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Developmental Support Services

1st Five

1st Five Healthy Mental Development Initiative

TABLE OF CONTENTS

Developmental Support Services

1st Five includes developmental support services to connect families to local community resources to address a variety of needs related to healthy development and the social determinants of health including, but not limited to, food, transportation, housing, childcare/preschool, energy assistance, and infant supplies. Developmental support services reduce barriers to follow-through with developmental intervention recommendations. These services may be carried out through telephone contacts and written correspondence.

Developmental support services are short-term in nature (not case management) and include:

1. Receiving referral information about children ages birth to five years from primary care practices located within the 1st Five service delivery area.
2. Contacting the child's caregiver to review and assess identified needs.
3. Providing information about community resources available to address identified needs.
4. Assisting the caregiver with accessing community resources.
5. Following up with the caregiver to assure that connections with community resources were made.
6. Providing feedback to the referring primary care provider regarding follow-up that took place and results.

Areas of Knowledge and Experience

- 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. They need to be aware of the local and regional resources available and have relationships in place to access resources.

- A central part of the success of this role relies on the process of relationship building with families. They must be comfortable partnering with the DSS staff who will assist them in identifying needs, connect them to services or support and work through the process with them.
- Developmental Support Specialists must be well trained and competent in understanding and responding to risk factors affecting children's social and emotional development.

Activity Table

Type of Activity	Signify Community Documentation	When to use
PHONE CALLS		
Introduction Call	**TYPE FIELD** ● **Outgoing Call** ○ Introduction Call	● **Documents initial attempt to contact a client that does not result in direct contact.** ● **It's possible to have multiple introduction calls if you have never been able to connect with the client.** ● **Introduction Calls can also be used to document an introduction text message sent to initiate a reply/conversation. Similar to a voicemail but sent via text message.**
Incoming Call	**TYPE FIELD** ● **Incoming Call** ○ Incoming Call	● **Documents voicemails received and/or missed calls from a client.**
Follow up Call	**TYPE FIELD** ✓ **Outgoing Call** ○ Follow Up Call	✓ **Documents attempts to contact a client that does not result in direct contact ***AFTER*** a care coordination activity has already occurred.** ✓ **Follow Up Calls are used when you are following up on prior conversations. You must have already connected with the family and introduced them to 1st Five.** ✓ **Follow Up Calls can also be used to document a follow up text message sent to initiate a reply/conversation. Similar to a voicemail but sent via text message.**
LETTERS		
Welcome Letter	**TYPE FIELD** ● **Task** ○ Send Letter **TYPE OF DOCUMENT FIELD** ● Program Introduction	● **Documents a stock welcome letter to the referred client.** ● **If not including additional materials/information relative to referrals and follow up to a conversation, it must be sent within 24 hours of receiving a referral.** ● **If including additional materials/information relative to referrals and follow up to a conversation, use Care Coordination Activity - Letter to document service.**

Follow Up Letter Letter	**TYPE FIELD** ● **Task** ○ Send Letter **TYPE OF DOCUMENT FIELD** ● Follow Up Letter	● **Documents attempt to contact letters to a client.**
Provider Update	**TYPE FIELD** ● **Task** ○ Send Letter **TYPE OF DOCUMENT FIELD** ● Referring Provider Letter	● **Documents correspondence to the referring primary care provider.** ○ **provider update letters** ○ **closing letters** ○ **preliminary fax letters if used** ● **These letters must be uploaded into Signify Community.**
Closing Letter	**TYPE FIELD** ● **Task** ○ Send Letter **TYPE OF DOCUMENT FIELD** ● Thank you to Family	● **Documents formal closing letter to the family.**
CARE COORDINATION		
Care Coordination (CALL)	**TYPE FIELD** ● **Service** ○ Care Coordination **TYPE OF SERVICE** ● Care Coordination Developmental	● **Documents when you are able to connect with a client and/or a referral resource in reference to your client.** ● **Add Needs to the Care Coordination Activity as identified.** ● **When making a referral in response to a Need, solve by adding a Program Referral within the activity.** ● **All fields within the Care Coordination Activity must be completed.**
Care Coordination (LETTER)	**TYPE FIELD** ● **Service** ○ Care Coordination **TYPE OF SERVICE** ● Care Coordination Developmental	● **Documents letters sent to the client that include materials/ information relative to referrals and available services i.e. Early ACCESS brochures, food pantry location and hours, applications for food assistance, applications for housing, home visiting brochures, etc.** ● **All fields within the Care Coordination Activity must be completed.**
Care Coordination (TEXT, EMAIL, FAX, OTHER)	**TYPE FIELD** ● **Service** ○ Care Coordination **TYPE OF SERVICE** ● Care Coordination Developmental	● **Documents when you are able to connect with a client and/or a referral resource in reference to your client** ● **If the care coordination interaction type is text, there must be a back and forth dialogue with the recipient in order for it to be considered a Care Coordination Activity** ● **There is not a fax option for Interaction Type in the Care Coordination Activity. Use "Other" to identify a fax. Document as fax in the comment section.**

		• **All fields within the Care Coordination Activity must be completed.**
Interpreter Services Referral	**TYPE FIELD** • **Task** ○ Interpreter Services Referral	• **Documents the use of an interpreter to contact a client** • **Complete this activity for each activity an interpreter was used.**

SECTION 1: Intake Process

1.1 Receive referral form

Receive referral form from primary care provider via fax and review.

✓ Is the referral complete?

A. If it is not complete, 1st Five staff will connect with the practice to gather missing information and support completion of the form.

B. If patterns of missing information are identified, this may be a great opportunity for you to share that with the site coordinator so that they can provide targeted education to the practice on how to complete the 1st Five referral form.

✓ Is it signed by the parent/caregiver?

A. If the release of information is not signed on the 1st Five referral form when received by the agency, 1st Five staff should follow up with the referring provider to obtain either a signed 1st Five referral form or a verbal confirmation provided by the referring provider that the family approved the referral and 1st Five is able to contact the family to discuss services for the child. Once you've connected with the family, you can attempt to to get a signed Release of Information. Follow your agency's ROI protocols.

   a. The release of information is necessary to allow the exchange information between community organizations when coordinating referrals for 1st Five clients.

   b. If verbal confirmation is provided by the referring provider, you must have that documented on the referral form.

B. Written consent is not a requirement of 1st Five. 1st Five is not a direct service and therefore does not require written consent to provide developmental support services.

   a. 1st Five Site Coordinators do not perform agency outreach for blanket consents to programs within their agency. Consents required by the agency for referral to inter-agency programs like home visiting, and child health for example, may be sought by the 1st Five Site Coordinator if and when a referral is needed. These consents are sought only when making a referral to a program that requires a signed consent as a part of the intake process.

b. Other programs within your agency that you may refer to may require written consent for services. It is the responsibility of that program to obtain consent for services. Because you have made contact with the client, those programs may request assistance from 1st Five to help obtain consent or contact with the client.

✓ Is the surveillance tool and/or screening tool noted?
✓ Is a language barrier or primary language specified on the referral?
✓ Is the referral for a child birth to 5?
✓ Is the referral from a primary care provider?

1.2 Intake Materials/Assessment

Prior to contacting the client's parent/caregiver, review intake materials

✓ Is there a medical home?
✓ Is there a dental home?
✓ What are the social determinants of health that are impacting the client?
✓ What demographic information needs to be collected from the parent/caregiver?

1.3 Respond to the Provider

Following your agency protocols, to let them know you've received the referral (if your protocols include this step) and, if necessary, request missing information.

SECTION 2: Signify Community Contacts

2.1 Search for Contact in Signify Community

Directions	Tips
A. Enter your Contact's name in the search field, located in the Navigation bar at the top of the page (next to the magnifying glass) OR click on the Records tab and select Contacts. B. Look through the list for your Contact and, if found, click the Contact's name. You will be directed to the Contact's Record. If contact is already in Signify Community, skip to Section 2.3.	✓ Before a Contact is created, it is best practice to first search the database to see if the record already exists. ✓ Always search for contacts by name, and by birthday to avoid creating duplicate records that need to be merged later. ✓ You can search First name and Last name, or Last name, First Name (We

C. If you don't find the Contact you're looking for, follow the next set of instructions for creating a new contact in Section 2.2.	recommend searching with partial information. ✓ If the client has Medicaid as their insurance, a record should already exist in Signify Community.

2.2 New Contact in Signify Community

2.2.1 Create New Contact

If the client is not already in Signify Community you'll need to create a new Contact in Signify Community.

Directions	Tips
A. Click the Create button on the navigation bar B. Choose Create a Contact C. Enter all of client's information including the following demographics: ● Race ● Ethnicity ● Interpreter needed ● Primary language D. When finished, save by clicking on Create	✓ If siblings are referred at the same time, each referred child age birth to age five will be entered into Signify Community separately. ✓ If a sibling over the age five is referred, that child's referral will be addressed by Child Health. ✓ Always complete the Race and Ethnicity fields in this Create Contact form if indicated on the referral form / referral materials. If this information is not indicated on referral materials you'll need to obtain this information during developmental support with the client. This information is required for program evaluation purposes.

2.2.2 Take ownership of 1st Five Client

To begin documenting interactions with your client, you must take ownership and become their Agency Home.

Directions	Tips
A. Hover over the ellipsis (3 dots) next to your client's name	✓ To add a 1st Five episode and begin documenting interactions with your client, you need to become the client's Agency Home.

B. If your agency does not have ownership, click Take Ownership.	✓ Multiple agencies can have ownership at the same time while working with a client.

2.3 Existing Contact in Signify Community

2.3.1 Take ownership of 1st Five Client

If a client is already in Signify Community, you must take ownership and become their Agency Home before you begin working on their case.

Directions	Tips
A. Hover over the ellipsis (3 dots) next to your client's name B. If your agency currently has ownership of the client, you will only have Release Ownership option C. If your agency does not have ownership, click Take Ownership.	✓ To add a 1st Five episode and begin documenting interactions with your client, you need to become the client's Agency Home. ✓ Multiple agencies can have ownership at the same time while working with a client.

2.3.2 Demographics and Contact Information

Review, confirm and update 1st Five Client's demographic information.

Directions	Tips
A. On the contact record page, click the edit pencil icon to the left of the universal Add (+) icon B. Enter and edit any necessary information C. Enter race and ethnicity information if incomplete D. Update the Interpreter Needed field if indicated on the referral form E. Click Save	✓ You cannot change the Medicaid or WIC address/phone ✓ Add additional addresses/phone numbers, as needed ✓ If race and ethnicity are not known and also incomplete, be sure to complete this information via DSS contact with the client. This information is required for program evaluation purposes. ✓ Some of this information may need to be obtained during your initial

	conversation with the parent/caregiver.

2.4 Add Related Contacts in Signify Community

Directions	Tips
A. From the Universal Add (+) button, choose Related Contacts B. In the search field enter the name and select search. Choose appropriate contact if found C. If not listed, click Create a New Contact D. Enter Related Contacts information and select appropriate relationship to the client E. Select save.	✓ If new contact has the same address/phone number as client, you can click the box “same as primary contact” and it will automatically add the data. Otherwise, add a new phone number/address. ✓ If you notice a related contact has been incorrectly added, hover over the contact. A box will appear which gives you the option to edit or delete related contact.

2.5 Adding & Connecting Related Contacts in Signify Community

Directions	Tips
A. Click the Universal Add (+) button, choose Related Contacts B. In the search field enter the name and select search. If they already exist in Signify Community, simply select the radio button next to their name and click Next. C. If not listed, click Create a New Contact D. Enter all information you know about the contact, including date of birth, gender, and contact information. Click Next, E. Select the Relationship from the dropdown that best describes how these contact’s know each other. F. Select save.	✓ In Signify Community, you have the option of connecting your contact with a Related Contact (such as a family member or friend). This can help identify your contact's support system. ✓ Before adding a related contact, it's important to first check if that contact already exists within Signify Community. ✓ If new contact has the same address/phone number as client, you can click the box “same as primary contact” and it will automatically add the data.

	✓ If you notice a related contact has been incorrectly added, hover over the contact. A box will appear which gives you the option to edit or delete related contact.

SECTION 3: Signify Community Episodes

3.1 Client Overview Episode

A Client Overview Episode is required on all clients. If one does not already exist, you must create one.

Directions	Tips
A. From the Universal Add (+) button, choose Episode B. Choose Client Overview as Episode type C. Choose agency pool as the owner D. Awareness Date is the day they became eligible for services E. Choose Member for episode status F. Choose any programs in which client currently enrolled G. Select Save	✓ Only one Client Overview Episode per client. ✓ For more information please refer to the 1st Five Signify Community Manual.

3.2 1st Five Episode

A 1st Five Episode will be created for each **NEW** referral to 1st Five. The client will have a separate 1st Five episode for each Provider Referral.

Directions	Tips
A. From the Universal Add (+) button, choose Episode B. Choose 1st Five as Episode type C. Assign the Episode Owner (this will be the individual DSS staff person – which might be yourself, or the agency pool, depending on your agency's protocols) D. In the Awareness Date field, enter the date the referral on the fax date stamp (which might be earlier than the date you are entering information into Signify Community) E. Episode Status is Member	✓ If a client is a recurring client (which means that the client was referred to 1st Five before and has a "Closed" 1st Five episode in Signify Community), add another 1st Five episode. ✓ Do not use the closed episodes for the new referral data.

F. In the Primary Payer field, select 1st Five G. Click Save	✓ Owner will automatically default to person entering data ✓ Additional notes are optional.

SECTION 4: Needs & Program Referrals

Beginning October 2020, Signify Community introduced new features related to identifying and solving barriers. Instead of documenting Barriers to Solve, users will now have the ability to document Needs to address by making Program Referrals.

4.1 Barriers to Needs Mapping

To aid in this transition, Signify Community adopted a small subset of the AIRS Taxonomy that most closely aligns with the Signify Community Barriers. This should help you find the new Need to use in place of the Barriers you've been accustomed to recording. As communities complete their migration and additional privacy functionalities are built into Signify Community, we expect to bring the entire AIRS Taxonomy into the application.

Follow the directions below to find the list of all Barriers that were previously available and the corresponding Need from the AIRS Taxonomy, which are now "Needs"in SignifyCommunity. Use the Barriers to Needs Mapping article found in Signify Community Help.

Directions	Tips
A. Click on your name in the top, right hand corner of the Signify Community screen. B. Select Support under the Help menu C. In the search box type Barriers to Needs Mapping and select the article as it appears in a dropdown box D. A list of all Barriers that were previously available and the corresponding Need from the AIRS Taxonomy will be displayed.	● All history currently completed will be frozen in time and available for review on your Contact Records and in reporting. ● Each existing Barrier will be automatically converted into a Need. ● Each Barrier listed on an Activity will have the corresponding Need listed for reference. ● For each Barrier converted that included a Solution, a corresponding Program will also be mapped, based on the Solution's details.

4.2 Documenting Needs

Directions	Tips
A. Find the Related Content menu at the bottom of the Activity. B. Click the Add Need button. C. If Needs already exists, you can choose one from the provided list. Otherwise, click the Create Need button. D. Use the search field or click the Need category of choice. This will highlight the Need, reveal any subcategories, and display a description. E. Once you have found the identified Need, select the Need, click Add to Contact and click Next. F. Enter the date the need was identified. The date field will be automatically set for the current date - change if necessary. G. Add any related Comments if desired to further describe your contact's Need. H. Save the Need. I. Save the Activity.	✓ Do not add Needs using the Universal Add button. Needs have to be added and attached within an activity. ✓ All concerns/needs indicated on the referral form by the Primary Care Provider will be added to the Referral Activity as a Need. ✓ All concerns/needs identified by DSS, not already identified by the primary care provider, will be added to the Care Coordination Activity in which they were identified. ✓ Identify Needs and make Program Referrals within the Referral Activity or Care Coordination Activity using the Related Content buttons. ✓ Each Need is housed within the activity in which they are identified. ✓ If a specific Need has already been added to the contact, you will be unable to add it again. ✓ You can view more levels within each Need but the more specific you get with the Need, the more difficult it may be when searching for a Program Referral. ✓ Add multiple Needs at the same time without leaving the "Need Picker" by clicking the 'Add to Contact'. All Needs selected will be displayed in the Selected Needs box. ✓ All Needs that are identified and added will be listed within the activity on the Activities timeline. ✓ Do not click on the Need to make a Program Referral. Clicking on the Need will bring you to the Needs tab with an option to Make a Referral for that Need. Do not Make a Program Referral from the Needs tab. For how to appropriately add a Program Referral, continue to Section 4.4. ✓ See Section 4.1 Signify Community Barriers to Needs Mapping if having difficulty locating appropriate needs.

4.3 Status of a Need

Tips

✓ New needs will generally be labeled as “Identified” and change to “Being Addressed” automatically when a Program Referral is linked to it. ✓ For data retrieval purposes 1st Five is not requiring that the status of Needs be updated using the “Resolve” button.

4.4 Documenting Program Referrals

A Program Referral is used to document a referral made to a community resource to meet a contact’s needs.

Directions	Tips
A. Scroll down in the Activities timeline and find the Activity with the Need you wish to address. B. Find the Related Content menu at the bottom of the Activity. C. Click the Add Referral button. D. If a Program Referral already exists, you can choose one from the provided list. Otherwise, click the Create Referral button. E. Use the search field to search for the program. F. Scroll through the list of matching programs, click on the desired Program, and click the Next button. G. In the Need field, select the Need that the Program Referral is addressing. H. In the Sender section, your name is the default; choose a different user if desired. I. In the Reason for Referral text box enter a brief description to provide any additional context necessary to facilitate the referral. J. The Respond By Date will be set by default in two business days. Update if necessary. K. Attachments are optional and not required. L. Save the Program Referral M. Save the Activity.	✓ Program Referrals will be created as connections are being made for the contact. ✓ When creating a Program Referral, you’re able to search available Programs in the Signify Community Resource Guide by program name, keywords, and location (city, state, & county). ✓ If the Need you are attempting to address does not appear in the drop down menu, you must contact Signify so they can link that Need to the Program you have chosen. For directions on how to send a request to Signify so that a Need is mapped to a Program Referral, continue to Section 4.7. ✓ When you select the Need that the Program Referral is addressing, this step links the Program to the Need in the Activity. This step assures that this Program Referral will be included in 1st Five population data. For this reason, the Needs tab is not used to add a Program Referral for 1st Five clients.

4.5 Needs & Program Referrals Tabs

Do NOT add Needs or Program Referrals from the Needs and Program Referrals Tabs

Tips

- A Standardized Assessment from Iowa Medicaid will be available for all users on the Needs tab.
- This assessment is NOT a required assessment.
- When the assessment is completed, Needs are automatically populated based on the answers given. The Needs that are identified are not linked to activities or the 1st Five Program.
- For reporting purposes, the Needs that are identified must be added through the Related Content buttons in activity in which they are identified (Referral Activity or the Care Coordination Activity).

4.6 Navigating the Signify Community Resource Guide

The Signify Community Resource Guide is divided into two sections: Programs and Organizations

Programs	Organizations
Programs are specific services offered by a given Organization. The CRG will not list a Program without first knowing the anchor Organization. Programs are listed with greater detail and are connected to Needs and/or Program Referrals, once identified. Programs are also connected to their corresponding Needs so that searches become more useful when looking to solve a need. To review all Programs and the Needs associated with them in the CRG: 1. Hover over the Records Menu at the top of the page 2. Click Programs under "Contact" 3. Use the search fields to narrow the types of Programs you're wanting to review	Organizations are facilities that offer several different types of services. Each Organization has a specified type assigned, to describe the type of service offered. Organizations also serve as the anchor for Programs, Locations and Staff members working for the Organization. To review all Organizations listed in the CRG: 1. Hover over the Records Menu at the top of the page 2. Click Organizations under "Contact" 3. Use the search fields to narrow the types of Organizations you're wanting to review

4.7 Adding a Program to the Signify Community Resource Guide

If you're searching for a Program to use as a Program Referral and just can't find it, the Signify Community Support Team can help! Send a request with as much information as you can, in order to get the best usage and understanding out of the Program you want to add. Send a request to signifycommunityhelpdesk@idph.iowa.gov with the following Information:

✓ **Organization Name** - This could be a church, non-profit, clinic or any facility that is providing the program requested

- ✓ **Program Name** - e.g. Emergency Food Assistance, Low Cost Medical Transportation, etc.
- ✓ **Program Location** - address of the location where the program is offered
- ✓ **Program Contact Information** - email, phone, website, name of primary contact, etc.
- ✓ **Program Description** - if there's something from the website about the Program or something you believe the description should include for better understanding of what the program offers
- ✓ **Needs the Program helps to solve/address** - e.g. Food, Shelter, Utility Assistance, Medical Assistance, Transportation, etc.

The Support team will assign someone to the request and you will be notified as soon as the Program has been entered or updated. Turnaround time is typically very fast, depending on the number of Programs sent.

SECTION 5: Signify Community- 1st Five Activity Bundle

5.1 1st Five Activity Bundle

Best practice is to use the preset 1st Five Activity Bundle in Signify Community. The activity bundle has time saving features such as cascading common fields, reminders and other reset values.

You'll be required to complete these activities within the bundle:

A. Referral
B. Complete Assessment (if applicable)
C. Care Coordination (if applicable)
D. Send Letter
E. Satisfaction Survey

Directions	Tips
A. From the Universal Add (+) button, choose Activity Bundle B. Choose 1st Five Episode with Member status C. Enter starting date as the date referral was received D. Owner will automatically default to person entering data E. Select bundle as 1st Five New Client Bundle F. Scroll all the way to the bottom of the bundle and save	✓ Scroll to the bottom of the bundle and save the activity bundle before entering any additional information. ✓ You will not be able to add "Organization", "Provider" and "Survey" in the Referral Activity until the bundle is saved. ✓ After you have saved the bundle, you can then go back and edit the activities within the bundle. ✓ If items in the bundle are not completed due to no contact, you can update the outcome of the activity as No Longer Necessary and the activity will no longer appear as overdue in your dashboard.

5.1.1 Referral Activity

Referral Activity documents a referral into the 1st Five Program and the outcome of the referral.

Directions	Tips
A. Scroll back up within the timeline and find the Edit pencil next to the Referral Activity, click on the pencil B. Owner is the Signify Community user assigned to the client C. Date referral received will be auto populated after choosing the bundle D. In the Time field enter the exact time you started working on the Referral E. In the Duration field, enter the amount of time you spent working on the referral, from start to finish F. In the Outcome Field, choose "Successful" from the drop down menu G. Topics will be listed as reminders to complete during this activity (this will be covered in the next step): a. Add 1st Five Consent b. Add 1st Five Release c. Add Needs/Program Referrals d. Add Referring Organization e. Add Referring Provider f. Add Survey Attachment g. Add Survey Scores	✓ When the primary reason for referrals has been addressed, you must go back into the referral activity to complete the Referral Outcome and Reconciliation Outcome fields. ✓ **Referral Outcome:** Document the Outcome status of the referral made by 1st Five. ✓ **Reconciliation Outcome:** Document the service gap code. Complete these responses relative to the primary reason for referral indicated on the 1st Five Referral form. ✓ The "Reason" field identifies the primary reason for referral identified by the referring provider, which is essentially the "need" that prompted the referral to 1st Five. All concerns/needs indicated on the referral form will be added to the Referral Activity as a Need.

H. In the County of Residence field, select the county in which the client lives I. Leave Referral Outcome and Reconciliation Outcome blank until the primary reason for the referral has been addressed J. In the Source field, select Primary Care Provider. This will be defaulted to primary care provider K. In the Reason field, select the primary reason for referral from the dropdown menu. This will be the main developmental concern that prompted the provider to refer the child L. In the Screening Type field, select two items: a. The surveillance type/tool indicated on the referral. If the item is unknown, choose, None – Surveillance b. The screening type/tool indicated on the referral. If the item is unknown, choose, None – Screening	✓ All other needs, that are identified during Care Coordination Activities, will be documented as a Need during the activity in which you become aware of them. ✓ 1st Five accepts referrals only from Primary Care Providers. If this Referral did not come from a primary care provider, seek guidance from your supervisor regarding next steps. ✓ Description and comment fields are optional.

5.1.2 Topics in Referral Activity

Scroll to the bottom of the Referral Activity to the Related Content buttons

Directions	Tips
Need A. Click the Add Need button. B. If Needs already exists, you can choose one from the provided list. Otherwise, click the Create Need button. C. Use the search field or click the Need category of choice. This will highlight the Need, reveal any subcategories, and display a description. D. Once you have found the identified Need, select the Need, click Add to Contact and click Next. E. Enter the date the need was identified. The date field will be automatically set for the current date - change if necessary. F. Add any related Comments if desired to further describe your contact's Need. G. Save the Need.	✓ Do not add Needs using the Universal Add button. Needs have to be added and attached within an activity. ✓ All concerns/needs indicated on the referral form by the Primary Care Provider will be added to the Referral Activity as a Need. ✓ All concerns/needs identified by DSS, not already identified by the primary care provider, will be added to the Care Coordination Activity in which they were identified. ✓ Identify Needs and make Program Referrals within the Referral Activity or Care Coordination Activity using the Related Content buttons. ✓ Each Need is housed within the activity in which they are identified. ✓ If a specific Need has already been added to the contact, you will be unable to add it again.

	✓ You can view more levels within each Need but the more specific you get with the Need, the more difficult it may be when searching for a Program Referral. ✓ Add multiple Needs at the same time without leaving the “Need Picker” by clicking the 'Add to Contact'. All Needs selected will be displayed in the Selected Needs box. ✓ All Needs that are identified and added will be listed within the activity on the Activities timeline. ✓ See Section 4.1 Signify Community Barriers to Needs Mapping if having difficulty locating appropriate needs.
Program Referral A. Click the Add Referral button. B. If a Program Referral already exists, you can choose one from the provided list. Otherwise, click the Create Referral button. C. Use the search field to search for the program. D. Scroll through the list of matching programs, click on the desired Program, and click the Next button. E. In the Need field, select the Need that the Program Referral is addressing. F. In the Sender section, your name is the default; choose a different user if desired. G. In the Reason for Referral text box enter a brief description to provide any additional context necessary to facilitate the referral. H. The Respond By Date will be set by default in two business days. Update if necessary. I. Attachments are optional and not required. J. Save the Program Referral K. Save the Activity.	✓ A Program Referral is used to document a referral made to a community resource to meet a contact’s needs. ✓ Program Referrals will be created as connections are being made for the contact. ✓ When creating a Program Referral, you’re able to search available Programs in the Signify Community Resource Guide by program name, keywords, and location (city, state, & county). ✓ When you select the Need that the Program Referral is addressing, this step links the Program to the Need in the Activity. This step assures that this Program Referral will be included in 1st Five population data. For this reason, the Needs tab is not used to add a Program Referral for 1st Five clients. ✓ Do not click on the Need to make a Program Referral. Clicking on the Need will bring you to the Needs tab with an option to Make a Referral for that Need. Do not Make a Program Referral from the Needs tab. For how to appropriately add a Program Referral, review Section 4.4. ✓ If the Need you are attempting to address does not appear in the drop down menu, you must contact Signify so they can link that Need to the Program you have chosen. For directions on how to send a request to Signify so that a Need is mapped to a Program Referral, review Section 4.7.

Organization A. Click the Add Organization button. B. In the Add Organization block, enter the referring practice's name, city, and/or county and click Search. C. Within the returned search results, select the referring practice. D. Once selected, scroll down to the Relationship to [client name] field. Select Admitting Facility from the dropdown menu.	✓ If having difficulty finding an Organization OR Provider, click on the Records tab and select Organizations and/or Providers to search for them. Use the EXACT name you found in the search to enter in the referral activity. ✓ Organizations and providers may be listed differently depending on how they were entered into Signify Community. Be sure your agency staff are consistent with how you are selecting your referring organizations and providers.
Provider A. Click the Add Provider button. B. In the Add Provider block, enter the referring provider's name, city, and/or county and click Search. C. Within the returned search results, select the referring provider. D. Once selected, scroll down to the Relationship to [client name] field. Select Referring Provider from the dropdown menu.	✓ If having difficulty finding an Organization OR Provider, click on the Records tab and select Organizations and/or Providers to search for them. Use the EXACT name you found in the search to enter in the referral activity. ✓ Organizations and providers may be listed differently depending on how they were entered into Signify Community. Be sure your agency staff are consistent with how you are selecting your referring organizations and providers. ✓ If you discover duplicate providers, please contact Signify Community Helpdesk so that they can merge those providers.
1st Five Release Form Attachment A. Click the Add Attachment button. B. In the description field, type 1st Five Release Form. C. Select Upload File and attach the document from your computer.	✓ Upload the referral form from the referring provider. ✓ 1st Five does not require a separate ROI or Consent form apart from the completed section on the referral form called "Release of Information" ✓ Attachments will need to be added and saved separately.
Survey (Screening Tool) A. Click the Add Survey button. B. Choose the appropriate survey from the list of assessments/tools. C. Enter the date the survey was completed D. Enter survey results.	✓ This is not a requirement for the performance measure. ✓ If the referring provider completed a screening and includes the scores with the referral, you may add the survey/assessment scores received from the provider (ASQ-3, ASQ-SE, MCHAT, etc) ✓ Uploading the entire screening tool via scanned documents is optional. ✓ Attachments will need to be added and saved separately.

CLICK SAVE AT THE BOTTOM OF THE REFERRAL ACTIVITY FIELD ONCE ALL TOPICS HAVE BEEN COMPLETED

5.2 Satisfaction Survey Reminder

Directions	Tips
A. Find the Satisfaction Survey in the timeline and click the Edit pencil B. In the Owner field, assign the agency staff member who will complete the Family Satisfaction Survey during the closing process C. Other fields will remain untouched at this time. They will be completed later, during the closing process D. Click Save	✓ Check your agency protocols for how to determine who will complete this activity. ✓ The Date field will be auto-populated for 10 weeks past the date of the Referral Activity. You may decide to change this later; however, it is too early to determine the date right now.

SECTION 6: Initial Contact with Client

6.1 Contact Timeline

- Phone calls must be made at different times of day and/or on a different day of the week from your previous attempts.
- The frequency of provider updates may depend on provider preferences.
- If you are unable to reach the client and have completed 3 attempts to contact by phone and 3 attempts to contact by letter, then at that time their episode can be closed.

Welcome Letter	Welcome letter must be sent within 24 hours or by the end of the next business day of receiving the referral.
1st Call	Contact the referral within 48 hours (2 business days) of receiving the referral.
1st Attempt to Contact Letter	An attempt to Contact Letter is sent within 24 hours or by the end of the next business day if unable to connect with family via phone call.
2nd Call	Approximately five business days after you send the 1st Attempt to Contact Letter, call the parent/caregiver.

2nd Attempt to Contact Letter	Send 2nd Attempt to Contact Letter within 24 hours or by the end of the next business day if unable to connect with family after 2nd phone call.
Provider Update	If attempts to contact are not successful with a client, send a provider update 2 weeks from the 1st attempt to contact a family. Update will include dates and times of attempted points of contact.
3rd Call	Approximately five business days after you send the 2nd Attempt to Contact Letter, call the parent/caregiver.
3rd Attempt to Contact Letter	Send a final Attempt to Contact Letter within 24 hours or by the end of the next business day if unable to contact family.
Close 1st Five Episode Thank you to Family Letter	If you are still unable to make contact, follow the closing protocol in Section 9.
Provider Closing Letter	Send a Provider Closing Letter to inform them of status.

6.2 Welcome Letter/Packet

Directions	**Tips**
A. From the Universal Add (+) button, choose Activity B. Select 1st Five Episode in Member status C. In the Type field, Select Send Letter from the dropdown menu D. Owner is the person who is sending the letter E. Enter the date the activity was completed F. In the Time field, document the time you began working on this activity G. In the Duration field, enter the amount of time you spent creating and sending the letter H. In the Outcome field, select Successful from the dropdown menu I. In the Type of Document field, select Program Introduction J. In the comment field, list the materials included in the packet K. Click save	✓ Welcome letter must be sent within 24 hours of receiving the referral. ✓ Note the time you started/ended the letter. ✓ This letter can be sent before or after calling parent/caregiver. ✓ Welcome letters do not need to be attached to the activity.

Content of Welcome Letter/Packet (at 5th grade reading level or below)

✓ 1st Five brochure
✓ Any necessary releases or exchange of information forms
✓ Include the URL for the resource directory or guidance on how to search for the resource directory via a search engine (i.e., search “Polk County Resource Directory”).
✓ The packet should NOT include unnecessary amounts of information and should remain succinct and specific to 1st Five. Do not use the 1st Five welcome packet as agency outreach.

6.3 Guidelines for Contacting Client

Attempt making contact with the family must begin within 48 hours (2 business days) of receiving the referral.

Directions	Tips
A. Contact the client's parent/caregiver using the contact number provided in the referral B. Take note of the time you are beginning your attempt to contact the parent/caregiver (you will use this later with your Signify Community data entry) C. If using an interpreter to contact the client,you will need to add an Interpreter Services Referral activity for each time an interpreter was used.	✓ Introduction Call activity is used to document when attempts to make an initial contact with parent/caregiver is unsuccessful. ✓ Care Coordination activity is used to document calls to the caretaker when contact with the parent/caregiver is made, and when referrals are made out. ✓ All activities are marked as successful even when calls do not result in actual contact with the client. Your attempt at contacting the client is successful.

6.4 Interpreter Service Referral

Documents the use of an interpreter to contact a client. Must be completed in addition to the activity that the interpreter was used to communicate with the client.

Directions	Tips
A. From the Universal Add (+) button, choose Activity B. Select the 1st Five Episode in Member status C. In Type, select Interpreter Services Referral from the dropdown menu D. Owner is the person who used the interpreter E. Enter the date the activity was completed F. Complete the Time field with the exact time the interpreter was provided G. Duration of amount of time an interpreter was used during the activity H. In the Outcome field, choose Successful from the dropdown menu I. In the Comment field, document details and click Save	✓ All activities are marked as successful. ✓ Be sure to complete an Interpreter Services Referral activity for <u>each</u> time an interpreter was used.

6.5 Able to Connect with the Client's Parent/Caregiver

6.5.1a Initial Phone Contact

If you reach the parent/caregiver, include the following in the initial contact

Directions	Tips
A. Provide the following information about 1st Five: a. 1st Five will be assisting to connect the child to services b. 1st Five will report to the child's doctor about referrals made and how connections are working for the child c. Inform the parent/caregiver that the likely time you will be working with them is approximately four months or less d. 1st Five will not be providing services directly, but will assist the parent/caregiver in knowing where and how to access services they need B. Confirm the client's address and best days/times to reach the parent/caregiver C. Gather additional demographic information, such as race, ethnicity,primary language and the need for interpreter services D. Confirm that the child has a medical home and a dental home E. Verify the most recent medical & dental appointments. Typically, the medical appointment will be the appointment that generated the referral. F. If known immunizations are not up-to-date, provide information relative to immunizations compliance G. Review the referrals you have addressed with the parent/caregiver and their plan of action to follow-up, including specific calls they will make and appointments they will schedule. Confirm these with the parent/caregiver	✓ Update relevant demographics and contact information in Signify Community ✓ It's important to establish rapport with the parent/caregiver and seek to learn whether there are additional concerns that weren't conveyed by the faxed referral. For example, in addition to the primary referral reason of speech concerns, the parent/caregiver may identify challenges with getting transportation to the speech evaluation appointment or being able to pay for the evaluation. ✓ Take note of the start/end time of the call (you will use this later with your Signify Community data entry). ✓ If using an interpreter to contact the client you will complete the Interpreter Services Referral activity.

H. If you have specific steps that will take follow-up, such as connecting the family to an ongoing service that will help them with follow-through, review the steps you will take, including specific calls you will make and calls they may receive from others (such as a home visiting agency) in follow-up. Confirm these with the parent/caregiver I. Call should include a planned time frame for your next contact with the parent/caregiver, along with the follow-up steps they will complete in that time frame.	

6.5.1b Initial Phone Contact = Care Coordination Activity

If you connect with the parent/caregiver, include the following in the initial contact documentation.

Directions	Tips
A. Pull up the client record in Signify Community B. Locate the Care Coordination Activity in the list of activities on the timeline. Click the Edit pencil C. Owner is the person who completed the call D. Enter the date the activity was completed E. Enter the exact time you started the call (Time In) and the time the call concluded (Time Out) F. In the Outcome field, select Successful from the drop down menu G. In the location field report the specific location of where the service is provided. H. In the Type of Service field, select Care Coordination Developmental from the drop down menu I. In the Primary Payer field, select 1st Five from the dropdown menu J. In the Interaction Type field, choose Phone from the drop down menu K. In the Service Provider field, verify that your name appears in the field. If not, select your name from the drop down menu	✓ Take note of the start/end time of the call (you will use this later with your Signify Community data entry). ✓ Care Coordination time includes the time it takes to complete the task, call and documentation. ✓ The Universal Add Button can be used to create as many individual Care Coordination Activities as needed. ✓ All concerns/needs identified by DSS, not already identified by the primary care provider, will be added to the Care Coordination Activity in which they were identified. ✓ Each Need is housed within the activity in which they are identified. ✓ Program Referrals will be created as connections are being made for the contact to address identified Needs. ✓ Identify Needs and make Program Referrals within the Care Coordination Activity using the Related Content buttons.

L. In the County of Service field, select the county in which you were located when you conducted the call. Typically, this will be the county in which your office is located M. Scroll down to the list of open text boxes. Complete each text box. The Description and Comment fields may be left blank if not needed. a. **Contacted person:** Enter the person's name with whom staff spoke to complete the service. b. **Concerns and issues:** Describe the concerns/issues discussed with the parent/caregiver during the call. c. **Staff response**: Record the services and follow-up you suggested during the call. Report staff responses shared with the family related to the expressed concerns or issues. d. **Medical Appointment Summary:** If the care coordination service involves coordination of well child medical appointments, report the name of the child's medical provider and timeframe of appointment/visit. e. **Dental Appointment Summary:** If the care coordination service involves coordination of dental appointments, report the name of the child's dental provider and timeframe of appointment/visit. f. **Referrals, Outcomes, and Plan for Follow-up**: Describe and document the actions the parent/caregiver and you will take to access services and community resources as listed, clearly indicating the steps to be completed by the parent/caregiver delineated from the steps to be completed by you. g. **Client/family feedback:** Report any feedback from the parent/caregiver, such as declining specific services or suggestions or requests for specific assistance. Circumstances or	✓ All Needs that are identified and Program Referrals that are made to address those Needs will be added and listed within the activity on the Activities timeline. ✓ Do not add Needs or Program Referrals using the Universal Add button. Needs and Program Referrals have to be added and attached within an activity. ✓ When creating a Program Referral, you're able to search available Programs in the Signify Community Resource Guide by program name, keywords, and location (city, state, & county). ✓ When you select the Need that the Program Referral is addressing, this step links the Program to the Need in the Activity. This step assures that this Program Referral will be included in 1st Five population data. For this reason, the Needs tab is not used to add a Program Referral for 1st Five clients. ✓ Do not click on the Need to make a Program Referral. Clicking on the Need will bring you to the Needs tab with an option to Make a Referral for that Need. Do not Make a Program Referral from the Needs tab. For how to appropriately add a Program Referral, review Section 4.4. ✓ If the Need you are attempting to address does not appear in the drop down menu, you must contact Signify so they can link that Need to the Program you have chosen. For directions on how to send a request to Signify so that a Need is mapped to a Program Referral, review Section 4.7. ✓ Review Section 5.1.2 for more information on adding Needs and Program Referrals to an Activity using the Related Content buttons. ✓ You may postdate activities for reminders on your daily dashboard in Signify Community.

recent/upcoming life events that are impacting the child may be indicated here, such as an upcoming move, changes in daily schedule and when the parent/caregiver can be reached, a recent death or illness in the family, or other items which may serve to remind you of important considerations as you continue to work with the family. h. **Enter your comment:** Use this field for additional summaries that you or another developmental support specialist or supervisor may need for follow-up with this child. P. Click Save.	

6.5.2a Complete Assessment Activity (within the bundle)

Directions	Tips
A. Find the Complete Assessment activity in the timeline B. Click the edit pencil C. Owner is the person who completed the assessment D. Enter the date the activity was completed E. Time field is optional F. Duration field is optional G. Description field is optional H. In the Outcome field, select Successful from the drop down menu I. In the Provider Type, select the option that describes the child's medical home status J. In the Assessment Type, select the correct type of intake assessment (see descriptions below). K. In the Topics field, select Intake Assessment L. Scroll down until you see the Add Related Content menu. M. Click the Add Survey button. N. In the Survey field, select Intake Assessment from the drop down menu	✓ Verify the child's immunization status via your agency's protocols for accessing this information electronically if your agency manages immunization data in this manner. The Intake Assessment is to be completed by the Developmental Support Specialist via discussion with the client. ✓ This information will be entered in Signify Community when you document your initial call with the parent/caregiver. ✓ **Complete Assessments are completed every 30 days by adding a new Complete Assessment Activity.** ✓ When posting a new or updated Intake Assessment, complete all questions on the survey. ✓ If you identify the client's Medical/Dental Home while interacting with the client, you can add Providers or Organizations by clicking the Add buttons and choose Relationship as Medical Home or Dental Home. (For

O. In the Comment field, enter the date of the review of the Intake Assessment when no changes are needed (if still current) P. Complete the information and click Save	reporting purposes, medical home data is pulled from the up- to -date Intake Assessment)

Types of Intake Assessments

- **Intake Assessment - Initial Survey Attached**: This assessment is selected upon reviewing an existing Intake Assessment for a new client or it's been longer than 1 year since a previous Complete Assessment has been completed in the client's timeline.
- **Intake Assessment - Reviewed w/New Survey Attached:** This assessment is selected upon reviewing an existing Intake Assessment, identifying changes and attaching a new Intake Assessment. A new Intake Assessment must be posted each year (one year from the previous posting) OR the next time the client is served by your agency (if it has been longer than a year). This annual activity must be made whether or not changes have occured.
- **Intake Assessment - Reviewed w/No Changes**: This assessment is selected upon reviewing a current Intake Assessment (a posting within the last year) where there are no changes. Best practice is to add a comment stating, "Intake Assessment of (date) is current".

6.5.2b Complete Assessment Activity (outside of the bundle)

Complete Assessments are completed every 30 days by adding a new Complete Assessment Activity.

Directions	Tips
A. From the Universal Add (+) button, choose Activity B. Select the 1st Five Episode in Member status C. In the Type field, select Complete Assessment from the dropdown menu (under the Task heading) D. Owner is the person who completed the assessment E. Enter the date the activity was completed F. Time field is optional G. Duration field is optional H. Description field is optional I. In the Outcome field, select Successful from the drop down menu J. In the Provider Type, select the option that describes the child's medical home status K. In the Assessment Type, select the correct type of intake assessment (see descriptions below).	✓ Verify the child's immunization status via your agency's protocols for accessing this information electronically if your agency manages immunization data in this mannerThe Intake Assessment is to be completed by the Developmental Support Specialist via discussion with the client. ✓ When posting a new or updated Intake Assessment, complete all questions on the survey.

L. In the Topics field, select Intake Assessment M. Scroll down until you see the Add Related Content menu. N. Click the Add Survey button. O. In the Survey field, select Intake Assessment from the drop down menu P. In the Comment field, enter the date of the review of the Intake Assessment when no changes are needed (if still current) Q. Complete the information and click Save	

6.6 Unable to Connect with the Client's Parent/Caregiver

6.6.1 Introduction Call

If you were unable to reach the parent/caregiver, take the following actions to make entries in Signify Community to document this attempt.

Directions	Tips
A. From the Universal Add (+) button, choose Activity B. Select the 1st Five Episode in Member status C. In Type, select Introduction Call from the dropdown menu D. Owner is the person who completed the call E. Enter the date the activity was completed F. Report the exact time of the day activity started G. In the Outcome field, choose Successful from the dropdown menu H. In the Comment field, document details and click Save	✓ Comment should include what happened over the phone call: a. Did you leave a voice message b. Was the number disconnected? c. Was the voicemail box full or not set up? ✓ Comments should also include the next steps that you will take since this call did not result in a conversation with the parent/caregiver. ✓ If your attempt resulted in an inability to leave a message, send an Attempt to Contact Letter within 24 hours or by the end of the business day if Friday. ✓ You may have multiple Introduction Calls if you are unable to contact the family. ✓ If using an interpreter to contact the client you will complete the Interpreter Services Referral activity.

6.6.2 Call Reminder

If your attempt resulted in leaving a message, determine the next date and time that you will attempt another call and document in Signify Community to set up a reminder.

Directions	Tips
A. From the Universal Add (+) button, choose Activity B. Select the 1st Five Episode in Member status C. In the Type field, select Introduction Call from the dropdown menu D. In the Date field, select a date approximately one week from this first attempted call E. Click Save	✓ You may postdate activities for reminders on your daily dashboard in Signify Community.

6.6.3 Attempt to Contact Letter

Send an Attempt to Contact Letter within 24 hours or by the end of the next business day if unable to contact family.

Step by Step Directions	Tips
A. From the Universal Add (+) button, choose Activity B. Select the 1st Five Episode in Member status C. In the Type field, select Send Letter D. Owner is the person who is sending the letter E. Enter the date the activity was completed F. In the Time field, document the time you started the letter G. In the Duration field, enter the amount of time you spent creating and sending the letter H. In the Outcome field, select Successful I. In the Type of Document field, select Follow Up Letter J. Click Save	✓ Use the Comment field at your discretion to remind you of information you want to have or remember if you return to the case. ✓ Approximately five business days after you send this first Attempt to Contact Letter, call the parent/caregiver (at a different time of day and/or on a different day of the week from your first attempt).

6.6.4 Texting

If your agency's protocols include texting, you may also send a follow-up text.

Directions	Tips
Document text messages as an Introduction Call Activity if no contact has been made to date.	✓ Follow your agency's protocols relative to maintaining client confidentiality during developmental support.

Document text messages as a Follow Up Call Activity if there has been contact with the client previously. Document text messages as a Care Coordination Activity if you receive a response from the parent/caregiver. A. Refer to Care Coordination Activity section 6.5.1b for detailed directions on how to document care coordination. B. Click Save	✓ Text messages can be documented differently depending on the type of contact that has been made with the client's parent/caregiver. ✓ Use the Comment field at your discretion to include what was sent via text.

6.6.5 Incoming Calls

Documents when you've missed a call from a client or they leave you a voicemail.

Directions	Tips
A. From the Universal Add (+) button, choose Activity B. Select the 1st Five Episode in Member status C. In the Type field, select Incoming Call D. Owner is the person who received the incoming call E. Enter the date the activity was completed F. Complete the Time field with the exact time of the call G. In the Outcome field, choose Successful from the dropdown menu H. In the Comment field, document details and click Save	✓ Do not use this to document when a client calls you and you have a conversation - that would be documented as a care coordination activity.

6.6.6 Provider Update

If attempts to contact are not successful with a client, send a provider update 2 weeks from the 1st attempt to contact a family.

Directions	Tips
A. From the Universal Add (+) button, choose Activity B. Choose the 1st Five Episode in Member status C. In the Type field, select Send Letter D. Owner is the person who is sending the letter E. Enter the date the activity was completed	✓ Update will include dates and times of attempted points of contact and request additional contact information such as alternative phone numbers or addresses.

F. In the Time field, document the time you began working on this activity G. In the Duration field, enter the amount of time you spent creating and sending the letter H. In the Outcome field, choose Successful I. In the Type of Document field, choose Referring Provider Letter J. In the Comment Field, document the updates included in the letter K. Click Save	✓ All activities are marked as successful. ✓ These letters must be uploaded into Signify Community. ✓ Provider updates may occur at various points in time during the DSS process.

6.6.7 Closing Letter = Thank You Letter to Family

Thank you letters to the family document the formal closing letter to the parent/caregiver. This will inform the parent/caregiver that you are closing the case and thank them for their work with 1st Five. It will include:

- 1st Five Contact information
- Reminder that referrals are only accepted via primary care providers for developmental intervention, to reduce the likelihood that a client will attempt to "self-refer"
- Encouragement for the parent/caregiver to contact their child's primary care provider regarding any future concerns

Directions	Tips
A. From the Universal Add (+) button, choose Activity B. Select the 1st Five Episode in Member status C. In the Type field, select Send Letter under the Task heading D. Owner is the person who is sending the letter E. Enter the date the activity was completed F. In the Time field, document the time you began working on this activity G. In the Duration field, enter the amount of time you spent creating and sending the letter H. In the Outcome field, select Successful I. In the Type of Document field, select Thank You to the Family J. Click Save	✓ All activities are marked as successful.

6.6.8 Close 1st Five Episode

If you are unable to reach the client and have completed 3 attempts to contact by phone and 3 attempts to contact by letter (not including the introduction letter), then at that time you can close their 1st Five episode.

There are 2 separate steps you must complete when closing a client's 1st Five episode due to no contact.

- Complete the Reconciliation Outcome and Referral Outcome in the Referral Activity.
- Edit the 1st Five Episode member status to CLOSED and enter the end date.

Directions	Tips
Reconciliation Outcome and Referral Outcome A. Within the client's timeline, find the Referral Activity and select the Edit pencil B. Select an outcome from the Referral Outcome field C. Select an outcome from the Reconciliation Outcome field D. Click save	✓ **Referral Outcome:** Document the Outcome status of the referral made by 1st Five ✓ **Reconciliation Outcome:** Document the service gap code ✓ Complete these responses relative to the primary reason for referral indicated on the 1st Five Referral form. This is the information that is documented in the "Reason" field in the Referral Activity.
Episode Status A. In the left panel, scroll down until you see the EPISODE block. Select the 1st Five Episode in Member status. This will briefly highlight the 1st Five Episode in the timeline. B. Select the Edit pencil C. In the Episode Status field, select Closed from the dropdown menu D. In the End Date field, select the date you sent the Referring Provider Letter to close the case E. At your discretion, you may complete the Note field with a summary of the results of the referral, especially the primary reason for referral F. Click save	✓ Make sure the owner of the episode is the person who worked the case. ✓ Verify that the case has been closed by checking the status in the left panel by scrolling down to the EPISODE block. ✓ There may be some activities within the bundle that will not be completed due to no contact. For example, Care Coordination and Complete Assessment. Do not delete these activities.

6.6.9 Satisfaction Survey

Clients that did not participate with 1st Five due to no contact, or who refused/declined services will not receive a survey but the activity still needs to be completed in Signify Community.

Directions	Tips
A. Find the Satisfaction Activity in the client's timeline B. Owner is often another agency staff person that does not perform the developmental support C. Enter the date the activity was completed D. In the Time field, document the time you began working on this activity E. In the Duration field, enter the amount of time you spent completing the survey F. In the Outcome field, choose Successful from the dropdown menu G. In the Topics field, select the question within the dropdown menu H. In the Survey Score field, select the appropriate response from the dropdown menu I. Click save.	✓ Survey score 6 can be used for those who declined services. ✓ Survey score 7 can be used for those that could not be reached.

SECTION 7: Follow Up

7.1 Scheduling Reminders for Care Coordination

If you will be making calls later to follow up on referrals or contact's progress, create a reminder for each call. You may postdate activities and they will appear as reminders on your daily dashboard in Signify Community.

Directions	Tips
A. From the Universal Add (+) button, choose Activity B. Select the 1st Five Episode in Member status C. In the Type field, select Care Coordination Activity from the dropdown menu (under the Service heading) D. Owner is the person responsible for completing that activity E. In the Date field, select the date that you plan to attempt the referral F. Click Save	✓ Review Appendix B for more information about using the My Overview Dashboard feature.

7.2 Referrals to Community Resources = Care Coordination Activity

Contact the community resources to which you are referring the client (for the contacts that the parent/caregiver is not making directly) and make appropriate referrals as identified by the provider and parent/caregiver.

Make referrals to a given community resource according to your agency protocols for referring to that specific resource (via phone, fax, e-mail, online referral system, etc.).

Directions	Tips
A. From the Universal Add (+) button, choose Activity B. Select 1st Five Episode in Member status C. In the Type field, select Care Coordination Activity from the dropdown menu D. Owner is the person who completed the activity E. Enter the date the activity was completed F. In the Time field, document the time you began working on this activity G. In the Outcome field, select Successful from the dropdown menu H. In the location field report the specific location of where the service is provided. I. Topics field is a reminder to add any Needs or Program Referrals you may discover during this activity J. In the Type of Service field, select Care Coordination Developmental from the dropdown menu K. In the Primary Payer field, select 1st Five from the dropdown menu L. Select the Interaction Type that corresponds with the activity. M. In the Service Provider field, select your name from the dropdown menu N. In the County of Service field, select the county within which you are located when providing the service O. Scroll down to the list of open text boxes. Complete each text box. The Description and Comment fields may be left blank if not needed. a. **Contacted person:** Enter the person's name with whom staff spoke to complete the service. If a fax was sent, enter the name of the lead contact person that your agency has established as the 1st Five contact or enter "Online submission referral form" or other information as appropriate.	✓ Note the time you started working on this activity. ✓ Repeat this process for each referral to each community resource. ✓ Each individual contact should be documented in Signify Community separately. Do not combine documentation. ✓ All activities are marked as successful. ✓ Early ACCESS referrals are documented as a Care Coordination Activity, not as Care Coordination Referrals. ✓ Referral documents do not need to be attached to the activity.

b. **Concerns and issues:** List the concerns/issues leading to the referral, including the reason for referral. c. **Staff response:** Document information you provided or highlighted while making the referral. Record the services and follow-up you suggested during the call. d. **Medical Appointment Summary:** If the care coordination service involves coordination of well child medical appointments, report the name of the child's medical provider and timeframe of appointment/visit. e. **Dental Appointment Summary:** If the care coordination service involves coordination of dental appointments, report the name of the child's dental provider and timeframe of appointment / visit. f. **Referrals, Outcomes, and Plan for Follow-up:** Describe and document the actions the community resource will take and your plan for follow-up about the outcome of the referral. g. **Client/family feedback:** This field may not be needed. h. **Description/Comment:** These fields may not be needed. P. Click Save.	

7.3 Follow Up Calls to Client with Contact = Care Coordination Activity

Care Coordination service activity is used to document care coordination services, including a call when you speak or correspond with a family. Follow-up with the parent/caregiver should occur within two weeks of the first time you reached the parent/caregiver. Execute periodic follow-up as needed with parent/caregiver to obtain information about referral status.

- Was the client able to connect with the referral resource?
- What is the status / eligibility status of the referral?
- What services are being provided?

Follow-up with the parent/caregiver may occur at varied frequencies depending on the nature of the needs and solutions

Directions	Tips
A. From the Universal Add (+) button, choose Activity B. Select 1st Five Episode in Member status C. In the Type field, select Care Coordination Activity from the dropdown menu D. Owner is the person who completed the activity E. Enter the date the activity was completed	✓ Interaction type may vary depending on how family was contacted. ✓ Each individual contact should be documented in Signify Community separately.

F. In the Time field, document the time you began working on this activity
G. In the Outcome field, select Successful from the dropdown menu
H. In the location field report the specific location of where the service is provided.
I. Topics field is a reminder to add any Needs or Solutions you may discover during this activity
J. In the Type of Service field, select Care Coordination Developmental from the dropdown menu
K. In the Primary Payer field, select 1st Five from the dropdown menu
L. Select the Interaction Type that corresponds with the activity
M. In the Service Provider field, select your name from the dropdown menu
N. In the County of Service field, select the county within which you are located when providing the service
O. Scroll down to the list of open text boxes. Complete each text box. The Description and Comment fields may be left blank if not needed.
    a. **Contacted person:** Enter the person's name with whom staff spoke to complete the service. If a fax was sent, enter the name of the lead contact person that your agency has established as the 1st Five contact or enter "Online submission referral form" or other information as appropriate.
    b. **Concerns and issues:** List the concerns/issues leading to the referral, including the reason for referral.
    c. **Staff response:** Record the services and follow-up you suggested during the call. Report staff responses shared with the family related to the expressed concerns or issues.
    d. **Medical Appointment Summary:** If the care coordination service involves coordination of well child medical appointments, report the name of the child's medical provider and timeframe of appointment/visit.
    e. **Dental Appointment Summary:** If the care coordination service involves coordination of

✓ If a follow up attempt with a parent/caregiver does not result in speaking or corresponding with parent/caregiver, the activity will be documented in Signify Community as a Follow Up Call.
✓ All activities are marked as successful even when calls do not result in actual contact with the client. Your attempt at contacting the client is successful.
✓ If the primary reason for referral has been addressed you will edit the Referral Activity and complete the Reconciliation Outcome and Referral Outcome in Signify Community at this time.

✓ In most cases, there will be approximately four follow-up contacts with the parent/caregiver.
✓ Until services are in place, additional Follow Up calls should occur at a minimum of one per month following the second time you reach the parent/caregiver.
✓ Client's episodes should be closed if they have been connected to resources, are on a considerable waitlist and not have additional needs. Report this information to the PCP in the closing letter.
✓ Clients that report no additional developmental needs and have been connected to resources are appropriate to close at this time. Discuss with the client and begin the closing process.
✓ If using an interpreter to contact the client you will complete the Interpreter Services Referral activity.

dental appointments, report the name of the child's dental provider and timeframe of appointment/visit. f. **Referrals, Outcomes, and Plan for Follow-up:** Describe and document the actions the community resource will take and your plan for follow-up about the outcome of the referral. g. **Client/family feedback:** Report any feedback from the parent/caregiver, such as declining specific services or suggestions or requests for specific assistance. Circumstances or recent/upcoming life events that are impacting the child may be indicated here, such as an upcoming move, changes in daily schedule and when the parent/caregiver can be reached, a recent death or illness in the family, or other items which may serve to remind you of important considerations as you continue to work with the family. h. **Description/Comment:** Use this field for additional summaries that you or another developmental support specialist or supervisor may need for follow-up with this child. P. Click Save.	✓ Review Section 6.5.1b on how to document Needs and Program Referrals within the Care Coordination Activity.

7.4 Follow Up Calls to Client without Contact = Follow Up Call

Attempts to contact a client that does not result in direct contact after a care coordination activity has occurred.

Directions	Tips
A. From the Universal Add (+) button, choose Activity B. Select the 1st Five Episode in Member status C. In the Type field, select Follow Up Call D. Owner is the person who completed the call E. Enter the date the activity was completed F. In the Time field, document the time you began working on this activity G. In the Outcome field, choose Successful from the dropdown menu H. In the Comment field, document details and click Save	✓ Follow Up calls are attempts to contact a client that does not result in direct contact AFTER a care coordination activity has already occurred. ✓ Follow up calls are used when you are following up on prior conversations. You must have already connected with the family.

	✓ If using an interpreter to contact the client you will complete the Interpreter Services Referral activity.

7.5 Follow Up Letters to Client = Care Coordination Activity

Care Coordination Activity is used to document follow-up letters with parent/caregiver to share brochures or information related to resources they are being connected to through 1st Five.

Directions	Tips
A. From the Universal Add (+) button, choose Activity B. Select 1st Five Episode in Member status C. In the Type field, select Care Coordination Activity from the dropdown menu D. Owner is the person who completed the activity E. Enter the date the activity was completed F. In the Time field, document the time you began working on this activity G. In the Outcome field, select Successful from the dropdown menu H. In the location field report the specific location of where the service is provided. I. Topics field is a reminder to add any Needs or Program Referrals you may discover during this activity J. In the Type of Service field, select Care Coordination Developmental from the dropdown menu K. In the Primary Payer field, select 1st Five from the dropdown menu L. Select the Interaction Type that corresponds with the activity M. In the Service Provider field, select your name from the dropdown menu N. In the County of Service field, select the county within which you are located when providing the service O. Scroll down to the list of open text boxes. Complete each text box. The Description and Comment fields may be left blank if not needed. a. **Contacted person:** Enter the person's name with whom staff are contacting to complete the service.	✓ Follow up letters are helpful in summarizing phone calls so that the parent/caregiver has the contact information necessary to follow through with referrals discussed. ✓ Each individual contact should be documented in Signify Community separately. ✓ All activities are marked as successful.

b. **Concerns and issues:** Describe the concerns/issues reviewed with the parent/caregiver. c. **Staff response:** Record the services and follow-up you suggested. d. **Medical Appointment Summary:** If the care coordination service involves coordination of well child medical appointments, report the name of the child's medical provider and timeframe of appointment/visit. e. **Dental Appointment Summary:** If the care coordination service involves coordination of dental appointments, report the name of the child's dental provider and timeframe of appointment/visit. f. **Referrals, Outcomes, and Plan for Follow-up:** Describe and document the actions the parent/caregiver and you will take to access services and community resources as listed, clearly indicating the steps to be completed by the parent/caregiver delineated from the steps to be completed by you. g. **Client/family feedback:** Report any feedback from the parent/caregiver, such as declining specific services or suggestions or requests for specific assistance. Circumstances or recent/upcoming life events that are impacting the child may be indicated here, such as an upcoming move, changes in daily schedule and when the parent/caregiver can be reached, a recent death or illness in the family, or other items which may serve to remind you of important considerations as you continue to work with the family. h. **Description/Comment:** Use this field for additional summaries that you or another developmental support specialist or supervisor may need for follow-up with this child. P. Click Save.	

7.6 Follow Up with Program Referral = Care Coordination Activity

Care Coordination Activity is used to document care coordination services, including follow up interactions with community resources. Execute periodic follow-up as needed with community resources to obtain information about referral status. Follow-up with community resources should occur no longer than two weeks following the send date of your referral.

- Was the client able to connect with the referral resource?
- What is the status / eligibility status of the referral?
- What services are being provided?

Directions	Tips
A. From the Universal Add (+) button, choose Activity B. Select 1st Five Episode in Member status C. In the Type field, select Care Coordination Activity from the dropdown menu D. Owner is the person who completed the activity E. Enter the date the activity was completed F. In the Time field, document the time you began working on this activity G. In the Outcome field, select Successful from the dropdown menu H. In the location field report the specific location of where the service is provided. I. Topics field is a reminder to add any Needs or Program Referrals you may discover during this activity J. In the Type of Service field, select Care Coordination Developmental from the dropdown menu K. In the Primary Payer field, select 1st Five from the dropdown menu L. Select the Interaction Type that corresponds with the activity	✓ Each individual contact should be documented in Signify Community as Care Coordination separately. ✓ Follow-up may occur at varied frequencies depending on the referral protocols of the resources and availability of the service. ✓ Interaction type may vary depending on how the referral resource was contacted. ✓ If follow up attempts with community referral does not result in speaking or corresponding with them, the activity will be documented in Signify Community as a Follow Up Call. ✓ All activities are marked as successful even when calls do not result in actual contact. Your attempt at contacting was successful.

M. In the Service Provider field, select your name from the dropdown menu N. In the County of Service field, select the county within which you are located when providing the service O. Scroll down to the list of open text boxes. Complete each text box. The Description and Comment fields may be left blank if not needed. a. **Contacted person:** Enter the person's name with whom staff spoke to complete the service. b. **Concerns and issues:** List the concerns/issues leading to the referral, including the reason for referral. c. **Staff response:** Document information you provided or highlighted while making the referral. Record the services and follow-up you suggested during the call. d. **Medical Appointment Summary:** If the care coordination service involves coordination of well child medical appointments, report the name of the child's medical provider and timeframe of appointment/visit. e. **Dental Appointment Summary:** If the care coordination service involves coordination of dental appointments, report the name of the child's dental provider and timeframe of appointment/visit. f. **Referrals, Outcomes, and Plan for Follow-up:** Describe and document the actions the community resource will take and your plan for follow-up about the outcome of the referral. g. **Client/family feedback:** This field may not be needed.	

h. **Description/Comment:** These fields may not be needed. P. Click Save.	

7.7 Referral Outcome & Reconciliation Completion

When the primary reason for the referral has been addressed, you will complete the Reconciliation Outcome and Referral Outcome within the Referral Activity.

Directions	Tips
A. Within the client's timeline, find the Referral Activity and select the Edit pencil B. Select an outcome from the Referral Outcome field C. Select an outcome from the Reconciliation Outcome field D. Click save	✓ **Referral Outcome:** Document the Outcome status of the referral made by 1st Five ✓ **Reconciliation Outcome**: Document the service gap code ✓ Complete these responses relative to the primary reason for referral indicated on the 1st Five Referral form. This is the information that is documented in the "Reason" field in the Referral Activity.

SECTION 8: Reporting Back to Provider

8.1 Provider Updates

After appropriate referrals and connections are made, send an update letter to the provider.

- Suggested points in time are at 2 months following the date of referral and at the end of the case.
- Additional letters may be sent if appropriate for the individual case. It is unlikely that these would occur more than every two months.
- Include information on:
  - client contacts (including attempted contacts that were not successful)
  - referrals approved & made out
  - future plan for follow up

Directions	Tips
A. Use the Universal Add (+) button to add an Activity B. Choose the 1st Five Episode in Member status C. In the Type field, select Send Letter	✓ All activities are marked as successful.

D. Owner is the person who is sending the letter E. Enter the date the activity was completed F. In the Time field, document the time you began working on this activity G. In the Duration field, enter the amount of time you spent creating and sending the letter H. In the Outcome field, choose Successful I. In the Type of Document field, choose Referring Provider Letter J. Upload a copy of the provider closing letter: a. Scroll down to Add Related Content b. Select the Attachment button and upload the letter. K. Click Save	✓ Attach provider updates to the Send Letter activity.

SECTION 9: Closing the Case

9.1 Closing Letter = Thank You Letter to Family

Thank you letters to the family document the formal closing letter to the parent/caregiver. This will inform the parent/caregiver that you are closing the case and thank them for their work with 1st Five. It will include:

- 1st Five Contact information
- Recap of referrals and contact information for the community resources to which the child was connected
- Reminder that referrals are only accepted via primary care providers for developmental intervention, to reduce the likelihood that a client will attempt to "self-refer"
- Encouragement for the parent/caregiver to contact their child's primary care provider regarding any future concerns

Directions	Tips
A. Use the Universal Add (+) button to add an Activity B. Choose the 1st Five Episode in Member status C. In the Type field, select Send Letter D. Owner is the person who is sending the letter E. Enter the date the activity was completed	✓ All activities are marked as successful.

F. In the Time field, document the time you began working on this activity G. In the Duration field, enter the amount of time you spent creating and sending the letter H. In the Outcome field, choose Successful I. In the Type of Document field, choose Thank You to Family J. In the Comment Field, document the updates included in the letter K. If you prefer to or if your agency protocols require it, include the letter within Signify Community, upload it using the following steps: a. Scroll down to Add Related Content b. Select the Attachment button and upload the letter L. Click Save	

9.2 Provider Update

Write an individualized letter to the provider. The letter is not a form with check boxes. This letter will inform the provider that you are closing the case and thank the provider for the referral.

- It will include:
  - A summary of the community resources to which the child was connected and the results of the connections offered.
  - A copy of the closing letter to the family.
  - An invitation for the provider to refer again if additional developmental concerns are identified before the child's 5th birthday.

Directions	Tips
A. Use the Universal Add (+) button to add an Activity B. Choose the 1st Five Episode in Member status C. In the Type field, select Send Letter D. Owner is the person who is sending the letter E. Enter the date the activity was completed F. In the Time field, document the time you began working on this activity G. In the Duration field, enter the amount of time you spent creating and sending the letter H. In the Outcome field, choose Successful I. In the Type of Document field, choose Referring Provider Letter J. Upload a copy of the provider closing letter:	✓ Attach provider updates to the Send Letter activity.

a. Scroll down to Add Related Content b. Select the Attachment button and upload the letter. K. Click Save.	

9.3 Close 1st Five Episode

Directions	Tips
A. In the left panel, scroll down until you see the EPISODE block. Select the 1st Five Episode in Member status. This will briefly highlight the 1st Five Episode in the timeline. B. Select the Edit pencil C. In the Episode Status field, select Closed from the dropdown menu D. In the End Date field, select the date you sent the Referring Provider Letter to close the case E. At your discretion, you may complete the Note field with a summary of the results of the referral, especially the primary reason for referral F. Click save	✓ Make sure the owner of the episode is the person who worked the case. ✓ Verify that the case has been closed by checking the status in the left panel by scrolling down to the EPISODE block.

9.4 Satisfaction Survey Reminder

Schedule the date to complete the satisfaction survey(s).

Directions	Tips
A. Find the Satisfaction Survey in the client's timeline and click the Edit pencil B. In the Date field, choose the date based on the child's birthdate C. Click save	✓ If the child's birth date is on the 1st through the 10th of the month, select a date two weeks from today. ✓ If the child's birth date falls on other days of the month, select a date four weeks from today.

9.5 Satisfaction Survey

- All clients will receive a satisfaction survey.
- This may be completed by the Developmental Support Specialist who provided the support if they are the only 1st Five staff member at the agency. If another Developmental Support Specialist or Site Coordinator is available, they will complete the survey instead.

- 3 attempts to complete the satisfaction survey must be completed. Attempts to contact the client's parent/caregiver must be made at different times/days.
- Follow your agency protocol (checklist, word document, etc.) for asking the five required questions and recording the responses. (These are not recorded in Signify Community.)
- Transfer the responses to the individual at your agency who completes the Satisfaction Survey spreadsheet monthly for the program evaluation contractor. (The Satisfaction Survey spreadsheet template is available from the program evaluation contractor.)

Directions	Tips
A. Find the Satisfaction Activity in the client's timeline B. Owner is often another agency staff person that does not perform the developmental support C. Enter the date the activity was completed D. In the Time field, document the time you began working on this activity E. In the Duration field, enter the amount of time you spent completing the survey F. In the Outcome field, choose Successful from the dropdown menu G. In the Topics field, select the question within the dropdown menu H. Call the parent/caregiver and ask the question I. In the Survey Score field, select the appropriate response from the dropdown menu J. Click save.	✓ If the child's birthday falls on the 1st through the 10th of the month, the long survey, consisting of five questions, will be given to the parent/caregiver and should be completed 2 weeks from the closing date. ✓ If the child's birthday falls after the 10th of the month, the short 1 question survey will be given to the parent/caregiver and should be completed 1 month from the closing date.

APPENDIX A

Developmental Support Specialist Required Trainings

Developmental Support Specialist(s) will be expected to complete the core competency training requirements outlined below within the first six (6) months of the contract period or within the first six (6) months of hire. Staff that have already completed training in prior contract years do not need to repeat the same training, this includes subcontracted personnel.

Training opportunities may be accessed by trained internal agency staff, statewide training, or national training. Face-to-face, online modules, and on-site training are recommended. Minimum training requirements:

1. Traumatic Stress on Brain Development
2. Caregiver Depression
3. Active Listening/Motivational Interviewing
4. Child Development and Attachment
5. Working with Families Affected by Substance Abuse Disorders
6. Working with Families Affected by Domestic Violence
7. ASQ and ASQ:SE Developmental Screening Tools
8. Title V Maternal Child Health online training modules
    a. CAH/EPSDT
    b. Informing
    c. Care Coordination
    d. IDPH data system
9. Adverse Childhood Experiences Training Modules
10. Cultural Competency

APPENDIX B

My Overview Dashboards

The My Overview Dashboard gives you a quick snapshot of all assigned and overdue activities for the week. This is the best place to ensure you stay up-to-date on all your open Activities.

Directions
A. To view your available Dashboards, hover over the Dashboard button in the Navigation Bar. B. Choosing My Overview will take you back to the homepage where you can reference all current activities. These include: a. Overdue Activities: Activities assigned to you that are past the scheduled due date b. Today's Activities: Activities assigned to you that are scheduled for the current date c. Activities Completed Today: Activities assigned to you that have been completed d. Program Referrals Created: Referrals created by you, still pending completion