



CHANGE IDEA: Partner with community service providers to improve care coordination for families with complex medical, behavioral, and social needs.

STEP 1: GET READY (TASKS)

- A. Convene a small team of providers, care coordinators, and administrative staff to improve referral communication and follow-up with one key behavioral health agency partner.
- B. Contact your infant mental health association or state mental health system to identify local mental health clinicians trained in early childhood evidence-based treatment.
- C. Communicate with other programs that receive a high volume of your referrals, such as libraries with quality playgroups, dental and vision care, local schools, peer navigators, and public health programs.
- D. Define roles and responsibilities. Designate a referral coordinator at the health center and a contact person at the behavioral health agency.
- E. Select a simple communication method to pilot (e.g., shared [referral tracking spreadsheet](#), [secure email template](#)).
- F. Schedule a brief training to introduce the communication process and expectations.

STEP 2: PLAN AND PRACTICE

Co-design a short workflow to improve visibility and follow-up on referrals sent to the behavioral health agency.

SAMPLE PROCESS:

- A. The referral coordinator enters a referral into a shared spreadsheet and sends a secure message to the agency contact.
- B. The behavioral health agency acknowledges the referral within 2 business days and updates the spreadsheet when the patient is contacted or scheduled.
- C. The referral coordinator checks the spreadsheet every 2-3 days and follows up if no update is received within 5 business days.
- D. Pilot this process with referrals from one care coordinator for 2 weeks.

STEP 3: REVIEW AND REFINE

Hold a review huddle with staff and the community partner to assess:

- A. Number of referrals acknowledged within 2 days
- B. Number of patients scheduled
- C. Barriers to timely communication or tracking
- D. Usability for both organizations

Use feedback to identify pain points (e.g., need for clearer fields, privacy concerns, time burden) and adjust the workflow.

STEP 4: EXPAND

If successful, expand the workflow to additional care coordinators or providers. Consider adding a second community behavioral health partner. Continue short weekly huddles to address issues and reinforce consistent use.

STEP 5: SUSTAIN

Review implementation data and gather feedback from staff and partner contacts. Refine the communication tool or process as needed, such as:

- A. Simplifying spreadsheet layout
- B. Standardizing message templates
- C. Integrating into electronic health record workflows
- D. Updating referral workflows and providing refresher training

Embed the process into routine operations by:

- A. Including it in standard operating procedures for care coordination and referrals
- B. Training new staff on workflow expectations
- C. Regularly reviewing referral follow-up metrics to ensure accountability
- D. Celebrating improvements in referral success and partnership strength