WELL-CHILD VISITS
Playbook

March 2025

For questions, please contact us at hvcoiin@edc.org

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About This Document

Key Driver Diagram

The Key Driver Diagram displays a shared theory of how outcomes might improve based on information gathered from research, observation, and experience, and sets forth the collaborative's goal. The primary drivers represent key components of the system that need to be in place to achieve the goal.

Change Package

The Change Package includes a set of change ideas (specific actions, practices, and interventions that teams can test), example Plan-Do-Study-Act cycles from previous home visiting programs, and links to supportive resources.

Measurement System

The Measurement System details the shared aim and set of common process measures that teams will report during the collaborative. Data are graphed on run charts and shared with all participants to promote shared learning.

Key Driver Diagram

SMART Aim	Primary Driver (PD) *Critical system elements that are necessary and sufficient to achieve the aim*
By March 2026, 75% of children enrolled in home visiting receive their last expected well-child visit on time, based on the American Academy of Pediatrics schedule.	**PD1: Knowledgeable, supported workforce**
	PD2: Knowledgeable, supported caregivers
	PD3: Connections and communication

Change Package

PD1: Knowledgeable, supported workforce

Secondary Driver (SD)	Change Ideas	PDSA Examples	Resources
At hire, at start of CQI project, and at least annually	Provide training days on medical home, well-child visit timing, content, and value, and resources to support well-child visits	PD1.SD1.C1.Example 1.Training on WCV information PD1.SD1.C1. Example-2. Training for New Home Visitors PD1.SD1.C1.Example 3.Refresher training	AAP/Bright Futures Periodicity Schedule AAP Bright Futures Pocket Guide Bright Futures slides, Infant Visits: • BF_Infant_Priorities_Screens.pptx (live.com) • BF_EC_Priorities_Screens.pptx (live.com) Birth to Five: Watch Me Thrive! A Home Visitor's Guide for Developmental and Behavioral Screening Institute for the Advancement of Family Support Professionals webinars: • The Medical Home and Bright Futures Guidelines • Family Partnerships that Support Health and Mental Health WCV Self Efficacy Scale From Coverage to Care: A Roadmap to Better Care and a Healthier You – information about finding a provider, defining health terms, receiving services and following up on care. Motivational interviewing resources to support home visitors' conversations with families:
	Recruit local primary care provider to conduct Bright Futures training, including local context	PD1.SD1.C2.Example 1.PCP training	

			• What is Motivational Interviewing? • Motivational Interviewing Network of Trainers • Readiness Ruler • Motivational Interviewing Reminder Card
Before and after well-child visit appointments	Create and implement well-child visit tracking tools for home visitors	PD1.SD2.C1.Example 1.WCV interval tracking PD1.SD2.C1.Example 2.WCV window tracker	Optional WCV Registry created by HV CoIIN See PDSA examples for additional tracking tools created by LIAs. WCV E-Packet
	Standardize documentation alerts and reminders	PD1.SD2.C2.Example 1.WCV completion reminders	

PD2: Knowledgeable, supported caregivers

Secondary Driver (SD)	Change Ideas (for LIAs)	PDSA Examples	Resources
Before well-child visit appointments	Use evidence-informed materials or curriculum to guide education to families about medical home and timing, content, and value of well-child visits	PD2.SD1.C1.Example 1.Bright Futures materials PD2.SD1.C1.Example 2.Well Visit Planner	Bright Futures Parent Educational Handouts (available in multiple languages) The Child & Adolescent Health Measurement Initiative (CAHMI)'s Cycle of Engagement Well Visit Planner approach to care builds the capacity of families, communities, and pediatric primary care teams to partner in the work of promoting the wellbeing of all children. The Well Visit Planner is available in English and Spanish to support families and care teams in well-child visits from the first week of life through age 6: • One Big Doable Thing! webinar from Early Childhood Developmental Health Systems Evidence to Impact Center (presentation slides, recording, and key takeaways)
	Facilitate transportation (e.g., ride shares or bus vouchers) for	PD2.SD1.C2.Example 1.Uber Health transport	

	families to and from well-child visits		• Family-facing overview videos in English and Spanish, provider overview video • Well Visit Planner website for families • Cycle of Engagement Well Visit Planner website and account sign up for providers • 2-page overview of Well Visit Planner for family partners and professionals • Educational family resource sheets based on age appropriate topics for well visits • Example of a customizable family outreach flyer (more family engagement resources are available) • 2-page provider overview of Cycle of Engagement Well Visit Planner • Summary of content and benefits of the Well Visit Planner and Promoting Healthy Development Survey From AAP: • *The Well-Child Visit: Why Go and What to Expect* (English and Spanish) • *Team Up with Your Child's Doctor for the Best Care* (English and Spanish) CDC Milestones Moment Booklet Baby Checkups Guide CDC: Talking to Parents About Infant Vaccines and Questions Parents May Ask About Vaccines offer suggested prompts and responses Reasons to Follow CDC's Recommended Immunization Schedule YouTube Series from the AAP: For New Parents – The Complete Guide to Childhood Vaccinations Childhood Immunizations from the AAP: English and Spanish
	Connect families to linguistic resources to support well-child visits in their primary language	PD2.SD1.C3.Example 1.Planning for linguistic resources to support WCV	

			Available in Alabama: Born Ready Initiative provides developmentally appropriate messages and tips to parents Look for local transportation programs in your community (e.g., Kid One Transport in Alabama) Language access resources from Family Voices include flyers for families (all available in English and Spanish)
After well-child visit appointments	Develop standardized process for discussing well-child visit results with families	PD2.SD2.C1.Example 1.WCV follow up	Support families to engage in developmental promotion activities and connect to needed developmental services and supports (see HV CoIIN's Developmental Promotion, Early Detection, and Linkage to Services Playbook) Support families to incorporate recommendations from provider plans of care into goal setting (e.g., introducing solid foods, safe sleep practices) Healthy Steps Topical Caregiver Handouts (available in multiple languages) Bright Futures at Georgetown University Health Record: English and Spanish "Birth to 5: Watch Me Thrive" Screening Passport: English and Spanish
	Support families to use parent-held and maintained well-child visit and screening records	PD2.SD2.C2.Example 1.Developmental screening passport	

PD3: Connections and communication

Secondary Driver (SD)	Change Ideas (for LIAs)	PDSA Examples	Resources

When communicating between families, home visitors, and providers	Use standardized informed consent for sharing family authorized information between the primary care practice and home visiting program	PD3.SD1.C1.Example 1.Provider acknowledgment letter PD3.SD1.C1.Example 2.PCPs and releases	Pediatrician Provider Acknowledgement Care coordination form in English and Spanish Permission to obtain and release confidential information
	Partner with the primary care provider to support individual family needs through joint well-child visits, case conferences, and/or shared service plans	PD3.SD1.C2.Example 1.Joint case conference PD3.SD1.C2.Example 2.Joint WCV	Institute for the Advancement of Family Support Professionals webinar, *Confidentiality: The Bridge of Trust*, introduces federal confidentiality laws and their importance in building trusting and respectful relationships with families. From the National Resource Center for Patient/Family-Centered Medical Home: • Shared Plan of Care Center for Medical Home Improvement: *Extra-Ordinary Care: A Learning Guide for Families and Caregivers* From AAP: • Medical Home resources in English and Spanish • *Using a Team Approach to Support & Monitor Your Child's Development* (English and Spanish) • Shared Plan of Care The Child & Adolescent Health Measurement Initiative (CAHMI)'s CARE_PATH for Kids resources support families of children and youth with special health care needs to engage, plan, and improve care planning and outcomes in partnership with their child's care team(s). (short video explaining the model)
When building relationships	Conduct outreach to primary care practices to increase mutual	PD3.SD2.C1.Example 1.PCP outreach	AAP state chapter websites

between home visiting programs and primary care practices	understanding of the primary care practice and home visiting program		Sample Memorandum of Understanding The Transforming Pediatrics for Early Childhood Program (TPEC), funded by HRSA, is working to improve access to pediatric care that promotes early developmental health, school readiness, and child and family flourishing. Their interactive map shows what organizations near you are focused on systems building and pediatrics transformation. Visit medicaid.gov to find information on partnering with state Medicaid agencies to improve well-child visits in early childhood. Redesigning Primary Care Well-Child Visits: A Group Model, Page, C., Reid, A., Hoagland, E., & Leonard, S. B. (2010). WellBabies: Mothers' perspectives on an innovative model of group well-child care. Family Medicine, 42(3), 202–207.
	Expand partnerships with primary care providers and practices through a signed MOU and/or advisory board or council appointments	PD3.SD2.C2.Example 1.MOU with primary care practice PD3.SD2.C2.Example 2.Invite PCP to CQI meeting	

The Measurement System

SMART AIM: By March 2026, 75% of children enrolled in home visiting receive their last expected well-child visit on time, based on the American Academy of Pediatrics schedule.

PROCESS AIMS:

- For 90% of children due for a well-child visit, caregivers plan for the well-child visit with the home visitor.
- For 80% of children with a completed well-child visit, the home visitor has follow-up with the caregiver within 14 days.
- Increase by 20% children with a completed well-child visit for whom the home visitor and primary care team communicate within 30 days.

MEASURES:

Measure #1 (SMART Aim): % of children enrolled in home visiting who receive their last expected well-child visit on time, based on the American Academy of Pediatrics schedule [column E]

- *Numerator:* # of children due for a well-child visit in the reporting month who received a timely well-child visit [column D]
- *Denominator:* # of children due for a well-child visit in the reporting month [column C]

Measure #2 (Primary Driver 1): % of children due for a well-child visit whose caregivers plan for the well-child visit with the home visitor [column G]

- *Numerator:* # of children due for a well-child visit in the reporting month whose caregivers plan for the well-child visit with the home visitor before the well-child visit [column F]
- *Denominator:* # of children due for a well-child visit in the reporting month [column C]

Measure #3 (Primary Driver 2): % of children with a completed well-child visit for whom the home visitor has follow up with the caregiver within 14 days [column J]

- *Numerator:* # of children for whom the date of their most recently completed well-child visit + 14 days falls within the reporting month and for whom the home visitor had follow up with the caregiver within 14 days [column I]
- *Denominator:* # of children for whom the date of their most recently completed well-child visit + 14 days falls in the reporting month [column H]

Measure #4 (Primary Driver 3): % of children with a completed well-child visit for whom the home visitor and primary care team communicate within 30 days [column M]

- *Numerator:* # of children for whom the date of their most recently completed well-child visit + 30 days falls within the reporting month and for whom the home visitor and primary care team communicated within 30 days [column L]
- *Denominator:* # of children for whom the date of their most recently completed well-child visit + 30 days falls in the reporting month [column K]

OPERATIONAL DEFINITIONS:

- Last expected well-child visit: The last expected well-child visit is based on the child's age and the American Academy of Pediatrics schedule.

- Timely well-child visit: A well-child visit is counted as timely if it occurs during the following intervals, which are defined related to the child's birthdate, align with MIECHV performance measurement guidance, and are based on the American Academy of Pediatrics schedule. These intervals allow for a window for the visits to occur. For example, the 9-month visit could occur for the child anytime between 9 months, 0 days and 10 months, 30 days. Well-child visits are counted as timely if the visit occurs anytime during the interval, even if it occurs outside the month when a child is considered "due for a well-child visit." We will provide teams with a data registry that calculates well-child visit intervals based on birthdate and determines if a visit is timely.
    - 3 to 7 days
    - 2 to 4 weeks
    - 2 to 3 months
    - 4 to 5 months
    - 6 to 7 months
    - 9 to 10 months
    - 12 to 13 months
    - 15 to 16 months
    - 18 to 19 months
    - 2 to 2.5 years
    - 3 to 3.5 years
    - 4 to 4.5 years

- Due for a well-child visit: Child reaches the last day of a well-child visit interval in the reporting month. For example, a child who reaches age 10 months, 30 days in the reporting month is counted as "due" for the well-child visit that month.

- Caregiver: Caregiver refers to the adult participant enrolled in the home visiting program. May include biological, adoptive, or foster parent, relative, or other adult with a significant emotional connection to the child.

- Plan for the well-child visit: Verbal and/or written content to actively promote the benefits of and prepare caregivers for the well-child visit, including:
    - What caregivers should expect from the well-child visit (e.g., the primary care provider will weigh and measure your child to ensure they are growing appropriately; observe their movements, behavior, and interactions; model for you ways of interacting with a child this age; provide needed vaccinations and testing for lead; and ask you about any concerns or questions you have)
    - Pre-visit planning to assess barriers and facilitators to complete the visit and ensure it meets the needs of the family (e.g., inquiring about the scheduling of the well-child visit appointment, answering caregiver questions, and providing resources to ensure the family can successfully complete the visit). Common barriers to address with caregivers include lack of transportation; need for child care for siblings; underinsurance or lack of health insurance; knowledge of sliding fee documentation requirements; office protocols for scheduling (e.g., open access, timeliness, notice of cancellations, communication challenges with scheduling staff, etc.); language barriers; lack of trust; limited availability of healthcare providers; and conflicts with job/school schedules.

- Follow up with caregiver: After the well-child visit, the home visitor engages with the caregiver to discuss how the visit went, if it met the family's needs, if they have any questions, and if any support or follow up is needed. This should be more than just confirmation that the visit occurred. Communication may be initiated by home visitor or caregiver and may occur in person, over the phone, or via text, email, etc.

- Communication with primary care team: After the well-child visit, the home visitor and primary care practice communicate about the visit, including any needed support or follow up. Communication may be initiated by home visitor or primary care practice and may occur in person, over the phone, or via text, email, etc.

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