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Issue Brief

Iowa's 1st Five Initiative: Improving Early Childhood Developmental Services Through Public-Private Partnerships

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ABSTRACT: The Iowa Department of Public Health's 1st Five Healthy Mental Development Initiative is bridging public and private health care systems to improve early detection of social-emotional delays and prevention of mental health problems among young children and their families. Key features of the 1st Five model include: user-friendly mental and developmental health screening and referral forms; ongoing education and support for medical office staff on healthy development and use of screening and referral tools; specially trained care coordinators to identify and address a wide range of children's and families' needs; relationships with community resources that provide early intervention; and timely notification of outcomes to the referring physician offices. With an evaluation under way, early 1st Five experience indicates that families identified through the program have a range of unmet needs: each physician referral results in an average of three to five follow-up referrals for services.

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THE ISSUE

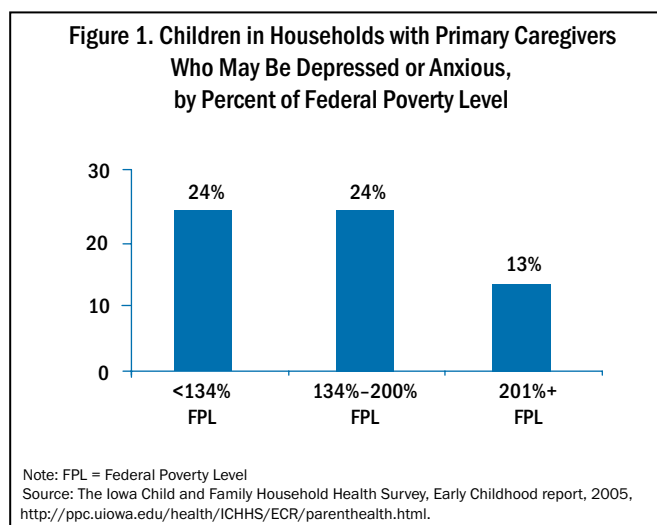
There is overwhelming evidence that early childhood experiences strongly influence children's future health and development. As such, Iowa is developing strategies to improve healthy mental development among young children. Through The Commonwealth Fund's Assuring Better Child Health and Development (ABCD) II project, a coalition of public and private partners in Iowa identified and tested strategies for improving the screening and surveillance used by pediatric providers.¹ As a result of these efforts, public health and child development experts have recommended that the state engage in policy and system changes

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that emphasize mental health promotion, prevention, and treatment for young children and their families. Key elements involve ensuring that primary care providers systematically screen for social and emotional health risk factors and make appropriate and timely referrals for further assessment and coordinated, follow-up care when needed.

While pediatricians and family practitioners have contact with most children during their first five years of life, these providers often do not recognize risk factors related to developmental issues, including parental stress or depression, which can have an impact on children's mental health and emotional and social development. Nearly one-quarter of lower-income children in Iowa have caregivers who may experience depression or anxiety (Figure 1).



Less than half of Iowa children ages 0 to 1 enrolled in Medicaid receive basic developmental screening, and less than 30 percent of children ages 1 to 2 years receive it.² Pediatricians and other primary care providers may also be unaware of available community resources or may find the process of referring patients to public health agencies and providing follow-up too cumbersome or beyond their staff's capacity.

"Data from our state's early intervention program have consistently reflected a lower than expected referral rate for the birth to 3 population," said Jane Borst, chief of the Bureau of Family Health, Iowa Department of Public Health.

IOWA'S 1ST FIVE INITIATIVE

About the Program

The 1st Five Healthy Mental Development Initiative is intended to design, test, and identify best practices for enhancing health care providers' mental health screening and referrals for all young children and their families, and ensure effective coordination of assessment, intervention, follow-up, and communication back to the primary care practitioners.

The key elements of 1st Five approach are:³

1. The primary care practice enhances well-child exams to assess social and emotional developmental skills, autism, and family risk factors including caregiver stress and depression.
2. If a problem is identified, the provider makes a referral to a care coordinator at a community-based child health center designated by the state as a 1st Five lead agency.
3. The care coordinator links the child and family to intervention services.
4. The care coordinator follows up with the provider regarding the status of the referral.

Target Population

1st Five targets all young children ages 0 to 5 years and their families, with a goal of universal surveillance and screening. Within that broad group, the program particularly targets families for which a "low level" of intervention—for instance, to address parental stress or early signs of child emotional disorder—can help deter a smaller problem from developing into a major crisis. These families often have problems that go undetected and ignored.

How It Works

The 1st Five system is intended to bridge the public and private systems of care. The primary care provider screens children and their caregivers when they come for well-child or other visits. Using a one-page, age-specific form ([Appendix 1](#)) that combines surveillance

and screening standards, the provider assesses developmental milestones, family stress, and possible caregiver depression.⁴ In addition to observing the behavior of the child, a nurse or physician may ask the child's parent or caregiver questions. The provider may also choose to have the parent or caregiver fill out the form.

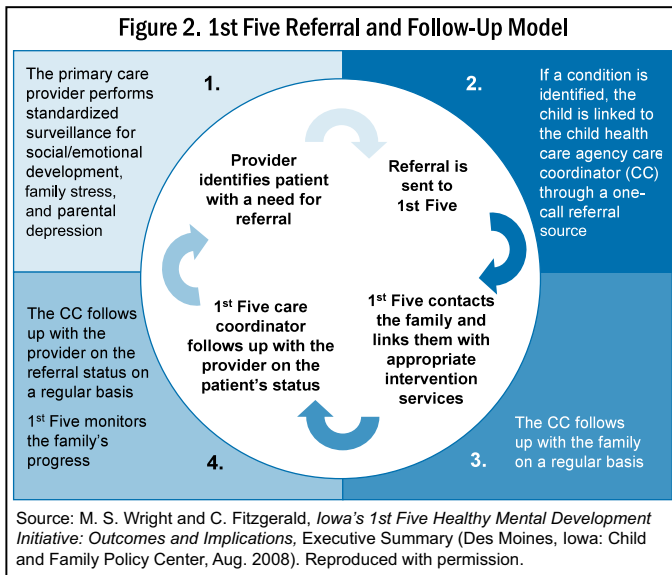
When a concern is identified, the physician or clinic staff member sends the form to a designated 1st Five Child Health Center. A care coordinator from the Center contacts the family—generally within 24 hours—and further assesses the family's needs, often discovering concerns in addition to the primary need identified in the referral. Assessments generally take place over the telephone, although a home visit may be made when necessary. The care coordinator helps to link the family to appropriate services in the community and informs the referring physician of the status. The timing and method of this feedback loop is according to the physician's preference. For example, practices may request notification through fax or by telephone; some prefer status updates once a week, while others prefer monthly updates (Figure 2).

bid process, the Iowa Department of Public Health selected four community-based child health centers as lead agencies for the 1st Five demonstration, and three other agencies received community planning grants.

All the agencies are Title V Maternal and Child Health organizations, with care coordinators who generally work with children covered under Medicaid or the State Children's Health Insurance Program (SCHIP), as well as uninsured children, to arrange Early Periodic Screening, Diagnosis, and Treatment (EPSDT) and other services.⁵ Designation as a 1st Five Child Health Center expands the care coordinators' roles to integrate the principles of children's healthy mental development into their work.⁶ It also expands their client base to include all children referred by participating medical practices, including those with commercial insurance. The 1st Five agencies include visiting nurse agencies and county health departments.

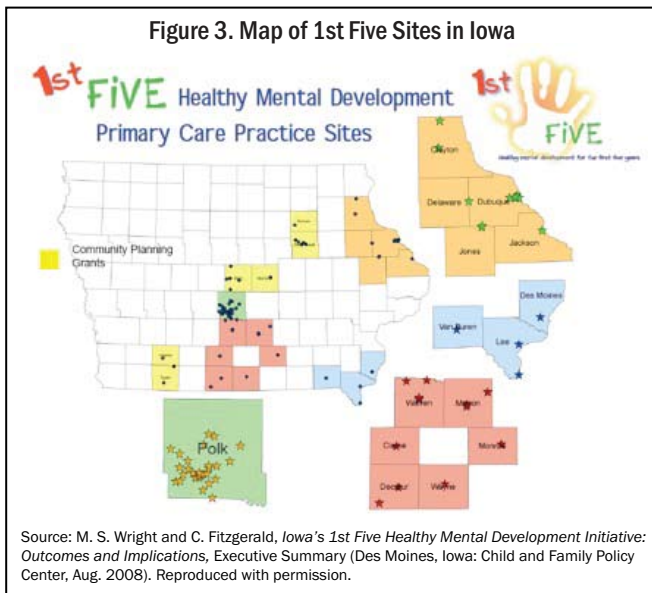
Implementation strategies began among three agencies in September 2006 in Clayton, Dubuque, Jackson, Lee, Van Buren and Polk counties. The agencies immediately began building and strengthening relationships with medical practices and community organizations.

During the first year, nearly 30 medical practices expressed interest in participating in 1st Five, resulting in enhanced developmental screening for an estimated 22,000 children ages 0–5. An additional 35 medical practices within the agencies' service areas were brought on board during the second year, and a fourth implementation site was selected early in that year. Three other Title V Child Health Centers covering five counties in central, southwest, and northeast Iowa received community planning grants, and as of August 2008, two of these sites had begun 1st Five provider recruitment activities and engaged four physician practices (Table 1). 1st Five activities now span 21 counties (Figure 3). Some practices decided to implement the 1st Five process throughout their entire clinics, while others are phasing it in by starting with one or two physicians or nurse practitioners.



Program Development and Implementation

In 2006, the Iowa legislature allocated funding for the 1st Five demonstration project, which grew out of the ABCD II program (2004–2006). Through a request for



The lead agencies for the participating sites, each with a 1st Five project coordinator, work closely with private health care providers, local community-based agencies, and referral resources to introduce and implement the enhanced screening, referral, and follow-up process. The partners participate in adapting the 1st Five approach to their specific communities.

Engaging and Educating the Medical Community

Recruiting and retaining medical practices for 1st Five involves hands-on outreach, education, and on-going support and encouragement. The first challenge is to engage primary care physicians and their staff. Project coordinators report that it is critical to identify both physician and staff “champions” in each medical practice—individuals who are enthusiastic about the model and willing to encourage their colleagues to participate and comply. They must help address resistance by staff members who see participation in 1st Five as an added burden to their workload.

The 1st Five model involves integrating a broader view of health into traditional medical practice. “This often requires a change in mindset about how health care practitioners do well-child exams,” says Sonni Vierling, 1st Five state coordinator.

The project coordinator works with each participating medical practice—including private multi-physician practices, hospital clinics, and county health

departments—to develop and implement a streamlined referral and follow-up process. This includes teaching practitioners about healthy social and emotional development, refining the screening tool or referral form to fit the practice’s need, training staff to use the tool and ask sensitive questions appropriately, and establishing timing and mechanisms for informing the practice of the family’s status.⁷

1st Five coordinators report that input from medical staff has been critical for buy-in. But even once a medical practice is officially on board, ongoing communication and encouragement are needed to maintain compliance. The project coordinator calls, e-mails, or visits participating practices on a regular basis (ranging from three times per week to every two weeks), attends nurses’ meetings, and talks with front-office staff. Doing so allows the coordinator to continually check in to build and maintain relationships and to assess whether providers are fully implementing the 1st Five process.

The project’s consultant, Mary Larew, M.D., plays a key role in helping physicians review their current well-child assessments and plan strategies for practice changes. The physician consultant provides direct technical assistance, especially in addressing barriers to change and linking practices with medical education resources available through the University of Iowa Center for Disabilities and Development.

Building Local Referral Capacity

The four lead agencies must identify and remain up-to-date on referral resources in their communities. The Lee County project coordinator, for example, has created and regularly updates a resource notebook, which she distributes to community providers. The Polk County Child Health Center, which covers Des Moines and adjacent areas, developed and updates a Web-based resource directory for that region. The resources include community providers of mental health services, as well as services related to child care, nutrition, housing assistance, transportation, and others needs. The care coordinators work closely with the families to find and access services.

In addition, 1st Five agencies coordinate and partner with a range of community, state, and federal initiatives, including Iowa's Healthy Mental Development Health Provider Education Initiative, Medical Home Initiative, Early ACCESS, Community Empowerment, Child Health Specialty Clinics, Head Start, the juvenile court system, the state's foster care system, child care providers, and local social service agencies.⁸ Site coordinators participate in community advisory teams that identify local resources and service barriers, and raise awareness of healthy mental development.

Professional Development

1st Five project coordinators undergo intensive training, hold monthly conference calls, and meet with the 1st Five state coordinator on a quarterly basis to share their experiences, challenges, and successes. At a conference in spring 2007, they presented best practices to Title 5 agency care coordinators. In addition, each site's project coordinator, care coordinators, and medical practice staff meet as needed to discuss the basic 1st Five framework and address questions and problems (e.g., lower than expected number of referrals) that arise.

Financing and Sustainability

In fiscal year 2006, the Iowa legislature appropriated \$325,000 in Healthy Mental Development Funds each year for three years. The 2007 General Assembly added \$200,000 using the state's Health Care Trust Fund (financed by a tobacco tax) to extend the program to

additional communities in year 2. Continuing funding for existing sites will allow further development of the program and expansion to additional physician practices. However, the current funding level is inadequate to extend the initiative statewide. Program administrators are exploring options for maintaining and expanding funding beyond year 3.

Once referrals are made by a physician, 1st Five care coordination for Medicaid beneficiaries—the majority of referrals—are reimbursed as a covered EPSDT service. Because private commercial insurance does not reimburse for care coordination, 1st Five covers these costs. For uninsured children, Title V funds help to cover these services. There is concern among 1st Five administrators that new Medicaid billing code definitions may affect the availability of federal funding for care coordination services. Interim final rules recently issued by the Centers for Medicare and Medicaid (CMS) provide definitions for targeted case management that differ from previous interpretations. The new definitions are not as easily applicable to preventive health services for children typically served by the 1st Five program. These new CMS rules will require changes in the business relationship with the state's Medicaid program. Medicaid officials in the state recognize, however, that the 1st Five program's care coordination services as necessary and proper for the efficient use of Medicaid funds and are actively working to establish formal agreements that will continue to support appropriate care coordination services.

Impact on Child and Family: Example #1

A new mother was screened at the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) for parental depression and referred for follow-up. She said, "Being told I was depressed helped in so many ways. It meant I could tell other people when they asked how I was. I was amazed how many people said they had had it themselves. Before, I couldn't tell anyone, I just pretended I was fine. I thought no one would understand. But everyone seemed to have a story about someone they had known who was depressed. If everyone was more open about it, people could help each other more." This mother is linked to services and is doing well. She continues to be followed by the Visiting Nurse Association (VNA)/Maternal and Child Health program on an ongoing basis.

Source: Dubuque VNA, 1st Five Healthy Mental Development Initiative.

RESULTS AND NEXT STEPS

According to a forthcoming report by the Child and Family Policy Center, an Iowa organization that conducts research, facilitates forums, and provides technical assistance to state and community policymakers on vital children's issues, primary care practices participating in the 1st Five initiative referred 486 young children, as of June 2008. These referrals were based on the following concerns:⁹

- 66 percent were related to family stress, including difficulty locating community resources, family and parenting issues;
- 22 percent were based on child development concerns;
- 6 percent were based on social and emotional development, primarily behavioral issues; and
- 6 percent were related to caregiver depression and other mental health issues.

1st Five care coordinators subsequently made more than 1,575 referrals to services for those children

and families. Thus on average, three to four service needs were identified for each child referred by the primary care provider. The 1st Five initiative is scheduled to expand over the next year, both in terms of increased referrals among participating practices, and adding new practices. In state fiscal year 2008, 39 practices serving 41,000 children are participating in the 1st Five initiative. Program administrators expect that in fiscal year 2009, 80 medical practices serving about 74,445 children will be participating in 1st Five.

The impact of 1st Five has reached beyond the participating practices. Because of recruitment and consultation activities in Polk County in the past year, all 120 Iowa Health Systems clinics and 14 partner hospitals in Iowa that see children now have social, emotional, and family risk questions as part of assessments that are embedded into their electronic medical records. In addition to expanding 1st Five practices, the program will focus on coordinating training and technical assistance opportunities within the Iowa Health Systems' regional clinic structure to build on this recent system improvement.

Impact on Child and Family: Example #2

"Virginia" gained custody of her six grandchildren after they were removed from the care of a drug-addicted parent. The children, ranging in age from 19 days to 8 years, were moved to Virginia's home where she also cared for her mother and uncle. The children suffered from a variety of behavioral and mental health issues that required extra attention. During one of the children's well-child exams, the pediatrician asked about her grandchild's social-emotional development and asked if Virginia had been experiencing any potential depression and family stress in her new caregiver role. This opened the door for Virginia to share her feelings of stress and anxiety, and of feeling down.

The pediatrician referred Virginia to the local 1st Five care coordinator because of her caregiver depression and family stress. The care coordinator arranged to meet with her and together they identified a variety of concerns underlying her stress and depression. The care coordinator linked Virginia to 16 community-based resources to begin addressing these concerns, ranging from Early ACCESS and WIC, to section 8 housing, a local food pantry, a home visiting program, and an outpatient counseling program for both her and her grandchildren. Thanks to the pediatrician who questioned her about stress and depression, and to the 1st Five care coordinator who linked her to community-based resources, Virginia and her grandchildren now have numerous supports in place and a better chance for success.

Source: M. S. Wright and C. Fitzgerald, *Iowa's 1st Five Healthy Mental Development Initiative: Outcomes and Implications*, Executive Summary (Des Moines, Iowa: Child and Family Policy Center, Aug. 2008).

LESSONS LEARNED

The Child and Family Health Policy Center is conducting an ongoing, independent evaluation of 1st Five. The evaluators contact each 1st Five site monthly to assess the program's progress, barriers, and challenges.

Based on 1st Five's early experience, the evaluators prepared a set of recommendations that emphasize leadership in implementing the 1st Five model. The recommendations include the following requirements for community-based coordinators:

- Must be knowledgeable about early child development, and understand the culture of medical practices;
- Must balance accountability for making progress and meeting deadlines with flexibility to make adjustments as needed;
- Must track community services and resources on an ongoing basis, as the coordinators are viewed as the “clearinghouse” for timely and appropriate referrals;
- Must gain the trust of physicians and staff, community service providers, families, and other stakeholders.

(A complete list of these recommendations are available in [Appendix 2](#).)

Based on interviews with program planners, staff, and evaluators, lessons learned during the early experience of the 1st Five Initiative include:

- A partnership between public and private health systems must begin at the community level, and involve medical practitioners, public health care coordinators, service providers who receive referrals, and potential local funding sources.
- One challenge is making sure key players understand the model and helping primary care providers and their staff expand their view of health. Parental stress and depression in particular are beyond many providers' traditional

medical purview. Medical provider education can play a key role in providing critical information about healthy mental development and a framework for making the changes needed to enhance screening and referrals.

- On an anecdotal basis, many participating physicians seem to appreciate the 1st Five model, noting that the standardized screening and referral process saves time, catches problems early, and reassures them that difficult family situations are being addressed. 1st Five administrators noticed that some participating physicians are not making referrals. These physicians did not understand how to use the forms or the screening or referral protocols were stuck in committee processes, especially in larger practices. 1st Five has a physician consultant to help work with participating physicians.
- While finding a physician champion is essential, most physicians are too busy to track details of implementation. It is usually necessary to find a nurse or office manager to follow through with office protocol changes. Ongoing support and encouragement by 1st Five staff are critical for integrating the screening and referral process into daily routine.
- Each physician referral results in an average of three to four follow-up referrals for services, indicating that most families identified through 1st Five have a range of unmet needs.
- The adequacy of resources varies considerably across communities, but one common gap is in treatment for parental depression. Other resource gaps noted include early intervention and other services for children ages 3 to 4, services for families without residency documentation, treatment for children exposed to violence, and psychiatric services for young children.¹⁰ Service gaps are particularly severe in rural areas and for conditions that are less severe but may in the future lead to a crisis level or

diagnosable condition. This information is being collected and will be presented to the legislature so public policy may help target resources.

- 1st Five coordinators find the regular communication and sharing of experiences very valuable, even though the sites often serve different types of populations and have different resources available.

CONCLUSION:

PROMISE FOR IMPROVING CARE

The early experience in Iowa indicates that there are substantial opportunities to improve early detection of social-emotional delays and problems and prevention of mental health problems by strengthening the connection between physicians and the public health system and providing comprehensive care coordination. This requires building relationships and changing mindsets and practices at the community and clinic level. It requires modest funding and does not happen overnight.

An ongoing evaluation of the 1st Five initiative will yield important evidence about the benefits and challenges of this approach. If early indications are borne out, adoption and replication in other communities and states may be warranted. The Iowa model itself is adapted from similar programs in North Carolina and Connecticut.

The model can be a “win-win-win” situation. It can provide overburdened primary care physicians

and their staff with the knowledge and tools to identify at-risk patients and make easy, fast referrals, with the assurance that they will be informed of the outcomes. It can also allow the public health system to better perform its surveillance and early intervention functions. Finally, it can provide critical treatment and relief to young children and their families, alleviating or avoiding exacerbation of early developmental problems and other family crises and enhancing the likelihood of a healthy, productive future.

FOR MORE INFORMATION

Contacts: Sonni Vierling, State Coordinator for 1st Five Healthy Mental Development Initiative, Iowa Department of Public Health, svierlin@idph.state.ia.us or (515) 281-3108; or Jane Borst, Bureau Chief, Bureau of Family Health, Iowa Department of Public Health, jborst@idph.state.ia.us or (515) 281-4911

Resources: <http://www.state.ia.us/earlychildhood/docs/1stFiveAccomplishments6.07.pdf>

Also see: *Iowa’s 1st Five Healthy Mental Development Initiative Outcomes, Lessons Learned & Implications*, Prepared by Michelle Stover Wright, Senior Research Associate and Carrie Fitzgerald, Senior Health Policy Associate, Child and Family Policy Center. Forthcoming on www.idph.state.ia.us.

NOTES

- ¹ Supported by the National Academy for State Health Policy and The Commonwealth Fund.
- ² Iowa Department of Public Health, “Healthy Mental Development Accomplishments” Fact Sheet, (Des Moines, Iowa, 2007), <http://www.state.ia.us/earlychildhood/docs/1stFiveAccomplishments6.07.pdf>.
- ³ Iowa Department of Public Health, Bureau of Family Health.
- ⁴ Iowa EPSDT Care for Kids Provider Resource Web Site, “Child Health and Development Record Forms” (Des Moines, Iowa, 2006–2008), <http://www.iowaepsdt.org/ScreeningResources/CHDR.htm>.
- ⁵ Through a partnership between the Iowa Department of Public Health and Medicaid, about 22 agencies serving Iowa’s 99 counties are selected as Title V child health screening centers through a competitive bid process every five years. With state, local, and federal funding from a Maternal and Child Health Block Grant, as well as Medicaid reimbursement for covered services, these agencies coordinate screening and referrals for Early Periodic Screening, Diagnosis, and Treatment services (including periodic screening, vision, dental, and hearing services) and conduct public health training, nutrition, and other preventive health services and referrals.
- ⁶ While such screening and referral has long been an EPSDT requirement, this requirement is often not closely adhered to.
- ⁷ The lead agencies use variations of the state’s [Child Health and Development Record](#) (CHDR), which each clinic adopts or adapts for its practice. For example, some clinics that did not have a standard screening form adopted the CHDR in full, others incorporated the key components of CHDR into a form they previously used, and some are working toward putting the tool into electronic form.
- ⁸ Iowa’s Health Provider Education Initiative provides education and training to medical practitioners about healthy mental development, surveillance, screening, and referral development. The state’s Medical Home Initiative is a multi-agency collaborative effort to enroll children with chronic conditions and special health care needs into medical homes by 2010. Early ACCESS is a partnership among the Iowa Departments of Education, Public Health, and Human Services and the Child Health Specialty Clinics to identify, coordinate, and provide needed services and resources to Iowa’s infants and toddlers, from birth to age 3, and their families. Community Empowerment is a partnership between communities and Iowa state government. There are 58 Community Empowerment Areas representing Iowa’s 99 counties to promote early care, health, and education services for children, from before birth through age 5, and their families (<http://www.iowa.gov/educate/content/view/630/593/>). Child Health Specialty Clinics, located in 14 areas around Iowa, provide clinical services to children with chronic physical and mental health problems, including heart problems, diabetes, sickle-cell disease, bone and joint diseases, and behavior problems. It also helps families find and organize other local services (<http://www.uihealthcare.com/depts/med/pediatrics/divisions/childhealthspecialty.html>).
- ⁹ M. S. Wright and C. Fitzgerald, *Iowa’s 1st Five Healthy Mental Development Initiative: Outcomes and Implications*, Executive Summary (Des Moines, Iowa: Child and Family Policy Center, Aug 2008).
- ¹⁰ The Infants and Toddlers program is Part C of the Individuals with Disabilities Education Act, enacted by Congress in 1986. Under Part C, states may participate in a program that provides early intervention services and resource development for children ages 0 to 3 demonstrating delays in social and emotional development.

Table 1. 1st Five Designated Child Health Centers, August 2008

Region	Lead agency	County	Number of Participating Clinic Sites and Providers (e.g., M.D.s, nurse practitioners)
Central Iowa	Visiting Nurse Services	Polk County	15 clinics, 36 providers
	Mid Iowa Community Action	Marshall County Story County	2 clinics, NA 1 clinic, NA
Northeast Iowa	Visiting Nurses Association	Clayton County	2 clinics, 8 providers
		Dubuque County	6 clinics, 28 providers
Jackson County		1 clinic, 2 providers	
	Black Hawk Public Health Department	Black Hawk County	2 clinics, 36 providers
Southeast Iowa	Lee County Health Department	Lee County	3 clinics, 4 providers
		Van Buren County	1 clinic, 2 providers
Southwest Iowa	Taylor County Public Health	Taylor County	4 clinics, 18 providers
South Central Iowa	Marion County Public Health Department	Marion County	3 clinics, 27 providers
		Decatur County	1 clinic, 3 providers

Source: Iowa Department of Public Health, August 2008.

Appendix 1.



**18 Months
1st Five Screening & Referral**

Date _____ Age _____ Male Female
 Name _____
 Birth date _____ Patient # _____
 Address _____
 Phone Number _____
 SS# _____
 Name of Parents: _____
 Lives with: 1 parent 2 parents Other family Other _____
 May release information to: (parent, guardian, other family – list) _____

**Current complaints/
 concerns:** _____

DEVELOPMENTAL MILESTONES Additional screening or referral if concerns of “No” response on underlined milestones

Yes No

- Family/care provider concerns about speech, learning or motor skill? _____
- Behavior concerns? _____
- Concerns about loss of speech or social skills****
- May walk up steps
- Good eye contact*
- Interested in other children*
- Looks at object when someone points to it*
- Points to or shows objects to share interest*
- Says 3 or more besides mama, dada*
- Follows one step commands*
- Responds to his/her name*
- Imitates people*
- May point to pictures or body parts
- Stacks at least two blocks
- Uses cup
- May use spoon or fork
- Helps in house
- Walks well

* at risk for autism

SOCIAL HISTORY:

Stress: How much stress are you and your family under now?

- None
- Slight
- Moderate
- Severe

What kind of stress? Relationships Drugs Alcohol Violence/Abuse Lack of help Financial
 Health Insurance Child Care Other _____

How stressful is caring for your child?

- None
- Slight
- Moderate
- Severe

Parental/Caregiver Depression: In the past month, have you felt down, depressed or hopeless?

- No
- Sometimes
- Often

In the past month have you felt little interest or pleasure in doing things?

- No
- Sometimes
- Often

FAMILY HISTORY: Circle if present

Depression or other mental illness, substance use, abuse, learning problems, violence, heart disease, hypertension, diabetes, kidney disease, deafness, cancer, other (note): _____

REFERRAL INFORMATION: Please fax ATTN to 1st Five at VNS 288-0437 or call at EPSDT POOL line at 283-1422.

Referring Professional: _____

Referring Practice Name: _____ **Phone Number** _____

Release of Information

I give _____ permission to contact Visiting Nurse Services.

Signature _____ Date _____

Appendix 2.

Iowa's 1st Five Initiative Leadership wRecommendations Prepared by the Child and Family Policy Center

Specific Areas of Knowledge or Experience

For successful and timely implementation: the coordinator should have some early childhood experience regarding child development 0–5.

- The coordinator will be expected, from the project start, to be able to discuss appropriate screening protocols and tools and encourage “buy-in” to help doctors, staff and other stakeholders “get it.”
- Some experience or understanding regarding the culture of a medical practice is needed. They have to be able to successfully gain access and address underlying and ongoing concerns doctors and staff might have that could stop forward progress.

Assure Accountability and Forward Movement

Local coordination must include the ability to move the project ahead and hold others to deadlines and start dates while assuring accountability to the plans outlined in the grant application.

- There must also be some flexibility and ability by the coordinator and other local team members to change plans and strategies as needed.
- The project must be responsive to external factors in the community and at the state level.
- Most practices will require continuous education and support to successfully integrate screening and referrals into their every day work.

Responsiveness

The coordinator must show a consistent level of responsiveness throughout the process and with all the stakeholders including doctors and staff, state coordinators, evaluators, community representatives, and others.

- Timely referrals increase buy-in from the practices as the system rolls out and ongoing communication with other stakeholders is seen as a real strength among sites.
- Provide feedback and lessons learned to state and other 1st Five initiative site local coordinators as well as barriers to referrals and services in addition to overall initiative implementation.

Resources in the Community

There must be accurate and timely awareness of available services and relationships in the community in order to identify additional resources or potential referral sources.

- Collecting these services and resources is an ongoing and necessary part of the project. Good referrals can only be made and accomplished when the referral is to a viable, appropriate resource or program.
- The coordinator is often seen as a clearinghouse for barriers and issues that are uncovered during the referral process.

Time for Coordination

There must be support from the oversight organization at the local level, particularly within management.

- The provision of consistent and appropriate levels of time for project coordination and work is central to the implementation and ongoing success of this initiative.
- The coordinator becomes the face of the project and the primary advocate for this work in the area. The actual time commitment required will vary depending on the number of practices and other factors.

Promotion

Local sites must have some ability to promote and explain the importance of the project and be able to convey enthusiasm around what this will do for kids and families in the area.

- This type of passion is needed to not just bring practices on board but their staff, community planning organizations, funders, parents, legislators, community and state partners, and so on.

Relationship Building

A central part of the success of this project relies on the relationships already in place or the process of relationship building among all the stakeholders.

- The coordinator must gain the trust of the practices, community programs, families and others.
- The families must be comfortable partnering with the coordinator or the staff who will work through the process with them and share stories and successes as well as barriers and gaps in services or support.

ABOUT THE AUTHOR

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