Resource Packet for Partnerships Between Community Based Organizations and Healthcare Providers

Purpose: Provide community-based organizations (CBOs) with materials to help them engage and partner with providers to use the Well Visit Planner

What's in this document:

1. Mapping CBO-Provider Relationships: How to Evaluate Your Relationship with Providers

<u>You are a CBO with existing provider partnerships</u>

1. Consider current partnership/relationship
    a. Do you refer to them or do they refer to you, or both ways? This will determine who would be best for initiating WVP use and information sharing
2. Initial WVP engagement
    a. Call and discuss the WVP (we can make a script for this)
    b. Use email template provided (draft needed) with content from letter
    c. Share provider COE 2 pager and WVP 1 pager
    d. Set up a meeting to discuss deepening partnership using WVP (can provide slides)
    e. Share an example WVG/CS
3. Provider Engaged
    a. If interested in account- have them email info@cycleofengagement.org
    b. If not interested in account, but willing to partner with you/use WVG/CS, review materials with them
4. Send MOU
    a. Review together
    b. Make edits as needed based on agreed workflow
    c. Consent concerns
    d. Establish data sharing and which WVP account to use
    e. Consider linking accounts

<u>You are a CBO and do not currently partner with providers</u>

1. Initiating a relationship
    a. Go to local provider practices, drop off informational materials
        i. Your CBO flyer, your WVP flyer, WVP 1 pager
    b. Cold call local provider clinics and describe how you can partner
        i. Referrals, screeners
        ii. How you may refer families to them, or vice versa
    c. After initial contact, propose partnering using WVP
        i. Share websites
        ii. Use script provided
2. Connecting with a provider whose families already use WVP (but CBO does not currently partner with)
    a. share family letter with WVG/CS to provider
    b. provide contact information for developing partnership
    c. After checking in with families following well visit, contact providers via phone call or emails to discuss their thoughts on WVG
    d. Gauge interest in partnering in care
        i. Would provider like CBO to refer to them
        ii. Is provider interested in continuing to receive WVG/CS from families

2. Email Template to Providers

Dear [Provider/practice name],

I would like to introduce you to the Well Visit Planner® (WVP), an evidence-based digital tool for families that we have started using at _____. The WVP was developed by the Child and Adolescent Health Measurement Initiative (CAHMI), a research center housed at Johns Hopkins University and was created in collaboration with families, pediatric providers, and experts, including leaders of Bright Futures Guidelines.

Families take about 10 minutes to complete screeners recommended in Bright Futures Guidelines and pick their priorities among the many age-specific Bright Futures recommended educational topics. Once completed, families get a Well Visit Guide with their results and resources specific to their needs and priorities. As an account holder, we get a Clinical Summary which is an at-a-glance summary of family responses so that we can plan to meet their needs. **Healthcare providers can use the Clinical Summary to prepare for a family-centered well child visit and to document and bill for services.**

Fifteen years of research on the WVP has demonstrated that its use results in dramatically **improved quality of well child visits, increased screening and follow-up rates, and decreased urgent care visits, all with no change to visit length.** Over 90% of families and providers say they would recommend the WVP to others.

We hope to partner by sending you the Clinical Summaries of the families we refer to you. It will help you prepare for the well visit to ensure all child and family needs and priorities are met. If you are interested in creating your own account to better streamline referrals with us, we have attached a two page overview with more information about the CAHMI tools, a summary of the contents and benefits of these tools, and a one-pager about the WVP. You can also go to www.wellvisitplanner.org and www.cycleofengagement.org for more information.

Please let us know if you are interested in using the WVP tools with us. We would love to meet with you about this and plan our workflow and referral process so that we are better able to streamline care and support each other in serving families.

-Org Name

3. Phone Script Template to Providers

Introduction

Hello, how are you?

I wanted to talk today about advancing our partnership using a tool called the Well Visit Planner. We have been using it with our families to help us complete developmental screening and other assessments to provide families with personalized care, referrals, and support. Families are also asked to choose their priorities so we can discuss what's most important to them. Have you heard of the Well Visit Planner or Cycle of Engagement before?

→**If yes:** That's great you've heard of it. What do you know about the tools *(use information shared in following section to address questions; also see FAQ document for common questions and responses)*

→ **If no, share WVP info:** No problem, it's very straightforward. The Well Visit Planner is a guidelines and evidence based digital screening tool for families to complete before the well visit. It was developed by the Child and Adolescent Health Measurement Initiative (CAHMI) which is a research center at the Johns Hopkins University Bloomberg school of Public Health, in collaboration with families, pediatric providers, and experts, including leaders of Bright Futures Guidelines.

At [*org name],* we have our own customized WVP website and Data Dashboard to receive and review the family's screener results immediately after they complete it. We share our WVP link with families and it takes them about 10 minutes to complete Bright Futures recommended screeners and assessments, and they pick their priorities based on age-specific Bright Futures anticipatory guidance topics. Families get a Well Visit Guide that summarizes their results and resources specific to their needs and priorities, and we get an at-a-glance Clinical Summary, in addition to the Well Visit Guide, which is a summary report of the family's scores and responses. This helps us plan resources and referrals families might need.

We think you could also benefit from the Clinical Summary to document and bill for services and prepare for a family-centered well child visit.

We would like to continue partnering with you by having families complete all of the screeners with us, pick their priorities, review their well visit guides with us, and then we can send you the clinical summary so you are prepared to address their needs and priorities, while also celebrating their strengths. *And* you won't have to spend as much time on screening and assessments, but still be able to bill for services provided afterwards.

As I mentioned, this is evidence based. Over the past 15 years, several studies have shown the WVP is effective for providers and families alike. The WVP has been found to improve quality of well child visits, increase screening and follow-up rates, and decrease urgent care visits, with no change to visit length. Over 90% of families and providers say they would recommend the WVP to others.

Are you interested in trying this out?

→ If Yes:
Let's schedule a meeting for us to plan out a referral process in which we can securely share the clinical summary with you. We can also consider your practice making its own account so that we can share information easier. I will send you some additional materials on the WVP so you can learn more about it. *Try to schedule in the moment to ensure follow-up.*

→ I need more information
I will email you some provider-specific materials about the WVP. Are there specific questions I can answer now though? *See next section*

→ No:
Ok, thanks for listening. Excited for us to continue to work together in whatever capacity!

Following the meeting send the three documents included in the email script:

1. *Provider 2 pager*
2. *Contents and benefits*
3. *WVP one pager*

Also share the 2 websites: wellvisitplanner.org and cycleofengagement.org

4. FAQs for Conversations with Providers

→ What are the assessments/screeners used

1. Child and parent/caregiver **strengths** (what is going well!)
2. Open-ended questions about family/parent specific **goals and concerns** for the well visit
3. **Developmental surveillance and standardized developmental screening using the Survey of Well-Being of Young Children (SWYC)**
4. Autism spectrum disorder screening using the **Modified Checklist for Autism in Toddlers, Revised (M-CHAT-R™)** for 18-and 24-month visits
5. Caregiver concerns about **speaking, vision, hearing**
6. Open-ended question on any **additional concerns** about child's development or health
7. Caregiver depression using the **Patient Health Questionnaire-2 (PHQ-2) or Edinburgh Postnatal Depression Scale (EPDS)** (based on child's age)
8. **Family psychosocial issues** (e.g., meeting basic needs, alcohol and substance use, smoking, emotional support, parent/caregiver coping, experiences of racial discrimination, etc.)
9. Intimate partner violence using the **Women Abuse Screening Tool-Short (WAST-Short)**
10. **Anticipatory guidance** and parental education prioritization checklists and provision of family-centered topical Family Resource Sheets (can pick up to five; average selected=3)
11. Other **general health information** recommended in guidelines (age-specific; nutrition, medications, vitamins/herbs, special health care needs)
12. Other **family health history and updates** (heart problems, stroke, high blood pressure, new problems, recent changes or stressors)
13. Other **context and environmental assessments** (e.g., living situation, lead, fluoride)
14. questions about **COVID's impact**
15. **Telemedicine** interest

Others can be added (see contents and benefits 2 pager attached to phone script)

→ How can I use these tools if the families I work with have limited or no internet access?

Families can complete on devices in our office or your waiting room. You can also verbally administer the WVP in person, over the phone or video platforms.

→ What if the families I serve do not speak English?

Currently the WVP is in English and Spanish

→ Can I get The Clinical Summary information directly integrated into my electronic records?

Yes. The WVP was developed and tested for full integration into electronic records. Right now, families can upload their Well Visit Guides to the EMR via a patient portal if you have one. You can scan Clinical Summaries into your EMR to support billing and documentation. Direct integration into your EMR is possible if your EMR is able to receive WVP data. Collaboration with your EMR vendor and additional data sharing agreements are required. If you want more information on that, go to the cycle of engagement website, I will send you the link!

→ Who pays for this?

The CAHMI is dedicated to making the COE free to use for families. With the support from private foundation funders, providers can currently get an account and use the WVP and PHDS if they are willing to share their experience using these tools.

→ Why switch to the Well Visit Planner If we already use the ASQ (or another screening tool)?

While there are many comprehensive screening tools, they are all provider-facing. The Cycle of Engagement is the only comprehensive screening tool that shares the data back with families so that families can be knowledgable partners in care. We can then review family results and priorities with the family so they are empowered for the well child visit. Also, I want to emphasize that the developmental screener included in the WVP, the Survey of Wellbeing of Young Children, has similar sensitivity and specificity to the ASQ and other common developmental screeners

→ If my practice screens for all of the health risks using all the assessments included in the WVP, I am concerned we will screen for conditions I cannot treat.

This is a common concern, but fortunately we are partners and can share resources with each other. Also, providers who have used the WVP have found that families appreciate an empathetic ear to hear their concerns and help engage in problem-solving collaboratively. Some providers have noted that it is rare there is not a single resource to provide that could help a family. Additionally, if you make an account, you will get guidance on how to develop your resource section of the customized WVP so that it is as comprehensive and responsive to family needs as possible.

5. Letter for Families to Show Provider with Well Visit Guide

The *Well Visit Planner*® and My Child's *Well Visit Guide*

Dear Provider,

I would like to introduce you to the Well Visit Planner® (WVP), an evidence-based digital tool for families developed by the Child and Adolescent Health Measurement Initiative (CAHMI), a research center housed in Johns Hopkins University, in collaboration with families, pediatric providers, and experts, including leaders of the American Academy of Pediatrics' Bright Futures Guidelines. Here's how it works. I take about 10 minutes to complete the WVP on my computer or phone. I learn about well visits, complete and get results on the many screeners recommended in Bright Futures Guidelines, and I read about and pick my priorities among the many age-specific educational topics important to my child and family. When I complete the WVP, I get a family friendly **Well Visit Guide with my results and resources specific to my needs and priorities. This guide summarizes the strengths, priorities, and the needs** of my child and family that we can discuss during the well child visit. If you use the WVP you can get a Clinical Summary and additional resources too.

When I complete the WVP you can be assured that 1) I have completed all screens recommended for my child's age/well visit and that both you and I get those results with tailored resources before the visit; 2) we address my priorities among all the topics prescribed in Bright Futures Guidelines; 3) we will partner to build trust, celebrate my child's strengths, and address my parenting concerns and (4) you can learn about and connect me to resources my family might need.

Fifteen **years of research on the WVP** has demonstrated through repeated studies in diverse populations that the use of the WVP results in **dramatically improved quality of well child visits, increased screening and follow-up rates, and decreased urgent care visits, all with no change to visit length.** Over **90% of families and providers** say they **would recommend** the WVP to others. I think using the WVP is a change worth making.

If you are interested in using the WVP with families like me in your practices, go to www.wellvisitplanner.org to see the family website and www.cycleofengagement.org to learn how you can sign up. Thank you for reading this letter and my Well Visit Guide to help me be the best possible advocate for my child and family.

-Family, and the CAHMI team

6. Memorandum of Understanding

Between [Community-Based Organization (CBO)] and [Healthcare Provider/Clinic]

Prior to sharing this MOU, ensure both partners have:
1. Interest in continuing or developing a partnership to improve care for their families
2. Are familiar with the Well Visit Planner and have interest in implementing it in their practice or organization
3. At least one partner has a Cycle of Engagement account and customized WVP website

Purpose: This MOU will establish a mutual agreement between *[CBO]* and *[healthcare provider]* to facilitate sharing family Well Visit Planner (WVP) results with each other. Further, it will promote a trusting and collaborative relationship between two partners working together to provide comprehensive services to children and families.

These goals will be accomplished by:

1) **Obtaining family consent:** Families will consent to their WVP results being shared between *[CBO]* and *[health provider]* using a verbal or written consent form issued by *[CBO or health provider]*. Consent implies agreement that the family's Well Visit Guide/Clinical Summary (WVG/CS) will be sent to the partner agency, *[health provider or CBO]*. Families will also receive a copy of the consent form for their records. **If the family does not consent to share their WVG/CS** with the partner agency, then their WVP will not be shared outside of the family's trusted provider/organization.

2) **Establishing a data sharing method:** Partners will decide how to share family data. There are 3 secure options.
   a. **Link COE accounts:** If each partner has a Cycle of Engagement (COE) account, then they will name each other or the same additional staff member on their accounts to share data via their WVP Data Dashboard.
   b. **Share via secure method of communication outside COE account.** If a partner does not have an account, the account-holding partner is responsible for receiving and sharing the family WVG/CS to the non-account holder prior to the family's visit.
   c. **Family brings the printed WVG or CS from one partner to the other**. If both parties prefer not to use their COE accounts or any other electronic sharing method.

Proposed data sharing process from [CBO] to [health provider]:
1. Family completes CBO customized WVP before or while meeting with CBO
2. CBO obtains consent from family to share their WVP results with partner provider/clinic
3. If needed, CBO will help connect family to partner provider/clinic (who uses WVP based on MOU) and set up a well child visit
   a. For families that do have a provider, the CBO will ensure the family shares the provider letter that explains the WVG/CS. The CBO may follow-up with this provider to develop a partnership.
4. CBO will share the WVG/CS with partner provider via established data sharing method. Provider will review the CS/WVG prior to visit and plan potential needed referrals.

    a. It is recommended providers and CBOs discuss billing insurance for the screeners used in the WVP.
5. CBO will follow up with family 2 weeks following initial contact to ensure well visit is either scheduled or completed.
6. As families continue to use the WVP, both partners will establish which WVP account to use for continued sharing.
    a. Name partner here: _____
    b. Ex. Partners agree that family will continue to use CBO customized WVP as the family's initial point of contact, and CBO is responsible for sharing results accordingly.
7. If any technical issues occur in accessing the WVG/CS or sharing these documents, CBO will contact the CAHMI for tech support at info@cycleofengagement.org

Proposed data sharing process from [health provider] to [CBO]:

1. Families will complete provider customized WVP and review results during well child visit.
2. Provider will refer family to partner CBO depending on unique needs and explain what the family can expect from CBO services.
3. Providers will obtain consent from the family to share their WVG/CS with partner CBO (see example consent form in reference materials).
    a. If families do not consent to sharing with CBO, provider should ensure their WVG is saved for future reference.
4. Provider will share the WVG/CS with CBO via their WVP Data Dashboard (ensure both COE accounts are linked).
5. As families continue to use the WVP, both partners will establish which WVP account to use for continued sharing.
    a. Name partner here: _____
    b. Ex. Partners agree that family will continue to use provider customized WVP as they will be the provider for multiple well child visits, and they will share WVG/CS with CBO accordingly.
6. If any technical issues occur in accessing the WVG/CS or sharing these documents, CBO will contact the CAHMI for tech support at info@cycleofengagement.org

Duration

This MOU is at-will and may be modified by mutual agreement from both partners. This MOU will be effective upon both partners' signature and will remain in effect until modified or terminated by any one of the partners by mutual consent.

_____Date:
(Partner signature)
(Partner name, organization, position)

_____Date:
(Partner signature)
(Partner name, organization, position)

7. Appendices

A. Page One of Provider 2-Pager

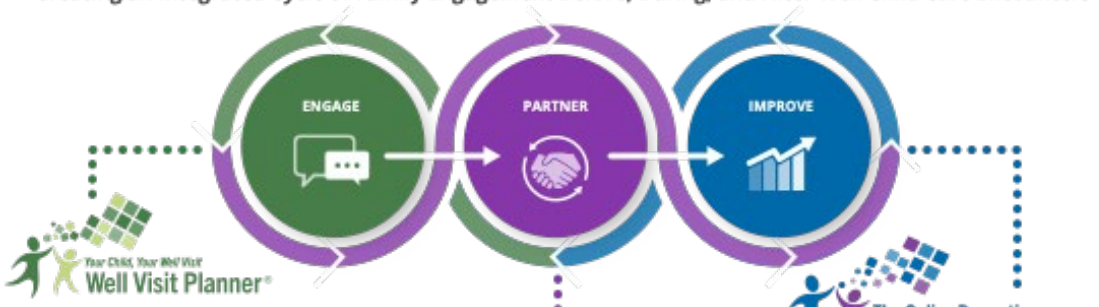
The Early Childhood Cycle of Engagement Model and Tools –Your Families, Your Partners

Prioritizing Possibilities for Child and Family Well-Being Using Family-Centered Data and Tools

The Early Childhood Cycle of Engagement (EC_COE) builds the capacity of families, communities, and pediatric primary care teams to partner in the joyful work of promoting the well-being of all children. Currently available for children from the first week of life through age six, the EC_COE's online, guideline-based and family-driven ***Well Visit Planner® (WVP)*** and post visit ***Promoting Healthy Development Survey (PHDS)*** quality assessment give voice to families and help child and family care teams:

1. ***Integrate and streamline*** family-reported screening and priority setting
2. ***Prepare for and optimize time*** during visits to focus on the family's agenda
3. ***Focus on building strengths*** and coordinating resources and supports
4. ***Continuously improve*** in partnership with families and communities
5. ***Track population-level*** needs, priorities, and quality of care

Creating an Integrated Cycle of Family Engagement Before, During, and After Well Child Care Encounters



Personalize Care Using the Family Driven Well Visit Planner (WVP)

What is it?

- **Brief**: A 10-minute web-based tool where families share strengths; complete developmental, psychosocial screens; pick priorities for support/education; note concerns; & learn. Mobile optimized.
- **Transparent & Secure**: Providers receive Clinical Summaries with results and resources for families.
- **Supported**: Family-owned accounts store child Visit Guides & support use for multiple children. Customized provider accounts offer access to Well Visit Guides, Clinical Summaries and resources to support implementation.

Optimize Time Spent During Encounters

- **Focus:** Use the at-a-glance Well Visit Planner child Visit Guides and your Clinical Summary report to prepare for and make the best use of time during encounters.
- **Your Well-Being:** Increase your joy in work by using time freed up to deepen your connection with your patients and rest knowing you met their priorities, celebrated strengths, addressed risks, and linked families to needed supports.

Measure & Improve Using the Promoting Healthy Development Survey (PHDS)

What is it?

- **Meaningful**: A family-completed survey yields 8 meaningful quality indicators aligned with Bright Futures guidelines.
- **Flexible**: Use on an ongoing or periodic basis based on your needs.
- **Confidential**: Generate your own confidential, aggregate quality report after each of 25 completions.
- **Shared**: Families receive a personalized report with resources to partner in improving care.

Studies to date have demonstrated acceptability, feasibility, improvements in screening and quality, and reductions in urgent care.

Over 92% of providers and families recommend the Well Visit Planner.

What users have to say about the Well Visit Planner:

Providers: "The Well Visit Planner enriches and reinforces what we do as providers... We didn't have to ask as many questions .. If you want to provide comprehensive, guideline-based care that is personalized to each child and family, you have to use the Well Visit Planner!"

Families: "I liked it! Using the Well Visit Planner was fast, helped me plan my child's visit and identify questions. During the well visit the providers were prepared to focus on my child and family."

Learn More!

- **Sign up** to join a live demonstration.
- **Learn** more about the Well Visit Planner content and benefits.
- **View** a short video.

Try It Out!

Register to get a free, customized, and secure Cycle of Engagement (COE) account and dashboard. From here you can:

1. **Customize the Well Visit Planner** to use with the children and families you serve and use your use portal to access Well Visit Guides, Clinical Summaries and resources
2. **Customized the Online Promoting Healthy Development Survey** and use your use portal to get aggregate reports on quality and resources to improve care

Get Help!

Please email us at info@cahmi.org for more information or questions. We aim to partner to continuously improve and look forward to hearing from you!

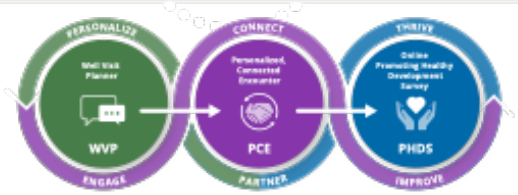
B. Page 1 of Contents and Benefits Summary

Well Visit Planner® and Promoting Healthy Development Survey:

Summary of content, reports, implementation and alignment with screening and quality of care standards

CAHMI's Early Childhood Cycle of Engagement
The Child & Adolescent Health Measurement Initiative

The **CAHMI's Early Childhood Cycle of Engagement** ***Well Visit Planner (WVP)*** and ***Promoting Healthy Development Survey (PHDS)*** family completed tools include valid content aligned with national standards of care. Actionable reports for families and child health professionals are generated to help you meet recommended standards of care based on Bright Futures Guidelines and to improve aspects of care aligned with performance measures used to evaluate quality of care.



Family Tools and Reports

Provider and Care Team Dashboards and Reports

Topics Assessed Using the Well Visit Planner (WVP)

The Well Visit Planner® is a brief family-completed, pre-visit planning tool anchored to Bright Futures guidelines for all 15 well visits recommended from a child's first week to sixth year of life.

CORE CONTENT

- Tailored for 15 recommended visits based on *Bright Futures* guidelines (first week to 6th year of life)
- English and Spanish
- Mobile optimized
- Not all content applies for all ages

1. Child and parent/caregiver **strengths** (what is going well)
2. Open ended questions about family/parent specific goals and concerns for the well visit
3. Developmental **surveillance and standardized developmental screening** using the Survey of Well-Being of Young Children **(SWYC)**
4. **Autism spectrum disorder screening** using the Modified Checklist for Autism in Toddlers, Revised **(M-CHAT-R™)** for 18-and 24-month visits
5. Caregiver concerns about speaking, vision, hearing
6. Open ended question on any additional concerns about child's development or health.
7. Caregiver **depression** using the Patient Health Questionnaire-2 (PHQ-2) or Edinburgh Postnatal Depression Scale (EPDS) (based on child's age)
8. Family **psychosocial issues** (e.g., meeting basic needs, alcohol and substance use, smoking, emotional support, parent/caregiver coping, experiences of racial discrimination, etc.)
9. **Intimate partner violence** using the Women Abuse Screening Tool-Short **(WAST-Short)**
10. **Anticipatory guidance and parental education** prioritization checklists and provision of family-centered topic by topic Family Resource Sheets (can pick up to five; average selected=3)
11. **Other general health information recommended in guidelines** (age-specific; nutrition, medications, vitamins/herbs, special health care need)
12. Other family health history and updates (heart, stroke, blood pressure, new problems, recent changes or stressors)

Other context and environmental assessments (e.g., living situation, lead, fluoride)

OTHER ASSESSMENTS AND TOPICS THAT CAN BE ADDED

- Short **Child Flourishing Index (CFI)**
- Short **Family Resilience Index (FRI)**
- Short Parent-Child **Emotional Connection** Items
- Short **Protective Family Routines and Habits (PFRH)**
- **Pediatric ACEs and Related Life-events Screener (PEARLS)**
- **Other social-emotional screening** (Baby Pediatric Symptom Checklist (BPSC) and Preschool Pediatric Symptom Checklist (PPSC)).
- **Other social determinants topics.** SEEK coming soon as core.
- **Interconception Care** (ICC)

Other assessments can be added by you during customization of your WVP.

Aspects of Quality Assessed Using the Promoting Healthy Development Survey

The Online PHDS is a valid family-reported, post-visit assessment of quality of care for families of children 3 months to 6 years.

QUALITY OF CARE MEASURES

- **Anticipatory guidance and parental education** needs are met
- Recommended developmental **surveillance** and standardized **developmental screening** occurs
- **Follow up occurs** for children at risk for developmental problems (using PEDS)
- Basic **psychosocial screening occurs**
- Surveillance of caregiver **mental health conducted**
- **Family concerns** about child development are addressed
- Surveillance about problems/issues in the **community** occurs and resources provided
- **Core medical home criteria are met** (e.g., personal doctor or nurse; access to and coordination of care, family centered care)

Quality measures are stratified by child/family demographics, caregiver mental health, child developmental status and having a special health care need (CSHSCN Screener).

OPTIONAL CONTENT

- Caregiver interest in telemedicine and concerns/barriers to telemedicine
- Impact of COVID-19 on child's well visits and daily life
- Feedback on the use of the Well Visit Planner (if using this tool)

Additional assessments will be added as we discern their need by EC_COE users.

C. Well Visit Planner 1-Pager for Providers

Use **The Well Visit Planner®** to improve care in your practice

Your Child, Your Well Visit
Well Visit Planner®
The Child & Adolescent Health Measurement Initiative

The Well Visit Planner® is a brief, family completed online pre-visit planning tool carefully aligned with national Bright Futures guidelines for children from the first week of life through six years of age.

"From a provider point of view, it was beneficial because we didn't miss a screen, we knew we met family priorities and were keyed into things that the families might not have otherwise shared."

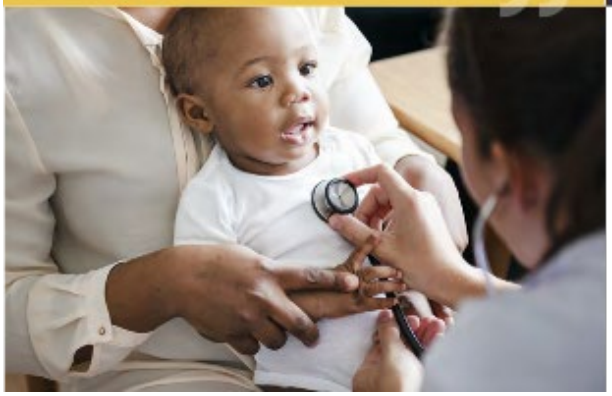
What The Well Visit Planner® **does**:

- ✔ Families reflect, learn, identify goals, complete assessments and choose priorities before their child's visit—it only takes about 10 minutes! They can even complete it while in the waiting room on their smartphone.
- ✔ Families receive a guide to help them navigate their visit to maximize their child's care
- ✔ Clinicians receive an at-a-glance summary of family priorities, children's strengths, concerns and needs with links to resources to share with families and support care
- ✔ Streamlines the visit and builds trust between you and your patients and families

The Well Visit Planner® is incredibly **easy to use**:

- You can register and start using it on day one!
- Add additional screening tools and resources to share with and the families you serve
- Registration is easy and free for early adopter innovative health practices. Contact us at *info@cycleofengagement.org*.

"**I liked it!** Using the Well Visit Planner was fast, helped me plan my child's visit and identify questions. **During the well visit the providers were prepared to focus on my child and family."** [Parent]



The WVP was designed and validated by the **Child and Adolescent Health Measurement Initiative** (2008-2016) and is available for free as we scale use across innovative pediatric health practices.

D. Example Clinical Summary to Show Providers

Date of Well Visit: No response • **Date WVP Completed:** 2/4/2023 • **Birth Month & Year:** 7/2021

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

Well Visit Planner®

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

Child Development

Developmental Surveillance and Screening

☐ **Developmental Screening SWYC milestones score[1]:** 12 (Results from 18 Month SWYC: met age expectations); score may or may not indicate a delay. Clinical review with family needed.

Very Much
- Kicks a ball
- Names at least 5 body parts - like nose, hand, or tummy
- Names at least 5 familiar objects - like ball or milk
- Runs
- Walks up stairs with help

Somewhat
- Climbs up a ladder at the playground
- Uses words like "me" or "mine"

Not Yet
- Jumps off the ground with two feet
- Puts 2 or more words together - like "more water" or "go outside"
- Uses words to ask for help

☑ **Autism spectrum disorder screen (M-CHAT R/F):** 4 (Moderate risk);

Administer M-CHAT Follow-Up for specific responses
- Child does not like climbing on things
- Child does not show caregiver things just to share
- Child does not try to get caregiver to watch them
- Child gets upset by everyday noises

☑ **Caregiver reports completing standardized developmental, behavioral screening:** No
☑ **Caregiver's overall level of concern about child's development, learning, behavior:** A little
☐ **Hearing concerns:** No
☑ **Speaking concerns:** Yes
☐ **Lazy or crossed eyes:** No
☐ **Bowel movements/urination concerns:** No

Health Behaviors

☐ **Smoking**
☐ **Flag for potential alcohol misuse**
☐ **Recreational/non-prescription drug use**

Relational Health Risks

☐ **Intimate partner violence risk[2]**
- Caregiver and partner work out arguments with some difficulty

Social Factors/Determinants

☑ **Economic Hardship:** Somewhat/very often hard to cover costs of basic needs, like food or housing
☐ **Positive impact of COVID-19 on child:** A little
☑ **Negative impact of COVID-19 on child:** Somewhat
☑ **Impact of Covid-19 on family's well-being:** More stress

Caregiver Emotional Health

☐ **Depression risk: PHQ-2[4] Score: 1:** Down, depressed, or hopeless several days over the past 2 weeks
☑ **Caregiver social support:** Does not have at least one person they trust and can go to with personal difficulties
☑ **Caregiver self care/hobbies:** Has not spent time in last 2 weeks doing things they enjoy
☑ **Caregiver coping:** Not Very Well

Other assessments added by provider:

Preschool Pediatric Symptom Checklist (PPSC): no/low risk
Safe Environment for Every Child (SEEK) : At-risk
PEARLS ACEs score[3]: 2
PEARLS Toxic Stress Risk Factor score[3]: 1
Child flourishing: At Risk
Family resilience: Caregiver did not respond
Parent-child connection: No/Low Risk

See details on 2nd page

Additional caregiver/parent goals and/or concerns to address during the visit:
Finding a pre-school

About This Child

Name: Example Child **Initials** (F M L): EC
Special Keyword: Example WVP
WVP completed by: Mother
Gender: Female
Insurance coverage/type: Private or Employment-based
Interested in telemedicine visits: No
Concerns about telemedicine to address: Losing a sense of connection, respect and warmth with provider

General Health and Updates

Child's Health and Health History

☐ **Child has ongoing health problem requiring above routine services (CSHCN screener[5])**
☑ **New medications:** Amoxicillin
☐ **Currently taking vitamins/herbal supplements**
☑ **Dentist:** Currently no dentist
☐ **Fluoride**
☐ **Lead exposure**

Family History and Updates

Lives with both parents: No
☑ **Recent family changes (e.g. move, job change, separation, divorce, death in the family):** Job change
☑ **New medical problem in family**
☐ **Parent/grandparent had stroke or heart problem before age 55**
☐ **Parent has elevated blood cholesterol**

Strengths to Celebrate!
Connect & Celebrate

One thing that is going well for the caregiver as a caregiver:
Finding time to do chores while girls nap or play together

One thing the child can do that caregiver is excited about:
Communicating with us and her sister more every day!

Child Flourishing
Details on 2nd page

Parent-child connection
Details on 2nd page

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. Making sure you have somewhere or someone to turn to for emotional support
2. Sibling rivalry
3. Ways to read to your child that promote his language development
4. What to do if your child swallows poison and when to call the poison control center

[1]SWYC Milestones: The developmental screening instrument of the Survey of Well-Being of Young Children (SWYC), which meets American Academy of Pediatrics' developmental screening guidelines [2]Intimate partner violence risk assessed using the Woman Abuse Screening Tool-Short (WAST-Short), a two-question abuse screening tool [3]The 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 [4]Caregiver depression risk is assessed using the Patient Health Questionnaire-2 (PHQ-2) for the 9 month well visit and beyond [5]TThe 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

Additional pages of clinical summary share resources based on family priorities and risks.