años de vida porque los niños están creciendo rápidamente.

Three Easy Steps for Using the Well Visit Planner

1

REFLECT & ASSESS



Reflect on what's going well and identify your goals and concerns. Assess your child's healthy development and family's unique needs.

2

PRIORITIZE



Prioritize what you want to discuss during visits. Pick from recommended topics specific to your child's age and add your own topics.

3

PARTNER



Partner with your child's provider(s). Your Well Visit Guide helps you and your provider focus care on your goals, concerns, needs and priorities.

The Well Visit Planner was created to be used in partnership with your provider.
If you have a unique code from your provider, enter it here now:

Enter provider ID code

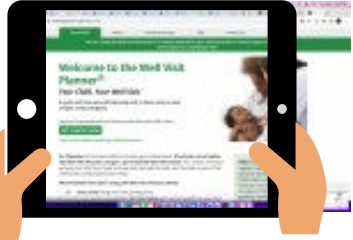
3 Parts to the Well Visit Planner Take About 10 Minutes to Complete

1. Complete **Bright Futures Guidelines-Based Screeners/ Assessments** (age specific)
2. Choose **Guidelines-Based priorities to discuss with provider** at the well visit (age specific)
3. Receive a **Well Visit Guide** and **Clinical Summary** (choose to share with provider)

“The WVP empowers families to direct the visit so we can support their goals and needs. It gives us the reassurance all screens are done and we meet family priorities. Saves time to connect, build trust and link to supports.” (Pediatrician)



Core Bright Futures Screeners and Assessment Topics (Plus Options to Add Other Assessments)



Reflect and
Assess

What's going well?

**General health
information**

**e.g. special needs,
insurance, family health
history, etc.**

**Context and
environmental
assessments**

**(e.g., lead,
fluoride, etc.)**

Overall goals and concerns

**Developmental surveillance
and screening - **SWYC****

**Autism screening -
M-CHAT-RTM**

**Concerns about **speaking,
vision, hearing****

**Caregiver depression -
PHQ-2 & EPDS**

**Healthy relationships and
social determinants
(IPV/WAST-Short;
ACEs/PEARLS, SEEK;
economic hardship)**

**Caregiver **anticipatory
guidance** and education
priorities**

**Parent/caregiver emotional
support, coping and self-
care**

**Household smoking and
substance use**

Other options:

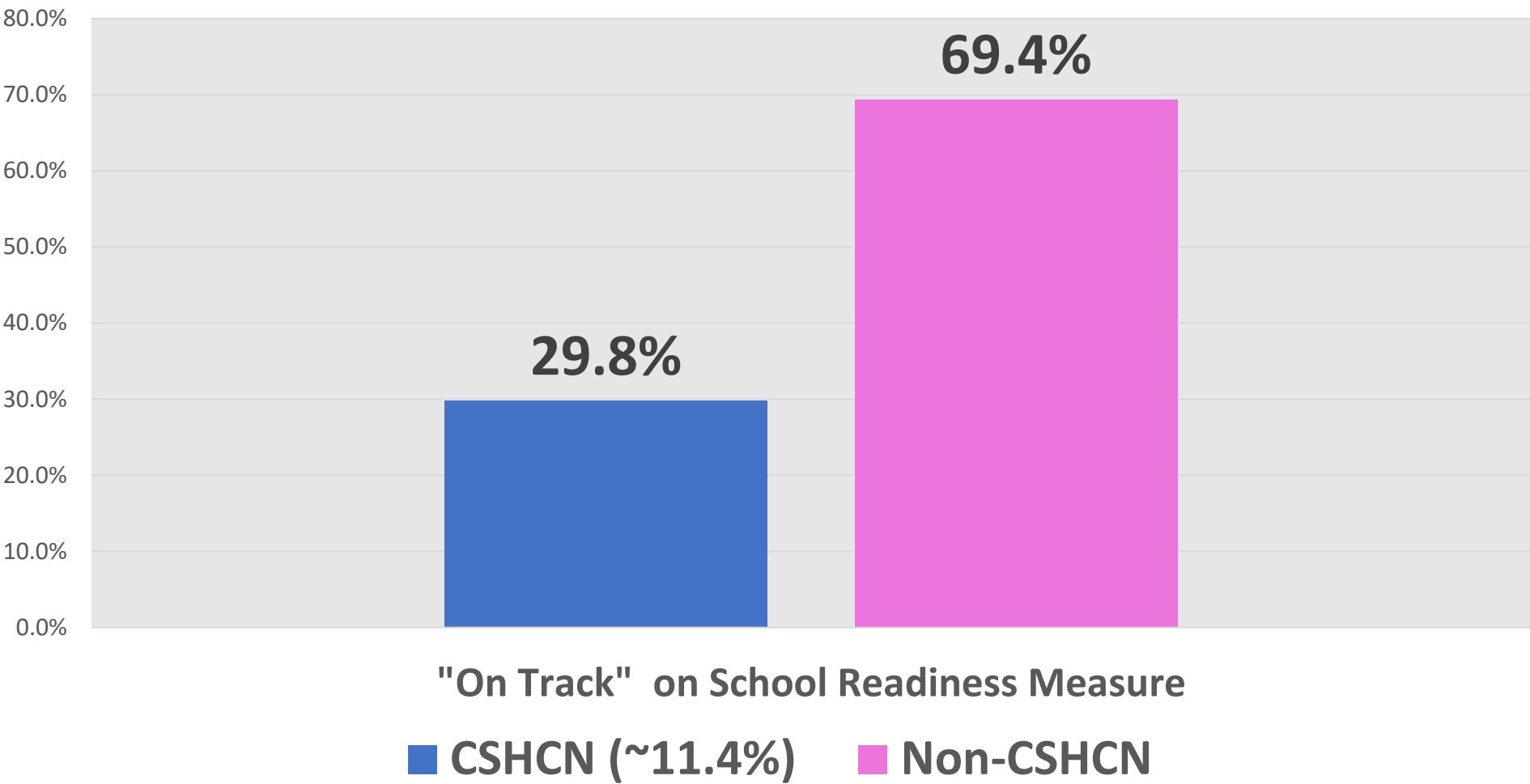
- **Child social and emotional development**
- **Family resilience**
- **Child flourishing**
- **+ More**

*ACEs/PEARLS, SEEK, BPSC, PPSC, optional-many other optional additions.

Critical for early identification of children with special health care needs who are especially vulnerable but whose flourishing can be promoted with effective supports

School Readiness (Age 3-5) by Children With Special Health Care Needs Status

2022 NSCH Data: National



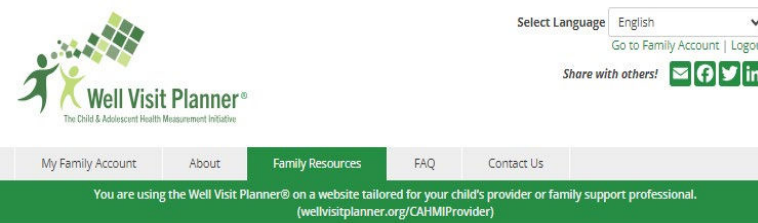
Both families and “providers” get auto-generated summaries to save, share, send and use to partner with each other and across care teams

Can be led by the community in partnership with child serving professionals and services.



Your Child, Your Well Visit

Your Child's Personalized 15 Month Well Visit Guide



Your Child, Your Well Visit

Your Child's Personalized 15 Month Well Visit Guide

Clinical Summary of Well Visit Planner® Findings: 15 Month Well Visit

Date of Well Visit: 5/14/2021 • Date WVP Completed: 5/11/2021 • Birth Month & Year: 3/2020

Key: ☐ family response indicated no or low risk ☒ family response indicated some risk or concern ☐ family did not respond; nonresponse could indicate risk

Screening and Assessments Summary and Topics to Address: Assess & Address

Child Development

Developmental Surveillance and Screening

☐ **Developmental Screening SWYC milestones score¹:** 18 (met age expectations; score may or may not indicate a delay. Clinical review with family needed.

Very Much

- Copies sounds that you make
- Calls you "mama" or "dada" or similar name
- Follows directions - like "Come here" or "Give me the ball"
- Looks around when you say things like "Where's your bottle?" or "Where's your blanket?"
- Names at least 5 body parts - like nose, hand, or tummy
- Names at least 5 familiar objects - like ball or milk
- Runs
- Walks across a room without help

Somewhat

- Kicks a ball
- Walks up stairs with help

☒ **Awareness of developmental screening:** Family not aware of having had developmental screening

☐ **Hearing:**

☐ **Speaking:**

☐ **Lazy or crossed eyes:**

☒ **Caregiver's overall level of concern about child's development/learning/behavior:** A little (I have some concerns about fighting naps)

Health Behaviors

☐ **Flag for potential alcohol misuse**

☐ **Recreational/non-prescription drug use**

☒ **Smoking:** Child exposed to smoking

Relational Health

☐ **Intimate partner violence risk²:**

☐ **Intimate partner violence risk²:** Caregiver and partner work out arguments with some difficulty

Social Factors/Determinants

☒ **Lives with both parents:** Yes

☐ **Concerns with meeting basic needs**

☐ **Treated unfairly due to racism**

☒ **Positive impact of COVID-19:** Somewhat

☒ **Negative impact of COVID-19:** A little

Impact of Covid-19 on family's well-being: We've been able to spend more time together as a family, but have definitely missed our extended family

Caregiver Emotional Health

☒ **Caregiver social support:** Does not have at least one person they trust and can go to with personal difficulties

☒ **Depression risk: PHQ-2⁴ Score of 4:**

- Down, depressed, or hopeless several days over the past 2 weeks
- Little interest or pleasure in doing things several days over past 2 weeks

☐ **Caregiver self care/hobbies**

☐ **Caregiver/parent coping**

Other assessments added by provider: None

Additional caregiver/parent concerns to address during the visit (open-ended): (Sleep routines and when to drop a nap)

Anticipatory Guidance Priorities Selected by the Family: Coach & Educate

View educational materials for the 15 Month Well Visit here:

<https://www.wellvisitplanner.org/Education/Topics.aspx?id=5>

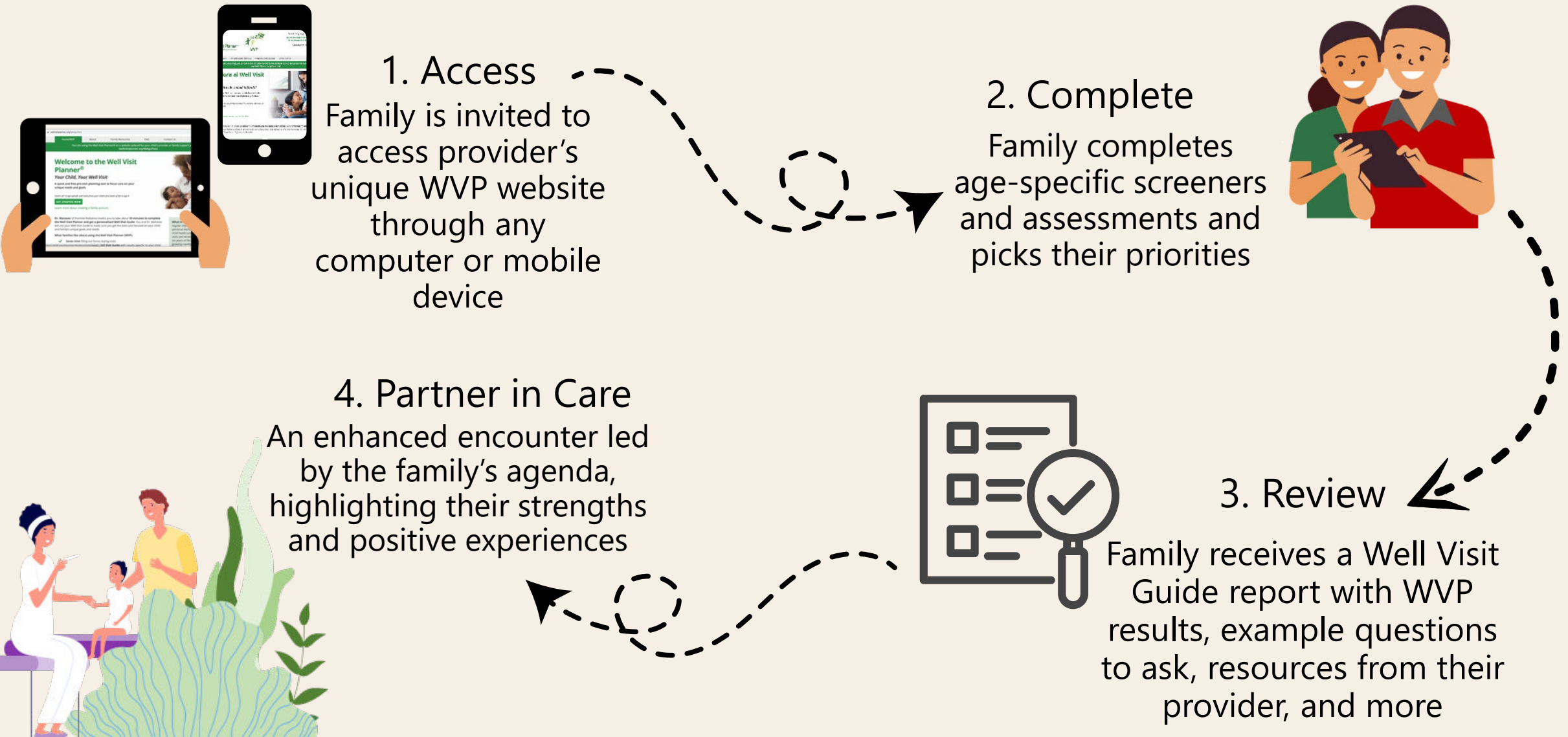
This child's parent/caregiver selected the following top 4 priorities across each of the 30 recommended Bright Futures anticipatory guidance topics for the 15 Month Well Visit. You may use the resources on the next page to address these priorities.

1. [Behaviors to expect in the next few months](#)
2. [Sleep routines and sleep habits](#)
3. [Temper tantrums: tips for dealing with them and avoiding triggers](#)
4. [Your child's moods and emotions](#)

¹SWYC Milestones: The developmental screening instrument of the Survey of Well-Being of Young Children (SWYC), which meets American Academy of Pediatrics' developmental screening guidelines. ²Intimate partner violence risk is assessed using the Women Abuse Screening Tool-Short (WAST-Short), a two-question abuse screening tool. ³The Pediatric ACEs and Related Life Events Screener (PEARLS) screens for a child's exposure to adverse childhood experiences (ACEs) and risk factors for toxic stress. ⁴Caregiver depression risk is assessed using the Patient Health Questionnaire-2 (PHQ-2) for the 9 month well visit and beyond. ⁵The Children with Special Health Care Needs (CSHCN) Screener is a validated 5-item screening tool identifying children with ongoing conditions and above routine service needs.

- ✓ Providers can use to **document** and **secure payment** for screening and care.
- ✓ Families can **save** to **track child** and **family well being** over time.
- ✓ Families can **share across family** members and/or care team members.
- ✓ Families and provider can be **confident** all required screening was conducted and child and family priorities were met
- ✓ **Aggregate WVP data** can be used to track community and population needs, health and strengths and **advocate for change** using your family centered data

How It Works for Family: It takes families about 10 minutes to complete the WVP at home, in the waiting room, or anywhere else



Family signs up for an account and personal, secure dashboard-- or they can use as a guest! Families “own” their data!

Log In, Create a Family Account, or Continue as a Guest

To start a Well Visit Planner, you can create a family account, log in to an existing

A family account automatically saves your Well Visit Planners for all of your children. You can start a new WVP, view previous Well Visit Guides, and access family resources.

Login

Email Address

LOGIN WITH SECURE CODE

LOGIN WITH PASSWORD

Welcome to your Well Visit Planner Family Dashboard!

Here, your Well Visit Guides and family resources from previously completed Well Visit Planners will be saved in each child profile for easy access. To start a new Well Visit Planner:

- 1. Click “**Start a New WVP**” for your child
- 2. Confirm your **provider's ID code**

If you need to step away and come back later, your WVP will be saved in your child's profile for one week. Click “**Incomplete - Resume Now**” to complete an unfinished WVP. You can opt out from receiving reminder notifications in the “My Account” tab.

To plan visits for other children, click “**Add Child**” below and create new profiles for each child using their first name or nickname.

Jane (Edit/Remove)		
Visit	Well Visit Planner Started	
18 Month Well Visit	8/6/2024	View my Well Visit Guide Family Resource Sheets Update WVP Responses

Families consent to sharing their WVP data with their provider. Only respond to what they want to share. Get all results/resources ASAP!



Select Language English

Do you have a family account? Log in here
Are you a provider? Log in to your COE account

Share with others!    

Home/WVP

About

Family Resources

FAQ

Contact Us

You are using the Well Visit Planner® on a website tailored for your child's provider or family support professional.
(wellvisitplanner.org/PCC)

Your Basic Information

0%

Items marked with * are required. All other fields are optional and you can skip questions you do not feel comfortable with. However, we encourage you answer as many as questions, so your child's well visit is focused on your needs and priorities.

Let's get started!

First, we need some information to make sure you, your child's provider, and whomever else you share your child's Well Visit Guide with will be able to know it belongs to you and your child.

NOTE: All information you share is confidential and securely stored/encrypted to protect your privacy.

PLEASE CONFIRM: I understand that People's Community Clinic will receive all information I provide in the Well Visit Planner.

☒ Yes

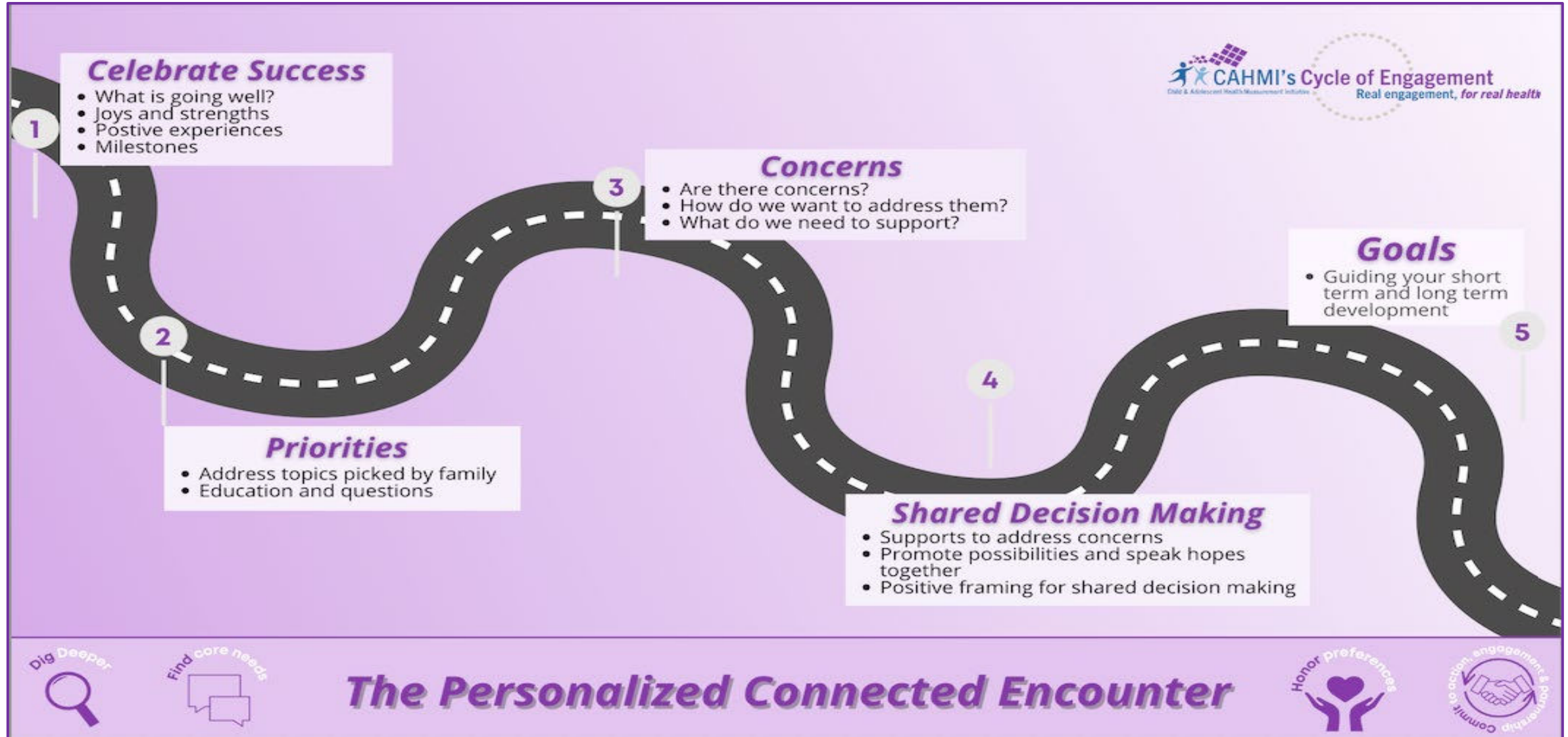
☐ No

Please provide **your child's first and last names**. This will be in your child's Well Visit Guide and Clinical Summary shared with your child's provider.

1. Child's first name: *

2. Child's last name: *

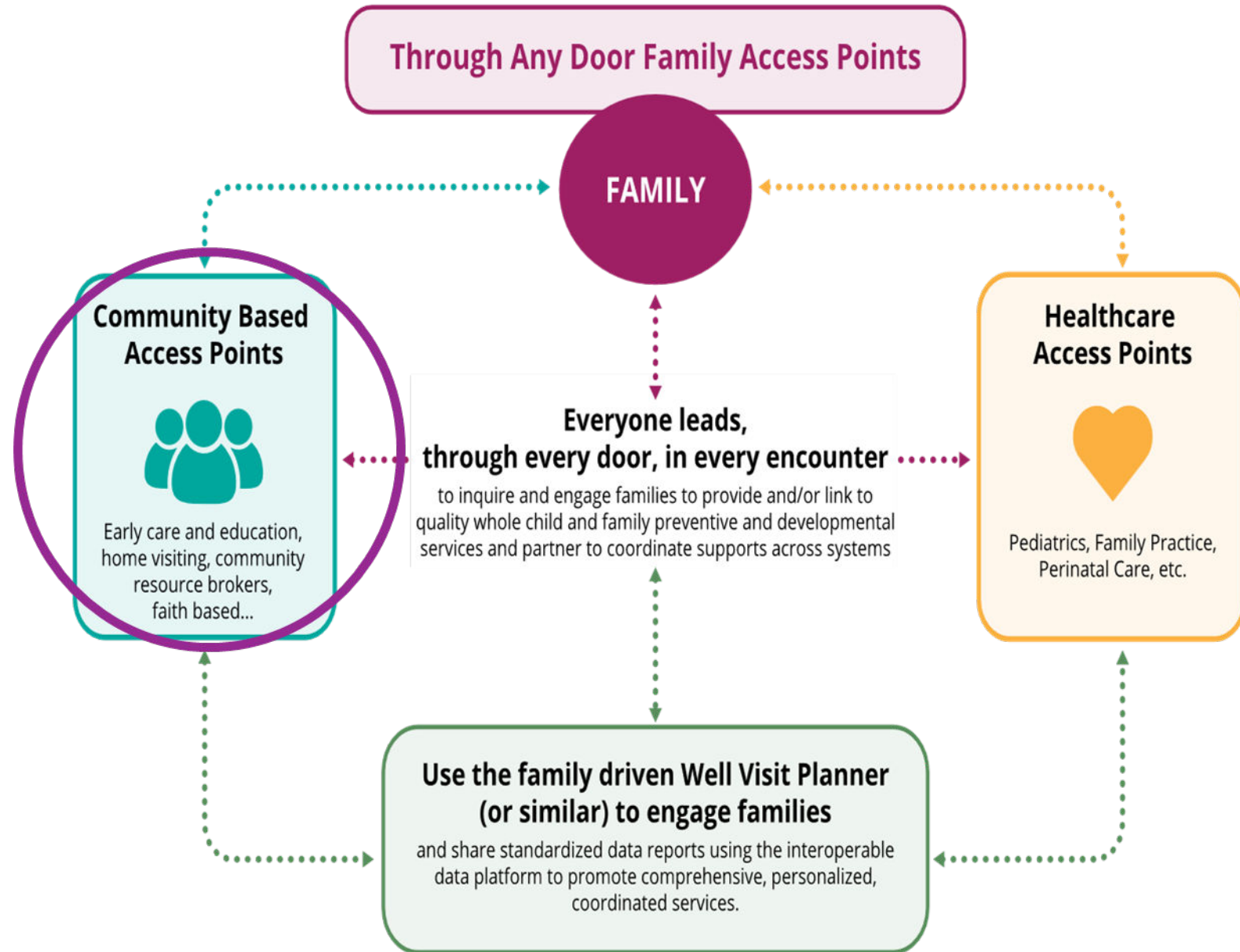
The Goal: The Personalized Connected Encounter



Through Any Door!

***Health Care and Family
and Community Support
Professionals Can
Partner to MEET
FAMILIES WHERE THEY
ARE!***

***An Interoperable, Standardized
Tool Like the WVP is Essential!***



Example: Mississippi Families for Kids / Help Me Grow (MFFK/HMG)

Example workflow

Engagement and Introduction

Initial engagement with families at school-based site

- Care coordinators introduce the WVP to families
- Families are given resources and encouraged to complete WVP
- WVP assesses their child's development, strengths, needs, and priorities

WVP Utilization and Assessment

Families complete the Well Visit Planner

- Families use MFFK's customized WVP website for assessments aligned with Bright Futures Guidelines
- Care coordinators assist in navigating the WVP to generate a personalized Well Visit Guide based on screening results

Partnering with Health Providers

Well Visit Guide/Clinical Summary shared with providers

- Care coordinators share the WVG/Clinical Summary with pediatric providers via their WVP data dashboard and help schedule well-visits
- Providers access the Clinical Summary through their data dashboard to review assessment results and family priorities to prepare for the well visit

Follow-ups and Referrals

Follow-ups and referrals ensure care is being received

- MFFK/HMG staff can use the WVP data dashboard to identify children needing referrals for additional services
- Follow-ups to track if referrals and services are initiated, promoting effective care coordination

Key Success Factors Identified



Implementation and team engagement

- All team members were on the same page regarding goals and motivation – systems change mindset/HMG model
- Consistent engagement from leadership positions
- Identified team roles
- Training for team members to use the WVP platform



Ensuring family engagement

- Sufficient and adequate sharing of WVP family resources
- Transparent and open communication with families about their benefits and role throughout
- MFFK/HMG team were able to answer questions
- Meaningful conversations were easy to have using the results presented in the family-facing Well Visit Guide



Fostering partnerships and relationships with health providers

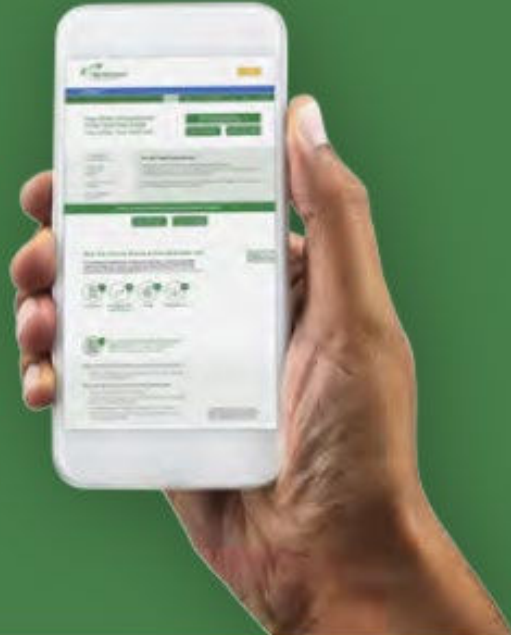
- Mutual respect and understanding of expectations and goals (an MOU was established)
- Documenting a workflow for data sharing
- Families were empowered to share the WVP Well Visit Guide with providers that did not already know about the WVP

Your Providers, Your Partners!

What Families Say?

92%

of families using the **Well Visit Planner** report they were **comfortable with the amount of time it took** and they would recommend the WVP to other parents.



“[The Well Visit Planner] asks me if I have any questions that I would like to discuss with the doctor before the physical. So, then it *makes my job easier* when I go in to see the doctor, everything is written down back there.”

“I had no idea I could talk with my child’s doctor about how I was doing or my child’s behavior—I just thought I was a bad parent. Having example questions to ask and knowing what my doctor is supposed to ask me and talk about made all the difference.”

- Parent





- Would recommend to other parents 90% phase 1 input; 100% phase 2 input
- Creates more time to talk with the pediatrician 100%
- I like using the WVP to ensure that the visit is based on my priorities 100%
- I was comfortable sharing about the questions asked 89%
- Does not take too much time 86%

Caregivers/Parents Learn, Engage and Want to Partner

Online PHDS Results Showed:

- 92% of study families completing the PHDS said they are interested in using online pre-visit planning tool to partner in care

- ❖ "For me, having the Well-Visit Planner **would be a necessity to have a tele- well visit**" - a caregiver
- ❖ "I thought it [VG] **was helpful. I liked having it in my phone**, as I always don't have time to get it printed." - a caregiver
- ❖ "I thought it [WVP] was a **helpful way to organize my thoughts** and it kind of gives you a structured plan and some kind **information to take with you and take notes** for the visit" – a caregiver
- ❖ "**I didn't find time to be an issue.** I think the very first time it [filling WVP] took me a little longer..But once we get used to it, it is set up in a way that it is pretty simple" – a caregiver

Well Visit Planner: A Primary Care Clinic Perspective

People's Community Clinic (PCC)

- Founded in 1970
- Became FQHC in 2012
- Annual patients (total, pediatric/adolescent, pediatric < 6 yrs. old)

Pediatrics

- Primary care and wraparound services
- Team-based approach to care
- More than a decade developing our ability to focus on **early brain development and early relational health**:
 - HealthySteps
 - Filming Interactions to Nurture Development
 - Promoting First Relationships in Pediatric Primary Care





PCC'S EARLY CHILDHOOD INITIATIVES

Goals



Support families to set their children on a **trajectory for lifetime health and well being by...**



Making the promotion of **early brain development and early relational health** the organizing principle of our well-child care for young children

STRATEGIES OF PCC'S EARLY CHILDHOOD INITIATIVES

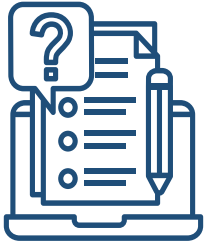
- *Increase parents'/caregivers' understanding of how powerfully their interactions* can promote children's brain development
- *Build parents'/caregivers' responsive parenting skills* through strengths-based approaches
- *Build pediatric providers' and other staff's skills* to support caregivers in developing nurturing, responsive relationships with their children
- *Reconfigure the well-child check* visit to allow for more strengths-based focus on early relational health and responsive parenting
- *Reduce underlying sources of stress* for parents/caregivers by connecting them to resources and working upstream on social drivers of health

Losing the forest for the trees

- Screenings started **getting in the way** of building stronger relationships with our families:
 - Number of screenings
 - Complexity of screening schedule (which screeners at which visits)
 - Process of completing and scoring screenings
- **Screenings are not enough**—we need to educate and engage families so they can identify their priorities and needs and partner to address each of these

Screening the “old” way was not meeting goals and resulted in less time to engage with our families on relational health issues and discussing families’ priorities.

Context for Well Visit Planner (WVP) adoption



Multiple paper screening instruments

- ASQ, MCHAT, SDOH, post-partum depression, Welch Emotional Connection Screen
- Largely on paper during check-in
- Complicated schedule to spread out different screenings



Long-standing issues of pediatric screening questionnaires

- Informally raised by families and staff
- Resulted in formal family interviews, MA focus groups, and provider focus groups



Program required switching screenings

- Needed to switch from WECS social-emotional screen to Baby/Preschool Pediatric Symptom Checklist
- Needed to add screening for intimate partner violence and household substance use

Context for WVP adoption: family and staff feedback



Family feedback indicated willingness, but pressure

- Willing to complete questionnaires if helpful in care
- Questionnaires were long, hard to complete with time pressure, especially with siblings
- Unclear why questions were asked, what results were, and how they figured into care



Staff feedback revealed flaws in the system

- Process was complicated due to the schedule of which screeners to use at visits
- Time-consuming, hard to complete
- Some families confused by some questions on ASQ and MCHAT, necessitating MA clarification

Parent/caregiver feedback

*“...I honestly **don’t always have a good idea or understanding of what comes out of filling them all out.** I can only really remember a few I have filled out and I feel like any time I am asked to fill something out I don't have enough time to do it.*

I feel rushed in asking questions about it or I forget, because I am too scared to ask to take up more time, but I wouldn't mind being asked more if it meant my doctors learned more about us.”

- Parent from an interview on clinic’s screening process

Parent/caregiver feedback (cont'd)

*“I think the amount [of questionnaires] is fine, but I feel like if we could fill them all out before we came in it could relieve a lot of stress. As well as **give time to explain the goal of each form** versus filling it out and turning it in.*

*In addition, if **we received more information** from whoever wants this filled out, I would feel more confident in filling them out accurately.”*

- Parent from an interview on clinic's screening process

Provider feedback

*“And then we're asking so many questions. I mean, at some visits **it's like we spend our whole time doing [a developmental screen]**, this, that, that, that. I mean, I wish we could streamline and do the ones that really are giving us what we want. We've got way too much, to me. **I'm overwhelmed.**”*

- Provider at a focus group on clinic's screening process

Reconfigure the well-child check visit to allow for more strengths-based focus on early relational health and responsive parenting

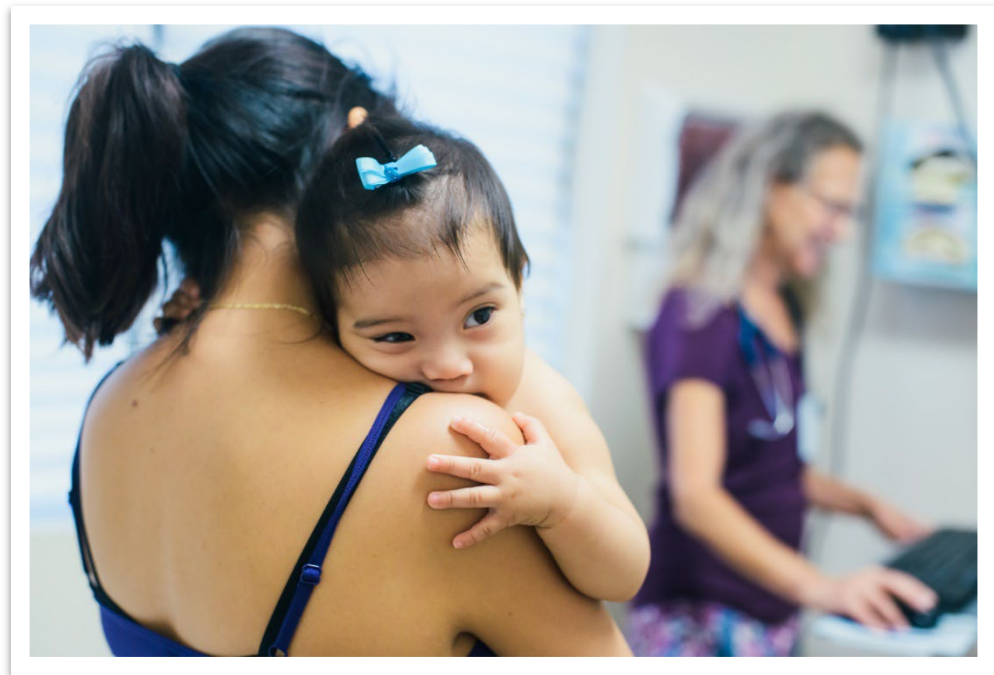
We are trying to...

- Engage better
- Explain better
- Understand family priorities
- Focus on strengths
- Strengthen our relationship with the parent/caregiver
- Recognize the parallel process occurring in provider-caregiver and caregiver-child relationships

And we need all this to be time efficient and sustainable.

**Beyond
screening**

- Family engagement
- Workflow and efficiency (MA and provider engagement)
- Comprehensive Content and Clinical Summary



Clinical Summary

□ Screening Results

Family Goals

Concerns

□ Educational Priorities

Clinical Summary of Well-Visit Planner Findings: 15 Month Well-Visit		
Date of Well Visit: No response Date WPP Completed: 9/17/2021 Birth Month & Year: 4/2021 Key History Indicators: 5 family members indicated 15 month well did not respond no or low risk some risk or concern nonresponse could indicate risk		
Screening and Assessments Summary and Topics to Address: Assess & Address		About This Child
Child Development Developmental Surveillance and Screening: - Developmental Screening SWYC Decisions: All 15 months from 15 Month SWYC did not meet age appropriate scores may need further evaluation. Did not indicate a delay. Clinical review with family needed on all risks. Very Much - Looks around when you say things like "Where's your bottle?" or "What's your blanket?" - Narrated at least 5 body parts: like nose, hand, or tummy - Walks across a room without help Somewhat - Copies sounds that you make - Uses words "mama" or "dada" or similar terms - Follows directions: like "Come here" and "Put down the ball" - Names at least 5 familiar objects - like ball or truck Not Yet - Kicks a ball - Runs - Walks up stairs with help Caregiver reports completing standardized developmental behavioral screening: Caregiver's overall level of concern about child's development, learning, behavior is: - Hearing concerns: No - Speaking concerns: No - Late or crossed speech: No - Bowel movements/incontinence: No	Name: Sara initials: F M J: SM Special Keyword: By Mother WPP completed by: RMJ Gender: Female Insurance coverage type: No response Interested in telemedicine visits: No Concerns about telemedicine to address: Family privacy	
Social/Family Determinants		General Health and Updates
Economic Hardship: Some hard/hardly often have to cover costs of basic needs, like food or housing. Negative impact of COVID-19: Not a lot. Little interest or pleasure in doing things several days past week 2 Caregiver social support: Caregiver self care/hobbies: has spent time in last 2 weeks doing things they enjoy with coping: Not very rich	Family Health History - Child has ongoing health problem requiring above routine services (asthma, diabetes, etc.) - New medications - Currently taking vitamins/herbal supplements - Dentist: Currently no dental insurance - No Rx Insurance source Family History and Updates - Recent family changes (e.g. move, job change, separation, divorce, death in family) - New medical problem in family - Patient dependent had stroke or heart problem before age 5 - Parent has elevated blood pressure	
Other assessments added by provider: Autism spectrum disorder screen (M-CHAT RFL) Moderate risk Infant Behavior Checklist score 9 PEARLS Test: Stress Risk Factor score: 2 Child Flourishing: At Risk Parent resilience: At risk Parent-child connection: At Risk See details on 2nd page	Strengths to Celebrate: Content & Confident Caregiver social support: Caregiver has at least one person they trust and can go to for personal distress Caregiver self care/hobbies: Caregiver has spent time in the last 2 weeks doing hobbies or spare-time activities they enjoy They are doing things that are good for the caregiver as a caregiver: My parents are very supportive and they love my child	
Anticipatory Guidance Priorities Selected by the Family: Coach & Educate View educational materials for the 15 Month Well-Visit Here: https://www.well-being.org/docs/default-source/topics/anticipatory-guidance-for-the-well-visit?sfvrsn=1 The following 5 priorities across each of the 22 recommended Bright Futures anticipatory guidance topics for the 15 Month Well-Visit. Click on the links below to access information and resources to share with families on these priorities. See page 2 for additional resources. Behaviors to expect in the next few months: 1. Watch your child start to become more independent and explore away from you 2. Separation anxiety: how you child responds to new people or caregivers 3. How you balance taking care of yourself and the best way possible 4. Ways to guide and discipline your child		One thing the child can do that caregiver is excited about: He can identify colors and point to her body parts. Child Flourishing: Parents concerned about their child's mental health. Parent-child connection: Details on 2nd page

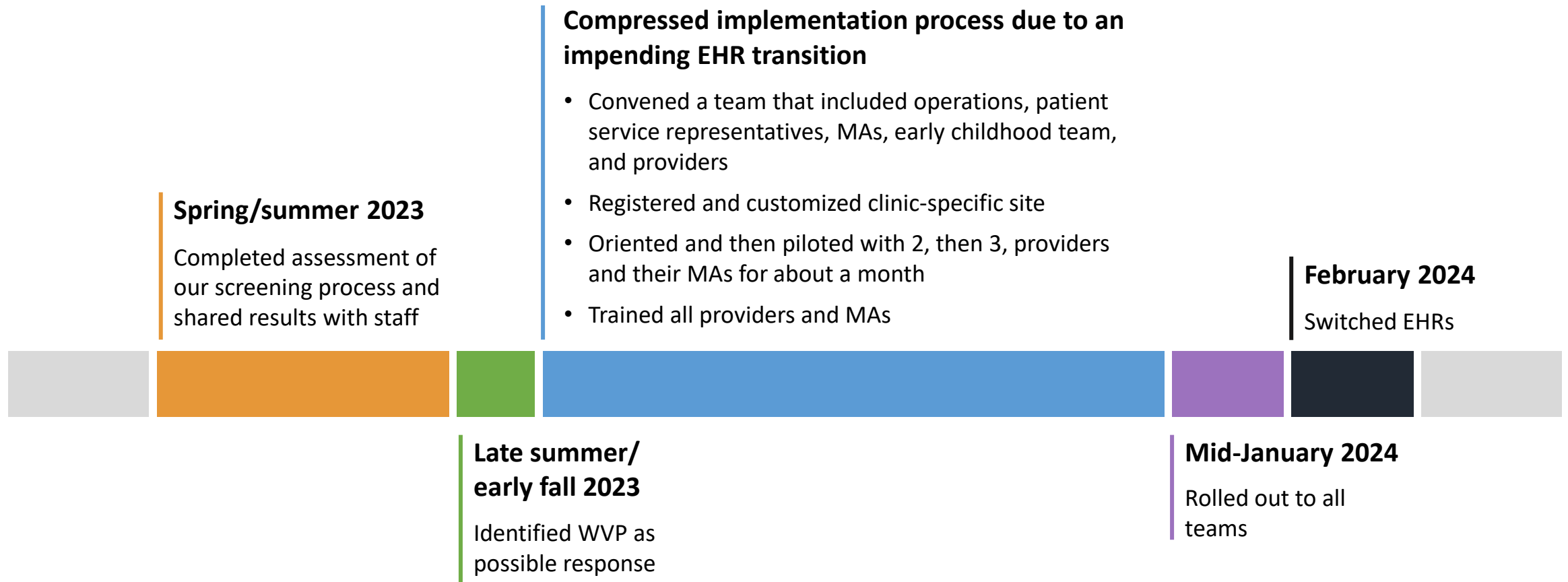
*SWYC Milestones: The developmental screening instrument of the Society of Well-Being of Young Children (SWYC) which meets American Academy of Pediatrics' developmental screening guidelines. • Estimate parent violence risk assessed using the Revised Abuse Screening Tool (RAST) (Koss et al., 2000), a five-question abuse history tool developed by the Center for Disease Control and Prevention. For complete information on RAFT see [http://www.cdc.gov/nchs/data/ncj/raaft.pdf](#). © 2019 Well-Being of Young Children. All rights reserved.

Screening	Codes
Developmental Screening (SWYC)	96110
Autism spectrum disorder (M-CHAT-R™)	96110 with modifier KX
Caregiver depression (PHQ-2 or EPDS)	96161, G8510, G8431
Adverse Childhood Experiences (PEARLS)	96160, G9919, G9920
Baby Pediatric Symptom Checklist (BPSC)	96127
Preschool Pediatric Symptom Checklist (PPSC)	96127
Safe Environment for Every Kid (SEEK)	96160

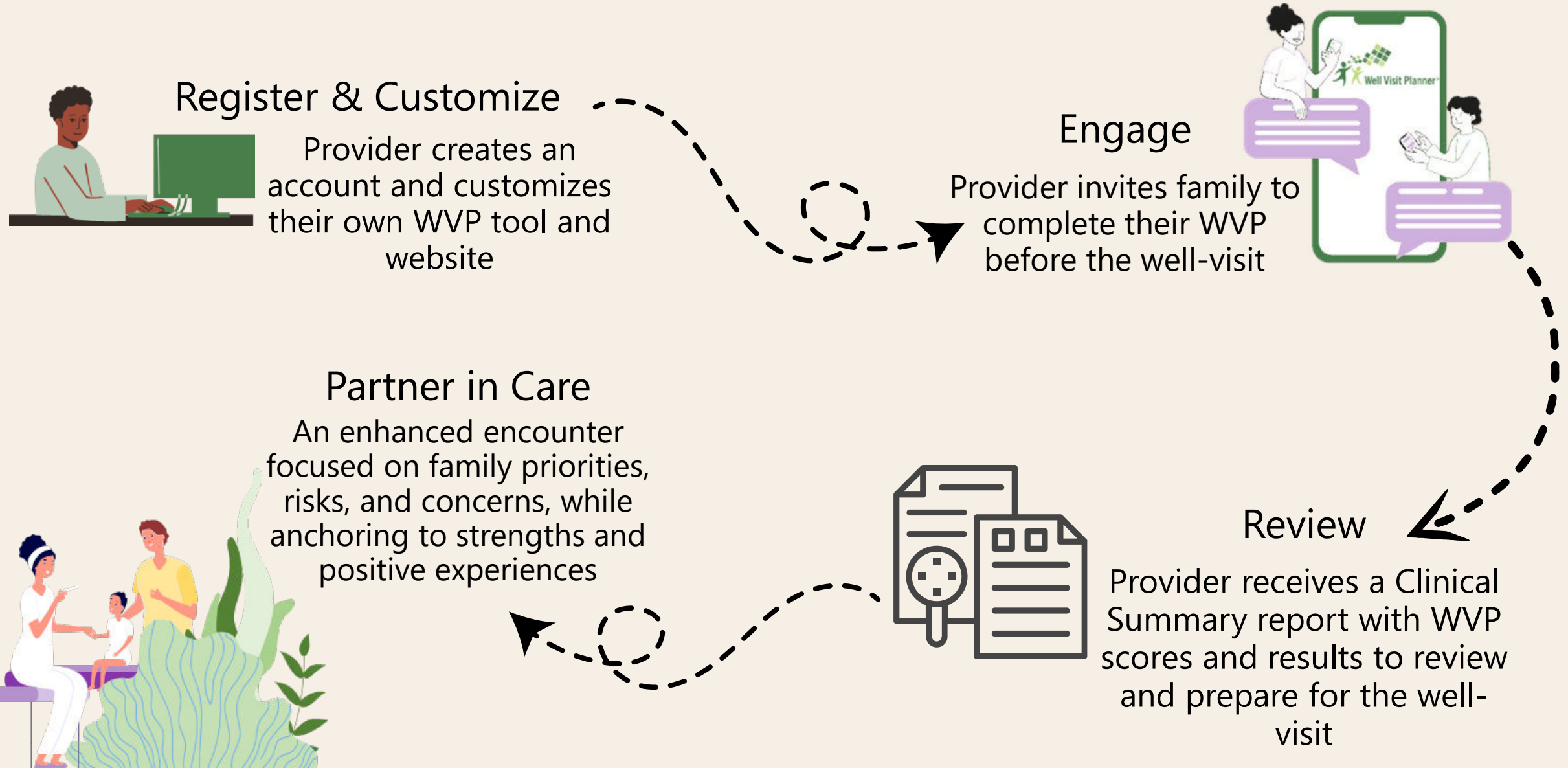
Alignment: Our needs and the WVP

Family Engagement	Workflow (MA and provider engagement)	Content
• Pre-visit planning approach • Provide context to families about the screeners/questions asked • Opportunities to share & highlight strengths • Provide family results and personalized resources in a meaningful way • Available in English and Spanish • Intentional flow and presentation of screeners/questions	• Paperless and pre-visit approach • Automatic scoring and reporting in an efficient way to view the whole-child and family • Periodicity flexibility/customization • EHR integration	• Include required screeners by TX Medicaid, HealthySteps, and grants • Aligned with national standards (Bright Futures) • Includes at least 1 approved developmental screening tool • Strengths-based questions and positive health factors reported • Available in English and Spanish • One platform, easy to follow and navigate

PCC's WVP Implementation Timeline



We created a customized WVP in just 15 minutes and began learning and engaging families immediately



Louis Appel

Logout

WVP Use Portal

Get Results: Your Data Dashboard

Download a WVP data file

Engage Your Families

Implementation Roadmap: Create Your Plan

Phase 1: Exploration

Phase 2: Preparation

Phase 3: Implementation

Phase 4: Sustaining

Partner in Care

Keep Improving

Five Steps to implement the Well Visit Planner approach to care:



Create Your Plan



Engage Your Families



Get Results



Partner in Care



Keep Improving

Quick Links to update your WVP:



Update your customized website



Add additional questions and assessments



Add or update special resource links

Your Portals:



COE Dashboard



PHDS Use Portal

Our Iterative process



Improving pre-visit completion rate

- Separate text from visit reminder text → combined text
- Determine how many days prior to visit to include the link to complete WVP
- Evolution of role of MAs in contacting family if WVP not completed



Optimize process when WVP is not completed pre-visit

Determine best ways for staff to support family in getting started and finishing the WVP



Having families complete as guest versus creating an account



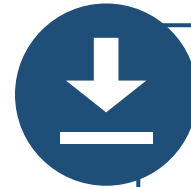
Working with the CAHMI/WVP team

Get support to address issues as they arise



Follow up trainings for MAs and providers

Specifically centered on reviewing how to respond to certain areas of concern reported from the WVP



Child-level aggregate data available to integrate while working towards streamlined EHR integration

WVP Use at PCC: 12/13/2023- 8/30/2024

Total number of completed WVPs
as of August 2024

~n=5650 (average of 700 per
month)

**Median completion time: 11
minutes;** Completion rate prior
to visits about 60%; 40%
complete in office or visit room
while waiting for provider.
Rates expected to improve as
we normalize WVP use.

Well Child Visit Age	%
1 st week	6.3%
1 month (PCC 2 week visit)	2.2%
2 month visit	8.7%
4 month visit	10.6%
6 month visit	12.1%
9 month visit	9.7%
12 month visit	5.9%
15 month visit	4.5%
18 month visit	6.8%
2 year visit	7.7%
2 ½ year visit	5.6%
3 year visit	7.0%
4 year visit	6.8%
5 year visit	5.0%
6 year visit	1.1%

Clinical Summary of Well Visit Planner® Findings: 18 Month Well Visit

Date WVP Completed: 6/30/2024 • Birth Month & Year: 12/2022 • WVG ID: 30-40865Z630-409

Key: ☐ family response indicated ☒ family response indicated ☒ family did not respond;
no or low risk some risk or concern nonresponse could indicate risk



Screening and Assessments Summary and Topics to Address: Assess & Address

Child Development

Developmental Surveillance and Screening

☒ **Developmental Screening SWYC milestones score¹:** 8 (Results from 18 Month SWYC: did not meet age expectations, cutoff score of ≥ 9); score may or may not indicate a delay. Clinical review with family needed.

Very Much

- Runs
- Uses words to ask for help

Somewhat

- Climbs up a ladder at the playground
- Kicks a ball
- Names at least 5 familiar objects - like ball or milk
- Walks up stairs with help

Not Yet

- Jumps off the ground with two feet
- Names at least 5 body parts - like nose, hand, or tummy
- Puts 2 or more words together - like "more water" or "go outside"
- Uses words like "me" or "mine"

☒ **Emotional/behavioral screening (PPSC Score 9)** At Risk; See details on 2nd page.

☒ **Autism spectrum disorder screen (M-CHAT R/F):** Moderate Risk

Administer M-CHAT Follow-Up for specific responses

1. If caregiver points at something, child does not look
2. Caregiver has wondered if child might be deaf
3. Child does not play pretend or make-believe
5. Child makes unusual finger movements near eyes

☐ **Caregiver's overall level of concern about child's development, learning, behavior**

- ☐ **Hearing concerns:** No
- ☐ **Speaking concerns:** No
- ☐ **Lazy or crossed eyes:** No
- ☐ **Bowel movements/urination concerns:** No

Anticipatory Guidance Priorities Selected by the Family: Coach & Educate

View educational materials for the 18 Month Well Visit here:

<https://www.wellvisitplanner.org/Education/Topics.aspx?id=6>

This child's parent/caregiver selected the following top 4 priorities across each of the 24 recommended Bright Futures anticipatory guidance topics for the 18 Month Well Visit. Click on the links below to access information and resources to share with families on these priorities. See page 2 for additional resources.

1. [Your child's moods and emotions](#)
2. [Behaviors to expect in the next few months from your 18-month-old](#)
3. [Toilet training](#)
4. [What to do if your child swallows poison and when to call the poison control center](#)

¹SWYC Milestones: The developmental screening instrument of the Survey of Well-Being of Young Children (SWYC), which meets American Academy of Pediatrics' developmental screening guidelines ²Intimate partner violence risk assessed using the Woman Abuse Screening Tool-Short (WAST-Short), a two-question abuse screening tool ³The Pediatric ACEs and Related Life Events Screener (PEARLS) screens for a child's exposure to adverse childhood experiences (ACEs) and risk factors for toxic stress ⁴Caregiver depression risk is assessed using the Patient Health Questionnaire-2 (PHQ-2) for the 9 month well visit and beyond ⁵The Children with Special Health Care Needs (CSHCN) Screener is a validated 5-item screening tool identifying children with ongoing conditions and above routine service needs

Health Behaviors

- ☒ **Smoking:** Child exposed to smoking
- ☐ **Flag for potential alcohol misuse**
- ☐ **Recreational/non-prescription drug use**

Relational Health Risks

- ☐ **Intimate partner violence risk²**
 - Caregiver and partner work out arguments with some difficulty
 - Some tension in relationship with partner

Social Factors/Determinants

- ☐ **Economic Hardship:** Rarely hard to cover costs of basic needs, like food or housing

Caregiver Emotional Health

- ☐ **Depression risk: PHQ-2⁴ Score: 2:** Little interest or pleasure in doing things more than half the days over past 2 weeks
- ☐ **Caregiver social support**
- ☒ **Caregiver self care/hobbies:** Has not spent time in last 2 weeks doing things they enjoy
- ☐ **Caregiver coping:** Somewhat Well

Other assessments added by provider:

None

Additional caregiver/parent goals and/or concerns to address during the visit: Test specific goals/concerns comment

About This Child

Name: Test18month Testlastname

Special Keyword:

WVP completed by: Father

Gender: Male

Insurance coverage/type: Medicare

General Health and Updates

Child's Health and Health History

- ☐ **Child has ongoing health problem requiring above routine services (CSHCN screener⁵)**
- ☐ **New medications**
- ☐ **Currently taking vitamins/herbal supplements**
- ☒ **Dentist:** Currently no dentist
- ☐ **Fluoride:** Unsure if fluoride in water source.
- ☐ **Lead exposure**

Family History and Updates

- ☒ **Recent family changes (e.g. move, job change, separation, divorce, death in the family):** Move
- ☐ **New medical problem in family**
- ☒ **Parent/grandparent had stroke or heart problem before age 55**
- ☒ **Parent has elevated blood cholesterol**
- Lives with both parents:** Yes

Strengths to Celebrate! Connect & Celebrate

Caregiver social support:

One thing that is going well for the caregiver as a caregiver:
enjoy reading at night with them

One thing the child can do that caregiver is excited about:
running at park

Screening and Assessments Summary and Topics to Address: Assess & Address

Child Development

Developmental Surveillance and Screening

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One thing the child can do that caregiver is excited about:
running at park

Successes 1

Supporting a relational health approach

Providers	
Feature	Metrics of success and benefits
Strength-based/positive questions	Conveys things that are going well which can be used by providers to connect positively with caregivers Aligns with work we have done to improve providers' skills at connecting with families during the visit.
Screening information and family-identified interests prior to visits	Providers are more efficiently able to address concerns and family-selected priorities
Families	
Ability to complete screenings at home	Families are less stressed due to fewer questions during the visit
Explanations of questions	Families have a better idea of why specific questions are being asked

Successes 2

Providing families with access to resources linked to their specific areas of interest

Feature	Metric of success and benefits
Well Visit Guide	Families receive the Well Visit Guide, which provides them with detailed information on topics they expressed interest in Families can choose their level of engagement in terms of how much they use the resources offered by the WVP platform

Meeting screening requirements we have for HealthySteps, Texas Medicaid, and specific grants

Feature	Metric of success and benefits
Comprehensive screening by the Well Visit Planner	Staff do not need to keep track of a complicated periodicity Staff and families do not need to navigate multiple paper screening tools

Successes 3

Increasing efficiency and using screenings to inform visits	
Feature	Metric of success and benefits
WVP Clinical Summary	Provides a beautifully concise and easy to quickly review summary of all the information shared by the family, and takes only moments for the provider to assess areas needing attention
Ability to complete the WVP pre-visit	As we increase the proportion of families completing the WVP pre-visit, we are seeing important gains in efficiency of the visit for intake and for recognizing and addressing concerns
Comprehensive screening and resource sharing capabilities	HealthySteps screenings are meant to help us support families and connect them to resources when needed With the WVP, we are doing a better job of identifying needs and referring to resources, including related to maternal behavioral health and child social-emotional development

Successes 4

Supporting team-based care	
Team unit	Contribution to care
Operations team	Ensures families are being sent the link prior to the visit
MAs	Contact families if WVP not completed at time of the chart prep
Platform	Handles the scoring and highlights areas needing attention
Providers	Use the results to refer to early childhood intervention, to social work for caregiver behavioral health support Call for or refer to our early childhood team, especially around specific social-emotional needs identified

Provider feedback 1

*“I really **love the ‘strengths to celebrate’** section when it’s filled out. I find it’s a good way to start the visit when the well visit planner is done ahead of time.*

*I usually go in and while EPIC is loading, I’ll bring up ‘thanks for filling that planner out ahead of time, I see (whatever the positive item was the parent shared),’ and it usually **gets parents pretty excited** and they’ll go on about other milestones that they’re excited about.”*

Provider feedback 2

*“The thing that has stood out most to me is the **depression screener for the moms**.*

*“I have had so many conversations with moms about how they are feeling since starting the WVP, and I think they **feel more comfortable opening up** in this platform. I have been able to provide support through just listening in some cases or referring to Social Work for more help.”*

*“It’s been **impressive to me how many moms are sharing this feedback via the Well Visit Planner** and I am grateful for that.”*

Provider feedback 3

*“It’s a **nice summary of multiple domains**. It’s especially useful having the SDOH and maternal depression screening built in. I also like the questions about recent changes in the family (separation, death in the family, etc) as parents don’t always volunteer this information.”*

Provider feedback 4

*"I like to read about the **good things that parents are noticing about their kids.** I really like that question.*

*When [the WVP] is filled out before the visit, it certainly **allows for more time to hone in and discuss a particular concern....**it really makes for a smoother and more productive visit if I can focus on the parent/patient....*

*I like the break up of sections on the WVP (Clinical Summary)...it allows me to **easily get a quick glance at development/family/environment (issues) and any major concerns.**"*

WVP Data Download Feature

Logout

WVP Use Portal

Get Results: Your Data Dashboard

Download a WVP data file

Engage Your Families

Implementation Roadmap: Create Your Plan

Phase 1: Exploration

Phase 2: Preparation

Phase 3: Implementation

Phase 4: Sustaining

Partner in Care

Keep Improving

Your WVP Family Website

Update your customized website

Add additional questions and assessments

Update links to additional assessments

Update links to additional resources

Update notifications and ways to receive family data

COE Dashboard

Download a WVP data file

To download your WVP data file:

1. Select a start date and end date below for the data collected on your customized WVP. Then click **Add Request**.
2. Click on "Request a code to download the data file".
3. After submitting your request, check your email used to register for this account and enter the code to download the data file.

Start date

1/1/2023

End date

7/26/2024

Add Request

WVP Data files: You will need to request a code every time you download the data file.

Creation Date	Start Date	End Date		
7/26/2024	1/1/2023	7/26/2024	Request a code to download the data file	Delete
7/19/2024	1/1/2024	6/30/2024	Request a code to download the data file	Delete
7/2/2024	1/1/2023	7/2/2024	Request a code to download the data file	Delete
6/3/2024	1/1/2023	6/3/2024	Request a code to download the data file	Delete
5/21/2024	1/1/2023	5/21/2024	Request a code to download the data file	Delete

I	FirstName	LastName	DOB	AgeGroup	surveyStartDate	surveyEndDate	S1D_DepInterest	S1D_DepEmot	PHQ2Score	PHQRiskFlaggedCS
35194	CAHMItest			1 Month W	1/22/2024 13:51		90	90	90	
36273	CAHMItest	Test	4/3/2023	9 Month W	1/29/2024 17:27	1/29/2024 17:38	1	2	3	Yes
36275	CAHMItest	Test	1/29/2023	12 Month W	1/29/2024 17:44	1/29/2024 17:55	1	2	3	Yes
36276	CAHMItest	Test	#####	15 Month W	1/29/2024 17:58	1/29/2024 18:08	3	3	6	Yes
36277	CAHMItest	Test	7/20/2022	18 Month W	1/29/2024 18:10	1/29/2024 18:19	1	1	2	No
36278	CAHMItest	Test	1/1/2022	2 Year Wel	1/29/2024 18:20	1/29/2024 18:26	0	0	0	No
36288	CAHMItest	CAHMItest	7/1/2020	3 Year Wel	1/30/2024 6:22		99	99	99	Caregiver did not resp
36290	CAHMItest	CAHMItest	7/1/2020	3 Year Wel	1/30/2024 6:41	1/30/2024 7:03	0	1	1	No
36292	CAHMItest	CAHMItest	9/13/2021	2 1/2 Year	1/30/2024 7:05	1/30/2024 7:20	1	0	1	No
36294	CAHMItest	CAHMItest	9/9/2019	4 Year Wel	1/30/2024 7:26	1/30/2024 7:35	1	1	2	No
36295	CAHMItest	CAHMItest		5 Year Wel	1/30/2024 7:36	1/30/2024 7:44	99	99	99	Caregiver did not resp

Example Population Data We Get:

SWYC, IPV, EPDS and PHQ Screening Results

SWYC age-appropriate developmental expectations	%
Met age expectations	52.4%
Did not meet age expectations	47.6%
Not scored (all items missing)	0.8%

Patient Health Questionnaire – 2 PHQ Risks (9 month – 6 year visits)	%
Yes	2.1%
No Risk	95.8%
No Risk (some items missing)	2.0%
Not Scored (all items missing)	2.0%

Edinburgh Postnatal Depression Scale (EPDS) Risks (1-6 month visits)	%
High Risk	3.9%
At Risk	5.5%
Low/No Risk	83.9%
Low/No Risk (some items missing)	6.7%
Not scored (all items missing)	1.7%

Intimate Partner Violence Screening	%
Yes	9.3%
No Risk	88.7%
No Risk (1 item missing)	1.9%
Not Scored (missing data)	2.5%

Example Population Based Data We Get:

M-CHAT, BPSC, PPSC

M-CHAT Risks (18 month, 2 year, 2 ½ year visits)	%
High Risk	1.9%
Moderate Risk	7.6%
Low Risk	67.8%
<i>Low Risk (some items missing)</i>	22.6%
<i>Not scored (all items missing)</i>	1.1%

Baby Pediatric Symptom Checklist Risks (1 m – 17 months, 31 days old)	%
At Risk	36.8%
Low/No Risk	56.7%
<i>Low Risk (some items missing)</i>	6.5%
<i>Not scored (all items missing)</i>	1.3%

Preschool Pediatric Symptom Checklist Risks (18 – 66 months old)	%
At Risk	21.2%
Low/No Risk	65.2%
<i>Low/No Risk (some items missing)</i>	13.6%
<i>Not scored (all items missing)</i>	1.2%

Example Population Based Data We Get

Family Strengths to Celebrate

Do you have at least one person whom you trust and to whom you can go with personal difficulties?

- Yes: 86%

How many times in the last 2 weeks have you gone out socially or spent time doing hobbies, self-care or spare-time activities you enjoy?

- None: 40.9%
- 1-2 times: 43.0%
- 3-5 times: 12.8%
- >5 times: 3.3%

In general, how well do you feel you are coping with the day to day demands of parenthood?

- Very well: 51.9%
- Well: 35.9%
- Somewhat well: 10.2%
- Not very well/Not well at all: 2.0%

Lessons and Tips

Implementation logistics

- Time to prepare and coach families on the WVP
- A small percentage of families require more support to learn WVP account management, password, and technology --but influence staff impressions disproportionately
- EHR integration process is mostly difficult due to EHR side, but hopeful!

Improving efficiency

- Pre-clinic completion makes a big difference
- Improving the pre-clinic completion rate has required an iterative quality improvement approach - work in progress
- WVP completion during intake can slow clinic flow
 - Yet, paper screeners were at least as time consuming and not as extensive or integrated like in the WVP

Family feedback

- Families like learning and getting results and knowing what to expect
- Families like partnering around their stated goals and priorities
- Some families find select questions confusing or interpret questions differently than intended
- A small number of families object to a few of the questions (e.g. alcohol use by a family member)—yet, they do not have to complete ANY items they do not wish to complete or share

Next steps

EHR Integration

- Data, interpretation/clinical summary, family-identified topics, family-shared positive reports, family-directed resources
- EHRs need to understand families and clinical staff need more than just screening questions in an electronic format

WVP data flowing into EHRs allows the tools HealthySteps has developed to automate a lot of reporting and tracking required by HealthySteps

Promoting Healthy Development Survey

- Aggregate reporting of results back to the clinic to provide family feedback on their experience

Aim to use the PHDS to obtain feedback from families based on their experiences

Use feedback to improve our care and support value-based contracting with managed care organizations

Screening completion data

Will be used to support value-based contracting with managed care organizations

Resources for providers

Providers can use WVP links to provider-centric resources to gain familiarity with the tool and increase the value of their services

Future Well Child Check (WCC)

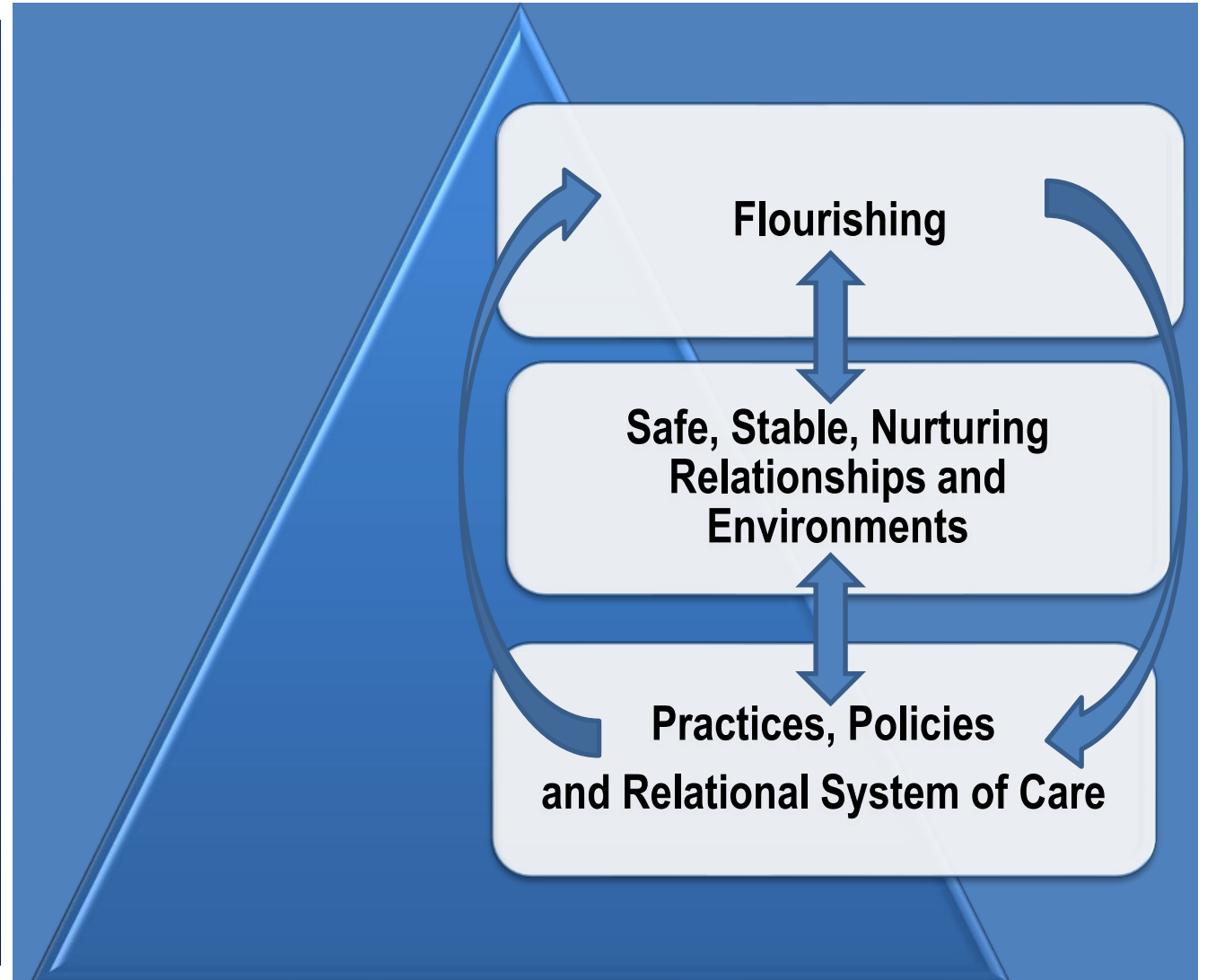
We are looking to create a Well Child Check that provides space for promoting early relational health.

Guided by ongoing staff training, improvements in workflow, WVP integration, and further implementation of anticipatory guidance videos, the WCC aims to:

- Allow the team to discuss information and help caregivers grow their skills for nurturing, responsive relationships with their children
- Focus on family-identified areas of interest
- Help families feel connected to the clinic, heard, and engaged in their child's health and healthcare
- Help the clinic team feel effective and engaged in the care they are providing



Start Where We Want to End Up



Imagine

a world where...

- every child and family can flourish despite experiencing adversity
- every child, from the time they're born, has equitable access to high-quality care regardless of social factors
- every physician has the tools to adequately support their families and experience joy in their practice
- every community and care team collaborates effectively with health systems for the well-being of their families
- every child health and family support service available is optimized and leveraged



“

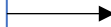
Promoting positive health and flourishing of children, youth and families is our greatest public health need and opportunity! Trusting relationships, personalized care, reliable and comprehensive data and ongoing engagement of families and communities is required. This is the goal of the CAHMI's Cycle of Engagement model and tools.

”

What Would It Take?

Developmental Screening

Current Rate of
Developmental
Screening for Children
Under 3 in the US



33.7%
Range Across States:
24.5-49.1%

Current Rate of
Developmental
Screening for Publicly
Insured Children
Under 3 in the US



28.7%
Range Across States:
8%-54.6%

How many publicly
insured children would
we need to screen to
improve current rates?

By 5 points to 33.7%
n=146,476

By 20 points to 48.7%
n=585,905

By 30 points to 58.7%
n=878,857

By 60 points to 88.7%%
n=1,757,714

What Would It Take?

Well Visit Rates (CMS Data)*

Proportion of publicly insured children **under 15 months** of age that had at least **6 of 9** recommended well visits

2022: 55.7%
Range Across States:
28.2%-77.5%
(1/2rd visits occur)

Proportion of publicly insured children **15-30 months** of age that had at least **2 of 4** recommended well visits

2022: 64.9%
Range Across States:
36.5%-84.4%
(2/3 visits occur)

How many publicly insured children would we need to ensure had well visits to improve current rates?

Age 0-15 months by 20 points to 75.7% ~n=321,000

Age 0-15 months by 45.3 points to 100% ~n=715,000

Age 15-~30 months by 20 points to 85% ~n=307,000

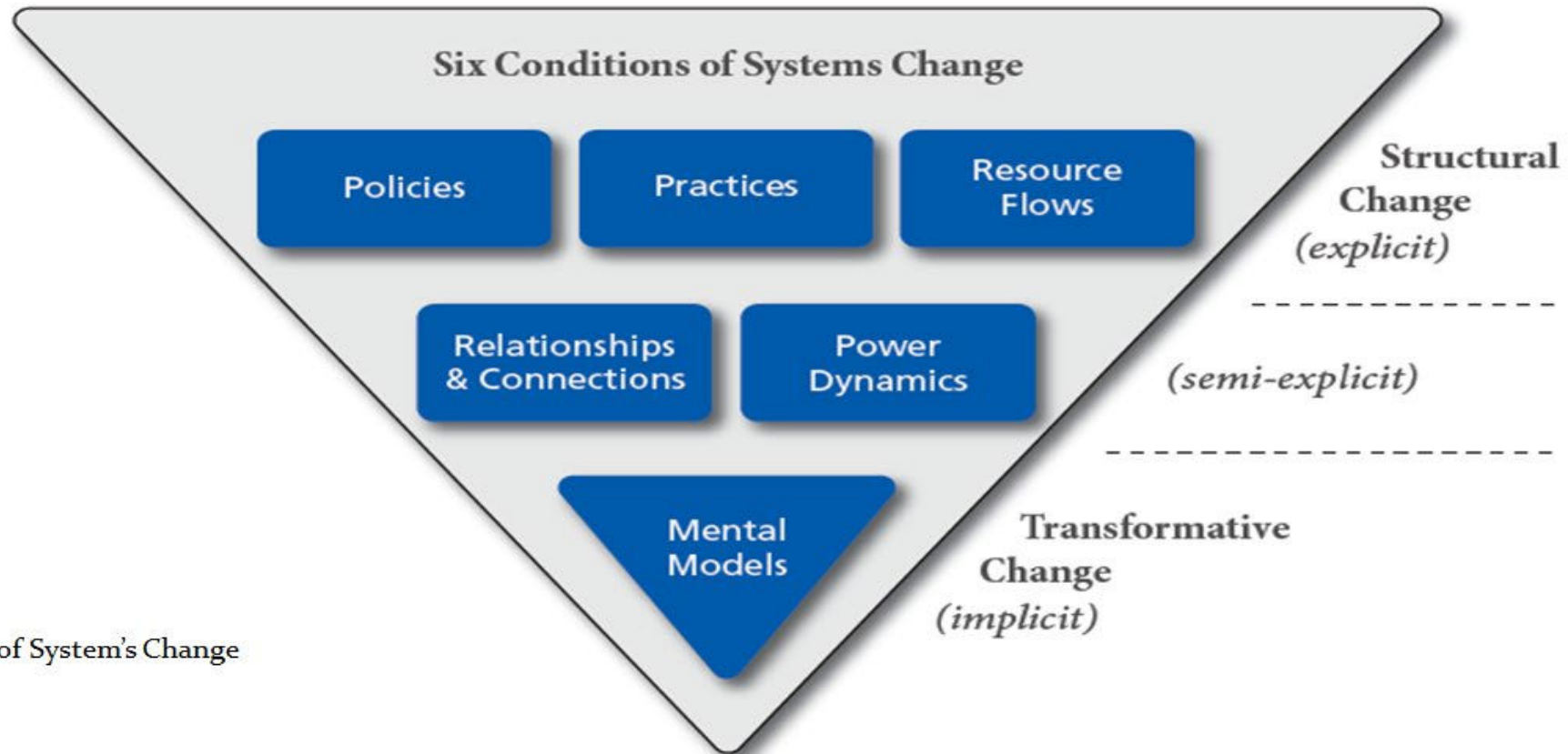
Age 15-30 months by 35 points to 100% ~n=538,000

*<https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html>

Key Conditions of Systems Change

A fish is swimming along one day when another fish comes up and says “Hey, how’s the water?”
The first fish stares back blankly at the second fish and then says “What’s water?”

FIGURE 1. SHIFTING THE CONDITIONS THAT HOLD THE PROBLEM IN PLACE



Source: Waters of System's Change



RESOURCE & REFERRAL CENTER



PEDIATRIC PRIMARY CARE



HOME VISITING



EARLY CARE AND EDUCATION



PEDIATRIC PRIMARY CARE



EARLY INTERVENTION



FAITH BASED HEALTH PROGRAM



PEDIATRIC PRIMARY CARE



Safe Babies
A Program of ZERO TO THREE

INFANT TODDLER COURT



COMMUNITY-BASED RESOURCES



PEDIATRIC PRIMARY CARE



COMMUNITY-BASED SUPPORTS

THE
POSSIBILITIES
TO ENGAGE AND
ENSURE
FAMILIES
RECEIVE
QUALITY
PREVENTIVE
SERVICES AND
SUPPORTS ARE
ENDLESS—BUT
INTEROPERABLE
FAMILY
ENGAGEMENT
AND WHOLE
CHILD
ASSESSMENT
APPROACHES
AND LINKAGES
ARE ESSENTIAL!

Multiple Entry Points for Catalyzing Positive System Change



ENGAGEMENT IN ACTION

ENGAGEMENT IN ACTION (ENACT!) FRAMEWORK

*Toward an Integrated Early Childhood Health System to
Promote the Early and Lifelong Health of Children and
Families*



<https://cahmi.org/our-work-in-action/engagement-in-action/EnAct!Framework>

One Big Doable Thing! Elevating Comprehensive Developmental Promotion and Preventive Services With the Family-Engaged Well-Visit Planner Approach (September 10, 2024)

Quick Links to Key CAHMI Resources

The Cycle of Engagement Well Visit Planner Approach to Care (COE WVP)

- Videos
 - COE WVP Overview: [Cycle of Engagement Well Visit Planner](#)
 - Well Visit Planner Introduction for Families: [English](#) and [Spanish](#)
 - Get a Demo on the [Cycle of Engagement Account System and Key Features](#)
- Family Engagement Models and Tools
 - COE WVP Approach Overview: [Clinical Focus](#)
 - COE WVP Approach Overview: [Community Partner Focus](#)
 - [Summary of Content and Benefits](#) of the COE WVP
 - The Engagement In Action (EnAct!) [Framework Summary](#)
 - [Family Outreach Flyer](#) (example of many family resources)

Explore Data Findings from the National Survey of Children's Health (NSCH) from Your State!

- [Data Resource Center](#) Interactive Data Query

Additional Resources

- [Key Research Publications](#) related child flourishing, school readiness, and ACEs/PCEs
- [Quick Links to Priority Technical Assistance Resources](#) on Early Childhood Systems Transformation

Access all resources in our [Google Drive Folder](#)

Resources



Poll #3. What next step(s) will you consider after participating in this webinar? Select all that apply.





Together We Can Achieve
One Big Doable Thing!

Questions

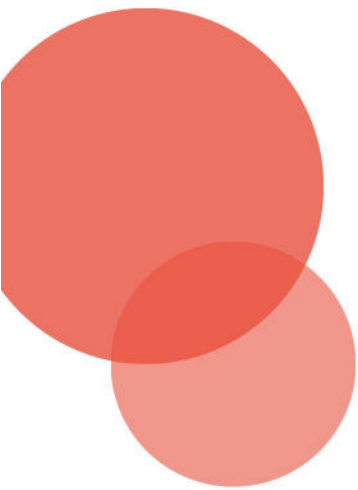


How Did We Do?

- Please take a moment to complete a brief survey to support the Evidence to Impact Center in improving its trainings and technical assistance offerings and assessing program outcomes over time.
- The survey is anonymous, voluntary, and should take **no longer than 5 to 10 minutes** to complete.

To complete the survey, please click on the link in the chat or scan the QR code below on a mobile device.





CEUs

- Go to the “Contents” tab on the event page.
- Select “CEU Survey.”
- Enter the verification code provided at the end of the survey. (Code is case sensitive.)
- Complete the quiz.
- Once all items are completed the certificate will become available for download.
- You have 30 days to return to the event page and complete items for CEU credit.

Event page link: [https://elearn.zerotothree.org/p/ECDHS-WellVisitPlannerApproach#tab-product tab contents](https://elearn.zerotothree.org/p/ECDHS-WellVisitPlannerApproach#tab-product%20tab%20contents) 5



Thank you again for joining us!

Please scan the QR code to complete our feedback survey.

