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Practice Summary & Implementation Guidance

The Cycle of Engagement Well Visit Planner Approach to Care

The Cycle of Engagement Well Visit Planner (COE WVP) Approach is a whole-child family-centered model developed by the Child and Adolescent Health Measurement Initiative (CAHMI) that provides digital tools to support high-quality, personalized care while streamlining collaboration across health care, home visiting, and other state and local early childhood systems.

Location	Topic Area	Setting
National	Primary & Preventative Care, Safe and Connected Communities	Clinical, Community

Population Focus	Date Added
Families & Caregivers, Medical and Public Health Professionals, Children	June 2025

Contact Information
Christina Bethell, Child and Adolescent Health Measurement Initiative, 971-404-7234, cbethell@jhu.edu

Section 1: Practice Summary

PRACTICE DESCRIPTION

Cycle of Engagement Well Visit Planner Approach to Care fills gaps and addresses existing barriers to the comprehensive, family engaged, personalized care needed to effectively promote child and family health. For infants and young children, the pediatric well-child visit is among our greatest opportunities to promote children's healthy development and prevent future issues. Since 1990, Bright Futures Guidelines have recommended 15 well-child visits in a child's first 5 years of life; yet half of these visits are not occurring. This is especially true for our youngest children (under 15 months of age) where the opportunities to promote healthy development and identify and address risks early are greatest. For visits that do occur there are still wide gaps in care driven by logistical challenges related to conducting the comprehensive child and family health assessments, difficulties engaging families to ensure their needs and priorities are met, and little time to build the trust and relationships required for effective, quality care (Bethell et al, 2004; Norlin et al, 2011; Schuster et al, 2000). Even today, only one in three children in the US receive screening for their development before age three. To address utilization, quality, and cross-system collaboration barriers to implementing Bright Futures Guidelines, and to improve health outcomes for all children and families, the CAHMI created the three-part **Cycle of Engagement (COE) Approach to Care and Tools,** consisting of the **Well Visit Planner (WVP), Personalized Connected Encounter (PCE), and Online Promoting Healthy Development Survey (PHDS)**. The COE WVP engages families before, during, and after well-child visits, empowering families and their child health professionals to transform screening into a whole child and family learning and personalized care experience ensuring time is used to address family goals, needs, and priorities. This novel approach addresses many barriers in care delivery by helping health care providers and professionals to align with best practice approaches to care, including national performance measures, Bright Futures Guidelines, and growing efforts to link payment to quality of care.

The pre-visit tool, the Well Visit Planner (WVP), is an evidence-based family-facing digital health tool that takes about ten minutes for families to complete and can be used by any child health professional (e.g., pediatricians, community health workers, home visitors, educators, etc.). The WVP operationalizes Bright Futures Guidelines while educating families about well visits and their child's development, promoting health literacy and empowering families to be partners in care. Families are guided through all recommended screeners for their child's age, are asked to reflect on strengths, goals and concerns, and select their unique priorities to discuss with their health care provider. The WVP automatically generates and enables interoperable sharing of an "at a glance" summary of findings, resource links, and tips for both the family and child health professionals. After completing the WVP, families receive their results with educational explanations and links to Family Resource Sheets provided from a downloadable Well Visit Guide. Providers using the WVP receive a one-page Clinical Summary of family responses. This at-a-glance summary of screening results, family goals, concerns, and priorities help providers prepare for and focus well visits on the family's agenda and ensures high quality care while streamlining documentation, billing, reducing emergency room visits, and increased coordination with community supports.

As a result of this pre-visit investment, the time providers and families spend engaging in meaningful discussion during a well-child visit is maximized. This enhanced well visit creates a Personalized Connected Encounter (PCE) and empowers providers to easily identify and celebrate strengths, share decisions about whether and how to address concerns or risks, focus education and linkages to community supports based on the priorities of each child and family, and strengthen the provider-family relationship, increasing the family's adherence to well-child visits.

Finally, the COE takes the partnership between providers and families one step further by providing an easy-to-use, validated digital tool to help providers and families assess and get feedback on the quality of care they received or provided using the Online Promoting Healthy Development Survey (PHDS). After use by at least 25 families, providers receive an aggregate quality report on a range of quality measures aligned with the Bright Futures Guidelines. These reports help providers continuously learn and improve quality of care while partnering with families and other early childhood health systems in addition to deepening their understanding of the needs of their patient population. After completion of the PHDS families receive a personalized feedback report with tips and resources to get the best care possible for their child and family.

COE tools can be used individually but are most effective together. Non-healthcare professionals, including educators, home visitors, community-based workers, and social workers, can also leverage the WVP to connect families with healthcare providers and community resources and educate and engage families in their children's health care. These tools were developed through extensive partnerships with providers, families, community-based organizations.

To learn more about our COE Model and Tools, please view the following videos and resources:

- COE Video for Providers
- 2 Minute Video Overview of the WVP for Families
- 2 Minute Video Overview of the WVP for Families (Spanish)
- COE Getting Started Toolkit
- Summary of the Cycle of Engagement Model and Tools for Child Health Professionals
- Possibility Prototypes Across Ten Early Childhood Health System Partners

Finally, please see below for images of webpages and images of our materials for your reference:

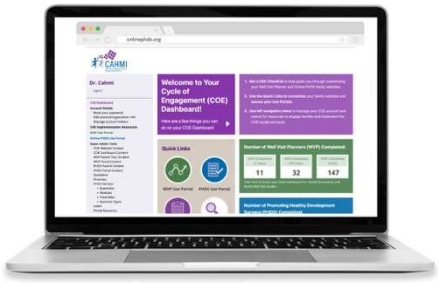
Well Visit Planner Family Facing Website (English)

wellvisitplanner.org

Well Visit Planner Family Facing Website (Spanish)

wellvisitplanner.org

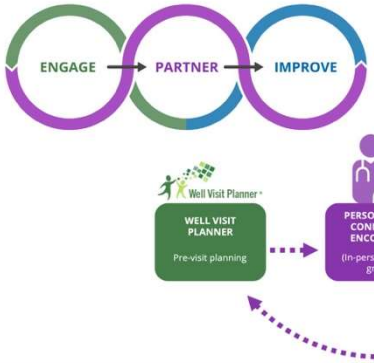
Cycle of Engagement Provider Account Dashboard



Example Provider Clinical Summary

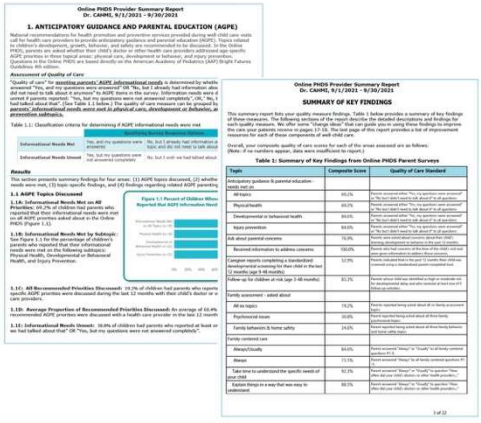
Example Family Well Visit Guide (Also Available in Spanish)

Cycle of Engagement Visualization

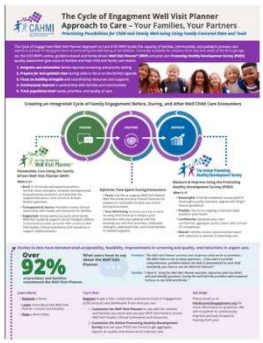


Promoting Healthy Development Survey Website

Promoting Healthy Development Survey Provider Report



Example Engagement Flyers for Providers and Families



CORE COMPONENTS & PRACTICE ACTIVITES

The Cycle of Engagement Well Visit Planner Approach (COE WVP) helps families partner in their child's care and supports providers in delivering whole child, family-centered care. Families use the Well Visit Planner (WVP) and the Promoting Healthy Development Survey (PHDS) through public websites where they can create accounts, complete tools, and receive personalized guide and feedback reports. These reports include family-friendly educational information, resource links, and age-appropriate anticipatory guidance. Providers access their own dashboards to view Clinical Summaries and Well Visit Guides from the WVP, aggregate PHDS data report, and to customize their tools. The COE also includes the Personalized Connected Encounter (PCE) which helps care align with Bright Futures Guidelines and promotes ongoing family engagement across systems to support high quality, whole child and family care.

Core Components & Practice Activities		
Core Component	**Activities**	**Operational Details**
Well Visit Planner (WVP) The Family Facing WVP Website	Parents/Caregivers complete the public or provider customized WVP online at wellvisitplanner.org. Families can create a family WVP account	Families can complete the WVP online or on their phones using the public use tool or provider customized WVP before or at their visit. They can create an account to save results and share them with their provider. Providers can customize the WVP for their patients and access family data and Clinical Summaries through their COE account.
Well Visit Planner (WVP) Family and Provider Reports	Well Visit Guide (WVG): Families review their completed WVP to identify areas where they need support to prepare for their upcoming visit. Clinical Summary (CS): Providers review WVP results in a summary sent to their account or shared with them by a family.	Families automatically receive a Well Visit Guide (WVG) with educational resources, links to supports, example questions to ask their provider, anticipatory guidance, and explanations of screeners and assessments results. Providers receive an at-a-glance Clinical Summary (CS) with family responses, helping them prepare for the visit. Both support the Personalized Connected Encounter and care coordination.
Personalized Connected Encounter (PCE)	A healthcare provider or early childhood professional spends time celebrating strengths and addressing family needs and priorities.	Providers and early childhood professionals use the PCE roadmap to strengthen family partnerships through shared decision-making, priority-based discussions, and resource connections to build trust and relationships.
Online Promoting Healthy Development Survey (PHDS)	Parents/Caregivers complete a short survey on the quality of care	This family-completed survey yields 8 meaningful quality indicators aligned with Bright Futures guidelines and is designed to

The Family Facing PHDS Website	they received online at www.onlinephds.org website.	foster improvements in quality as measured by the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures and the Medicaid Core Measurement Set. It also aligns with the American Board of Pediatrics' Continuing Education and Maintenance of Certification requirements.
Online Promoting Healthy Development Survey Family and Provider Reports	Families receive personalized feedback to partner in improving care, while providers can access aggregate data reports for quality improvement planning	Providers can generate confidential, aggregate quality report after 25+ PHDS completions to inform quality improvement efforts. They can use the data to adjust care to address potential gaps and can celebrate their team's strengths. Families receive a feedback report of the quality of care they experienced with resources to partner in improving care.
Full Cycle of Engagement Approach to Care Family Engagement	Families are engaged at every part of the well-child visit and are empowered to be partners in care.	Providers and family facing organizations can partner to help families complete the WVP and PHDS, using promotional materials provided to engage them in care. This supports family participation in the Personalized Connected Encounter (PCE) and links them to needed resources
Full Cycle of Engagement Approach to Care Family and Provider Accounts	Family account online saves child/children's information and previous reports. Through a provider account, providers can access their dashboard to share and receive family data and customize the WVP and PHDS.	Family accounts store child results and resources, while provider dashboards offer access to WVP data, customization tools, and implementation supports. Interoperability allows care teams to share WVP responses across early childhood partners.
Full Cycle of Engagement Provider Portals	Providers can create a Cycle of Engagement provider account at implement.cycleofengagement.org.	With an account providers can access their unique WVP and PHDS Use Portals and Data Dashboards. Providers can use these portals to customize their tools for the families they serve and access family data and reports. Through these portals providers, with family consent, can share Clinical Summaries with other provider accounts.
Full Cycle of Engagement	The Cycle of Engagement is aligned with Bright Futures best	Section 2713 of the Public Health Service Act requires all health plans to provide

Approach to Care Bright Futures Guidelines	practice guidelines and its tools operationalize these guidelines.	preventive care aligned with Bright Futures Guidelines. The WVP supports standardized screenings and the PHDS aligns with performance measures evaluating care quality.
Full Cycle of Engagement Approach to Care Whole Child and Family Centered Care	The entire Cycle of Engagement model ensures the whole child is addressed and care is centered around families' unique needs.	The WVP screens for development, social needs, family functioning, and maternal depression. The PCE helps providers address family strengths and needs, connecting them to appropriate resources.

COMMUNITY WELLBEING

The CAHMI has always been informed by quality principles as we seek to serve children and families. Our primary focus has been to ensure comprehensive and engaging well-visits for all children and youth as they are a powerful mechanism for uplifting family needs and priorities and ensuring consistent levels of care through the COE. The power of the COE approach to care is that it uplifts the needs and priorities of children, families, and communities across the United States.

The COE is designed to meet families where they are and provide the tools and resources needed to reduce differences in care and outcomes. They include comprehensive whole child and family health screeners and assessments to ensure families can share any information that may impact a child's healthy development. It also provides family resources on health topics so families can take the lead in learning about and supporting their child's development. To ensure different populations' needs are met, we have had COE materials translated into Spanish, so providers working in Hispanic communities are able to offer high-quality care to all patients. COE tools also address different health needs by helping families receive comprehensive care for children with special healthcare needs. To assess that health care providers and systems are making strides towards quality health, the COE tool, the PHDS provides an opportunity for families to share feedback on the quality of care they received so that providers can make important adjustments.

In terms of outcomes, these materials have a great impact on child and family health. In a Mathematica independent evaluation, the Well Visit Planner (WVP) was found to be an important tool to promote health literacy in families, improve rates of early screening, and addresses societal challenges. Further, qualitative data reveals providers report experiencing that more families share social health risks through the WVP enabling providers to then connect families with resources and reduce harmful outcomes. The WVP has also been found to reduce urgent care visits and increase adherence to well visit schedules (Coker et al, 2016).

EVIDENCE OF EFFECTIVENESS

Both the WVP and PHDS have been evaluated in multiple studies. Development and testing have been made possible through grants such as those provided by Health Resources and Services Administration Maternal and Child Health Bureau (HRSA/MCHB) (R40 MC08959), and Administration for Children and Families, Office of Head Start (#90HC0005) as examples. Across these studies the WVP and PHDS have consistently demonstrated they have positive impacts on care quality, family engagement, and clinic efficiency and families consistently rated

the tools as easy to use and valuable in improving their engagement and understanding of their child's health care.

Early Development and Testing of the Promoting Healthy Development Survey (2001)

The PHDS was sent to families from three managed care organizations (MCOs). 1478 families received the survey by mail. There were 36 items of the survey assessing seven quality measures related to provision of services:

1. Anticipatory guidance from providers
2. Anticipatory guidance from health plan
3. Follow-up for children at risk for developmental problems
4. Assessment of psychosocial well-being and safety in the family
5. Assessment of substance use in the family
6. Family-centered care
7. Helpfulness and effect of information from providers and plan on confidence

Several analyses were conducted to assess the reliability, validity, and patterns of variation in PHDS measures. Both factor analysis and internal consistency measures demonstrated that the PHDS is a reliable tool. Validity tests of family responses on questions that were related (e.g., parent behavior concerns addressed and provision of anticipatory guidance about behavior) also revealed the PHDS is a valid tool. As one example, significantly fewer parents reported child behavior concerns if they also reported that their provider shared anticipatory guidance about behavior they could expect to see in their child. 19 of 21 hypothesized relationships between questions were found to be significant in parent responses, demonstrating the PHDS is a highly valid tool. Cognitive testing was also conducted with 15 families across racial, education, and income groups. Testing revealed families were able to complete the survey in 10-15 minutes, and the survey was readable across education levels.

Patient Centered Quality Improvement of Well-Child Care Final Report for MCHB, HRSA (2012)

An early version of the WVP called the "Plan My Child's Well Visit Tool" was implemented at one pediatric clinic, The Children's Clinic (TCC) in Tualatin, Oregon, with 12 pediatricians. A total of 2,075 parents completed the online tool before their child's well-child visit. The tool was evaluated using:

1. The Promoting Healthy Development Survey (PHDS) before and after the tool was implemented
2. Parent feedback on usability and value of the tool
3. Clinician and staff surveys and focus groups
4. Usage data to understand the acceptability and feasibility of provided educational sources for parents.

Parents who used the early version of the WVP rated their visits more positively. 86% said the tool helped them prioritize topics to discuss with their child's health care provider, 82% said that the WVP helped them understand goals for each well visit, and over 92% of the parents who participated said they would recommend the tool to others. Also, 59.6% of parents reported that the PHDS helped them to learn about what they can and should expect at a well-child visit.

Providers reported that the tool improved visit efficiency and supported more meaningful conversations. Providers and staff reported that implementation of the early WVP improved their office workflow and that they valued it as an important tool to support well child care in their practice. Providers and staff noted that use of the tool: (1) freed up nurses' time to address new issues and topics; (2) helped providers to prepare for the visit before they met with the parent; (3) allowed nursing staff to print materials targeted to parents' needs before the visit; and (4) helped to prevent delays in the appointment time.

A Randomized Controlled Trial Assessing the Effects of the Well Visit Planner on Well Visit Care Quality and Utilization Among Low-Income Children (2016)

In the initial RCT, the new model for well-child care (WCC) was developed with two pediatric practices in Los Angeles County that serve a high number of families insured by Medicaid and the practices' community advisory boards. The Well Visit Planner was included in the model in addition to a parent coach who served as a health educator to enrolled families, a text message system with age-specific health information for families, and a brief session with a provider. Control families received regular standard care, and both clinics received both experimental and control group patients. All pediatricians were enrolled in the study as health care providers.

Enrolled parents completed a baseline survey and a phone interview at the end of the 12-month period of the study. Several outcome measures were assessed via parent report on an enhanced version of the PHDS:

1. Utilization: up-to-date WCC, sick visits, and Emergency Department visits
2. Receipt of preventive care services: anticipatory guidance, assessment of psychological well-being and safety in the family, assessment for substance use in the home, developmental assessment, developmental concerns addressed, health information received
3. Experiences of care: helpfulness of care, family-centeredness of care, rating of care

Parents in the intervention group scored significantly higher than the control group on all preventive care measures (e.g., receipt of anticipatory guidance and assessments), all of which are included in the WVP. For example, 92.2% of intervention parents reported receiving developmental screening versus 81.1% in the control group. Ratings of care were also significantly higher for intervention parents which could be due to having specific priorities and concerns prepared at the start of the well visit from the WVP (94.5% vs 91.7%). Children in the intervention group were less likely to have emergency department visits (10.4% vs 21.6%).

An Analysis of Parent Experiences Using the Well Visit Planner (2017)

In the follow-up study, intervention parents were asked a range of questions about the intervention overall, with six questions focused specifically on the WVP:

1. Did they complete the WVP before any of their well visits
2. Where did they complete the WVP
3. How many well visits for which they completed a WVP
4. Ease of use
5. Helpfulness
6. If they would recommend that the pediatrician continue to make the WVP available

The survey data demonstrates that, overall, families used and appreciated the WVP as an easy-to-use tool that shared key information with them to best engage with the well visit. 94% reported it was easy to use, 97% reported it was helpful for preparing for the well visit and 96% said they would recommend their pediatrician to continue to make it available. The qualitative data revealed that families saw the WVP as an additional source for information and guidance and that they felt more prepared for the visit. These qualitative results underscore that families see the WVP as a useful tool to build their own confidence and knowledge base for engaging in their child's health care.

Section 2: Implementation Guidance

COLLABORATORS AND PARTNERS

The CAHMI deeply values the partnerships developed with our collaborators. The COE WVP has been intentionally and iteratively designed and tested with the input of collaborators to ensure it meets real-world needs and centers family and provider voices. Their contributions remain vital to the model's ongoing development and success.

Practice Collaborators and Partners			
Partner/ Collaborator	**How are they involved in decision-making throughout practice processes?**	**How are you partnering with this group?**	**Does this stakeholder have lived experience/come from a community impacted by the practice?**
Research Partners	Research partners have collaborated to design, develop, and implement studies and testing the effectiveness of the Well Visit Planner and PHDS.	The partnered in implementation of the COE and provided feedback on the design and implementation of the COE.	Yes, research partners extended to providers and families as well as academic researchers. These populations are directly impacted by the practice as implementers, facilitators, and users.
Families	In various research studies, families and community organizations (e.g., Family Voices) have been engaged to share feedback about their experience with the WVP and PHDS to improve the user experience.	Families complete the WVP/PHDS and CAHMI works closely with their providers to ensure implementation is successful, quality of care is improved, and changes can be made based on feedback. In the research context, families and providers both provide feedback on their use of the practice.	Yes, families are the target population for using COE tools, so their experiences and input are invaluable for continuous improvement in quality and design.

Health Care Providers	The CAHMI meets with providers to support their implementation process and guide them through any workflow or technology challenges. Providers using COE tools are routinely asked about their experiences using the tools and how the CAHMI can improve their user experience. Health care providers have also been included as research partners and have been involved extensively with the design, development, and research of the practice.	Early adopters are currently able to set up free COE accounts. Once they set up an account, a member of the CAHMI team meets with them to provide technical assistance and plan how to continuously support. The CAHMI works closely with new implementers to learn about their experiences and incorporate their feedback in the tools	Yes, health care providers are a key target population of the COE, so it is critical for the CAHMI to best understand their experiences and make changes based on their feedback.
Health Systems	Multiple health systems were engaged to share the COE tools with their provider networks (e.g., Lifebridge Health, Medicaid, Health Plans). These networks also were involved in data collection for research on COE effectiveness.	A provider from Lifebridge Health continues to serve on the COE advisory board to share ideas for further COE dissemination. The PHDS has been utilized by 11 Medicaid agencies and 4 Health Plans.	Yes, health care systems are critical to a wide dissemination of the COE tools among both providers and the families they serve. Health systems engaged with the CAHMI on the COE to improve patient engagement and outcomes.
Community Based Organizations (CBOs)	CBOs such as Mississippi Families for Kids, National Black Child Development Institute, Help Me Grow, and Head Start have learned about the COE tools and have engaged technical assistance support for implementing in their settings.	The CAHMI routinely provides technical assistance, training, and support to CBOs interested in using the COE to support families in engaging in the health care system	Yes, CBOs that have expressed interest in the COE are typically from communities that have greater gaps in child health outcomes due to differences in care quality, options, and access in healthcare services.
Health and Human Services (HHS) agencies and grants specifically under Health Resources and Services	Multiple agencies and grants that are part of HRSA have collaborated with CAHMI in the creation and dissemination of the COE tools. Bright Futures, Title V, Early Childhood Developmental Health System Grant, Child Care and	The CAHMI has previously and continues to support many technical assistance projects from agencies such as Title V and the Child Care and Development Fund	These collaborators support communities, e.g., families, health care providers, and early childhood professionals, that would use the COE tools.

Administration (HRSA) and Administration for Children and Families (ACF)	Development Fund have all been engaged in using the COE by sharing COE resources with key stakeholders.	such as making toolkits for lead members to plan use of the COE in their state or locality. CAHMI partnered with the Mississippi Thrive project under the Childhood Developmental Health System Grant to explore the use of the COE to integrate early childhood systems. Health care providers and leaders involved in Bright Futures contributed to the development of COE resources.	
Leadership Advisory Board	The LAB convenes bi-yearly to discuss COE projects. Members-- including health care providers, CBO leaders, researchers, healthcare consultants and others-- are frequently invited to share their experiences. Members share ideas for dissemination and strategies for overcoming barriers to implementation. Members may also volunteer to support new COE project efforts in their communities.	Members may choose to partner with COE projects in different ways, depending on their own expertise, the needs of their community, their organization's capacity, and how COE tools would be used. The CAHMI provides support and routinely collaborates with members who are using the COE.	Yes, many members have used the COE as providers or seek to use the COE to support families in their communities.
American Academy of Pediatrics (AAP)	The AAP helped to support the development of the WVP and PHDS as they operationalize the Bright Futures Guidelines put forth by the AAP	Members of the AAP have served on our boards to share their feedback and expertise on the development and implementation of the tools.	Yes, many members have experience as pediatric providers.
OCHIN Epic	OCHIN is currently working to guide, develop,	The CAHMI is currently meeting	Yes, specifically OCHIN provides Epic to Community

	and support ongoing efforts to integrate the WVP into OCHIN Epic.	once a week with OCHIN to support these efforts.	Health Centers which are key communities impacted by the practice.
American Board of Pediatrics (ABP)	The ABP has partnered to create reporting based on the PHDS quality reports for provider's Maintenance of Certification (MOC) Part 4 credit.	The CAHMI works with the ABP to ensure the proper processes are in place for the providers using PHDS quality reports to improve care quality for their credit.	No

REPLICATION

The COE WVP tools, specifically WVP, have been replicated in multiple settings. Since its initial evaluation in Los Angeles County, the WVP has since been used in a research study in a Maryland integrated health system, LifeBridge Health. Study findings showed 95% use of WVP "Whole Child and Family" Clinical Summaries in well visits improved trust to address social and relational health risks, time savings and more in-depth education and counseling on child/family priorities. All providers agreed the COE WVP is an important population health improvement strategy and reported more satisfaction with well visits using the WVP. Additionally, almost 100% of parents would recommend the WVP to other families and felt the visit was more focused on their priorities and needs when using WVP.

Additionally, the COE WVP is being utilized in the People's Community Clinic (PCC), a community health center in Austin, Texas. They are successfully using the WVP in all applicable well-child visits with almost 13,000 WVPs having been completed (June 2025). Visits have now turned into Personalized Connected Encounters (PCE) where staff are able to better connect with the families that they serve, deepening their relationships. The center has also been able to advocate for needed resources in their community around issues they are seeing appear in a significant number of their population through the COE account data download feature, showcasing population level data. The center is now taking steps to begin utilizing the PHDS to further improve their care and as a quality improvement tool.

Although the evaluation methods have differed between implementation sites the results from each point to the same conclusion, providers are more satisfied with well visits when using the COE WVP tools. Additionally, families are better informed and more engaged in their child's care, leading to stronger education and partnerships between families and providers.

Through replication in different settings, we've made adjustments based on implementers' and families' feedback to better meet their needs and improve user experiences. The COE platform is designed to be highly customizable, and we work closely with implementers to ensure its success. For example, we've modified the language used and adapted how families log into their accounts. Some families preferred completing the Well Visit Planner (WVP) in the clinic waiting room on tablets, so we simplified the login process to make it as easy as possible. Others completed the WVP using guest accounts but still wanted access to their results, so we developed a way for families to email themselves their summaries. Additionally, at providers' requests, we've added new screening tools alongside the existing ones to meet specific clinical requirements and created a population-level data download feature for clinic project reporting purposes.

INTERNAL CAPACITY

Several key personnel/roles are essential to support and implement the Cycle of Engagement Well Visit Planner (COE WVP):

- Site Champions: Serve as internal advocates who promote the COE WVP within their teams, help tailor workflows, and support peer learning.
- Program Coordinators: Manage overall implementation, coordinate between clinical teams, community partners, and CAHMI, and oversee training and data collection activities.
- Technical and Data Support Staff: Responsible for integrating the tools into electronic systems, troubleshooting technical issues, and supporting data reporting and use.

The successful implementation of the COE WVP has been strongly supported by a combination of leadership and staff development efforts. Leadership commitment played a key role, ensuring the model was prioritized, resources were allocated, and family engagement was seen as a strategic priority across teams. Staff capacity is further strengthened through training on the COE WVP supported by ongoing coaching and technical assistance. Additionally important is allowing staff to try out the COE WVP and gain firsthand experience to recognize its value in supporting their work before full implementation.

PRACTICE TIMELINE

Implementation timelines for the Cycle of Engagement Well Visit Planner (COE WVP) vary greatly by site and goals but generally follow the four EPIS phases, exploration, planning, implementation, and sustainability. The exploration phase consists of learning about the tools, creating accounts, and beginning to shape a vision and goals for implementation. In the planning phase, teams conduct workflow mapping, assess site readiness, and identify internal champions. Additional COE accounts are created, and the WVP and PHDS tools are customized to meet the user's needs. Staff are trained on the COE approach, and teams begin planning on how to engage families to complete the tools. Initial implementation then begins on a small scale with select providers and families, allowing time for feedback, workflow refinement, and ongoing coaching. As confidence grows, use of the WVP expands to more providers and families, and family-generated data is continuously integrated to support care and quality improvement efforts. During the sustainability phase, the model is embedded into standard workflows and becomes routine for families. Teams focus on continuous learning and long-term adoption through strong leadership, data use, and collaboration.

At-A-Glance Roadmap for Implementing the *Cycle of Engagement's Well Visit Planner®* *(WVP) Approach to Care [Engage, Partner, Improve]*

	Phase I: Exploration (1-8 weeks)	**Phase II: Preparation** (4-12 weeks)	**Phase III: Implementation** (4-18 months)	**Phase IV: Sustaining** (Ongoing)
Goals for each phase	**Decide & Design**: Create your vision and "why" for using the WVP.	**Create Your Plan:** Lay out your project plan, workflow & approach to engage your families.	**Implement & Innovate:** Launch, learn and innovate to make it work for you. Let us help!	**Show and Sustain** Demonstrate impact, integrate into operations & continuously improve
Step One:	**Discover**: Learn about the WVP model and tools. Read overviews. Join a demo. [*Overviews]*	**Team Up**: Gather a team and create your plan, workflow & approach to engage your families.[*Project Charter, Workflow, Engagement Toolkit*]	**Engage Your Families**: Optimize your opportunities to invite & engage families to use the WVP & *get WVP results* to prepare for personalized care.	**Track**: Routinely identify what is working, what could be improved. Use available PVS, *Provider Follow Up* survey & *Online PHDS* to track impact.
Step Two	**Decide:** Decide if you want to test out or use the WVP and assess your readiness to begin. *[Readiness Checklist]*	**Train Up**: Specify roles & specific processes to implement your plan. Identify & address barriers & strategies for success. [*COE Provider Baseline Survey*]	**Partner In Care**: Conduct the *Personalized Connected Encounter (PCE)*, build trust & connect with community supports for families. [*PCE guide, Family Resources, Community Resources Template*]	**Embed & Spread:** Solidify operational capacity to embed & spread use of the WVP as a standard of care; support existing and new use, innovate, improve. Join *the COE Learning Network.*
Step Three	**Design**: Create your vision & goals. Get your COE & *WVP* account to learn more & refine your vision. [*COE Registration & WVP Customized Account Guide; Project Charter]*	**Test Up**: Conduct rapid testing of the WVP for visits, report experiences, get help and finalize plan. [*Post Visit Survey (PVS); Success Tips, Technical Troubleshooting, Join the COE Learning Network]*	**Keep Improving**: Conduct rapid-cycle review & refine workflow. Implement the baseline *Online PHDS* to track quality. Conduct the *COE Provider Follow Up* survey to track impact & issues. Get feedback from families. [*Family Feedback Resources*]	**Integrate & Scale**: Integrate the WVP into training, incentives, performance measurement, branding and scale over time. [*How the COE supports the high quality medical home & integrated systems of care*]

Note: See www.cycleofenagement.org to learn more and sign up. Get help at info@cycleofengagement.org

Download our Roadmap for Implementing the Well Visit Planner Approach to Care here or create a COE account to use the Interactive Roadmap for Implementing the Well Visit Planner Approach to Care and access additional information and resources for each phase of implementation.

For more information on this practice's timeline and specific practice activities, please contact the CAHMI directly for support and advice at info@cahmi.org

PRACTICE COST

For more information on this practice's startup costs and budgets, please contact the CAHMI directly at info@cahmi.org.

LESSONS LEARNED

Implementing the COE WVP requires careful planning to adjust workflows, as transformation takes time. CAHMI provides many tools and resources to support changes but it's essential providers see the WVP as more than just a screening tool as its full potential lies in engaging families and personalizing care through the complete COE WVP approach. To support this change in workflow, it is critical to have a site champion, a member of the health center or organization who can support both staff and families with using the WVP and PHDS and managing workflow operations. The champion is also helpful to provide centralized communication with the CAHMI so that the CAHMI can provide any TA as needed.

A challenge that can halt implementation is managing WVP integration with an electronic health record system. Providers and clinics often think it is not feasible to easily integrate. To address this, the CAHMI offers sessions with a clinic's IT team to support integration efforts. Further, the clinical summary PDF is able to be uploaded into a patients' portal for proof of services received. While we have the technical capability and readiness to support full EHR integration, limited resources have constrained our ability to actively engage these partners. Though not a challenge for all providers, integration is often more difficult at the systems level, where alignment across multiple platforms and partners is required. That said, the current process in place does function effectively within the current EHR environment and is well positioned to support the transformation of data systems toward greater integration across health care, public health, and community-based providers.

Additionally, many providers are tied to using other developmental screeners such as the Ages and Stages Questionnaire (ASQ) either because they are required or recommended to do so by local and state guidelines. To address this, we share data demonstrating the free screener included in the WVP, the SWYC, has comparable validity and reliability in detecting developmental delay. The CAHMI was also able to get the SWYC approved as a billable developmental screener to use in well-child visits and the SWYC is continuing to expand in uptake across the country. Another potential challenge outlined by providers was the need to foster institutional support to address family engagement barriers and support resource links to address identified issues. CAHMI found that securing support from a single high-level leader within the organization was effective in getting the rest of the team on board.

NEXT STEPS

The CAHMI seeks to further expand uptake and use of the COE tools with a specific focus on leveraging the WVP to ensure all children receive comprehensive high-quality family-centered well-child visits. Current efforts to do so include focusing on CBOs and early care and education. We invite you to reach out to our Director, Dr. Christina Bethell, at cbethell@jhu.edu to inquire about partnering.

The CAHMI also seeks to further support the integration of WVP data with EHRs and has been actively working with EHR companies (Epic, Athena) towards EHR integration to make the implementation process that much easier. Additionally, a long-term CAHMI goal is to increase the number of ages addressed via the WVP. Currently the WVP is usable for up to age six (first 15 well visits of a child's life), but with feedback from multiple users and our leadership advisory board members, we recognize there is a need to expand the age range of children and families that can be supported by the WVP, and we wish to do so in the future. The CAHMI will continue to engage leaders in the field and COE users to incorporate their feedback for continuous improvement to the current tools.

RESOURCES PROVIDED

- COE Video for Providers
- 2 Minute Video Overview of the WVP for Families
- 2 Minute Video Overview of the WVP for Families (Spanish)
- COE Getting Started Toolkit
- Summary of the Cycle of Engagement Model and Tools for Child Health Professionals
- Summary of the Well Visit Planner Tool for Family Partners and Professionals
- Possibility Prototypes Across Ten Early Childhood Health System Partners
- Quick Guide to Getting a Cycle of Engagement Account
- Sign up for a Cycle of Engagement account
- At-A-Glance Roadmap for Implementing the Cycle of Engagement Well Visit Planner Approach to Care
- Frequently Asked Questions: Child Health Professionals
- Frequently Asked Questions: Family Partners

APPENDIX

- Example Family Well Visit Guide (supplemental material)
- Example Provider Clinical Summary (supplemental material)