Early Childhood Developmental Health Systems | EVIDENCE TO IMPACT CENTER

Transforming Pediatrics for Early Childhood Family-Centered Workflow

This sample workflow outlines the key elements of a family-centered practice environment and offers strategies for strengthening those elements. Pediatric practices can use this resource to identify areas for improvement, while state-level teams may use it to guide and support technical assistance efforts with practices.

STEP 1. Planning Before the Visit

Does this family require additional preparation or setup? Consider whether the child has a special accommodation (e.g., quiet room, same provider) or whether the family needs language interpretation.

Who leads the discussion around patient and family needs at morning huddles?

Who is responsible for preparing age- and language-appropriate screens for the patient and family? (See the Appendix for ages, screens, and CPT codes.)

How will caregivers access the screening tool to complete it (e.g., electronic health record portal, paper version or tablet in office, laminated wipe-away)?

If a screening tool is given in the office, who will give the caregiver the screening tool (e.g., front-office staff, medical assistant, nurse)?

Where will the caregiver receive and complete the screening tool (e.g., home, waiting room, exam room)?

If the screening tool is completed on paper, who will ensure that copies are available for caregivers to complete each day?

STEP 2. Patient Arrival and Screening Results

Patient and Family Arrive for Age-Specific Visit, Screen Is Administered

Is there an existing screening tool "script" or key talking points? Does the person giving the screening tool know this?

How will you ensure that the primary care provider receives the screening tool to score, brings it into the exam room to discuss it with the family, and works with the family to plan for next steps?

STEP 3. Discuss Visit Needs With Family

How will the primary care provider ask about family strengths? Example Tools: Center for the Study of Social Policy's Strengthening Families Action Sheets and Identifying Risks, Strengths, and Protective Factors for Children and Families: A Resource for Clinicians Conducting Developmental Surveillance

How will an at-risk score be documented in the diagnosis (e.g., z code, developmental concern)? Example: Early Childhood Development Social-Emotional Development Billing and Coding

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 (e.g., scanned into the chart, shredded, wiped away)?

STEP 4. Observation and Discussion With Family

Primary Care Provider Observes Parent-Child Interaction
Observe and name positive moments (e.g., "look how she smiles back at you").

Primary Care Provider Performs a Physical Evaluation
The appendix includes screenings that should be done during each visit and their aligned CPT code.

Partner With the Family to Discuss Screening Results and Supports for Healthy Development and Family Well-Being
Determine the best interventions for healthy development together with the family. Example: Common Factors Approach: HELP to Build a Better Alliance

Materials for Families

How will the primary care provider choose appropriate, child-specific, informational, and educational materials to be shared with the caregiver?

How will you ensure the process allows the primary care provider to review materials with the family that they will take home (e.g., show paper on screen and say why it matters to them)?

How will the team tailor informational materials for each patient?

Where will you keep your supply of educational materials (e.g., paper, QR code, electronic health record)?

Who will make sure that materials (including screening tools and educational materials) are restocked and readily available?

Referrals

How will referrals be handled for children who have an at-risk score?

Who will be responsible for facilitating the referrals?

Where will referrals be documented in patient charts? Is paperwork needed for the referral source?

STEP 5. Determine Next Steps With Family

Follow Up

How will follow-up notes be recorded in the chart?

How will next steps be documented to ensure family preferences are documented and met (e.g., chooses a food bank near work, prefers a Spanish-speaking therapist)? Example: "Learn the Sign. Act Early." Family Friendly Referral Guide (English and Spanish)

How will follow-up communication be documented to ensure family preferences are met (e.g., would like to check in via phone call in 1 week, will message in portal in 1 week, prefers a follow-up visit in 6 weeks or 45 days to access services)?

Who will facilitate following up with families to determine the outcomes of the referral?

Who will follow up with the caregiver? And when? What processes will be used (e.g., follow-up visit, phone call, electronic health record portal message)?

STEP 6. Data for Improvement

How will the practice team ensure the screening workflow is implemented and followed reliably? How will the team collect and use data for improvement?

Appendix. Ages, Screens, and CPT Codes

Bright Futures Screening Intervals With Coding at Well Visits From Age 0-5 Years

Visit	1 mos	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	96161	96161	96161	96161									
Development					96110			96110		96110	Consider a preschool screening as indicated	Consider a preschool screening as indicated	Consider a preschool screening as indicated
Autism								96110	96110				
Social-Emotional Development	96127	96127	96127	96127	96127	96127	96127	96127	96127	96127	96127	96127	96127
Health Related Social Needs (Risk & Protective Factors)	96160	96160	96160	96160	96160	96160	96160	96160	96160	96160	96160	96160	96160

AAP policy recommends additional screenings at any age at the discretion of the provider and family when a concern is identified to observe change over time, monitor risks, and intervene as needed.

The Early Childhood Developmental Health Systems (ECDHS): Evidence to Impact Center 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 $4,740,000 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.