

GETTING STARTED:IMPLEMENTING A SCREENING PROCESS

The following worksheet has been created as a guide to help you in developing a *screening process* workflow for your practice. For the purposes of this worksheet, a screening process is defined as the method of early identification and intervention for potential risks to a child's development through ongoing surveillance, routine screening per AAP guidelines, family-centered discussion of results, interpretation, and—when concerns are identified—referral and follow-up.

STEP 1: Identify current screening tools. What formal assessments are we currently using to identify concerns?

Developmental screenings:	
General developmental screening:	
Social-emotional screening:	
Autism screening:	
Maternal depression screening:	
Social determinants of health tool(s)/questions:	
STEP 2: Identify your practic implementing or improving the	e champion. Who will lead our team through e screening process?
implementing or improving the STEP 3: Identify the practice	
implementing or improving the STEP 3: Identify the practice	team members that will be part of the screening
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STEP 4: Select the screening tool(s) and educational materials that will be used. What fits best with our practice structure and patient population?

Developmental screenings:		
General developmental screening:	 	
Social-emotional screening:	 	
Autism screening:	 	
Maternal depression screening:	 	
Social determinants of health screening tool/questions:	 	
Educational materials:		

STEP 5: Plan key parts of the workflow/process for each of the screening categories. *How will we get this done?*

See Workflow Planning Worksheet on the following 2 pages.

	P 5: Workflow ning worksheet	DEVELOPMENTAL SCREENING	SOCIAL-EMOTIONAL SCREENING	AUTISM SCREENING	MATERNAL DEPRESSION SCREENING	SOCIAL DETERMINANTS OF HEALTH SCREENING
1.)	At what ages of the child will the family receive the screenings?					
	Recommendations:	9, 18, and 30 months	Regular intervals	18 and 24 months	1, 2, 4, and 6 months	Every visit
2.)	How will parents access the screening tool to complete it? (Ex: EMR portal, paper version in office, laminated wipe-away)					,
3.)	If paper, who will ensure that copies of the screening tool are available for parents to complete each day?					
4.)	When in the visit will the parent receive the screening tool?					
5.)	Who will give the parent the screening tool?					
6.)	Who will score the screening tool?					
7.)	When will the provider review the screening results with the parent and work with them to make a plan for next steps?					
8.)	How will referrals be handled for children at risk?					

	P 5: Workflow ning worksheet	DEVELOPMENTAL SCREENING	SOCIAL-EMOTIONAL SCREENING	AUTISM SCREENING	MATERNAL DEPRESSION SCREENING	SOCIAL DETERMINANTS OF HEALTH SCREENING
9.)	Who will be responsible for facilitating the referrals?					
10.)	Where will referrals be documented?					
11.)	What happens with the screening tool after it has been discussed with the parent? (Ex: results recorded in EMR, scanned into chart, shredded, wiped away)					
12.)	Who will give the parent educational materials? When will these be presented?					
13.)	Where will you keep your supply of educational materials?					
14.)	Who will make sure that materials (including screening tools and educational materials) are restocked and readily available?					
15.)	Who will facilitate following up with families to determine the outcomes of the referral?					
16.)	Where will follow-up notes be recorded?					

STEP 6: Identify program supports. What partners can we work with to support our patients? What materials do we need for our process?

RESOURCES FOR DEVELOPMENTAL CONCERNS

Local care coordination service program for children:	
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State Early Intervention services:	
Developmental behavioral pediatrician:	
Speech therapist:	
Occupational therapist:	
Physical therapist:	
Child Care Resource and Referral Agency (CCR&R):	
Child Care Health Consultants:	
Infant Mental Health Consultants:	
Head Start:	
Parents as Teachers:	
School system preschool coordinator:	
Local early childhood collaboration:	
Local family support group:	
School nurse contact:	
Exceptional child contact (school system):	
State/Local education office:	
Local Faster Seals:	

Local <u>The Arc</u> :	
School <u>United Way:</u>	
MENTAL HEALTH RESOUR	CES
Maternal depression:	
Local services identified by Postpartum Support International:	
Local new moms group:	
Parental/Caregiver depression:	
Child psychologist:	
Child behavioral therapist:	
Substance use support:	
Domestic violence support:	
Additional Resources: Postpartum Progress National Alliance on Mental Illn 800-950-NAMI (6264) National Institute of Mental He National Suicide Prevention Lift 1-800-273-TALK (8255) or Substance and Mental Health S SAMHSA Treatment Refere	alth eline Live Online Chat
FAMILY SUPPORT RESOUR	CES
State/Local health department:	·
Local home visiting program identified by the Maternal and Child Health Bureau:	
Parenting groups:	
Local food pantries listed on Feeding America website:	

Local homeless shelter:		
Local contact information for Public Housing Authority programs:		
Supplemental Nutrition Assistance Program (food stamps):		
Women, Infants, and Children (WIC) services:		
National Diaper Network:		
Local homelessness prevention provider:		
State/Local legal services agency:		
STEP 7: Engaging staff in the co	oncepts, principles and process.	
How will you work with staff to develop the concepts? How will staff be refreshed/remin	process? How will new staff receive initial training on the nded of this information?	
How will the team monitor progress and make changes as necessary? Will there be regular forums for feedback? Is there a structure to how feedback is presented?		

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