A Toolkit for Comprehensive Developmental Screening and Health Promotion Using a Whole Child and Family Approach*

A Pathway to Operationalize Bright Futures Early Childhood Guidelines

Mississippi Specific Version

*Visit https://mississippithrive.com/resources/ for National Version

Screening				Health Promotion		
Step 1 Plan	Step 2 Train	Step 3 Implement	Step 4 Resources	Reach Out & Read	Vroom	Wellness Packets

Comprehensive Screening Using the Cycle of Engagement
Whole Child Approach

Well Visit Planner

Quality Assessment
Promoting Health Development Survey

INTRODUCTION

Health care providers who work with infants, toddlers, and preschoolers have a critical role to play in laying the foundation for early brain development, which has a lifelong effect on health and wellbeing. This toolkit offers practical resources for health care providers who are looking to incorporate recommended developmental screenings and provide comprehensive well-child care services (WCC). Resources included can enhance the ways you equip parents and other caregivers to promote their children's development. The visual map to this toolkit at the top of this page allows you to quickly access each resource by clicking on the boxes shown. We suggest you review the information below to learn more about featured resources before deciding which you wish to use in your practice. If you already know what you want to focus on, just click the boxes in the visual above to get started.

This toolkit is flexible and credible. Whether you are just beginning to implement developmental screenings and health promotion into your practice or, you are looking to make your existing approach more efficient and effective, this toolkit has something for you. The toolkit includes high-quality information from trustworthy sources, checklists and self-assessments, and guidance to help you integrate developmental screening services into your day-to-day practice. Ultimately, this toolkit will help you improve both your clinical efficiency and your clinical outcomes while improving the well-being of children and families.

This toolkit is aligned with national Bright Futures Guidelines: As portrayed in the visual map of this toolkit above, in addition to developmental screening, the toolkit offers approaches to implement a more comprehensive and transformative change in the way you deliver WCC using a set of health promotion resources, like Reach Out and Read as well as a comprehensive screening and whole child and family health promotion model called the Cycle of Engagement Well Visit Planner (COE/WVP) approach, each of which are aligned with national Bright Futures Guidelines. These approaches are evidence-based. The COE/WVP offers a model and set of digital tools you can use for free to ensure comprehensive screening and health promotion is provided based on the unique needs and priorities of each child and family. The Well Visit Planner (WVP) is carefully aligned with Bright Futures Guidelines for each age visit from the first week of life to age six and produces an easy-to-read Clinical Summary for providers and Well Visit Guide for families to use to prepare for and conduct personalized, connected encounters. **Click here** for a short video about the Cycle of Engagement Well Visit Planner approach (COE/WVP) and click on the COE/WVP box above for more information.

This toolkit can help you move toward a whole child and family, integrated health system approach. The tools offered in this toolkit are part of a larger vision for helping providers and families have the supports needed to ensure that children and families are engaged and successfully connected to necessary resources as early as possible when needs are identified. Ideally, practices are connected to care-coordination resources and are part of a strong and comprehensive early childhood system able to address their developmental, physical, social, and relational health needs. We invite you to explore the **Engagement in Action Framework** to learn about an integrated early childhood health system approach that helps you to partner with community and family-based resources as you address child development, social determinants and other health risks and needs of the children and families you serve.

A. DEVELOPMENTAL SCREENING

When we incorporate validated, reliable developmental screening tools into our work with families with young children, we are better able to identify and address mild delays that might be easily overlooked with only routine surveillance.

And when providers combine developmental surveillance and developmental screening, the likelihood of identifying a developmental delay or behavioral concern increases by up to 90%.

Identifying a problem early lets us refer our patients to an appropriate intervention sooner when it is most effective.

If you are looking for ways that your clinical practice can have a greater impact on the lives of your young patients, this toolkit is for you. It will help you to build a streamlined system to spot developmental concerns more reliably, select an intervention, and connect families with the right supports and services.

For practices that already conduct developmental screening, these recommendations may help you make your established processes more efficient. For practices just beginning to implement developmental screening, this toolkit walks you through a step-by-step process for designing a workflow and plan based on your individual needs and capabilities.

If you are a physician seeking to qualify for the American Board of Pediatrics, you can use sections of this toolkit to develop a **Quality Improvement Project** (MOC-4 project) focused on improving developmental screening.

Developmental Surveillance and Developmental Screening: What's the Difference?

Surveillance is the ongoing, developmental monitoring that occurs at every well-child check. Noting whether a child is reaching developmental milestones and asking parents if they have concerns are components of surveillance. Developmental screenings are different in that they must take place using a validated tool and are performed at specific intervals.

At the 4- to 5-year well-child visit, when children are headed into kindergarten, special attention to surveillance is recommended and a developmental screen is suggested but not required unless a concern presents.

Developmental Surveillance, Screening, and Evaluation

	Surveillance	Screening	Developmental Evaluation
Who	Medical Home Provider Other Trained Providers and Partners	Medical Home Provider Other Trained Providers	Developmental Pediatrician, Child Psychologist, Trained Provider
What	CDC Developmental Milestone Checklist Other Similar Tools	SWYC-DM (embedded within WVP), ASQ-3, PEDS, etc	Battelle, Bayley, Mullen, etc.
When	Every Wellness visit	9, 18, 30 months Developmental Screen 18, 24 months Austism Screen Whenever there is a concern	As indicated
How	Elicit parental concerns Obtain developmental history Observation of child Maintain accurate record Share findings with other professionals	Formal Validated Tool	Detailed exam, formal assesment tools
Why	Early detection of developmental concerns	Increase rate of dection of developmental concerns Referral and Therapy	Formal diagnosis

*Note: The Well Visit Planner incorporates surveillance.
Developmental Surveillance Resources for Healthcare Providers | CDC
Developmental Surveillance and Screening Patient Care (aap.org)
Screening for Professionals | CDC

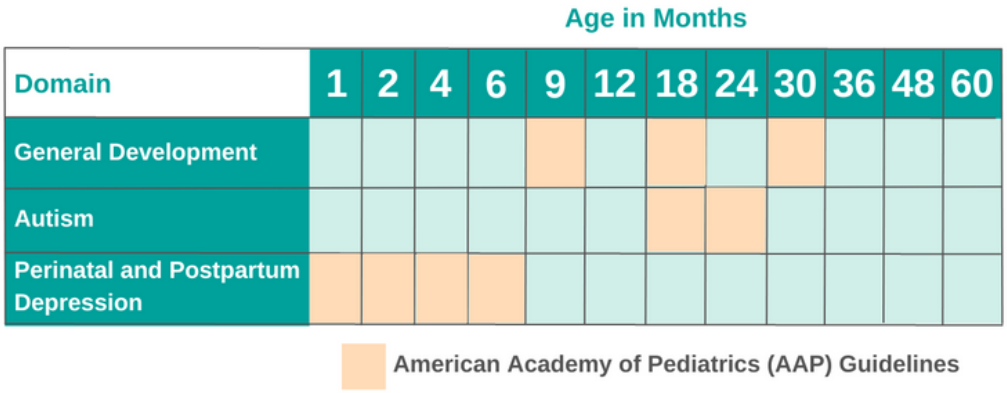
When to Screen

The Bright Futures Program maintains and shares clinical guidelines that are age specific, based on the best available scientific evidence, and help increase the quality of primary and preventive care.

All children should receive services that follow **Bright Futures periodicity schedule** and include full implementation of **Bright Futures**.

Recommended Timing and Frequency of Developmental and Maternal Depression Screenings

This table outlines recommended screening periodicity (timing and frequency) for three screening domains (development, autism, and perinatal and postpartum depression) based on a child's age months. These are baseline recommendations. If risk factors, provider concerns, or parental concerns arise, screening beyond what is outlined in the guidelines should occur.



Option

A more comprehensive screening approach, that includes the above along with assessments for family health, child physical health, social determinants of health, social emotional development, family strengths and much more is what is recommended as standard of care as set forth in **Bright Futures Guidelines** and you are strongly encouraged to work towards this whole child and family approach. We know that doing so in a busy practice can be challenging and that current data shows that there are big gaps in implementation.

The Cycle of Engagement Well Visit Planner approach featured in this toolkit addresses many documented challenges to full implementation of Bright Futures. See this **video** to learn more or by visit this **website**. As noted above, the Well Visit Planner is meticulously aligned with Bright Futures Guidelines for each age visit and provides you with an "at a glance" Clinical Summary with resources tailored to the unique needs and priorities of each child and family (see illustration below).

Clinical Summary of Well Visit Planner® Findings: 18 Month Well Visit

Date of Well Visit: No response • **Date WVP Completed:** 2/4/2023 • **Birth Month & Year:** 7/2021

Key: ☐ family response indicated no or low risk ☑ family response indicated some risk or concern ☒ family did not respond; nonresponse could indicate risk

Well Visit Planner®

Screening and Assessments Summary and Topics to Address: *Assess & Address*

Child Development

Developmental Surveillance and Screening

☐ **Developmental Screening SWYC milestones score[1]:** 12 (Results from 18 Month SWYC: met age expectations); score may or may not indicate a delay. Clinical review with family needed.

Very Much
- Kicks a ball
- Names at least 5 body parts - like nose, hand, or tummy
- Names at least 5 familiar objects - like ball or milk
- Runs
- Walks up stairs with help

Somewhat
- Climbs up a ladder at the playground
- Uses words like "me" or "mine"

Not Yet
- Jumps off the ground with two feet
- Puts 2 or more words together - like "more water" or "go outside"
- Uses words to ask for help

☑ **Autism spectrum disorder screen (M-CHAT R/F):** 4 (Moderate risk);

Administer M-CHAT Follow-Up for specific responses
- Child does not like climbing on things
- Child does not show caregiver things just to share
- Child does not try to get caregiver to watch them
- Child gets upset by everyday noises

☑ **Caregiver reports completing standardized developmental, behavioral screening:** No

☑ **Caregiver's overall level of concern about child's development, learning, behavior:** A little

☐ **Hearing concerns:** No

☑ **Speaking concerns:** Yes

☐ **Lazy or crossed eyes:** No

☐ **Bowel movements/urination concerns:** No

Health Behaviors

☐ **Smoking**

☐ **Flag for potential alcohol misuse**

☐ **Recreational/non-prescription drug use**

Relational Health Risks

☐ **Intimate partner violence risk[2]**
- Caregiver and partner work out arguments with some difficulty

Social Factors/Determinants

☑ **Economic Hardship:** Somewhat/very often hard to cover costs of basic needs, like food or housing

☐ **Positive impact of COVID-19 on child:** A little

☑ **Negative impact of COVID-19 on child:** Somewhat

☑ **Impact of Covid-19 on family's well-being:** More stress

Caregiver Emotional Health

☐ **Depression risk: PHQ-2[4] Score: 1:** Down, depressed, or hopeless several days over the past 2 weeks

☑ **Caregiver social support:** Does not have at least one person they trust and can go to with personal difficulties

☑ **Caregiver self care/hobbies:** Has not spent time in last 2 weeks doing things they enjoy

☑ **Caregiver coping:** Not Very Well

Other assessments added by provider:

Preschool Pediatric Symptom Checklist (PPSC): no/low risk
Safe Environment for Every Child (SEEK) : At-risk
PEARLS ACEs score[3]: 2
PEARLS Toxic Stress Risk Factor score[3]: 1
Child flourishing: At Risk
Family resilience: Caregiver did not respond
Parent-child connection: No/Low Risk

See details on 2nd page

Additional caregiver/parent goals and/or concerns to address during the visit:
Finding a pre-school

About This Child

Name: Example Child **Initials** (F M L): EC
Special Keyword: Example WVP
WVP completed by: Mother
Gender: Female
Insurance coverage/type: Private or Employment-based
Interested in telemedicine visits: No
Concerns about telemedicine to address: Losing a sense of connection, respect and warmth with provider

General Health and Updates

Child's Health and Health History

☐ **Child has ongoing health problem requiring above routine services (CSHCN screener[5])**

☑ **New medications:** Amoxicillin

☐ **Currently taking vitamins/herbal supplements**

☑ **Dentist:** Currently no dentist

☐ **Fluoride**

☐ **Lead exposure**

Family History and Updates

Lives with both parents: No

☑ **Recent family changes (e.g. move, job change, separation, divorce, death in the family):** Job change

☑ **New medical problem in family**

☐ **Parent/grandparent had stroke or heart problem before age 55**

☐ **Parent has elevated blood cholesterol**

Strengths to Celebrate! *Connect & Celebrate*

One thing that is going well for the caregiver as a caregiver:
Finding time to do chores while girls nap or play together

One thing the child can do that caregiver is excited about:
Communicating with us and her sister more every day!

Child Flourishing
Details on 2nd page

Parent-child connection
Details on 2nd page

Anticipatory Guidance Priorities Selected by the Family: *Coach & Educate*

View educational materials for the 18 Month Well Visit here:
https://www.wellvisitplanner.org/Education/Topics.aspx?id=6

This child's parent/caregiver selected the following top 4 priorities across each of the 24 recommended Bright Futures anticipatory guidance topics for the 18 Month Well Visit. Click on the links below to access information and resources to share with families on these priorities. See page 2 for additional resources.

1. Making sure you have somewhere or someone to turn to for emotional support
2. Sibling rivalry
3. Ways to read to your child that promote his language development
4. What to do if your child swallows poison and when to call the poison control center

[1]SWYC Milestones: The developmental screening instrument of the Survey of Well-Being of Young Children (SWYC), which meets American Academy of Pediatrics' developmental screening guidelines [2]Intimate partner violence risk assessed using the Woman Abuse Screening Tool-Short (WAST-Short), a two-question abuse screening tool [3]The Pediatric ACEs and Related Life Events Screener (PEARLS) screens for a child's exposure to adverse childhood experiences (ACEs) and risk factors for toxic stress [4]Caregiver depression risk is assessed using the Patient Health Questionnaire-2 (PHQ-2) for the 9 month well visit and beyond [5]TThe Children with Special Health Care Needs (CSHCN) Screener is a validated 5-item screening tool identifying children with ongoing conditions and above routine service needs

Common, Evidence Based Developmental Screening Instruments

Identify which instrument(s) is/are the best fit for you practice/population.

General Development		
Ages and Stages Questionnaire – 3 (ASQ-3)	Parents Evaluation of Developmental Status (PEDS)	Survey of Wellbeing of Young Children – Developmental Milestones
30 questions, 5 domains	10 questions, 5 domains	10 questions, 5 domains
Asks if a child does specific activities (age specific)	Asks if parents have concerns across domains	Asks if a child does specific activities (age specific)
Option to utilize ASQ: SE-2 if positive for social emotional concerns (for extra cost)	N/A	Option to utilize other SWYC screens for autism, socioemotional and other topics.
Most detailed		Demonstrated to be equally valid as ASQ

Click here to review a paper comparing these three screening instruments: [Comparative Accuracy of Developmental Screening Questionnaires – PubMed (nih.gov)]

Autism	Modified-Checklist for Autism in Toddlers-Revised w/Follow-up (M-CHAT-R/F)
Perinatal and Postpartum Depression	Edinburgh Postnatal Depression Scale (EPDS), Patient Health Questionnaire - 2(PHQ-2), Patient Health Questionnaire - 9(PHQ-9)

Developmental Screening Toolkit Steps

Step 1 Plan

Step 1: Plan
Assess present clinic practices in relation to developmental screening. Identify a team to lead and guide efforts to institute or improve the developmental screening process.

Step 2 Train

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This step has two parts – the first is to train clinic staff on the screening tools, and the second covers presentation of the results to patients/families.

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Step 3 Implement

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This toolkit uses the Plan, Do, Study, Act (PDSA) method of quality improvement to implement changes.

Step 4 Resources

Referrals & Resources
Referral resources are available for further evaluation, and intervention to address screening results that indicate concerns or delays. Resources are also available preventively, to promote healthy development. Resources for developmental screening and health promotion can be found **here.**

B. DEVELOPMENTAL HEALTH PROMOTION

Families play a significant role in fostering children's developmental and behavioral health. Developmental health promotion is the process of equipping families to engage in relationships, activities and behaviors with their child that improve overall developmental health and quality of life.

When you actively promote developmental health with families, you help to foster a stronger parent-child bond, which builds a child's capacity for strong relationships and establishes sturdy brain architecture. By integrating health promotion into every family's care plan, you can help to mitigate external conditions that might negatively influence a child's health, such as adverse childhood experiences in the home, financial instability, unhealthy neighborhoods or housing conditions, or other "social determinants of health."

Many strategies or programs are available to help you promote early developmental health and to equip families as "brain builders" who can support healthy development. In addition, there are many high-quality, evidence-based resources available to share with families directly. Mississippi Thrive! encourages you to integrate and share health promotion materials and implement evidence-based strategies that reach all children, like those

B. DEVELOPMENTAL HEALTH PROMOTION

suggested in Primary Care Interventions for Early Childhood Development: A Systematic Review | Pediatrics | American Academy of Pediatrics (aap.org) and Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health | Pediatrics | American Academy of Pediatrics (aap.org).

This toolkit features specific examples of health promotion strategies and resources to integrate into your practice.

- Reach Out and Read protocols to use with families
- Vroom digital app providing parent education information
- Wellness packets featuring family facing information about developmental screening and child health
- Well Visit Planner (WVP) digitally available family resource sheets for each anticipatory guidance and risk topic recommended in Bright Futures Guidelines. You can access and use these whether you use the WVP or not.

Reach Out & Read | **Vroom** | **Wellness Packets** | **Well Visit Planner**

DEVELOPMENTAL SCREENING STEP 1: PLAN

Part 1: Selecting and Training the Quality Improvement team

Each clinic will establish a quality improvement team to implement changes and to assess the impact on clinic operations and family outcomes. The make-up of the team will vary by clinic, but teams should consider representation from medical providers (**physicians, nurse practitioners, and physician assistants**), nurse managers, front office staff, triage nurses/medical assistants, clinic nurses, and other team members as determined by the clinics. Each team will also identify a clinic champion to guide the CQI process. The team should be **introduced** to the importance of developmental screening, **trained** on evidence-based screening tools, and **instructed** on using data driven decision-making for continuous quality improvement.

Champion: The Champion leads and sustains efforts for successful implementation of developmental screening (e.g., nurse practitioner, physician). This person also provides education and support to the rest of the team.

Practice Manager/Administrator: This team member assists in determining how developmental screening fits into practice workflow, documentation, and billing.

Front Desk Staff: These members may assist by flagging patients who present for age-appropriate developmental screening and those who present for follow up. In some clinics, they may hand out screens for patients to complete in waiting rooms or provide assistance completing the screen or electronic platforms for families to access as are available for the ASQ and when using the Well Visit Planner.

Clinical Staff: Nurses and medical assistants already gather information or conduct medical assessments. Their role in developmental screening may include starting conversations about developmental screening followed by administering screens or assisting patients to access online platforms to complete the screens. Community health workers, family navigators or child development support staff can play helpful roles when available. In some clinics, they may be responsible for scoring screens or presenting results to the medical provider.

Physicians: Providers are responsible for making sure the screening is completed and scored, and results are documented in the medical record. Providers use their expertise in discussing results with the family as they offer guidance when parents need to make decisions about their child.

Parent Leader/Advisor: Family centered care is best delivered when families lead and provide input into and play a role in practice change efforts and systems design. Identifying family leaders and ensuring their voices inform the effort is suggested. For tips on how to engage families in practice improvement efforts, explore here.

Part 2: Needs Assessment and Systems Mapping Strategies

A needs assessment is conducted to describe existing system capacities of clinics and the ability to implement developmental screening services. The systems mapping process is designed to illuminate areas of unmet needs and generate questions and priorities in terms of refining current policy and practices.

The overall objective of the mapping process is to create a visual representation of a typical patient visit flow. The team begins with a point of patient entry to the clinic and completes each layer by asking 'What happens next', noting at which points developmental screening or promotion occurs.

Systems mapping serves to:

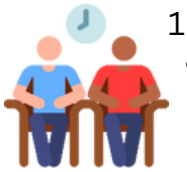
- Provide a clear picture (flow chart) of the current structure and functions of the clinic.
- Identify strengths and weaknesses and enhance service delivery by prioritizing workarounds and improvement opportunities.
- Bring key team members together to support the improvement of developmental health practices.
- Highlight and prioritize data requirements for monitoring and evaluating developmental health practices.

Determine When and Where to Screen

Not all screenings must be done in the same place or administered by the same people, but a standard clinic protocol helps ensure the goal is met. Some practices have families fill out the screen in the waiting room, others in the exam room, and some even email families a blank screen before their child's appointment. If the Well Visit Planner is used families can complete the digital tool using their phone, tablet, or computer either at home or in clinic.

Keep in mind that some families may need assistance reading and completing screening tools. When possible, provide the screen in the family's primary language. No matter where screens are conducted, all results of the screen should always be discussed in a private space. ***Across all these areas outlined below, language, literacy and equity issues should be considered and addressed.**

There are pros and cons to different locations and timing during the visit:



1. A public space such as a waiting room
   - Pros: Screening can be completed at home before patients arrive to the clinic or in the clinic while patients are waiting. This allows for easier scoring by the medical staff, and it can be scored before the provider sees the . If family completed and automatically scored tools are used, like the Well Visit Planner or the ASQ Online, time to score can be reduced and results can be shared ahead of time with providers and families so visit time can focus on results and needs.
   - Cons: When completing in the clinic, the caregiver may have reduced capability to supervise their child.

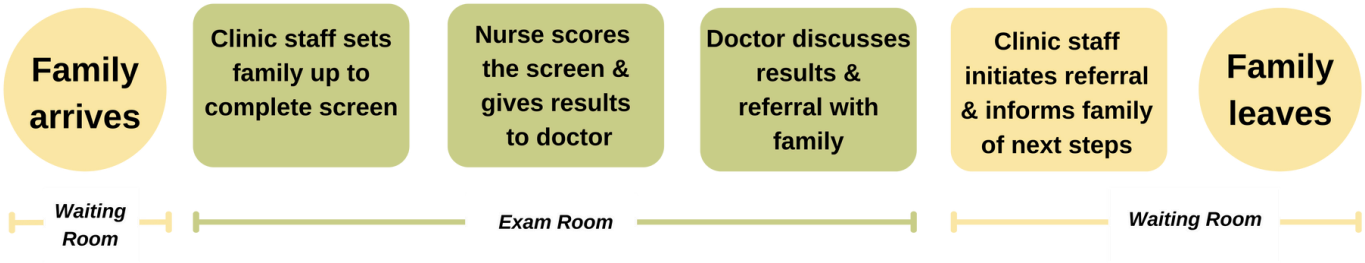
2. A private space such as an exam or triage room
- Pros: It provides lots of privacy. If required, the screening can be scored by clinical staff immediately in the room, and it can be scored before provider sees the family.
- Cons: It requires more time for clinical staff to distribute and score, if required.

3. Pre-Visit such as through electronic platforms and/or through community partnerships
- Pros: It frees up visit time to focus on promoting development and addressing identified issues. Family reflects and learns ahead of time and may be more engaged in discussions and counseling and come to the visit with their priorities identified. Community partners can be the lead to engage families that have been historically marginalized by our systems and then share results with providers having addressed family needs in areas that are appropriate (e.g. social determinants, ensuring child has a scheduled well visit, etc.). The Well Visit Planner provides data to the clinic on a data dashboard and can be shared across clinic and community-based settings.
- Cons: It requires establishing adequate communication, coordination and information sharing mechanisms. IT access gaps should be considered and addressed.

Fit the Strategies You Select into Your Workflow

Once the decision is made about where and when each screen will be performed, create a step-by-step process. Think about all the things that happen during a well-child visit, and where developmental screening will best fit in.

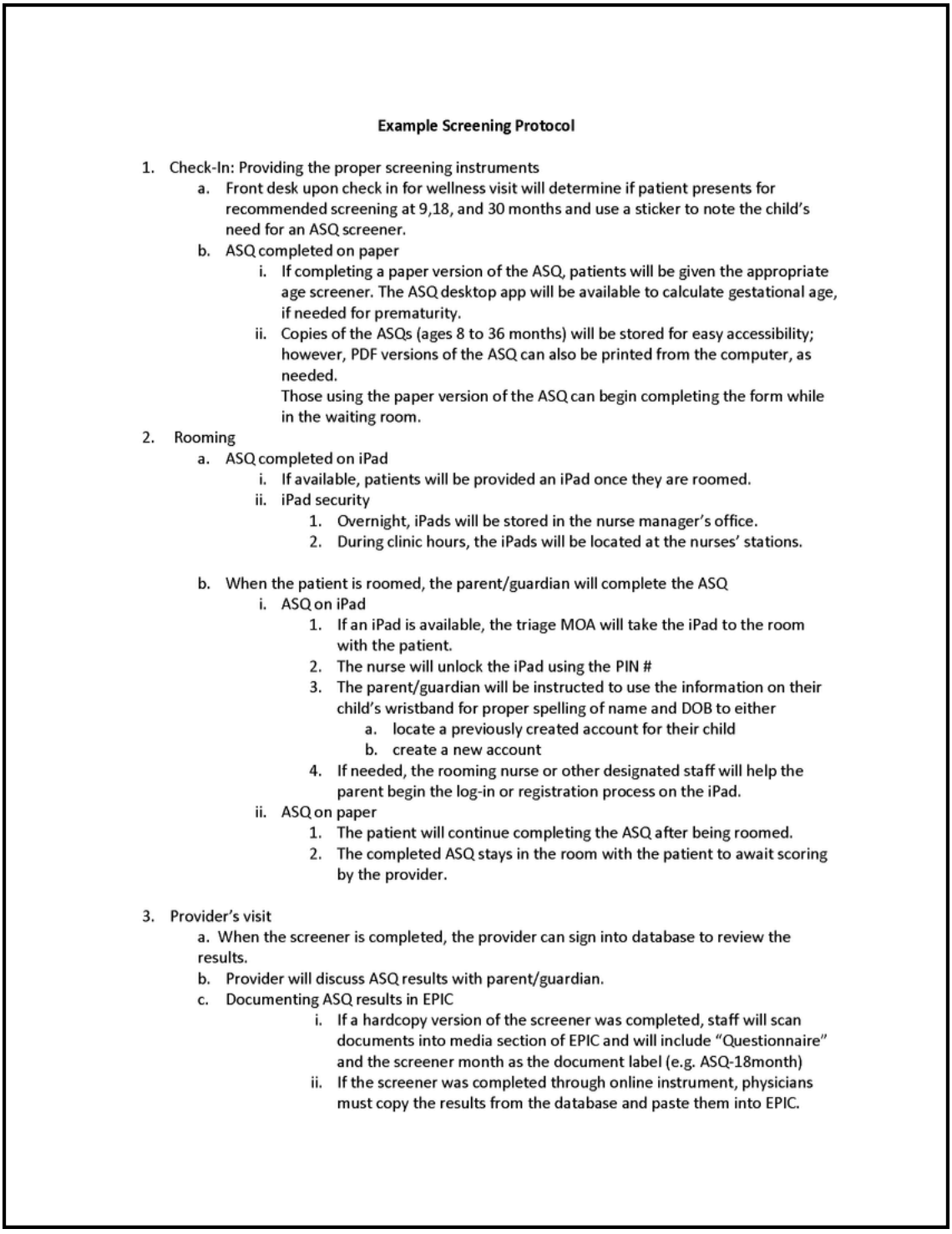
Example of conducing screening within the clinic (compared to pre-visit screening done at home)



Part 3: Develop Implementation Plan

Based on results from the needs assessment, the CQI team sets goals and develops an implementation plan. The implementation plan includes a standard protocol with step-by-step instructions for all providers for screening, documentation of results in the medical record and referrals, as needed, to any service provider.

Click on document below for a screening protocol example.



Example Screening Protocol

1. Check-In: Providing the proper screening instruments
    a. Front desk upon check in for wellness visit will determine if patient presents for recommended screening at 9,18, and 30 months and use a sticker to note the child's need for an ASQ screener.
    b. ASQ completed on paper
        i. If completing a paper version of the ASQ, patients will be given the appropriate age screener. The ASQ desktop app will be available to calculate gestational age, if needed for prematurity.
        ii. Copies of the ASQs (ages 8 to 36 months) will be stored for easy accessibility; however, PDF versions of the ASQ can also be printed from the computer, as needed.
        Those using the paper version of the ASQ can begin completing the form while in the waiting room.
2. Rooming
    a. ASQ completed on iPad
        i. If available, patients will be provided an iPad once they are roomed.
        ii. iPad security
            1. Overnight, iPads will be stored in the nurse manager's office.
            2. During clinic hours, the iPads will be located at the nurses' stations.

    b. When the patient is roomed, the parent/guardian will complete the ASQ
        i. ASQ on iPad
            1. If an iPad is available, the triage MOA will take the iPad to the room with the patient.
            2. The nurse will unlock the iPad using the PIN #
            3. The parent/guardian will be instructed to use the information on their child's wristband for proper spelling of name and DOB to either
                a. locate a previously created account for their child
                b. create a new account
            4. If needed, the rooming nurse or other designated staff will help the parent begin the log-in or registration process on the iPad.
        ii. ASQ on paper
            1. The patient will continue completing the ASQ after being roomed.
            2. The completed ASQ stays in the room with the patient to await scoring by the provider.

3. Provider's visit
    a. When the screener is completed, the provider can sign into database to review the results.
    b. Provider will discuss ASQ results with parent/guardian.
    c. Documenting ASQ results in EPIC
        i. If a hardcopy version of the screener was completed, staff will scan documents into media section of EPIC and will include "Questionnaire" and the screener month as the document label (e.g. ASQ-18month)
        ii. If the screener was completed through online instrument, physicians must copy the results from the database and paste them into EPIC.

DEVELOPMENTAL SCREENING STEP 2: TRAIN

Training the team occurs in two parts.

Part 1 focuses on how to use the recommended screening tools for each domain. A summary of each recommended tool is presented below.

Part 2 focuses on conversations with families. This includes the importance of reviewing results with families and navigating conversations when a screen indicates "monitoring" is needed or when a screen results in "at risk".

Training Part 1: Screening Instruments

Staff members who are involved in developmental screening require instruction on how to introduce, administer, and score each screen (unless they are using a tool that automatically scores such as the Well- Visit Planner).

Domain	Recommended Instruments
General Development	Ages and Stages Questionnaire - 3rd Edition (ASQ-3),SWYC-DM, and PEDS
Autism	Modified-Checklist for Autism in Toddlers-Revised w/Follow-up (M-CHAT-R/F)
Perinatal Depression	Edinburgh Postnatal Depression Scale (EPDS), Patient Health Questionnaire - 2(PHQ-2), Patient Health Questionnaire - 9(PHQ-9)

Developmental Screening for General Development—Featured Tools

Recommended Tool: ***Survey of Well-being of Young Children – Developmental Milestones Survey (SWYC-DM)***

The Survey of Well-Being of Young Children-Development Milestones (SWYC-DM) is a validated developmental screening tool that helps identify children at risk for developmental, behavioral, and social delays.

- Cost: There is no cost to use paper/pencil surveys or use online as a part of the Well Visit Planner and access automated results on the provider data dashboard. There is an option to pull results/findings into the Electronic Health Record. SWYC is included in EPIC for providers using this system.
- Languages Available: Arabic, Bengali, Burmese, Chinese, Chuuksee, English, French, Haitian-Creole, Khmer, Korean, Nepali, Portuguese, Russian, Samoan, Somali, Spanish, Tagalog, Traditional Chinese, Vietnamese (English and Spanish only if used as part of the Well Visit Planner)
- Age Range:1 month – 5 years and 6 months
- What is Assessed: Communication, fine motor, gross motor, personal-social, problem solving
- Length: 10 questions

- Time to Complete: 1 minute or less
- Time to Score: Automatic if using the Well Visit Planner; 1.5 minutes if by hand. Additional time if you scan findings into the Electronic Health Record
- When to screen: 9, 18, and 30 month well-child visits (other ages available for surveillance or when concern is present)
- For further information and instruction on the SWYC-DM and tools click here. For more information about the Well Visit Planner, which includes the SWYC, click here.

Recommended Tool: ***Ages and Stages Questionnaires, Third Edition ((ASQ®-3)***

The Ages and Stages Questionnaires-3rd Edition is a validated developmental screening tool that helps identify children at risk for developmental, behavioral, and social delays.

- Cost: **$295 for starter kit with paper/pencil surveys. Three options, each with an additional fee are available: (1) an online electronic system (Pro or Enterprise) to allow providers to enter family data and receive automated scores ($500); (2) an online family completion platform (ASQ Online) used with the Pro or Enterprise ($350); and (3) an option to have ASQ scores pulled into the Electronic Health Record (varies; $800 for 1000-2000 screens).**
- Languages Available: Arabic, Chinese, English, French, Spanish, Vietnamese
- Age Range:1 month – 5 years and 6 months
- What is Assessed: Behavior, communication, fine motor, gross motor, personal-social, problem solving
- Length: 30 questions
- Time to Complete: 10 – 15 minutes
- Time to Score:1-3 minutes (online option to enter data and generate an automatic score) Additional time for completion of paper version scoring and then scanning into the chart dependent upon clinic process
- When to screen: 9, 18, and 30 month well-child visits (available for other ages for surveillance or when concern is presented)
- For further information and instruction on the ASQ and tools click here.

Recommended Tool: ***Parents' Evaluation of Developmental Status (PEDS)***

The Parents' Evaluation of Developmental Status (PEDS) is a validated developmental screening tool that helps identify children at risk for developmental, behavioral, and social delays.

- Cost: **$349 for starter kit, options for online data entry and scoring and to transfer the scored instrument into the Electronic Health Record for additional fee.**
- Languages Available: Print available in English and Spanish. Can be licensed in 60+ languages.
- Age Range: Birth – 8 years
- What is Assessed: Behavior, communication, fine motor, gross motor, personal-social
- Length: 10 questions
- Time to Complete: 5 minutes

- Time to Score: 2 minutes. Option for online scoring for additional fee. Additional time for completion of paper version scoring and then scanning into the Electronic Health Record.
- When to screen: 9, 18 and 30 month well-child visits (other ages available for surveillance or when concern is present)
- For further information and instruction on the PEDS and tools click here.

Developmental Screening for Autism—Featured Tool

Recommended Tool: ***Modified Checklist for Autism in Toddlers Revised (M-CHAT-R/F)***

Symptoms of Autism Spectrum Disorder (ASD) often become apparent during the child's first year and can be identified by 18 months. This screen has two stages if a concern is identified. First, a 20-item questionnaire helps identify children at risk for ASD. The second stage, a short follow-up interview completed with the family immediately after the initial screen occurs if a concern is indicated and reduces the number of false positive results.

- Cost: **There is no cost. It is also included as part of the Well Visit Planner.**
- Languages Available: **40+ languages. Available in English and Spanish if used via Well Visit Planner**
- Age Range:16 – 30 months
- What is Assessed: Risk for Autism Spectrum Disorder
- Time to Complete: 5-10 minutes for initial questionnaire
- Time to Score: Initial score 1 minute, additional 10 minutes if follow-up interview is necessary (i.e., if initial score is between 3-7). Automatic scoring and reporting if use Well Visit Planner. Can be scanned into the Electronic Health Record.
- When to screen: 18 and 24 month well-child visits
- For further information and instruction on the M-CHAT-R/F™ and tools **click here**. For more information about the Well Visit Planner click **here**.

Screening for Perinatal and Postpartum Depression—Featured Tools

Recommended Tool: ***Edinburgh Postnatal Depression Scale (EPDS)***

The EPDS was developed to identify women who may have postpartum depression. Preferred tool for postpartum depression screening.

- Cost: **No cost. Also included as part of the Well Visit Planner.**
- Languages Available: English, Spanish
- Age Range: Not age dependent
- What is Assessed: Frequency of depressed mood and anhedonia over the past seven days
- Time to Complete: 5 minutes
- Time to Score: 2 minutes. Automatic scoring when used as part of the Well Visit Planner
- When to screen: 1, 2, 4, and 6 month well-child visits

Recommended Tool: ***Patient Health Questionnaire-2 (PHQ-2)***

The EPDS was developed to identify women who may have postpartum depression. Preferred tool for postpartum depression screening.

- Cost: **No cost**. **Also included as part of the Well Visit Planner.**
- Languages Available: English, Spanish
- Age Range: Not age dependent
- What is Assessed: Frequency of depressed mood and anhedonia over the past two weeks
- Time to Complete: Less than 2 minutes
- Time to Score: Less than 1 minute
- When to screen: 1, 2, 4, and 6 month well-child visits

Recommended Tool: ***Patient Health Questionnaire-9 (PHQ-9)***

In addition to recommending the Patient Health Questionnaire-9 as an option for initial screening for Perinatal Depression, we also recommend using it as a follow-up to a positive PHQ-2.

- Cost: No cost
- Languages Available: English, Spanish
- Age Range: Not age dependent
- What is Assessed: Frequency of depression symptoms over the past two weeks
- Time to Complete: Less than 2 minutes
- Time to Score: Less than 1 minute
- When to screen: 1, 2, 4, and 6 month well-child visits

All maternal depression screening tools can be integrated into the EHR.

NOTE: The Well Visit Planner also includes a post-partum depression screening tool using the Edinburgh Postnatal Depression Scale.

Developmental Screening for General Development—Featured Tools

For those considering an electronic/online format, a comparison was made of the following online platforms.

Comparison of Key Features and Costs for Online Screening Tools

	CHADIS	ASQ	WELL VISIT PLANNER® DIGITAL TOOLS
Cost for platform access	Contact CHADIS for current pricing, (In 2018, UMMC negotiated a price of $1000.00/provider/yr.	$149.95/site/year for ASQ Pro*- single site use only (no satellites) or $499.95/year for ASQ Enterprise** - multisite use (includes satellites). Extra for family online use ($350/yr) once have Pro or Enterprise. Other fees noted below.	Free for families. Currently free for providers/clinic early adopters. Future fees estimated $400 for single provider/clinic account.
Screening instrument included	500+ (ASQ, MCHAT, PHQ9, etc.)	ASQ-3 and ASQ: SE only. $295 for each ASQ-3 Starter Kit of paper/pencil screens for each language. Must have separate kit for each satellite.	All recommended by age of child using Bright Futures Guidelines plus numerous optional screens/content (SWYC, MCHAT, PHQ9, CSHCN Screener, SEEK, WAST, ACEs, Family Resilience, Child Resilience…)
Getting started resources	Contact CHADIS	ASQ-3 Starter Kit - $295 · ASQ Questionnaires · Universal screening intervals · All age intervals 1-66 months for concerns · Paper and disc · ASQ keycode for online access	Included: • Getting Started Toolkit • Video tutorials, Family Engagement Toolkit • Billing, quality measurement resources Framework for use in collaboration with community-based and other health system partners to improve quality and outcomes
Age correction	Reports age adjusted ASQ results based on DOB and weeks premature	Reports age adjusted ASQ based on DOB and weeks premature	Reports age adjusted SWYC results based on DOB. Automatically pulls age specific screeners/topics based on DOB.
Learning activities	Included	$50.00/book	Included
Family access for online completion	Included; Results shared with provider only	$350/yr for all sites. Results shared with provider only.	Included- Results shared "on the spot" with family and provider
Online data bank	Included	$.50 for each screener scored (in addition to the platform access fee)	Autogenerated Reports Included (with search features to find children by results)
iPad for parent to complete the screen electronically+	$550	$550	$550 or use any mobile devices/smartphones
iPad Cart++	$750	$750	$750
Provider/professional support	Contact CHADIS	Basic: $80/year. Fees for training ($200 per person); hands on help $395/hour (not required)	Technical assistance hotline and rapid response email
EHR integration	Contact CHADIS	$800 to transfer up to 2000 screening using an API bridge. Less for fewer screens/year. See Brookes Publishing for Tiered Pricing.***	Options to capture data using API, HL-7 data field transfer. Fees determined based on volume and requirements of the end user. Reasonable/low.
Developed by/owned by	Developmental Pediatrics, Inc.	Brookes Publishing, Inc.	Child and Adolescent Health Measurement Initiative, Center for the Advancement of Innovative Health Practices (501c3)

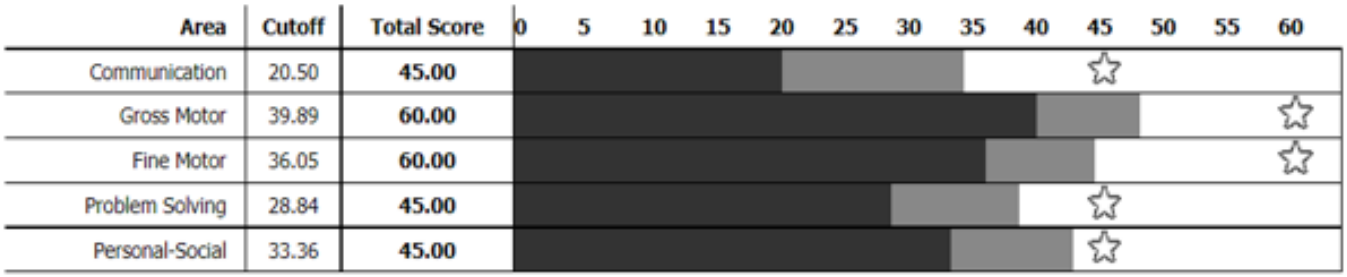
*ASQ Pro
**for ASQ Enterprise
***See Brookes Publishing for Tiered Pricing
+iPad used so that patients did not share computer with access to a patient's records
++iPad mounted on cart to eliminate likelihood that iPad would be removed from clinic, similar to computer on wheels
Note: For those choosing to perform paper screening, the ASQ-3 kit can be purchased without the addition of the online platform.
Please visit the AAP STAR Center Screening Tool Finder for more information on screening tools for use in the Pediatric Medical Home.

Documenting Results in the Electronic Health Record (EHR)

Integrating developmental screens and results into your practice's electronic health record (EHR) helps ensure consistent service delivery and simplifies data tracking. All recommended screens can be scanned into the EHR. Alternatively, clinics can opt to have these automatically placed into the record using each tool's API/HL-7 data transfer abilities. However, this option will require your EHR vendor/team to enable this to occur.

Option 1: When using an online platform, the medical staff may "copy and paste" the results by importing the performance chart from the online database into the patient visit note of the electronic record (see example below).

SCORING RESULTS:



Area	Cutoff	Total Score
Communication	20.50	**45.00**
Gross Motor	39.89	**60.00**
Fine Motor	36.05	**60.00**
Problem Solving	28.84	**45.00**
Personal-Social	33.36	**45.00**

Black: concern Gray: Monitor White: No concern

Option 2: Screening results can be entered into the EHR using a "dot phrase" (a dot followed by a short user-generated phrase which allows text to be easily inserted into patient notes) to document results. After generating the dot phrase, the provider adds patient scores to document screening results. It is possible to utilize this option whether the screening is completed on paper or electronically (see example below).

ASQ Results
9-Month-old administered on 9/8/2021, completed by mother

Communication = Pass 60

Gross Motor = Pass 60

Fine Motor = Monitor/Borderline 45

Problem Solving = Pass 60

Personal Social = Pass 60

Activities have been given for Fine Motor domains. Will follow up in 3 months.

Referrals: No referral needed

Billing and Coding

To maximize compensation, a clear understanding of billing processes related to developmental screening is necessary. It is important to ensure appropriate CPT codes and any modifiers are included in documenting screening procedures.

Developmental screening services are typically reimbursed but coverage varies depending on state and type of insurance provider. Children who are enrolled in Medicaid are entitled to all developmental screens recommended by AAP Bright Futures. These services are covered under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Children's Medicaid also covers most of the interventions or services that are recommended after a screening. These services may include speech, occupational or physical therapies, and behavioral health services. Increasingly, private insurance carriers are improving coverage for screening and recommended services.

Increasingly, insurance carriers are reimbursing developmental screening. Typically, carriers reimburse for the three universal developmental screening visits and the two recommended screening visits for autism. You can advocate for payment reform through your organization's legislative liaison or your local AAP.

Sensory Screenings and Developmental/Behavioral Assessments

Screening Code	EPSDT Service	Age of Child	Period Limitations	Unit
99173-EP	Vision Screen	3, 4, 5, 6, 8, 10, 12 & 15 years of age	3, 4, 5, 6, 8, 10, 12 & 15 years of age	1 per year
92551-EP	Hearing Screen	4, 5, 6, 8, 10, once between 11-14, 15-17, & 18-21 years of age	4, 5, 6, 8, 10, once between 11-14, 15-17, & 18-21 years of age	1 per year
96110-EP	Developmental Screen	9,18, & 30 months	9,18, & 30 months	1 per month
96110-EP	Autism Screen	18 & 24 months	18 & 24 months	1 per month+
96160-EP	Depression Screen	12-21 years	Annually beginning at age 12	1 per year
96161-EP	Maternal Depression Screen	1 – 6 months	1, 2, 4, & 6 months	1 per month
96127	Vanderbilt			2 units per yr; can be billed in one day; More units can be billed with ADHD follow up visit

+ Maximum 2 screenings

If there is a concern on a developmental or autism screen, the provider must document in the medical record the screening tool(s) used, the result of the screen, and any action taken.

Since both developmental screening and MCHAT are recommended at the 18 month visit and are billed under the same procedure code (96110) for the same day of service, some Medicaid Managed Care groups, as well as some insurance carriers, have difficulty recognizing both should be reimbursed. Providers may only receive reimbursement for one developmental and one autism screen per day of service.

To receive reimbursement for both services performed on the same day, providers may submit claims for two units of the relevant procedure code. If a child is at-risk or suspected of a developmental abnormality, developmental and autism screenings qualify as a covered service, when administered at intervals outside of EPSDT preventive visits.

Perinatal Depression Screen: To bill for depression screening documentation must include the tool used, the results, and any follow-up actions taken. If an enrollee's caregiver screens positive, the provider must refer the caregiver to available resources, such as their primary care provider, obstetrician, or mental health professionals, and document the referral.

Training Part 2: Conversations with Families

Once a screening is completed, it is important to discuss the results with the family and offer next steps as needed. Even if results are negative, anticipatory guidance for families in terms of growth and development of their children across all domains, should be part of every wellness visit. Developmental discussions and concerns should be family centered.

Conversations with families should emphasize realistic timelines for achieving developmental milestones and should be culturally sensitive to each family. Using milestone checklists, such as those provided by the **CDC's Learn the Signs. Act Early**, can help guide the conversation and serve as a helpful take-home tool for families. This resource may also be helpful: **Development is a Journey – Brazelton Touchpoints.** If using the Well Visit Planner, family resource sheets are provided based on results from the SWYC to support conversations. A Personalized Connected Encounter approach to visits is also provided. More resources are located on the **Mississippi Thrive Resources page**.

Screening Results: No Risk
Even when results show no concerns, it is still important to review results with the family and offer anticipatory guidance.

Screening Results: Monitoring
When a screen indicates a borderline performance in one or more domains, the following should occur:

- Close monitoring and follow-up,
- Offer developmental promotion activities, such as the ASQ Learning Activities, which help enhance skills in the area of concern,
- Re-evaluation in 1-3 months
- – According to AAP guidelines, if the child remains in the monitoring range, or falls to the “at risk” range on follow up, referral for further evaluation should occur.

Screening Results: At Risk
When a child falls in the “at risk” range, further assessment is required. It is crucial to discuss findings and involve family in decision-making. All children under 3 years of age with developmental concerns should be referred to **First Steps** (Part C) for further evaluation and treatment. Children over 3, should be referred to Child Find (Part B), which is part of the public education school system.
Important points to emphasize about Developmental/Behavioral Screening:

- A screen that indicates risk is not a diagnosis, but it indicates that further evaluation is needed to determine necessary intervention.
- Early identification of developmental delays through appropriate screening increases timely referral to services and ultimately can improve both child developmental and behavioral outcomes.

Postpartum and Perinatal Depression Screen

Select from the following validated screening tools:

- Edinburgh Postnatal Depression Scale (EPDS)
- Patient Health Questionnaire 9 (PHQ-9)
- Patient Health Questionnaire 2 (PHQ-2) and, if positive, a full PHQ-9
- Documentation must include the tool used, the results, and any follow-up actions taken. If a caregiver screens positive, the provider must refer the caregiver to available resources, such as their primary care provider, obstetrician, or mental health professionals, and document the referral.

DEVELOPMENTAL SCREENING STEP 3: IMPLEMENT

Plan Do Study Act (PDSA) Cycles

Plan-Do-Study-Act (PDSA) cycles are recommended to guide clinic efforts in developing plans, monitoring progress, and sustaining procedural changes. PDSA occurs in cyclical form so that modifications may be made based on what is learned. A one-to-three-week trial of the implementation plan is recommended with re-evaluation of procedures and modifications as needed. This process is repeated until desired objectives are met.

PLAN. Once the QI team is established, assessments are conducted to map the clinic flow, specifically when and where developmental screening occurs among clinics currently screening children. Using the feedback from these sessions, develop individualized protocols that outline the screening process at each point of contact (e.g. check-in, rooming, provider visit, and check-out) and who will perform each task within the clinic flow. In addition to providing information about the screening process, the protocol should also include information detailing how to document screening results, follow-up appointments, and referrals.

DO. Once the screening protocol is finalized, clinics should be given two to three weeks to implement the new screening procedure, choosing to pilot either with a few providers or the entire clinic.

STUDY. At the end of each trial period, the clinic's CQI team members should meet to discuss any challenges implementing the new screening procedure and determine ways to improve the protocol. If changes are made to the protocol, the clinic will enter a new PDSA cycle.

ACT. At the end of each PDSA cycle one of three outcomes should occur:

1. Adopt (integrate the practice given its overall success during one or more cycles)
2. Adapt (change the practice before adoption given its modest success or mixed effects)
3. Abandon (reject the practice given its failure to yield the expected results and consider other strategies to reach desired results).

DEVELOPMENTAL SCREENING: REFERRAL & RESOURCES

Our recommended resources for providers can help your practice expand and improve developmental screening services. Resources for families are also included – tell caregivers about these resources or distribute these materials to help them track and support their children's development.

Part 1: Making Referrals

When a screening, assessment, or surveillance indicates that a referral for further assessment or service provision is required, it is necessary to initiate the referral and engage the family to ensure successful connection to services. By developing a plan together, provider-family teams are more likely to be successful. Everyone on this team is invested in making sure the child receives the necessary assessments and interventions so both the child and family can thrive. When this team includes a family-navigator, case-manager, community partner or other support staff, it is ideal.

Participating in existing resource referral, care-coordination, early childhood systems networks, and using other supports available in the community to improve family experience and bring efficiencies to your practice (such as those available for **Helping Families Follow-Up with Referrals for Developmental Concerns**) has great benefits. Taking the time to explore what is available in your community is worthwhile, and this Bright Futures **Community Resources Handout** may be helpful. Also, if applicable in your state/community, connecting with **Early Childhood Comprehensive Systems Health Integration Prenatal-to-Three (ECCS) Program** , **Help Me Grow Mississippi**, or similar partners can support your efforts.

Developmental delays and issues may meet your state's early intervention eligibility requirements. If the child is under age three, state early intervention Part C provides follow up. For preschool children ages three through five, services are provided free of charge through the local public school system. State contact information can be found **here**. Additional information and resources can be found at: **Developmental Surveillance Resources for Healthcare Providers | CDC .**

While some tips and resources specific to basic developmental screening were put forward in this section, it is important ensure processes are in place to connect families and coordinate services that address whole child and family needs such as caregiver depression and food insecurity. There are also some referrals that can be made to support the development of all children such as quality **child-care (State by State Resources – Child Care Aware® of America)** or **local libraries** and parent-groups. A template with an array of important services can be found **here**.

Explore the Engagement In Action Framework for a statewide integrated early childhood health system which sets forth an approach and implementation roadmap to help promote connections across the early childhood system and highlights many partners that can collaborate to support early childhood development.

Visit the Mississippi Thrive **interactive resource maps** to find pediatric clinics, health care specialists, licensed child care centers, and family resources.

Statewide Referral Resources

First Steps
is the Early Intervention Program for Mississippi Families with children ages 0 – 3 years old. Anyone can refer a child to First Steps, and they will do the necessary evaluations to determine if the child is eligible for services. This includes delays in the following developmental domains: cognitive, physical (includes gross and fine motor), communication (includes receptive and expressive language), social-emotional, and adaptive behavior. Eligibility requires 33% delay in any developmental domain or 25% delay in any two or more developmental domains.

As such, many children are not eligible if they have risk indications in only one area, or are not already experiencing significant delays. Thus, it is crucial to ensure that First Steps is not the only referral – families should immediately be referred for additional evaluations and services beyond First Steps.

To learn more about First Steps and to find out eligibility, contact **your local health office**, or call (601) 576-7427 in the Jackson area, or call toll-free 1-800-451-3903.
The First Steps referral form can be found **here.**

Child Find:
Child Find is part of the Individuals with Disabilities Education Act (IDEA). The Child Find system is designed to locate, identify and evaluate any child, aged three (3) to twenty-one (21) years, who resides in a home, facility, or residence within its geographical boundaries, who may have a disability and be in need of special education and related services.

Additional information can be obtained by calling your **District Special Education** Contact or the MS Department of Education Parent Hotline 1-877-544-0408.

Statewide Resource Map:
Visit the Mississippi Thrive! **Statewide Resource Map** and click on “Healthcare Specialists” to locate service providers in your area.

Help Me Grow:
Help Me Grow National Center assists in the development of community systems across the country so that states and local areas establish a centralized access point for developmental screening and/or to connect children and families to the grid of available resources, including to primary care providers and those who can provide early intervention services. HMG maintains a current directory of affiliates and provides support to assist local affiliates as they created their own resource and referral capacity. Your **local Help Me Grow affiliate** can assist healthcare providers in developmental screening, linkage to services and community resources.

Part 2: Resources

Below are recommended resources for pediatric providers to use to learn more and to assist the expansion and improvement of developmental and behavioral screening services in their practices. In addition, resources are listed for providers to offer to families to help them track and support their children's development.

Resources for Providers

- Screening Technical Assistance & Resource Center: AAP's resources and trainings on comprehensive developmental screening. Offers free CME/MOC Part 2 trainings.
- AAP's Physical Developmental Delay Online Tool: This tool helps determine if a child has physical developmental delays. You can use this in your clinic or share it with families.
- Motivational Interviewing in Health Care Settings: Opportunities and Limitations: This paper provides a brief overview of Motivational Interviewing and suggestions for addressing issues you may experience when communicating with caregivers during the screening process.
- Reach Out and Read: A way to promote reading by providing books to families at well-child visits. Reach Out and Read Reach Out and Read Resources are available for parents of children of different abilities (e.g., language delay, developmental delay, ADHD, ASD).
- Center on the Developing Child: Harvard's research center with numerous resources to help communicate the science of child development.
- Child and Adolescent Health Measurement Initiative: CAHMI's Cycle of Engagement Model and Well Visit Planner Approach as well as related resources and research can help with conducting whole child and family well child care and engage families to provide personalized counseling and education.

Quality Improvement Resources

- American Academy of Pediatrics (AAP) Quality Improvement in the Pediatric Practice: This provides an introduction to QI and the PDSA framework. Topics covered include the basics of QI, creating a QI team, and how to complete a PDSA.
- The National Institute for Children's Health Quality (NICHQ) Quality Improvement 101: This is a self-directed course that introduces quality improvement science concepts. QI 102 provides lessons, exercises, and examples of best practice, and direction on moving from one PDSA cycle to another.
- The American Board of Pediatrics – Your Own QI Project: This resource provides instructions on how to create your own Maintenance of Certification Part 4 QI project
- Institute for Health Care Improvement (IHI): IHI provides cutting edge toolkits to support implementation of change, including this Project Charter template to support planning for change. This IHI Quality Improvement Toolkit offers help for improvement projects, continuous improvement, and quality management.

Resources to Share with Families

- **CDC's Learn the Signs. Act Early:** The program encourages parents and providers to learn the signs of healthy development, monitor every child's early development, and act early when there is a concern. Free checklists and other tools available in their **online toolkit** can be distributed and discussed during well-child visits to encourage developmental monitoring.
- **Milestone moments booklets:** These booklets help caregivers track their children's development, support their growth, and make a note of concerns. The booklets include guidance for what to look for at home, and what to ask providers about.
- **Children's books:** Books for caregivers to read to their 1-3 year-olds. These books include quick tips and information for caregivers related to milestones.
- **Milestone Tracker Mobile App:** Caregivers can access and complete developmental milestone checklists, watch videos of milestones in action, and find developmentally appropriate activities through this app.
- **Milestone Checklists:** Printable milestone checklists
- **Milestones in Action – Online Video Library:** An online library of videos demonstrating various milestones. We recommend showing these videos during appointments on a tablet or laptop to show parents different milestones.
- **AAP's Physical Developmental Delay Online Tool:** Helps parents and providers determine if a child has physical developmental delays.
- **Well Visit Planner Family Resource Sheets:** Provides family friendly information for each of the Bright Futures Recommended topics to be addressed across 15 well visits occurring in the first five years of life.

DEVELOPMENTAL HEALTH PROMOTION: REACH OUT AND READ

Reach Out and Read (ROR) is an excellent way to promote developmental health in primary care. Jill Sells, MD, Clinical Professor of Pediatrics at the University of Washington School of Medicine describes ROR as a developmental health promotion activity:

“The critical importance of child development from birth is indisputable. The home environment and nurturing relationships between parent/caregiver and child lay the foundation for healthy development, school readiness, and all future learning. Detailed and growing understanding of early brain development, both what promotes positive development and what works against it, continually provides greater scientific explanations for how language-rich interactions in the context of a loving, responsive relationship between adult and child help to shape children’s brains and promote health and development. Systematically incorporating Reach Out and Read into the health care system supports the foundational relationships between parent and child and promotes child development from birth, helping put children on a trajectory towards success in school and life.”

Program Overview

“Reach Out and Read (ROR) is an evidenced-based early childhood program that incorporates the reading and sharing of books into well-child visits for young children and encourages families to read aloud and create meaningful moments together. Primary care providers implement the research-based model to promote child development through daily, nurturing, language-rich interactions between parent and child at home.”

How it Works

“During each well-child visit from birth through age 5, Reach Out and Read doctors talk with parents about the importance of reading aloud with their young children, model how to do so, and offer age-appropriate tips and encouragement. During the visit, each child is given a new, culturally, and developmentally responsive children’s book to take home, building a collection of books in the home starting in infancy. Parents are engaged in the conversation and leave each visit inspired to read together at home.” (For access to the full article, click here.)

Proven Impact

Reach Out and Read has been examined extensively by academic investigators studying ethnically and
economically diverse families throughout the nation, providing a substantial body of peer-reviewed
research demonstrating the impact of the program, including:

- Families participating in Reach Out and Read read more frequently to their children.
- Children exposed to the program had higher receptive and expressive language scores.
- Increased exposure to Reach Out and Read led to larger increases in language scores.

Beginning Reach Out and Read at Your Clinic

Site Application

A site Coordinator and/or Medical Champion is established to oversee the medical and administrative aspects of the program. The medical champion takes the responsibility of encouraging all providers to complete training and maintain the fidelity in the way the books are distributed to families. The site coordinator takes the responsibility of restocking bookshelves, tracking the number of books distributed, ordering books, and completing required reporting.

An application is submitted to ROR as a primary site location which includes the following information:

Number of Well Child visits in the last 6 months

- 0 months-5 months
- 6 months-5 years
- Demographics:

- Insurance Coverage (% of population)
- Race (% of population)
- Languages (% of population)
- The application also requires a Letter of Support stating your practice's commitment to ongoing participation in the Reach Out and Read program. This is to be signed by the Departmental Head, Clinical Medical Director, or the Executive Director..

Book Support

Funding to guarantee an adequate book supply for a year is a requirement for approval of the application.

Training
A minimal completion rate of 75% is needed from the attending providers before the site status becomes active. When a new medical provider joins your site, they must be entered into myROR.org and complete the Reach Out and Read CME Training. When their contact information is entered into myROR.org, an invitation to the training will be sent to them via an email link. Once the training is completed, the provider will be Reach Out and Read certified and can establish the program in their practice. The training demonstrates how use of the book can enhance interactions and streamline developmental surveillance, especially by starting the visit with the book.

Ordering Books
There are two Reach Out and Read book catalogs, produced by Scholastic and All About Books, that contain books selected to conform to the program's standards for quality and content. Additional books may be obtained from other approved vendors.

Reporting Requirements
In order to remain an active Reach Out and Read clinic, each site must complete a biannual progress report noting the number of books handed out in the previous six-month period as it relates to the overall number of Reach Out and Read-eligible visits at the clinic during that same period. Reports are due March 1st and September 1st of each year. The March report includes data from July-December of the previous year. The September report includes data from January-June of the current year.

For more information, visit the National Reach Out and Read website.
To begin a new site, click here.

When Reach Out and Read is used, physicians may consider a **Quality Improvement (QI) project**, which qualifies for **American Board of Pediatrics MOC-4 credit.** This QI project measures increased reading in the home by caregivers to children after a book is introduced during a wellness visit.

DEVELOPMENTAL HEALTH PROMOTION: VROOM®

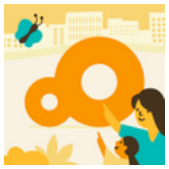
Vroom® is a global program of the Bezos Family Foundation that helps parents boost their child's learning during the time they already spend together. Vroom meets parents where they are, through the people they already trust and the places they already go. Vroom is built on the principle that our children's first years of life are when they develop the foundation for all future learning. Vroom turns everyday shared moments into brain building moments. Vroom offers many web-based resources for families, and can send daily messages to caregivers encouraging them to utilize everyday moments to promote brain building in their child.

Vroom was created by the nation's leading neuroscientists, psychologists, and experts in early child development. **You can find out more about the science and research behind Vroom here.**

Providers and staff are encouraged to tell families about downloading the free Vroom app. All providers and staff are encouraged to think about turning everyday clinic activities into brain building moments, such as counting steps from the waiting room to the nurse triage room. Vroom postcards and flyers can be placed at check-in desks and in waiting areas.

This video from Seattle's Odessa Brown Children's Clinic can be shared with healthcare staff to show ways to integrate easy-to-use brain-building tips and the science behind them throughout the clinic. Anyone, regardless of their role or responsibility, can support families in building strong foundations for children's futures.

Explore Vroom Resources



Search Vroom.org to download the app on Apple or Android devices.

Sign up to receive Vroom by text.

Sign up to receive VroDownload well-child visit handouts that extend your healthcare moments by sharing science-backed brain building ideas that families can use in everyday moments like mealtime and bath time. **om by text.**

Visit our MS Thrive Vroom Resource page to download and print free materials.

Register for a Vroom account.

Register for a Vroom account.

For further information please contact Monday through Friday:
Heather Martin
Mississippi State Lead for Vroom and Mind in the Making
Ph: 662-325-0105
Email: heather.martin@ssrc.msstate.edu

Vroom is not a diagnostic tool. Each tip is written to be developmentally appropriate. Vroom understands that every child develops differently and at their own pace, so each tip comes with a suggested age range to help parents find the right fit for their child.

*These resources are up to date as of February 2023.

DEVELOPMENTAL HEALTH PROMOTION: WELLNESS PACKETS

Wellness packets are a collection of age-appropriate health promotion materials to be given at each wellness visit. These packets include materials from a wide range of sources, including Mississippi Thrive-developed handouts, CDC Learn the Signs Act Early, Vroom, and Talking is Teaching. Below is a table of contents and electronic folders including each PDF file.

Contents Of Wellness Packets

2 Weeks
- Vroom new baby card – English
- CDC Milestone Tracker App
- Vroom Newborn Well-Child Handout

2 Months
- CDC Milestone sheet – English
- Vroom App card -English
- CDC Milestone Moments Booklet – English (print)
- Vroom 2 Month Well-Child Handout

4 Months
- CDC Milestone Sheet – English,
- Vroom Welcome Rack Card – English/Spanish
- Vroom 4 Month Well-Child Handout

6 Months
- CDC Milestone Sheet – English
- CDC App Flyer – English/Spanish
- Vroom 5 Brain Building Basics Sheet – English
- Vroom 6 Month Well-Child Handout

9 Months
- Mississippi Thrive Milestone Checklist – English
- CDC Milestone Sheet – English
- CDC Brochure
- Vroom info Card – English
- CDC promo Flyer – English/Spanish
- Vroom 9 Month Well-Child Handout

12 Months
- CDC Milestone Sheet – English
- Vroom 5 Brain Building Basics Sheet – English
- Vroom 12 Month Well-Child Handout

15 Months
- CDC Milestone Sheet – English
- CDC App Flyer – English/Spanish
- Talk, Read, Sing – Behavior Handout – English
- Vroom App Card -English
- Vroom 15 Month Well-Child Handout

18 Months
- CDC Milestone Sheet – English
- CDC Brochure
- Vroom Tip Card – English/Spanish
- Vroom 18 Month Well-Child Handout

2 Years/24 Months
- CDC Milestone Sheet – English
- Mississippi Thrive Milestone Checklist – English
- Vroom Brain Building 101 Card – English
- CDC Milestone Moments Booklet – English
- Vroom 2 Year Well-Child Handout

30 Months
- CDC Milestone Sheet – English
- CDC Brochure – English
- Vroom Info Card – English
- Vroom 2.5 Year Well-Child Handout

3 Years

- CDC Milestone Sheet – English
- Vroom 5 Brain Building Basics Sheet – English
- Vroom 3 Year Well-Child Handout

4 Years

- CDC Milestone Sheet – English
- Mississippi Thrive Milestone Checklist – English
- Vroom Info Card – English
- Vroom 4 Year Well-Child Handout

5 Years

- CDC Milestone Sheet – English
- Vroom Info Card – English
- Vroom 5 Year Well-Child Handout

Spanish Resources

CDC:

- CDC Milestone Sheets ALL AGES – Spanish
- CDC Milestone Moments Booklet – Spanish
- CDC Milestone Brochure: Track Your Child's Developmental Milestones – Spanish
- CDC Milestone Tracker App – Spanish

Vroom:

- Vroom new baby card – Spanish
- Vroom App card – Spanish
- Vroom Welcome Rack Card – English/Spanish
- Vroom 5 Brain Building Basics Sheet – Spanish
- Vroom info Card – Spanish
- Vroom Tip Card – English/Spanish
- Vroom Brain Building 101 Card – Spanish

Mississippi Thrive:

- Mississippi Thrive Milestone Checklist – Spanish

Resources in Other Languages

- CDC Milestone Sheets ALL AGES – Arabic
- CDC Milestone Sheets ALL AGES – Chinese
- CDC Milestone Sheets ALL AGES – Vietnamese
- CDC Milestone Brochure: Track Your Child's Developmental Milestones – Vietnamese

COMPREHENSIVE SCREENING USING THE CYCLE OF ENGAGEMENT WHOLE CHILD APPROACH

The Cycle of Engagement Well Visit Planner® Approach (COE/WVP)

General Information

As noted earlier in this toolkit, in addition to step wise implementation of developmental, autism and maternal depression screening and health promotion resources, this toolkit also features information and access to an integrated approach to conduct all screens and assessments recommended through Bright Futures Guidelines for each age of a child from the first week of life through age six; as well as to both educate families and capture their priorities for discussion across the many recommended anticipatory guidance and education topics relevant for each age child.

This approach and set of resources is called the Cycle of Engagement Well Visit Planner® approach (COE/WVP) and was created and tested by the Child and Adolescent Health Measurement Initiative in partnership with providers, the American Academy of Pediatrics, families and others. The evidence-based COE/WVP begins with engaging families to use the brief Well Visit Planner (WVP) digital tool specifically created for and with families and that provides both the family and you with instant results and resource links based on child and family needs and priorities. This comprehensive, whole child and family approach is designed to make it feasible for providers to provide high-quality, guideline-based care anchored to the unique needs and priorities of each child and family so that time during encounters can focus on addressing needs and priorities, building relationship, and making connections to important community-based and other resources. With the Cycle of Engagement models' Well Visit Planner (WVP), and its companion Online Promoting Healthy Development Survey family facing quality assessment and feedback tool, you can:

1. Integrate and streamline family-reported screening and priority setting
2. Prepare for and optimize time during visits to focus on the family's agenda
3. Focus on building strengths and coordinating resources and supports
4. Continuously improve in partnership with families and communities
5. Track population-level needs, priorities, and quality of care

Importantly, the COE/WVP approach helps you to both optimize billing for well child care visits and screenings, as well as to foster improvements in the quality of care you provide as measured by the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures and the Medicaid Core Measurement Set. Specifically, the COE's WVP and PHDS digital tools align with 7 of the 19 HEDIS measures for children, adolescents, and maternal health, 2 of the 4 HEDIS measures

related to preventive care for children, and 5 out of 8 Medicaid Core Set "Primary Care Access and Preventive Care" measures also employed by Medicaid health plans. More information about the WVP and PHDS are provided below in this toolkit.

The CAHMI provides additional information on the development, validation, and implementation of the COE/WVP approach on their **website**. Learn more about how to get a free account using this **Cycle of Engagement Sign Up Instructions worksheet.** Review the Provider Fact Sheet to read more on creating your COE account.
Be sure to watch these short introductory videos:
CAHMI's Cycle Of Engagement Well Visit Planner Approach to Care – Full Version (for Providers)
CAHMI's Cycle Of Engagement Well Visit Planner Approach to Care – Short Version (for Providers)
Please email CAHMI team for more information at **info@cycleofengagement.org** for technical support or questions.
The Cycle of Engagement and Well Visit Approach to Care design, testing and implementation has been led by Dr. Christina Bethell of the Child and Adolescent Heath Measurement Initiative (CAHMI) based out of Johns Hopkins University's Bloomberg School of Public Health and School of Medicine. The Cycle of Engagement model and Well Visit Planner and Promoting Healthy Development Survey digital tools were designed and tested by the Child and Adolescent Health Measurement Initiative in partnership with families, providers, experts, and researchers. Visit the **CAHMI website** to see more of their work.

Personalized Connected Encounters Using the Well Visit Planner™

Part 1: General Information
The Personalized Connected Encounter (PCE) is a well-child visit in which the family and provider share the same information about needs and priorities and have the time to build a trusting relationship, focus on and promote child and family strengths, address child and family needs and educational priorities and share decisions on whether and how to address risks and needs identified and help families connect to important community-based and other resources. This type of encounter is enabled by using the Well Visit Planner® (WVP), which was specifically designed with and for families to help them to engage, learn and partner in care. The Well Visit Planner® is a brief (about 10 minutes), family-completed digital pre-visit planning tool meticulously anchored to national Bright Futures Guidelines for each of 15 well visits recommended from a child's first week to sixth year of life. The WVP engages families in comprehensive whole child and family screening, assessment and priority setting using pre-visit planning (which can be done at home or in the office using a mobile phone, tablet or computer) and ensures encounters are based on the same information that is automatically generated and shared with both families (Well Visit Guide) and providers (Clinical Summary) about risks, needs and priorities. The Well

Visit Planner at-a-glance Clinical Summary, which also provides many tailored, linkable resources to address the unique needs and priorities of each child and family, can be scanned into the medical record or automatically integrated if your electronic medical record team agrees. See the Step 2-Training web page of the this toolkit for a comparison of the WVP with the ASQ or CHADIS online methods to conduct developmental screening. See this this 2 minute family facing video and the visual below to learn more about how the WVP works for families. See this short 4 minute video or this more comprehensive 9.5 minute video to learn more about using the WVP with the children and families you serve. The visual below summarizes the process families go through when using the Well Visit Planner digital tool.

Research shows that using the WVP dramatically improves care quality, saves time, and reduces urgent care. Recent studies show that >95% of providers were satisfied using the WVP and >95% of families would recommend its use to other parents. Most importantly, the Well Visit Planner frees up the limited time you have in well visits to focus on building trusting relationships with children and families, provide comprehensive, patient-centered care ensuring you did not miss a screen and met their unique needs and priorities. The Well Visit Planner was created and evaluated in partnership with families and child health care providers. Its efficacy and effectiveness have been validated through quasi-experimental and randomized control trials. Learn more on research and development here.

Part 2: What's in the Well Visit Planner™?

Fifteen categories of content are included in the Well Visit Planner tools and all assessments and questions are specific for each age across the 15 well-visits recommended to take place between a child's first week to sixth year of life. The core WVP tool is aligned with Bright Futures Guidelines and the screeners and content, scoring, reporting, and resources created by the CAHMI is reviewed in partnership with the American Academy of Pediatrics to ensure alignment. Additional assessments and questions can be added that you may find important to address (e.g., Adverse Childhood Experiences, Family Resilience, Child Flourishing), but that not formally recommended in Bright Futures Guidelines.

Well Visit Planner® Screeners and Topics Included

Bright Futures Guidelines Aligned Topics Addressed in the Core WVP Tool

1. Child and parent/caregiver **strengths** (what is going well!)
2. Open-ended questions about family/parent specific **goals and concerns** for the well visit
3. **Developmental surveillance and standardized developmental screening using the Survey of Well-Being of Young Children (SWYC)**
4. Autism spectrum disorder screening using the **Modified Checklist for Autism in Toddlers, Revised (M-CHAT-R™)** for 18-and 24-month visits
5. Caregiver concerns about **speaking, vision, hearing**
6. Open-ended question on any **additional concerns** about child's development or health
7. Caregiver depression using the **Patient Health Questionnaire-2 (PHQ-2) or Edinburgh Postnatal Depression Scale (EPDS)** (based on child's age)
8. **Family psychosocial issues** (e.g., meeting basic needs, alcohol and substance use, smoking, emotional support, parent/caregiver coping, etc.)
9. Intimate partner violence using the **Women Abuse Screening Tool-Short (WAST-Short)**
10. List of age-specific **Anticipatory guidance** and parental education topics for families to prioritize and provision of family-centered topical Family Resource Sheets (can pick up to five; average selected=3)
11. Other **general health information** recommended in guidelines (age-specific; breastfeeing, nutrition, medications, vitamins/herbs, special health care needs)
12. Other **family health history and updates** recommended in guidelines (heart problems, stroke, high blood pressure, new problems, recent changes or stressors)
13. Other **context and environmental assessments** (e.g., living situation, lead, fluoride) in guidelines
14. Questions about the impact of of the **COVID** pandemic on the child and family
15. Interest in **Telemedicine**

Optional Additional Assessments to Add When You Customize the WVP

- **Child Flourishing** (validated 4 item measure. Same as inNational Survey of Children Health)
- **Family Resilience** (validated 4 item measure. Same as in National Survey of Children Health)
- **Parent-Child Emotional Connection** (4 items based on Welsch Emotional Connection screen)
- **Short Protective Family Routines and Habits** (composite measure about caregiver parenting)
- **Pediatric Adverse Childhood Expeiences (ACEs) and Related Life-events Screener (PEARLS)**
- Other social-emotional screening, **Baby Pediatric Symptom Checklist (BPSC) and Preschool Pediatric Symptom Checklist (PPSC)** from Survey of Well-Being of Young Children (SWYC)
- Other social determinants screening: **Safe Environment for Every Kid (SEEK)**
- **Interconception Care** (ICC)
- **Links to other assessments can be added by you** during customization of your WVP.

Part 3: Implementation of the Well Visit Planner®

There are 4 quick steps to register for a Cycle of Engagement account to customize and start using the Well Visit Planner with the children and families you serve. Once you register and customize your online tools to use with the children and families you serve, you will receive a secure and easy-to-use WVP Use Portal for implementing the WVP the features a data dashboard where you can access pre-scored Clinical Summaries after each family completes the WVP, whether they do this at home or on their mobile phone before the visit or in the office. Go to www.cycleofengagement.org to begin.

You can sign up for a WVP account, customize your WVP and begin to use with the children and families you serve on the same day and the CAHMI recommends you try it out with a few families first to learn how to make it work best for you. During customization of your WVP website to share with families, you can add a personalized welcome message, office logo, add additional resources and assessments beyond those formally recommended through

families first to learn how to make it work best for you. During customization of your WVP website to share with families, you can add a personalized welcome message, office logo, add additional resources and assessments beyond those formally recommended through national Bright Futures Guidelines (e.g., Adverse Childhood Experiences, Family Resilience, expanded social determinants, like the SEEK).

What can you do on your Well Visit Planner (WVP) Use Portal?

- Get quick guides to implement the COE Well Visit Planner approach using five simple steps
- Get a customized flyer to share with families to learn about and use the WVP
- Get family engagement resources to partner in care with families and the community Change the customization of your WVP for PHDS family website, including additional content and adding or removing resources to share with families
- Track completions of the WVP by families
- Update or manage your WVP account information (e.g., password, account permissions, notification settings)

Quality Assessment Using the Online Promoting Healthy Development Survey (Online PHDS)

Part 1: General Information

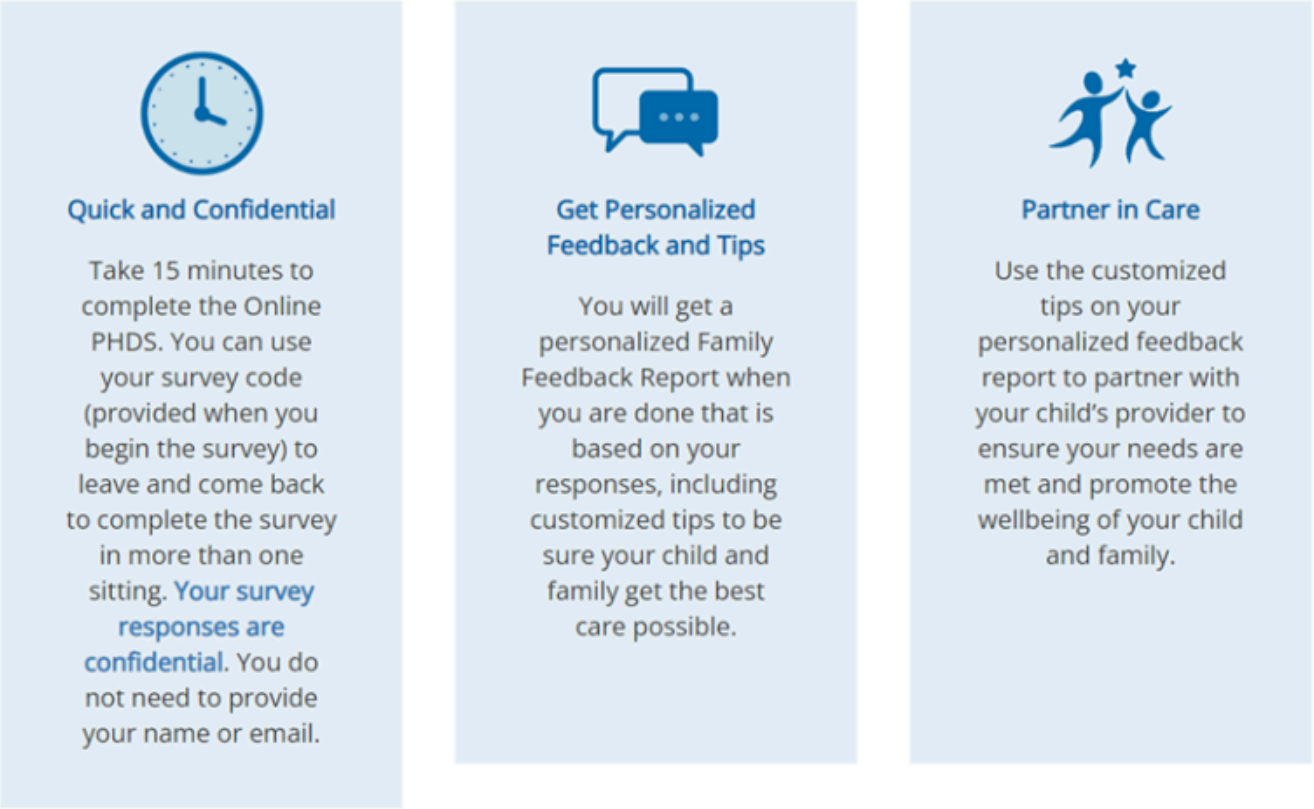
The Online Promoting Healthy Development Survey (Online PHDS) was designed and developed by the Child and Adolescent Health Measurement Initiative (CAHMI) as a tool to validly measure and drive family-centered improvements in the quality of care provided to young children and families across categories of quality set forth in the national Bright Futures Guidelines. The Online PHDS can be customized for your practice and families so you can invite families to link to your customized Online PHDS website and confidentially share information about their experiences and quality of care. Just like with the Well Visit Planner, both providers and families then get feedback reports on quality of care to identify needs and ways they can each partner to improve care. Providers use their Online PHDS Use Portal to generate aggregate, deidentified quality reports after at least 25 families complete the Online PHDS. This digital tool specifically assesses and reports on the quality of well-child care across areas of care recommended in the Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents—Fourth Edition.

The Online PHDS asks parents and caregivers directly about their experiences with their child's health care and providers, allowing them to indicate quality using a "needs met" approach, rather than an approach that assumes all children and families require the same

education and supports. This means that only topics families say they wanted to discuss but about which they did not get the information they needed are flagged as opportunities for quality improvement, ensuring providers are recognized for meeting child and family needs and priorities.

Research shows families appreciate providing feedback and learn a lot by completing the PHDS and providers report using the data to track and improve care. See the visual below for what families are asked to do when they use the Online PHDS. The PHDS has been used since 1998 by health care systems and provider care teams. Parents/caregivers across the United States have completed the PHDS to learn about and partner to improve the quality of well child care provided to their young children.

See this **short 4 minute video** or this more comprehensive **9.5 minute video** to learn more about using the Online PHDS with the children and families you serve. The visual below summarizes the process families go through when using the Online PHDS digital tool.



Part 2: What is measured using the Online PHDS?

Promoting Healthy Development Survey Quality Measures

The Online PHDS contains questions that generate quality measures across **11 topics:**

1. **Meeting family priorities for anticipatory guidance and education using a "needs met" scoring approach and stratified by developmental promotion, physical care for the child and injury prevention topical areas.**
2. **Family**- Centered Care: To what extent providers practiced family-centered care, such as by listening and spending enough time with the family, meeting the family's needs for information, partnering with the family in decision making, and respecting the family's culture and values.
3. **Developmental Surveillance**: Whether providers asked about the family's concerns related to child's development and behavior.
4. **Standardized Development Screening:** Whether providers conducted standardized development and behavioral screening at recommended ages (same as national metric and stratified by whether children have risks)
5. **Follow Up for Development Risk**: Whether children with developmental risks received any type of follow up for these issues (and stratified by type of follow up on aggregate reports)
6. **Psychosocial Assessment**: Whether providers assessed home safety and psychosocial concerns such as presence of a support system and family stressors.
7. **Parent/Caregiver Mental Health:** Whether parents/caregivers were asked about their mental health and emotions (stratified by presence of mental health risk)
8. **Addressing Concerns about Child Development:** Whether providers addressed and provided needed information/resources about parent/caregiver concerns about their child's development.
9. **Community Factors and Resources:** To what extent providers discussed available community resources and any community issues that may impact child health and development.
10. **Personal Doctor or Nurse:** Whether the family considers their child to have a personal doctor or nurse who knows the child well and is familiar with the child's health history.
11. **Access to and coordination of care**: Family access to and use of services in the last year, including types of visits, frequency of visits and receiving needed coordination of care.

Quality measures are stratified by child/family demographics, caregiver mental health, child developmental status and having a special health care need (CSHCN Screener).

Part 3: Implementing the Online PHDS With Families

There are 4 quick steps to register for a Cycle of Engagement account to customize and start using the Online Promoting Healthy Development Survey with the families you serve. You will receive an easy-to-use Online PHDS Use Portal for implementing the PHDS. Go to www.cycleofengagement.org to begin.

What can you do on your Online Promoting Healthy Development Survey Use Portal?

- Get quick guides to implement the COE Online PHDS using five simple steps
- Get family engagement resources
- Track completions of the Online PHDS by families
- Generate PHDS Aggregate Quality reports after at least 25 families complete the PHDS
- Update or manage your PHDS account information (e.g., password, account permissions, notification settings)

About This Resource

The overarching goal of the Child Health and Development Project (Mississippi Thrive!) has been to improve developmental health outcomes for young children through the building of a statewide developmental and behavioral health system. As part of the system build MST worked with health care providers to increase developmental screenings, connect more children to the services they need, and equip providers with materials and resources to promote developmental and behavioral health with caregivers at wellness visits. Additional work was conducted to advance more comprehensive, family-engaged, whole child approaches.

This toolkit provides information about the specific resources and approaches used to support health care providers at the University of Mississippi Medical Center to integrate developmental screening and additional approaches to engage families and conduct comprehensive screening and personalized health promotion into their pediatric practices as well as lessons learned. It was modeled after the **Louisiana Developmental Screening Toolkit** created by the Developmental Screening Initiative at the Louisiana Bureau of Family Health. It incorporates a Continuous Quality Improvement framework based on the clinical practice guidelines form the American Academy of Pediatrics.

This toolkit was developed by the Mississippi Thrive! Enhanced Pediatric Medical Home Services (EPMHS) team in partnership with The Child and Adolescent Health Measurement Initiative (CAHMI). The Child Health and Development Project: Mississippi Thrive! (CHDP) was a project of the University of Mississippi Medical Center's (UMMC) Center for the Advancement of Youth (CAY) and the Social Science Research Center (SSRC) of Mississippi State University (MSU).

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $17.4 million with 0 percent financed with non-governmental sources. The contents are those of the author(s) 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** today. The Child and Adolescent Health Measurement Initiative (CAHMI) is a national non-profit initiative founded in 1996 to promote the early and lifelong health of children, youth and families using family-centered health and health care quality data and improvement tools and research. The Cycle of Engagement Well Visit Planner approach was developed and is maintained by the Child and Adolescent Health Measurement Initiative (CAHMI).