



Getting Started Guide: *Implementing a Screening Process*

The following worksheet is a guide to help develop a screening process workflow for your pediatric 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 monitoring, routine screening per [American Academy of Pediatrics \(AAP\) Developmental Surveillance and Screening Guidelines](#) and [AAP Bright Futures Guidelines](#), family-centered discussion of results, interpretation, and—when concerns are identified—linkage/referral and follow-up. It is recommended that you incorporate your full practice transformation team (clinical staff, nursing staff, front office staff, and family leadership) in this process as this document is intended to be tailored to your practice. This worksheet can be completed using the fillable text boxes and dropdowns in each step.

STEP 1: Identify current screening tools. *What formal assessments are we currently using to identify concerns? Select an option from the dropdown list or write in a response with the fillable text box. If no screening tools are currently used, write none.*

Developmental screening: Choose an item.

Click or tap here to enter text.

Social-emotional development screening: Choose an item.

Click or tap here to enter text.

Autism screening: Choose an item.

Click or tap here to enter text.

Perinatal depression screening: Choose an item.

Click or tap here to enter text.

Social drivers of health tool(s)/questions: Choose an item.

Click or tap here to enter text.

STEP 2: Identify your practice champion. *Who will lead our team through implementing or improving the screening process?*



STEP 3: Identify the practice team members who will be part of the screening process. *Who is on our screening workforce team and what are their roles? (ex. clinical staff, nursing staff, front office staff, and family leadership)*

STEP 4: Select the screening tool(s) and educational materials that will be used. *What fits best with our practice structure and patient population?*

Use Table 1 with links to the [AAP Screening Tool Finder](#) to review all available tools for each screen and visit and find what works for your practice.

Factors to consider when selecting a screening tool: *What does the tool tell you? What do you want to know? What information do you not want to be surprised by? What feedback have you received from families?*

Other factors: *length, cost, language, electronic health record (EHR) considerations tools (like Well-Visit Planner, CHADIS, ASQ Online, Phreesia, etc), additional pros and cons of the tools*

Developmental screening: Choose an item.

Click or tap here to enter text.

Social-emotional development screening: Choose an item.

Click or tap here to enter text.

Autism screening: Choose an item.

Click or tap here to enter text.

Perinatal depression screening: Choose an item.

Click or tap here to enter text.

Social drivers of health tool/questions: Choose an item.

Click or tap here to enter text.

Follow-up caregiver educational materials:

Click or tap here to enter text.

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

See Table 1 and the Workflow Planning Worksheet on the following pages. Workflow planning should consider the well-visit schedule and where they occur as seen in Table 1. Use this as a reference tool to help guide and consider your answers to the Workflow Planning Worksheet questions. **Note:** Prior day, pre-visit planning for well visits will greatly facilitate the entire process in the worksheet.



TABLE 1. AAP Recommended Screening Intervals With Coding at Well Visits From Ages 0-5 Years

Visit	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	24 mos	30 mos	36 mos	4 yrs	5 yrs
Perinatal Depression Validated Tools: Edinburgh included in SWYC , PHQ2 , PHQ9	96161	96161	96161	96161									
Development and Behavior Validated Tools: ASQ , PEDS , and SWYC					96110			96110		96110	Consider a preschool screening as indicated	Consider a preschool screening as indicated	Consider a preschool screening as indicated
Autism Validated Tools: MCHAT , POSI included in SWYC								96110	96110				
Social-Emotional Development Validated Tools: ASQ-SE2 , BPSC/PPSC included in SWYC , BITSEA , and ECSA	96127	96127	96127	96127	96127	96127	96127	96127	96127	96127	96127	96127	96127
Social Drivers of Health (Risk and Protective Factors) PRAPARE , SEEK , SWYC , Health Leads , Strengths and Difficulties , Whole Child Assessment , WE CARE , Hunger Vital Signs , Accountable Health , IHELLP	96160	96160	96160	96160	96160	96160	96160	96160	96160	96160	96160	96160	96160



STEP 5: Workflow planning worksheet	Developmental Screening	Social-Emotional Development Screening	Autism Screening	Perinatal Depression Screening	Social Drivers of Health Questions
1. At what age of the child will the family receive the screenings? Who will ensure that families with a child who was premature receive the tool for the child's adjusted age? <i>Recommendations</i>	<i>9, 18, and 30 months and when a developmental concern is identified by a caregiver or provider (ensure periodic screens are completed if a child misses the designated visit)</i>	<i>Every visit</i>	<i>18 and 24 months</i>	<i>1, 2, 4, and 6 months</i>	<i>Every visit</i>
2. How and when will caregivers access the screening tool to complete it? (EHR portal, paper version or tablet in office, laminated wipe-away, pre-visit versus in office)					
3. If paper, who will ensure that copies of the screening tool are available for caregivers to complete each day?					
4. Where will the caregiver receive and complete the screening tool? (at home, in the waiting room, or in the exam room) <i>Recommendations</i>	<i>Prior to visit</i>	<i>Prior to visit</i>	<i>Prior to visit</i>	<i>Prior to visit</i>	<i>Prior to visit</i>



STEP 5: Workflow planning worksheet	Developmental Screening	Social-Emotional Development Screening	Autism Screening	Perinatal Depression Screening	Social Drivers of Health Questions
5. If given in the office, who will give the caregiver the screening tool and be available to assist with completion if necessary? For language, please consider screening tools in other languages, bilingual staff, interpreter. For literacy, please consider support from office and nursing staff.					
6. Do you have a screening tool “script” or key talking points? Does the person giving the screening tool know this?					
7. How will the screening tool be reviewed and scored? (auto-scored, primary care clinician, other team member, review of screen from a community partner)					
8. How will you ensure that the primary care clinician receives the screening tool to score, if necessary, brings it into the exam room to discuss with the family, and works with the family to make a plan for next steps?					
9. How will the primary care clinician ask about, and document, family strengths and protective factors? Ex: CSSP Strengthening Families Action Sheets					



STEP 5: Workflow planning worksheet	Developmental Screening	Social-Emotional Development Screening	Autism Screening	Perinatal Depression Screening	Social Drivers of Health Questions
10. How will an at-risk score be documented in the diagnosis? (z code, developmental concerns) Ex: Early Childhood Social-Emotional Development Billing and Coding <i>Recommendations</i>	<i>R62.5</i>	<i>F89.9</i>	<i>R62.5</i>	<i>Parent-child relationship concern</i>	
11. How will the screening tool results be reliably integrated as part of the visit template? What happens with the screening tool after it has been discussed with the caregiver? (scanned into chart, shredded, wiped away)					
12. How will the results of the discussion with the parents be recorded in the visit template?					
13. How will the clinician choose appropriate, child-specific, informational, and educational materials to be shared with the caregiver?					
14. How will you ensure the process allows the provider to discuss with the family the materials they will take home? (show paper or screen and say why it matters to them)					



STEP 5: Workflow planning worksheet	Developmental Screening	Social-Emotional Development Screening	Autism Screening	Perinatal Depression Screening	Social Drivers of Health Questions
15. What will be the role of the integrated mental health clinician/HealthySteps staff/community health worker/family navigator in resource sharing and coordination?					
16. Where will you keep your supply of educational materials? (EHR, etc)					
17. How will referrals be handled for children who have an at-risk score?					
18. Who will make sure that materials (including screening tools and educational materials) are restocked and readily available?					
19. Who will be responsible for facilitating the referrals?					
20. Where will referrals be documented in patient charts? (in paperwork needed for referral source)					
21. How will follow-up notes be recorded in the chart?					



STEP 5: Workflow planning worksheet	Developmental Screening	Social-Emotional Development Screening	Autism Screening	Perinatal Depression Screening	Social Drivers of Health Questions
22. Who will facilitate following up with families to determine the outcomes of the referral? Following the well-child visit, who will follow up with the caregiver? And when? What processes will be used? (follow-up visit, phone call, EHR portal message)					
23. How will the practice team ensure the screening workflow is implemented and followed reliably? How will you collect and use data for improvement?					



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

For the below sections, use this as a reference tool to help identify national and local partners that can support your screening process, practice, and patient families. Additionally, you can utilize the [AAP's STAR Center Referral Resource Directory Template](#) or the [ECDHS: Evidence to Impact Center Cross-Sector Engagement Tool](#) to identify other partners and assist with the relationship-building process.

STRENGTH-BASED, FAMILY-CENTERED DEVELOPMENTAL PROMOTION AND PREVENTION

Practice Enhancements

[Reach Out and Read:](#)

[Small Moments Big Impact:](#)

Family-Facing Apps and Education Materials

[CDC Learn the Signs. Act Early.:](#)

[CDC Milestone Tracker App:](#)

[HealthyChildren.org's "Your Child's Checkups":](#)

[Sesame Street Workshop](#) (Elmo Belly Breathing, Bubbles, Monster Calm):

[Vroom Brain Building:](#)

PARTNERS FOR CHILD DEVELOPMENTAL SUPPORT NEEDS

Developmental behavioral pediatrician:

[Early intervention services \(IDEA Part C\)](#) (ages 0-3):

Exceptional child contact (school system, [IDEA Part B](#)) (ages 3-21):

[Head Start:](#)

Infant and early childhood mental health (IECMH) consultants:



Early Childhood
Developmental
Health Systems

EVIDENCE TO
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Local care coordination service program for children:
Occupational therapist:
Physical therapist:
School system preschool coordinator:
School nurse contact:
Speech therapist:
COMMUNITY AND STATE PARTNERS TO PROMOTE EARLY DEVELOPMENT
These are organizations with existing partnerships, referral networks, systems-building efforts, process improvement, family engagement, and community-trust building that can come alongside a practice in support of families. Consider these like a “power grid” for early childhood development that a practice can plug into.
Child Care Resource and Referral Agency (CCR&R):
Head Start:
Help Me Grow:
Local early childhood collaboration:
Local home visiting program (e.g., MIECHV Home Visiting Program , Parents as Teachers , Nurse-Family Partnership):
State Coordinated Referral Systems:
CHILD AND FAMILY MENTAL HEALTH PARTNERS
Attachment Vitamins:



Circle of Security:
Child and adolescent psychiatrist:
Child mental health clinicians:
Domestic violence support:
IECMH-specific therapies (CPP , ChildFirst , PCIT , ABC, Circle of Security, Trauma-focused CBT):
The Incredible Years:
Local new moms' group:
Local services identified by Postpartum Support International :
Parental/caregiver depression:
Perinatal depression:
Resilience University:
State IECMH Association:
State Child Psychiatry Access Programs (CPAP):
Pediatric Mental Health Care Access (PMHCA):
Substance use support:



[Triple P – Positive Parenting Program](#):

Additional Resources:

- [Postpartum Progress](#)
- [National Maternal Mental Health Hotline](#)
- [National Alliance on Mental Illness](#)
 - 800-950-NAMI (6264)
- [National Institute of Mental Health](#)
- [National Suicide Prevention Lifeline](#)
 - 1-800-273-TALK (8255) or live online chat
- [Substance Abuse and Mental Health Services Administration](#)
 - SAMHSA Treatment Referral Helpline: 1-877-SAMHSA7 (1-877-726-4727)

RESOURCES FOR SOCIAL NEEDS

[211](#):

Local children’s museum:

Local EasterSeals:

Local family support groups (e.g., parent cafes, [Family Voices](#)):

Local food pantries (e.g., [AAP & FRAC Toolkit](#), [Feeding America](#)):

Local home visiting programs:

Local housing assistance program:

Local libraries:

Local [Public Housing Agency](#) programs:

[National Diaper Bank Network](#):



State/local health department:
State/local legal services agency (e.g., Legal Aid):
Supplemental Nutrition Assistance Program (food stamps):
Women, Infants, and Children (WIC) services (how to apply):

STEP 7: Engage staff in the concepts, principles, and process.
Key Principles of Screening • Screening has an important role in promotion and prevention, as well as for intervention, and assume routine discussion of strengths and protective factors. • Utilize validated screening tools/questions. • Family engagement: ○ Communicate with families regarding why screening is essential. ○ Engage families with screening as conversation, and as partners in care. ○ Engage the parent/caregiver as an expert on their child. ○ Involve family leaders in the development of the screening tool “script.” • Screened, now what? ○ Always have a conversation about the results and incorporate primary care intervention. ○ Make effective referrals/linkages, prioritizing a warm handoff. (Note the need to implement outreach to build collaborative relationships with community partners before beginning screening.) ○ “Close the loop.”
What staff will be involved in developing a screening tool “script” including key talking points? What are essential elements that should be communicated and/or asked at each screening?
How will you work with staff to develop the process? How will new staff receive initial training on the concepts? How will staff be refreshed/reminded 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?

Notes: The [Well-Visit Planner](#) and [CHADIS](#) are electronic systems with family-facing platforms that score screens and document two-way information release to facilitate implementation of screening tools and discussion with the family. For a comparison chart of CHADIS, ASQ, and the Well-Visit Planner, please see page 17 of the [Mississippi Thrive Screening and Health Promotion Toolkit](#).

Acknowledgements: This resource was adapted from a version developed by the [North Carolina Assuring Better Child Health and Development \(NC ABCD\) program](#). This worksheet was developed by AAP in consultation with the developers of the NC ABCD Project. The AAP is a core partner of the [Early Childhood Developmental Health Systems \(ECDHS\): Evidence to Impact Center](#), which provides technical assistance to early childhood development (ECD) health center grantees and Transforming Pediatrics for Early Childhood awardees to improve their implementation screening and referral in the ECD continuum of care.

This program was made possible through the support of the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling \$5,300,000 with 0% financed from non-governmental sources. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS, or the U.S. Government. For more information, please visit [HRSA.gov](#).



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