Children Now

Warm Handoffs

A Research Review of Warm Handoffs in Support of Early Childhood Development

March 2025

Warm handoffs are a person-centered approach that facilitates clear communication between providers and systems and that can improve clinical and behavioral outcomes for children and ensure they are matched with the best possible resources for their needs. To help inform how California could define warm handoffs to support early childhood development, this factsheet summarizes existing literature, research, and evidence from the field showing how warm handoffs can improve service utilization, empower families, and streamline workflows.

Specifically, this factsheet explores the following research questions:

1. How have Warm Handoffs generally been defined?
2. Have Warm Handoffs been shown to be successful?
3. What are the key elements of a successful Warm Handoff?
4. What are the challenges and limitations around Warm Handoffs?

The appendix on page 13 lists some California examples where warm handoffs for childhood development and early intervention supports are occurring.

Fundamental Components of a Handoff[1]

Listed below are the fundamental components of a handoff that must be identified:

- Who is the sender?
- Who is the receiver?
- Who or what is handed off (e.g., the patient, patient information, screening results, instructions)?
- How is the handed off made (e.g., in person, in a hybrid meeting, through the EHR, through a message on a whiteboard, by text)?
- Where is the handed off made (e.g., in the hallway, at the computer workstation, at the front desk)?
- When is the handed off made (e.g., after rooming, after the exam, at the conclusion of the visit)?

1

How have Warm Handoffs generally been defined?

Warm handoffs are sometimes called active, intensive, or facilitated referrals, and are generally considered to be "The process of transferring an individual from one provider to another in person and with the referring participant present, utilizing a foundation of trust and respect."[2]

Guidance for primary care clinicians defines a warm handoff as "a handoff that is conducted in person, between two members of the health care team, in front of the patient (and family if present)."[3] It is further explained that "In this strategy, the emphasis of the warm handoff is specifically on engaging the patient and family in the handoff within the primary care practice." A transparent handoff of care allows patients and families to hear what is said and engage in communication, giving them the opportunity to clarify or correct information and ask questions about their care. Warm handoffs have also been identified as a part of a trauma-informed care approach.[4]

Warm handoffs are a feature of exemplary and high-performing pediatric medical homes, which specifically: "Provide care coordination/case management at appropriate levels (low, moderate, and more intensive levels), depending on child and family presenting concerns. This includes supports for an effective warm "handoff" from the health practitioner to a care coordinator (based inside the medical home and/or in the community) to identify concerns, strengths, and needs, and to ensure referral and follow-up that connects families with resources and supports that meet needs and build strengths."[5]

When pediatric practices refer to services that address social drivers of health, "Effective follow-up entails a 'warm handoff' from the health practitioner to a care coordinator, social worker, family advocate, resource navigator, or other individual – either within the office or practice or through an outside resource (such as the care coordinators provided by Help Me Grow)....the screening tool is simply a starting point for referral and further discussion with a care coordinator; often, such a discussion results in uncovering family goals, ideas, or positive actions that are not evident from or directly tied to the survey [screening] responses. When additional services are needed, families generally benefit from the support care coordination can provide when navigating multiple systems of care."[6]

"Warm handoffs are sometimes called active, intensive, or facilitated referrals"

In the context of early intervention, "**A 'warm handoff' is a family-centered approach that helps to ensure a child is directly linked to an early intervention resource or transferred seamlessly from one provider to the next. In addition, the parent is provided with support in becoming an advocate for their child and learning how to navigate the service system.** Examples of a warm handoff may include:

- Giving the parent additional information about the agency where their child is being referred, including what to expect in terms of intake or further assessment;
- Helping the parent prepare their questions to ask the agency where they are being referred;
- Offering to call the agency together with the parent;
- If the call is made together, helping the parent to ask their questions and supporting them in ensuring they understand what will happen next; and
- Debriefing with the parent after the call."[7]

An Existing Definition for Medi-Cal Warm Handoffs

The Department of Health Care Services (DHCS) has defined the requirements and responsibilities of Warm Handoff as it relates to the CalAIM Justice-Involved Reentry Initiative, where an in-person or telehealth warm handoff is required that, at minimum, include the member and the community-based ECM Lead Care Manager, and will serve to introduce the new ECM Lead Care Manager, review the reentry care plan, including the health risk assessment and goals and objectives, with the member, and identify any additional needs.[8] This policy is specific to the Justice-Involved Reentry population—people who are now, or who have spent time in, jails, prisons, or youth correctional facilities. According to DHCS, "The warm handoff is a required meeting to ensure care coordination and is the first step in establishing a trusted relationship between the individual and the new care manager. The warm handoff ensures seamless service delivery and coordination."

Specific requirements for a warm handoff include:[9]

Participate in a face-to-face or telehealth visit with the member to meet new post-release ECM Lead Care Manager.
Review and update the health risk assessment and reentry care plan with the member.
Provide education on reentry care plan and reentry services.
Modify the reentry care plan based on new knowledge of community resources or input from member.
Post-release ECM Lead Care Manager must receive and discuss the reentry care plan with pre-release care manager and receive all appropriate records and information from the pre-release period.
Obtain any necessary consents for information sharing.

2

Have Warm Handoffs been shown to be successful?

Although warm handoffs can not necessarily guarantee a patient will attend an intake meeting or receive referred services,[10] there is ample experience and evidence to show that warm handoffs can make an important contribution. Research has shown that warm handoffs help engage patients and result in better utilization of services.

For example, one study found that warm handoffs are associated with some short-term benefits on patient engagement and systems utilization for consultation-based integrated pediatric primary care.[11] Warm handoffs can reduce the likelihood of no-shows,[12] increase the likelihood of engaging with mental health services,[13] and boost attendance at first appointments for behavioral health.[14] In fact, one study found that warm handoffs boosted completed behavioral health visits 7.5-fold for children with positive ACEs screening when referral workflows involved warm handoffs with social workers.[15]

Evidence shows that warm handoffs facilitate families in getting care. For example as part of a warm handoff, a home visitor "accompanied and introduced families to new service providers for their first visit to improve their comfort level;" this encourages "another level of 'accountability' for other service providers to follow up with families, because they knew that the [home visitor] would come back and check in to see how services were received."[16]

Warm handoffs can further help relieve caregiver stress and burden, which may contribute to a more supportive home environment and have an impact on the development of infants and toddlers.[17]

7.5x

Increase in completed visits for children with positive ACEs screening when referrals included warm handoffs with social workers.

3

What are the key elements of a successful Warm Handoff?

Although the effectiveness of any individual warm handoff is contextual, there may be some common elements that are most crucial to ensuring successful warm handoffs. For example, work in Los Angeles County found that influential factors for closed loop referrals to early intervention services include:[18]

Automatic referral tracking

Attentive staff

Relationship and communication with Regional Centers

Completion of the Early Start intake process

Similarly, efforts to transform how children access and benefit from developmental health resources have focused on: cross-sector collaboration, technology, and investing in partnerships.[19]

Based on the literature, an important theme of successful warm handoffs is **building trust and empowering families with reliable information**. Families make informed decisions when they have access to current, unbiased, varied, and accurate information and resources.[20] This information should be accessible in families' preferred language, culturally salient, and consistent across delivery systems. It can also be helpful to have an up-to-date brochure of all the different social service agencies and what group they fall under (e.g. early childhood, food, utility assistance, etc.) available to give to families. But there is also an active and relational aspects of a warm handoff. For example, one lesson learned within the context of CalAIM implementation, is to "Have trusted providers introduce services and make referrals and handoffs."[21] It is crucial to ask for permission to connect families with other providers, give control to families over how and with whom their information would be shared, and communicate about next steps.

Essentials of Information, Resources, and Referral in Family-Centered Care[22]

A knowledgeable, caring, and responsive person is the family's first point of contact.
Families have access to information in a variety of modalities (for example, print, audio, and video and in the language preferred by the family). Information includes topics such as assessment, various disabilities, education, recreation, social events, trainings, support groups, therapies, transition, advocacy, and respite.
Information is available by telephone, email, Internet, and/or fax.
Information is available during flexible hours, based on family needs.
Information is available throughout the community.
Parents are given opportunities to discuss and process information with someone who is knowledgeable about early intervention services and IDEA Part C.
Parents' rights and responsibilities are provided and reviewed with families on a regular basis.

Other important elements of successful warm handoffs involve the importance of **coordination and collaboration among child-serving providers and organizations**. For instance, many examples of successful warm handoffs happen in the same physical space, referred to as co-location, however providers are also leveraging telehealth and digital platforms to make warm handoffs. But perhaps more importantly than a physical proximity during the warm hand off is the partnership between providers. For example, cross-sector collaboration can be achieved through established formal mechanisms for regularly sharing information, using common validated screening tools, coordinating services, offering joint professional development, and tracking referrals between programs to ensure continuity of care and non-duplication of care for infants and toddlers with disabilities and their families. It is important that a warm handoff is made to a coordinated system that can provide a single point of entry for families into multiple services, programs, and community resources. Collaboration is also not just a singular event and can include the development of care plans; for example, engaging clinical and medical team members in the development of an Individualized Family Service Plan (IFSP), for example, can ensure that it encompasses the physical/mental health and social emotional developmental needs of the child and family.[23]

"More important than physical proximity during a warm handoff is the partnership between providers."

Finally, there are the operational aspects of articulated workflows, documentation protocols, and data-sharing practices related to warm handoffs.

Established workflows

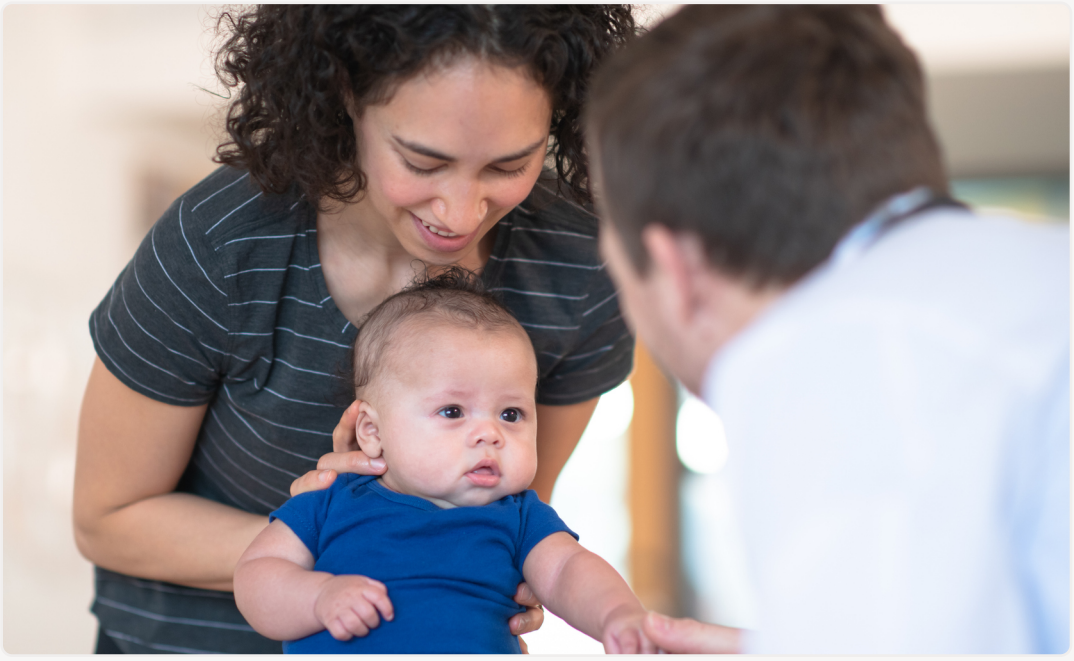
Standardized protocols and tools for identifying and referring children and their families between programs can increase consistency in services and improve coordination. A clear understanding of program eligibility may also help providers feel empowered to refer families to services and support families through the warm handoff and referral process. The box below with the example of a warm handoff workflow reinforces the importance of coordination and collaboration of providers within warm handoffs. And in fact, health care practices and clinics are encouraged to "seek input from everyone affected by the proposed new workflow", by getting their ideas and feedback and encouraging them to invest in the changes.[24] This includes inviting patients to provide input and feedback on the process changes, and involving patient and family advisory councils. In fact, the perspective of impacted patients and families should be considered in the development of all workflow phases, including documentation and data sharing.

Documentation

Warm handoffs should be documented at all steps, ideally with both the referring provider and the receiving provider who may eventually become the communications lead with the patient or family after the initial warm handoff occurs. Standardized referral forms with formal follow-up processes can help with documentation consistency.

Data sharing

Warm handoffs work best when screening results, health-related social needs, and care plans are shared between providers with privacy considerations or safeguards for which providers can access data and when there is clear communication with families about consent and use of data. Patient data and information must be accessible to members of the care team who are delivering services so that patients can receive tailored care, but sensitive social needs information may need to be more limited in how it is shared.



An example workflow for warm handoffs:[25]

1. The sending provider, in consultation with the service participant and the receiving provider, schedules the warm handoff.
2. The sending provider, with appropriate consents in place, shares all information regarding the service participant with the receiving provider.
3. The receiving provider reviews information prior to the meeting and prepares any questions of clarification they want to ask in the meeting.
4. The sending provider prepares the service participant for the warm handoff meeting. This includes things like reminding them when the meeting will occur, why it is occurring, and what happens during the meeting(s).
5. The service participant has the opportunity prior to the meeting to think about questions they wish to ask of the sending or receiving provider and any clarification or additional information they wish to share.
6. When the meeting date and time comes along, the sending provider calls the meeting to order. They introduce the receiving provider, and then outline the amount of time allocated to the meeting and again outlines the purpose of the meeting.
7. The sending provider reviews a summary of the work that has occurred with the program participant, assessment results, and their understanding of the service participant's strengths, goals and opportunities for improvement.
8. The service participant is afforded the opportunity to respond to, add or amend what the sending provider has shared.
9. The receiving provider then asks any questions of clarification followed by outlining how the support process will continue with them.
10. The meeting concludes with the receiving provider primarily responsible for further contact, guidance and support of the service participant.

4

What are the challenges and limitations around Warm Handoffs?

Research has shown that there are certainly challenges to implementing warm handoffs in practice, as well as limitations on the utility of warm handoffs. Below are some of the challenges and limitations around warm handoffs found in the literature.

- One study investigating barriers to accessing services for children under age 3 presenting with language delays and behavioral difficulties found that barriers including basic access (e.g., reaching a live person; response in the home language), and obtaining appropriate appointment or referral.[26]

- Among early childhood home visitors, some "Barriers to service coordination were: limited availability and accessibility of local resources, perceived stigma among other service providers, and families' ambivalence toward some services."[27]

- Warm handoffs often involve capturing and sharing sensitive health-related social needs. Caregivers have expressed concerns about how health related social needs information that is shared might impact their immigration status, eligibility for government benefit programs or health insurance premiums, involvement of Child Protective Services, and could lead to bias or discrimination.[28]

- Work in Los Angeles County found that barriers to referrals for early intervention services are: connecting to Regional Center staff to receive updates and share medical records; finding Applied Behavioral Analysis (ABA) services that match family preferences; and long wait times at Regional Centers.[29]

- Families who are eligible for early intervention services also may need assistance to secure access to other services that any family might need (for example, faith groups, community activities, food, clothing, shelter, health care, family planning, recreation, drug treatment, mental health services, protection from domestic violence, job training, parenting supports, literacy development, translation for families who are non-English speaking, English-as-a-second language [ESL] programs, adult education, family reunification, juvenile court, or probation).[30]

- Limited valid developmental screening tools in languages other than English may be a barrier to screening and referring young children to early intervention for evaluation among refugee and immigrant populations.[31]

- Families in rural areas report challenges with provider turnover rates, limited access to services or specialized knowledge, and travel distance required to receive services.[32] This can add turmoil to the already emotionally taxing and complicated referral process experienced by many families who have a child with a developmental concern.[33] A qualitative study of families going through the IFSP process found parents desired professionals who "could help to ease their emotional struggle over having a child with disabilities," and sought "emotional care as well as some practical considerations, such as financial and time constraints that many parents may struggle with by looking after a child with developmental needs."[34]

The evaluation of a four-year partnership between Help Me Grow LA and LA Care Health Plan found that all participating primary care and pediatric practices improved their workflow for developmental screenings and referrals and experienced significant increases in the number of developmental screenings, substantially exceeding benchmarks and surpassing L.A. Care's goal.[35] The other lessons learned and recommendations from the partnership evaluation highlight some of the key components for early childhood development referrals from health providers.

Lessons learned

Data Quality

Ensuring consistent and standardized data collection across practices is key to assessing equity and improving outcomes. Investments in automated tools and capacity-building are essential.

Referrals to Regional Centers

All practices faced challenges with referrals and closing referral loops, highlighting the need for standardized processes across regional centers.

Community and Provider Outreach

Outreach efforts effectively increased knowledge about child development and early intervention, with Community Resource Centers playing a key role in promoting education for families.

Data Quality

Technology and coaching helped practices revise workflows, improve data use, and increase developmental screenings; however, ongoing support is needed to sustain these efforts.

Recommendations

1	Build Data Capacity
2	Address Access Disparities
3	Advocate for Standard Regional Center Processes
4	Enhance Child Development Education and Resources
5	Provide Capacity-Building Support

Conclusion

Research suggests that warm handoff, as a family-centered approach, can successfully help to ensure a child is directly linked to early intervention services and seamlessly transferred across providers. Further, warm handoffs can help parents and caregivers feel empowered and supported in becoming an advocate for their child and learning how to navigate the systems of care their child needs. Key elements of successful warm handoffs include building trust with families, collaborating and coordinating across providers or delivery systems, and addressing the operational aspects like workflows and information sharing. Other lessons learned about warm handoff practices include challenges like the lack of available and accessible local resources and trained service providers, as well as the emotional burden families may experience when their child is identified with potential developmental delays.

The Essential Role of Family Centers

California has an infrastructure of state-funded family centers, including **Early Start Family Resource Centers** (FRCs) and Family Empowerment Centers (FECs), that provide support, information, and training to families of children with disabilities on a variety of topics, including transition. The FRCs actively work in partnership with local Regional Centers and education agencies and help many parents, families and children get information about early intervention services and how to navigate the Early Start system. Early Start FRCs serve families of children eligible for Part C services through age three, and they are mandated to provide parent-to-parent support and transition assistance for families (in contrast, FECs serve families of children ages three through twenty-two). These programs can provide information on parent and guardian rights, supports and services in the community, and strategies for communicating the child's strengths and needs. Parent-to-parent supports and additional information and training through FRCs and FECs can help caregivers feel more prepared for their children's service transitions.[36]

- County **Help Me Grow** models are an important link for families to the Regional Centers, the Early Start program, and other developmental supports for young children.[37] Each Help Me Grow is unique in its structure and features, but most provide developmental screening, advice on child development and milestones, care coordination to developmental services and referrals to other social supports, and opportunities for pediatric provider engagement. Help Me Grows are coordinated by county First 5 commissions. For example, Help Me Grow LA's Family Partners are available to help Los Angeles County families navigate the process of a Regional Center referral, providing an important and warm service.

- The **HealthySteps** program provides early childhood development support to families where they are most likely to access it – the pediatric primary care office. HealthySteps Specialists are an addition to the primary care team and can identify whether children are reaching developmental milestones, help connect families to additional services, and answer families' questions about child development and well-being so all babies and toddlers have a strong start in life. According to the HealthySteps model, "When possible, a provider may bring the HS Specialist into the exam room during the appointment to address concerns immediately or to facilitate a "warm handoff" where the HS Specialist can briefly meet the family, assess the severity of their concerns, and schedule a follow-up appointment." Research shows that "HealthySteps children were 8x more likely to receive a developmental assessment and had significantly higher rates of developmental and other nonmedical referrals, and one HealthySteps site with a dedicated family services coordinator quadrupled its early intervention (EI) successful referral rate after implementing HealthySteps.[38] There are currently 25 HealthySteps sites in California, with at least 19 additional practices moving through the onboarding process. (Note that the HealthySteps model is eligible for Medi-Cal billing under the new Medi-Cal dyadic services benefit, and the UCSF Center for Advancing Dyadic Care in Pediatrics has useful resources for providers and plans about the implementation of HealthySteps and the dyadic services benefit (see https://dyadiccare.ucsf.edu/).

- A groundbreaking program launched in 2006, the **Healthy Development Services** (HDS) program in San Diego County promotes young children's optimal development and learning by identifying and addressing problems early.[39] HDS was envisioned to eliminate gaps in services for all children ages 0-5 with mild to moderate developmental and behavioral concerns and designed to complement the existing infrastructure serving children with the most severe delays. HDS has evolved into a comprehensive system of care that is transformational for young children and their families, where families are supported by a family-centered, trauma-informed approach where care coordinators and service providers address the family's social determinants of health and barriers to service. HDS providers build trust with families, respecting the experience and values that each family brings when engaging in services. The HDS approach to engaging and supporting families creates the foundation for healing relationships that extend beyond traditional service delivery. Supporting families through care coordination and case management is critical for families' initial engagement in services and their ability to remain in services. However, service providers also need training and support to

provide family centered care. Frameworks, such as Motivational Interviewing, Trauma Informed Care, and Reflective Practice, all have a role in promoting family centered care. Supporting frontline service providers that work with families day-to-day is often overlooked in many systems of care, leading to staff burnout and turnover. The implementation of Reflective Practice and support calls provides concrete support for frontline providers and their supervisors. The HDS evolution demonstrates that creating a comprehensive system of care requires coordination, alignment, collaboration between community organizations, and ongoing work to maintain integrity.

- Based on a successful pilot program, the pediatric healthcare team at **Bay Area Community Health Center** (BACH), which serves southern Alameda County and Santa Clara County residents, uses a **pediatric care coordinator** tasked with supporting patients by closing the loop through referrals and "warm handoffs" to specialist providers, behavioral health practitioners, food, housing, and other key resources.[40] The pediatric care coordinator (in some cases a medical assistant) works with the rest of the trauma-informed care team to coordinate closely to provide culturally sensitive and racially equitable care. A clinic pediatrician has noted that "The coordinator has made tremendous progress with high-needs patients, such as children with autism and others with complex, chronic, and challenging physical, developmental, and behavioral health concerns."

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8 See Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative, Section 8.4.f on pg. 106 at https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf

9 Ibid. pg. 102

10 For example, one **study** of adults referred to behavioral health appointments via warm handoffs were not more likely to attend initial appointments; see https://www.annfammed.org/content/16/4/346

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We conduct non-partisan research, policy development, and advocacy reflecting a whole-child approach to improving the lives of kids, especially kids of color and kids living in poverty, from prenatal through age 26.

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Writers
Colleen Corrigan
Mike Odeh

Contributors
Rebecca Klein, *Start Early*
Jaren Gaither, *First 5 Center for Children's Policy*

Designer
Jose Murillo

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