INDIAN HEALTH SERVICE

Pediatric Primary Care Toolkit

2024

Table of Contents

Introduction

Caring for children through each stage of development is an essential way in which IHS clinics promote lifelong health. Not only do "Well Child Checks" provide the foundation for strong relationships with patients and families, they serve a vital role in supporting healthy habits, early detection, and disease prevention. The IHS recognizes that providing comprehensive pediatric primary care can be challenging, especially for small, rural clinics without pediatric-trained providers.

The Toolkit was developed in response to these challenges. **It was designed to ensure that all IHS clinics have the knowledge required to provide guideline-based primary care, from birth through adolescents**. In addition, the Pediatric Primary Care Toolkit reflects the IHS standard of care, which clinicians and health care leaders should strive to meet.

What's in the Toolkit?

Part 1: Site Self-Assessment Tool: This assessment tool allows clinics to measure how closely their current pediatric preventative services match established best practices in fifteen categories. The intent of this assessment is to identifying areas of strength as well as areas for improvement. The self-assessment should be repeated periodically to quantify the impact of a clinic's quality improvement efforts. To help clinics set priorities, the Site Self-Assessment Tool emphasizes certain components that are especially important to providing high quality care (e.g. case management, developmental screening, pediatrics champions).

Part 2: IHS Pediatric Primary Care Guidelines: These guidelines spell out the key considerations for each major developmental stage as well as the detailed priorities for each age-specific visit. In other words, how often should patients be seen for well-child checks and what should happen during each of those visits.

Part 3: Pediatric Primary Care Tools: Whenever possible, the Toolkit includes the specific resources recommended by the IHS Pediatric Primary Care Guidelines including:
Checklist to help clinics prepare for each age-specific Well Child Check

- EHR templates that prompt providers to perform comprehensive, developmentally appropriate care
- Parent and patient education handouts
- Developmental screening tools for all ages

Of course, caring for children is about much more than following checklists. In addition to following best practices, providing a caring, child-centered practice environment is equally important. Implicit in this Toolkit is the recognition that most preventable adult diseases are rooted in childhood and that fostering a supportive, safe, and accessible medical home for families should be a key priority for each IHS clinic.

Thank you for the work that you do every day.

Acknowledgements

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Disclaimer

This manual is intended to be used as a guide and is not a substitute for any applicable IHS policy or clinical judgment.

Part 1

SITE SELF-ASSESSMENT TOOL

PEDIATRIC PREVENTATIVE SERVICES SELF-ASSESSMENT TOOL

The following self-assessment is designed for clinical leaders to objectively measure how closely pediatric preventative services match established best practices in fifteen categories. The intent of this assessment is to help you provide the best possible longitudinal care for your patients. In addition to identifying areas for improvement, it is designed to highlight areas of strength. Additionally, it is designed as a way of quantifying the impact of your quality improvement efforts.

By its nature, this assessment tool can only identify the existence or absence of services. It is not meant to overlook the importance of providing a friendly, caring, and supportive environment for children and families.

Instructions: The following questions refer to your outpatient primary care services for children. It is not intended as an assessment for acute care settings. The assessment consists of a series of questions about your clinic. **After each question there is a "Max Points" score. Just assign a number that you think best reflects how well you can answer YES to the question. For example: "Are dental screenings integrated into primary care visits?" Max Points= 10. If you are doing dental screenings about half of the time, enter a score of 5.** *For an Excel copy of the tool, please email IHSMCH@ihs.gov.*

1. Patient Centered Medical Home

	Max Points	**Score**
Does your clinic have a defined patient population that is updated at least annually?	3	
Can your clinic have access to data regarding the health of your patient population (e.g. rates of obesity or injury)?	5	
Does your clinic have a system for ensuring that all patients receive appointments at the following ages: 3-5 days, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 18 months, 24 months, 30 months, 36 months, and annual after that?	20	
Does your clinic ensure that each patient is empaneled to a specific care-team whom they see for at least 75% of their scheduled visits?	10	
Does your clinic provide parents with a written summary of your mission, the services you provide, how to access care, as well as the patient and clinic responsibilities?	5	
Are patient satisfaction surveys for primary care visits performed at least annually?	5	
Are the results of patient satisfaction surveys disused with hospital leadership and the medical staff with appropriate actions taken when needed?	10	
Does your clinic have a designated staff member whose position description includes "Chief of Pediatrics" (or equivalent) and who has a voice with executive leadership (e.g. in included on governing body meetings).	10	
	Total Points	

2. Case Management System

	Max Points	Score
Does your clinic have a system for proactively scheduling patients at the appropriate intervals (e.g. proactively mailing appointments or reminding parents to schedule appointments)?	15	
Does your clinic have a system for identifying patients who fail to schedule or present for a primary care appointment, and are those parents contacted to reschedule?	20	
Does your clinic track Immunizations and have a system for reaching out to parents whose children are behind?	20	
Do you have an outreach system for families if concerns develop (e.g. nurse visit to families with multiple missed appointments)?	10	
Does the clinic have a way to perform home-based assessments of the patient, family dynamics, and safely? (e.g. public health nurse visits)	10	
Does the clinic have an established referral system with Social Services?	5	
Does the clinic conduct regular case-management meetings with local services for children with special needs (e.g. social services, Early Intervention, schools)?	5	
	Total Points	

3. EHR Characteristics

	Max Points	Score
Do providers have access to EHR templates which include standardization of age-specific developmental milestones, vaccines, and anticipatory guidance?	5	
Are growth parameters (height, weight, BMI, head circumference) automatically plotted in the EHR using CDC growth curves?	10	
Are age specific blood pressure percentiles available in EHR?	7	
	Total Points	

4. Supporting Transition for Newborn Babies

	Max Points	Score
Does your clinic have established agreements with OB/prenatal providers and delivering hospitals regarding neonatal follow-up and establishment of newborn care after delivery?	10	
Does a system exist for obtaining prenatal and delivery records for babies delivered at outside hospitals (e.g. newborn screen, CCHD and hearing screening)?	15	
Do you have a routine process for seeing babies at 3-5 days of life?	20	
Do parents have an opportunity to meet their pediatric provider prior to delivery?	5	
	Total Points	

5. Breastfeeding Support

	Max Points	Score
Do you have trained lactation support available (in house or by referral)?	5	
Do you routinely provide education that includes the benefits of breastfeeding for mother and baby?	10	
Do you record breast feeding status in all EHR notes for the first 6 months of life?	5	
	Total Points	

6. Assessment of physical growth

	Max Points	Score
Are height, weight, head circumference (until 24 months), and BMI automatically plotted in the EHR and discussed at each primary care visit?	15	
Are all weights recorded in grams or Kg?	10	
Are dietary services (ideally with an RD) available during every primary care visit when appropriate?	10	
Are referrals to local resources for physical activity and nutrition readily available?	5	
Is an assessment of nutrition documented in all primary care visits?	10	
	Total Points	

7. Developmental Screening and Management

	Max Points	Score
Is assessment of neurological and psycho-social development performed using validated screening tools[1] at least three times by age 3 years (ideally 9 months, 18 months, 30 months) and at other times as indicated?	20	
Do providers inquire about age-appropriate developmental milestones at each primary care visit?	15	
Does the clinic have a referral system for children who demonstrate signs of developmental delay (e.g. Early Intervention, Head Start)?	10	
Can providers obtain audiology screening within two months of referral for children with speech delay?	10	
	Total Points	

8. Vaccines

	Max Points	Score
Are routine childhood vaccines provided at your clinic during all primary care visits?	40	
Does the clinic use an "opt-out framing" for vaccine messaging to parents (i.e. written consent obtained, but vaccines are expected to be given unless parents opt-out)?	10	
Is written vaccine information provided with each vaccine administered?	5	
	Total Points	

9. Health Screenings

	Max Points	Score
Is blood pressure obtained at each primary care visit beginning at age 3?	10	
Is a second newborn screen performed at the clinic between 10-15 days of life (if offered in state)?	10	
Is anemia screening performed at age 1?*	5	
Is lead screening performed at 1 years of age?* *If not performed due low prevalence and this is documented in policy or meeting minutes, assign 3 points.*	3	
Is Autism Spectrum Disorder screening done using a validated tool at age 18 months and 24 months?[2]	15	
Is vision screening routinely provided annually beginning at age 3?	10	
Is hearing screening provided at age around the time of school entry?	5	
	Total Points	

10. Mental Health Screenings and Treatment

	Max Points	Score
Is depression screening and suicide assessment done at each visit for patients age 12 and older?[3]	15	
Are mothers screened for post-partum depression at the two-week, two-month, four-month, and six-month primary care visits?[4]	10	
Are mental health providers integrated into routine primary care (i.e. available at the time of the appointment if indicated)?	20	
Is a referral to a local mental health provider available with a wait time less than 4 weeks?	15	
Is referral for substance abuse treatment available within 2 weeks?	10	
	Total Points	

11. Adolescent Health

	Max Points	Score
Does the clinic use a standardized, confidential adolescent health questionnaire to assess for mood disorders, suicidal ideation, use of tobacco, alcohol, or drugs, and sexual activity?	5	
For all patients 12 years of age and older, is screening documented for mood disorders, suicidal ideation, use of tobacco, alcohol, or drugs, and sexual activity during all annual visits?	10	
Beginning by age 12-13, is a portion of each visit conducted without parents in the room to ensure confidentiality for the adolescent?	10	
Is information provided about healthy sexuality and contraception, emergency contraception, and Sexually Transmitted Infection (STI) prevention to all sexually active adolescents and those who plan to become sexually active?	10	
Is an assessment of school performance documented as a part of every adolescent health visit?	8	

Is an assessment of home dynamics documented as a part of every adolescent health visit?	5	
Is birth control prescribed at the clinic?	15	
Are Long Acting Reversible Contraceptives (e.g. Nexplanon, IUD) provided at the clinic?	15	
Is emergency contraception available at the clinic?	15	
Is HIV offered at least once between age 15 and 18?	5	
Is chlamydia screening routinely offered for sexually active girls at primary care visits?	10	
	Total Points	

12. Culturally Appropriate Care

	Max Points	**Score**
Are providers educated about Tribal culture and heritages as part of their orientation and ongoing education?	10	
Does the clinic's physical space include culturally affirming messages (e.g. art reflecting Tribal heritage)?	10	
	Total Points	

13. Oral Health

	Max Points	**Score**
Are dental screenings integrated into primary care visits?	10	
Is fluoride varnish provided during primary care visits every six months from first tooth eruption through age 5?	10	
Does your clinic offer pediatric dental services in-house?	5	
Is the wait time for a non-urgent pediatric dental appointment consistently less than two months?	10	
Is oral health education provided and documented at primary care visits?	5	
	Total Points	

14. Same Day or Urgent Care Visits

	Max Points	**Score**
Can patients be seen for a same day appointment Monday- Friday (either by calling for an appointment or presenting to an urgent care at your clinic)?	20	
Can patients be seen in clinic for a same day appointment on weekends?	5	
Can parents call for medical advice during business hours and speak with a nurse or licensed independent practitioner (e.g. physician, NP, or PA)?	10	
For patients being seen for urgent care visits, do you have written policies and standardized procedures for recognizing patients who require transfer to an emergency department?	10	
For patients who require transfer to an emergency department, do you have a written, established process for ensuring rapid transport?	5	
	Total Points	

15. Health Information		
Are parents provided with age-appropriate anticipatory guidance handouts at each primary care visit?	15	
Are children provided books at most primary care visits for children?	5	
	Total Points	
	Cumulative Total	
	Max Score	**755**
	Percent	
* Denotes an AAP recommendation, but USPSTF found insufficient evidence to recommend 1. Recommended screening tools include the Ages and Stages Questionnaire (ASQ), the Parents' Evaluation and Development Status (PEDStest) or the Survey of Well-being for young children (SWYC). 2. Recommended screening tool is the Modified Checklist for Autism in Toddlers Revised, with Follow-up (M-CHAT-R/F)3. Depression screening options include the Pediatric Symptom Checklist (PSC) PSC-17 for ages 4-17. Some sites choose the Patient Health Questionnaire-2 (PHQ-2) with follow-up PHQ9 if positive results on the initial screen.4. Recommended screening tool is the Edinburgh Postpartum Depression Scale		

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Part 2

IHS PEDIATRIC PRIMARY CARE GUIDELINE

IHS Pediatric Primary Care Guidelines

Background: IHS, Tribal, and Urban clinics are the primary medical home for many Indigenous children and families. Many clinics serve rural communities with relatively small numbers of children and do not have pediatric specialists on staff. While these clinics provide outstanding care, there may be variations in the core Preventative Pediatric Health Care Services offered.

Purpose: To equip IHS, Tribal, and Urban clinics with a core list of Pediatric Preventative Health Care Services that should be provided as part of routine care. This guidance is meant to serve as a floor, not a ceiling. It strives to recognize the special populations we serve and provide a framework upon which strength-based pediatric services can be built. Innovations that expand beyond this core standard are both encouraged and common, as they reflect our commitment to support the health of Indigenous children.

Overview: Core Pediatric Preventative Health Care Services should be available prior to conception and should extend to early adulthood (typically 21 years old). The frequency of visits should depend on the child's health status and the family's needs. These guidelines outline the minimum recommended visit frequency for a healthy child. While the focus of care will change with each major developmental period, all preventative care visits should generally include:

1. Addressing parental and patient concerns and questions
2. Assessment of physical growth (i.e. measurement of length or height, weight, and head circumference through age 2 plotted on a CDC or WHO growth curve)[1]
3. Assessment of neurological and psycho-social development using
    - Validated screening tools[4] at least three times by age 3 years (ideally 9 months, 18 months, 30 months) and at other times as indicated
    - Observation and parent interviews
4. Immunizations per CDC recommendations[2]
5. Assessment of mental health
6. Assessment and education regarding oral health
7. Assessment of family dynamics
8. Physical examination
9. Provision of developmentally appropriate anticipatory guidance and health promotion

Clinics should have reliable systems in place to address all of these areas. In addition, clinics should have a system for identifying children who are not receiving care at appropriate intervals. In these cases, clinics should have a case management system to ensure the safety of the child and support for the family when needed.

Clinics are also encouraged to become Reach Out and Read[6] sites as a way of promoting health literacy at every Well Child Visit.

Pediatric Preventative Health Care Services outlined below are based on the American Academy of Pediatrics' (AAP) Bright Futures (Fourth Edition)

Preconception and Infancy (through 11 months):

Areas of Focus: The Prenatal Visit is focused on establishing a relationship, providing important anticipatory guidance (e.g. breastfeeding, safety guidance such as car seats and safe sleep), discussing social determinants of health, and ensuring that family members are vaccinated against influenza and pertussis.

After birth, the focus shifts to feeding, growth, development, safety, and parent/family well-being. Safety Information should include Sudden Unexpected Infant Death prevention (e.g. "back to sleep"), coping with new parenting, including shaken baby prevention, and how to manage a fever. Throughout the first year, support for breastfeeding should be provided.

Age	**Special Priorities of Visit** (in addition to routine care)
3 to 5 days of life (within 2-3 days of hospital discharge)	1) Assessment of feeding, weight, jaundice 2) Physical Exam with focus on hydration, jaundice, serious congenital abnormalities 3) Obtain hearing screen and Critical Congenital Heart Disease screen results from discharge hospital 4) Ensure that newborn blood screen was performed 5) Administer Hepatitis B vaccine and RSV Prophylaxis (if applicable) if not done in newborn stay *Follow-up in the newborn period requires close communication among obstetrical providers, delivering institutions, and the pediatric clinic. A system for ensuring communication and easy scheduling is essential.*
2 to 4 Weeks	1) Assessment of feeding, weight 2) Maternal depression screen[3] 3) Verify documentation of newborn blood screen and repeat at 10-15 days (in some states)
2 Months	1) Growth and Development 2) Vaccinations[2] 3) Maternal depression screen[3] 4) Verify documentation of newborn blood screen results
4 Months	1) Growth and Development 2) Vaccinations[2] 3) Maternal depression screen[3] 4) Oral health (e.g. maternal oral health, avoidance of bottle in bed) 5) Nutritional guidance, including introduction of complementary foods between 4-6 months of age, avoiding soda, and juice
6 Months	1) Growth and Development 2) Vaccinations[2]

	3) Maternal depression screen[3] 4) Oral health: Verify fluoridated water source and if not prescribe systemic fluoride. Apply fluoride varnish after first tooth eruption every six months through age 5 5) Nutritional guidance, including introduction of complementary foods between 4-6 months of age, avoiding soda, and juice
9 Months	1) Growth 2) Development using a standardized developmental screening test[4] 3) Vaccinations[2]

Early Childhood: (1 through 4 years):

Areas of Focus: In addition to fostering a positive family relationship, monitoring growth, and development, early childhood visits are an opportunity to promote healthy habits around nutrition, oral health, screen time, and physical activity. Body Mass Index (BMI) should be calculated and plotted on CDC or WHO growth curve[1] beginning at two years of age. Early detection of overweight, developmental delays, and Autism Spectrum Disorder (ASD) are important aspects of Well Child Visits during these years. Providers should assess oral health and review hygiene practices at each visit.

Age	**Special Priorities of Visit** (in addition to routine care)
12 Months	1) Growth and Development 2) Vaccinations[2] 3) Anemia screen (hemoglobin or hematocrit)* 4) Lead screening (blood lead test) if high prevalence* 5) Apply fluoride varnish to teeth every six months from one to five years of age.
15 Months	1) Growth and Development with a focus on communication and social development 2) Vaccinations[2]
18 Months	1) Growth and Development- using a validated screening tool[4] 2) Vaccinations[2] 3) ASD Screening[5]* 4) Apply fluoride varnish to teeth every six months from one to five years of age
24 Months	1) Growth and Development 2) Vaccinations[2] 3) ASD Screening[5]* 4) Apply fluoride varnish to teeth every six months from one to five years of age
30 Months	1) Growth and Development- using a validated screening tool[4] 2) Vaccinations[2] 3) Apply fluoride varnish to teeth every six months from one to five years of age
3 Years	1) Growth and Development 2) Vaccinations[2] 3) Vision Screening (annually beginning at age 3) 4) Apply fluoride varnish to teeth every six months from one to five years of age 5) Blood Pressure measurement (with each visit beginning at age 3)*
4 Years	1) Growth and Development 2) Vaccinations[2] 3) Vision Screening (annually beginning at age 3) 4) Apply fluoride varnish to teeth every six months from one to five years of age 5) Hearing Screening

Middle Childhood: (5 through 10 years):

Areas of Focus: During this period children begin school, which is a major milestone for the child and the family. Focusing on school readiness, healthy separation from parents, and identifying barriers to successful learning (e.g. learning disabilities, ADHD) are important. School performance is a key functional marker of development across all developmental domains. Ongoing assessment of self-esteem and contributing factors, such as bullying, abuse, and neglect, are important aspects of each visit. In addition, screening for overweight and obesity while emphasizing healthy habits regarding nutrition, screen time, physical activity, and avoiding sweetened drinks (e.g. 5,2,1,0) is critical.

5 & 6 Years	1) Growth and Development 2) Vaccinations[2] 3) Hearing and Vision Screening 4) Apply fluoride varnish to teeth every six months from one to five years of age 5) School readiness
7 & 8 Years	1) Growth and Development 2) Vaccinations[2]
9 & 10 Years	1) Growth and Development 2) Vaccinations[2] 3) Puberty education 4) Dyslipidemia screening (Lipid profile once between 9 and 11 years old)*

Adolescence (11 through 12 years):

Areas of Focus: Adolescence is a time when patients may stop routine preventative care, so extra effort should be invested in maintaining a primary care relationship. Lifestyle habits that are formed in adolescence often persist into adulthood. Therefore, adolescence is a critical period for engaging youth regarding a variety of health-promoting and risk-reducing behaviors, such as diet, physical activity, avoiding substance use, and promoting healthy sexuality. In addition, adolescence can be a turbulent time during which providers can serve as a critical source for support, treatment, and reassurance (i.e. puberty, acne, social and dating relationships, pregnancy prevention, academic demands, and mental health needs). Since mental health disorders commonly present in adolescence, screening and treatment are also important aspects of good adolescent care. Beginning at least by age 12, a portion of each visit should be conducted without parents in the room with confidentiality for the adolescent.

11-14 Years	1) Growth and Development (screening for both obesity and eating disorders) 2) Vaccinations[2] 3) Puberty education and assessment 4) Mood Disorder and Suicide Screening starting at age 12[7] 5) Hearing Screen (once between the 11 and 14 year visits)[8]* 6) Tobacco, Alcohol, Drug Use Screen[9] 7) Vision Screen at age 12*
15-17 Years	1) Growth and Development (screening for both obesity and eating disorders) 2) Vaccinations[2] 3) Puberty education and assessment 4) Vision screen at age 15 5) Hearing Screen once between ages 15 and 17[8]* 6) Mood Disorder and Suicide Screening[7] 7) Tobacco, Alcohol, Drug Use Screen[8] 8) Provide information about healthy sexuality and contraception, emergency contraception, and Sexually Transmitted Infection (STI) prevention to all sexually active adolescents and those who plan to become sexually active. 9) Chlamydia and Gonorrhea screen if sexually active women (screening for other STIs and asymptomatic men based in risk factors)[10] 10) Dyslipidemia Screening (Lipid profile once between 17 and 21 years old)* 11) HIV once between 15 and 18 years old

18-21 Years	1) Growth and Development (screening for both obesity and eating disorders) 2) Vaccinations[2] 3) Mood Disorder and Suicide Screening[7] 4) Hearing Screen once between ages 18 and 21[8]* 5) Tobacco, Alcohol, Drug Use Screen[8] 6) Provide information about healthy sexuality and contraception, emergency contraception, and Sexually Transmitted Infection (STI) prevention to all sexually active adolescents and those who plan to become sexually active. 7) Chlamydia and Gonorrhea screen if sexually active women (screening for other STIs and asymptomatic men based in risk factors)[10]

References:

1. www.cdc.gov/growthcharts/clinical_charts.htm or https://www.who.int/tools/child-growth- standards/standards/weight-for-age
2. www.cdc.gov/vaccines
3. Recommended screening tool is the Edinburgh Postpartum Depression Scale
4. Recommended screening tools include the Ages and Stages Questionnaire (ASQ), the Parents' Evaluation and Development Status (PEDStest) or the Survey of Well-being for young children (SWYC).
5. Recommended screening tool is the Modified Checklist for Autism in Toddlers Revised, with Follow-up (M- CHAT-R/F)
6. https://reachoutandread.org/get-involved/start-a-site/
7. Depression screening options include the Pediatric Symptom Checklist (PSC) PSC-17 for ages 4-17. Some sites choose the Patient Health Questionnaire-2 (PHQ-2) with follow-up PHQ9 if positive results on the initial screen.
8. Audiometry including 6,000 and 8,000 Hz high frequencies
9. Screening (with interventions if applicable) for use of tobacco, alcohol, or other drugs. Validated, screening tools include CRAFFT (car, relax, alone, forget, friends, and trouble) or Screening to Brief Intervention (S2BI)
10. USPSTF Chlamydia and Gonorrhea Screening, September 14, 2021

* Denotes an AAP recommendation, but USPSTF found insufficient evidence to recommend

Part 3

PEDS PRIMARY CARE TOOLS

Well Child Checklists (WCC) by age

If GU exam required, documentation of parent/guardian presence required for patients 9 years or younger; non-parental chaperone required for patients 10 years and older.

Age/Type of Visit	Pre-visit Planning	Visit Elements for Clinical Support Staff	Provider
New Patients T- numbers	**CLINICAL SUPPORT STAFF:** *Request medical records from previous health care center/hospital if applicable *Look up immunizations in State Data Base	*New Patient Information *Medical History Form (includes: family, personal, allergies, meds, surgeries, hospitalizations, etc. information) *Nurse Screening note (age appropriate questions) *Add significant family history to family history tab in EHR *State Immunization Data base check *Records release as pertains to individual patient *Discuss empanelment and assign PCP – if modeling Medical Home *Fluoride Varnish appropriate for age	*Discuss empanelment and assign PCP *Reach out and Read (ROAR) Program – if available in your area (ROAR) Program
(Infancy) Newborn	**CLINICAL SUPPORT STAFF:** *Request medical records from previous health care center/hospital if applicable	*New Patient Information *Medical History Form (includes: family, personal, allergies, meds, surgeries, hospitalizations, etc. information) *Add significant family history to family history tab in EHR *Have parents sign records release *Congenital Heart Disease Screening (Pre and post ductal saturations: if not performed and/or no record of being performed and Passed) *Tobacco Screening *Breastfeeding screen *Hearing Screen – if able to repeat failed screens *Length, Height and Weight *Head Circumference *State Immunization Data base check *Immunization: Hepatitis B #1 – if not given in hospital *Newborn Bilirubin – if applicable *Discuss empanelment and assign PCP – if modeling Medical Home	*Discuss empanelment and assign PCP – if modeling Medical Home *Developmental Surveillance/Screening Tool *Psychosocial/Behavioral Assessment *Physical Examination *Reach out and Read (ROAR) Program – if available in your area (ROAR) Program *Start Vit D Supplementation – if breastfeeding exclusively or partially breastfed *Perform RSV prophylaxis screening for Mother (did she receive RSV vaccine between 32 – 36 weeks of pregnancy) and patient to see if meets monoclonal antibody criteria.
(Infancy) 2 week Well Child Check	**CLINICAL SUPPORT STAFF:** *Request medical records from previous health care center/hospital if applicable	*Newborn Screen (NBS) #2 *Length, Height and Weight *Head Circumference *Hearing Screen *State Immunization Data base check *Immunization: Hepatitis B #1 (if not already given) *Tobacco Screening *Breastfeeding screen *Maternal Postpartum Depression Screening – Edinburgh Screening (EPDS) *Discuss empanelment and assign PCP – if modeling Medical Home	*Discuss empanelment and assign PCP – if modeling Medical Home *Developmental Surveillance/Screening Tool *Psychosocial/Behavioral Assessment *Physical Examination *Maternal Postpartum Depression Screening – Edinburgh (EPDS) *Reach out and Read (ROAR) Program – if available in your area (ROAR) Program *Start Vit D Supplementation – if breastfeeding exclusively or partially breastfed – aim for 6 – 12

Age/Type of Visit	Pre-visit Planning	Visit Elements for Clinical Support Staff	Provider
			months of supplementation *Perform RSV prophylaxis screening for Mother (did she receive RSV vaccine between 32 – 36 weeks of pregnancy) and patient to see if meets monoclonal antibody criteria.
(Infancy) 1 month Well Child Check	**CLINICAL SUPPORT STAFF:** *Request medical records from previous health care center/hospital if applicable *Completed referrals should have notes available. Follow up on incomplete referrals.	*Length, Height and Weight *Head Circumference *State Immunization Data base check *Immunization: Hepatitis B #1 (if not already given) *Tobacco Screening *Breastfeeding screen *Maternal Postpartum Depression Screening – Edinburgh (EPDS) *Discuss empanelment and assign PCP – if modeling Medical Home	*Discuss empanelment and assign PCP – if modeling Medical Home *Developmental Surveillance/Screening Tool *Psychosocial/Behavioral Assessment *Maternal Postpartum Depression Screening – Edinburgh (EPDS) *Physical Examination *Reach out and Read (ROAR) Program – if available in your area (ROAR) Program *Start Vit D Supplementation – if breastfeeding exclusively – aim for 6 – 12 months of supplementation *Perform RSV prophylaxis screening for Mother (did she receive RSV vaccine between 32 – 36 weeks of pregnancy) and patient to see if meets monoclonal antibody criteria.
(Infancy) 2 month Well Child Check	**CLINICAL SUPPORT STAFF:** *Completed referrals should have notes available. Follow up on incomplete referrals. *Order immunizations	*Length, Height and Weight *Head Circumference *State Immunization Data base check *Immunization *Tobacco Screening *Breastfeeding screen *Maternal Postpartum Depression Screening – Edinburgh (EPDS) *Discuss empanelment and assign PCP – if modeling Medical Home	*Discuss empanelment and assign PCP – if modeling Medical Home *Developmental Surveillance/Screening Tool (such as *Psychosocial/Behavioral Assessment *Maternal Postpartum Depression Screening – Edinburgh (EPDS) *Physical Examination *Reach out and Read (ROAR) Program – if available in your area (ROAR) Program *Start Vit D Supplementation – if breastfeeding exclusively – aim for 6 – 12 months of supplementation *Perform RSV prophylaxis screening for Mother (did she receive RSV vaccine between 32 – 36 weeks of pregnancy) and patient to see if meets monoclonal antibody criteria.
(Infancy) 4 month Well Child Check	**CLINICAL SUPPORT STAFF:** *Completed referrals should have notes available. Follow up on incomplete referrals.	*Length, Height and Weight *Head Circumference *State Immunization Data base check *Immunization	*Discuss empanelment and assign PCP – if modeling Medical Home *Developmental Surveillance/Screening Tool *Psychosocial/Behavioral Assessment

Age/Type of Visit	Pre-visit Planning	Visit Elements for Clinical Support Staff	Provider
	*Order immunizations	*Tobacco Screening *Breastfeeding screen *Maternal Postpartum Depression Screening – Edinburgh (EPDS) *Discuss empanelment and assign PCP – if modeling Medical Home	*Maternal Postpartum Depression Screening – Edinburgh (EPDS) *Physical Examination *Reach out and Read (ROAR) Program – if available in your area (ROAR) Program *Perform RSV prophylaxis screening for Mother (did she receive RSV vaccine between 32 – 36 weeks of pregnancy) and patient to see if meets monoclonal antibody criteria.
(Infancy) 6 month Well Child Check	**CLINICAL SUPPORT STAFF:** *Completed referrals should have notes available. Follow up on incomplete referrals. *Order immunizations	*Length, Height and Weight *Head Circumference *State Immunization Data base check *Immunization *Fluoride Varnish *Tobacco Screening *Breastfeeding screen *Maternal Postpartum Depression Screening – Edinburgh (EPDS) *Discuss empanelment and assign PCP – if modeling Medical Home	*Discuss empanelment and assign PCP – if modeling Medical Home *Developmental Surveillance/Screening Tool *Psychosocial/Behavioral Assessment *Maternal Postpartum Depression Screening – Edinburgh (EPDS) *Physical Examination *Oral Health *Reach out and Read (ROAR) Program – if available in your area (ROAR) Program *Perform RSV prophylaxis screening for Mother (did she receive RSV vaccine between 32 – 36 weeks of pregnancy) and patient to see if meets monoclonal antibody criteria.
(Infancy) 9 month Well Child Check	**CLINICAL SUPPORT STAFF:** *Completed referrals should have notes available. Follow up on incomplete referrals. *Order immunizations	*Length, Height and Weight *Head Circumference *Tobacco Screening, Breastfeeding screen *State Immunization Data base check *Immunization *Fluoride Varnish *Vision screening *Anemia and lead screening (CBC, lead or POC Hgb/Hct and lead) *Discuss empanelment and assign PCP – if modeling Medical Home	*Discuss empanelment and assign PCP – if modeling Medical Home *Developmental Screening *Psychosocial/Behavioral Assessment *Physical Examination *Oral Health *Reach out and Read (ROAR) Program – if available in your area *Perform RSV prophylaxis screening for Mother (did she receive RSV vaccine between 32 – 36 weeks of pregnancy) and patient to see if meets monoclonal antibody criteria.
(Early Childhood) 12 month Well Child Check	**CLINICAL SUPPORT STAFF:** *Completed referrals should have notes available. Follow up on incomplete referrals.	*Length, Height and Weight *Head Circumference *State Immunization Data base check *Immunization *Tobacco Screening	*Discuss empanelment and assign PCP – if modeling Medical Home *Developmental Surveillance/Screening Tool *Psychosocial/Behavioral Assessment *Physical Examination

Age/Type of Visit	Pre-visit Planning	Visit Elements for Clinical Support Staff	Provider
	*Order immunizations	*Breastfeeding screen *Discuss empanelment and assign PCP – if modeling Medical Home *Fluoride Varnish *1st Dental Visit to be Scheduled	*Reach out and Read (ROAR) Program – if available in your area *Perform RSV prophylaxis screening for Mother (did she receive RSV vaccine between 32 – 36 weeks of pregnancy) and patient to see if meets monoclonal antibody criteria.
(Early Childhood) 15 month Well Child Check	**CLINICAL SUPPORT STAFF:** *Completed referrals should have notes available. Follow up on incomplete referrals. *Order immunizations	*Length, Height and Weight *Head Circumference *State Immunization Data base check *Immunization *Tobacco Screening *Discuss empanelment and assign PCP – if modeling Medical Home *Fluoride Varnish	*Discuss empanelment and assign PCP – if modeling Medical Home *Developmental Surveillance/Screening Tool *Psychosocial/Behavioral Assessment *Physical Examination *Reach out and Read (ROAR) Program – if available in your area *Perform RSV prophylaxis screening for Mother (did she receive RSV vaccine between 32 – 36 weeks of pregnancy) and patient to see if meets monoclonal antibody criteria.
(Early Childhood) 18 month Well Child Check	**CLINICAL SUPPORT STAFF:** *Completed referrals should have notes available. Follow up on incomplete referrals. *Order immunizations	*Length, Height and Weight *Head Circumference *State Immunization Data base check *Immunization *Tobacco Screening *MCHAT-R *Fluoride Varnish *Discuss empanelment and assign PCP – if modeling Medical Home	*Discuss empanelment and assign PCP – if modeling Medical Home *Development Screening *Autism Spectrum Disorder Screening (MCHAT – R) *Psychosocial/Behavioral Assessment *Physical Examination *Reach out and Read (ROAR) Program – if available in your area *Perform RSV prophylaxis screening for Mother (did she receive RSV vaccine between 32 – 36 weeks of pregnancy) and patient to see if meets monoclonal antibody criteria.
(Early Childhood) 24 month Well Child Check	**CLINICAL SUPPORT STAFF:** *Completed referrals should have notes available. Follow up on incomplete referrals. *Order immunizations	*Length, Height and Weight *Head Circumference *Body Mass Index *Immunization *State Immunization Data base check *Tobacco Screening *MCHAT-R *Anemia and lead screening (CBC, lead or POC Hgb/Hct and lead) *Fluoride Varnish *Discuss empanelment and assign PCP – if modeling Medical Home	*Discuss empanelment and assign PCP – if modeling Medical Home *Autism Spectrum Disorder Screening (MCHAT – R) *Developmental Surveillance/Screening Tool *Psychosocial/Behavioral Assessment *Physical Examination *Reach out and Read (ROAR) Program – if available in your area

Age/Type of Visit	Pre-visit Planning	Visit Elements for Clinical Support Staff	Provider
(Early Childhood) 30 month Well Child Check	**CLINICAL SUPPORT STAFF:** *Completed referrals should have notes available. Follow up on incomplete referrals. *Order immunizations	*Length, Height and Weight *Head Circumference *Body Mass Index *Immunization *State Immunization Data base check *Tobacco Screening *MCHAT – R *Anemia and lead screening (CBC, lead or POC Hgb/Hct and lead) – if not done at 24 month wcc *Fluoride Varnish *Discuss empanelment and assign PCP – if modeling Medical Home	*Discuss empanelment and assign PCP – if modeling Medical Home *Autism Spectrum Disorder Screening (MCHAT – R) *Developmental Surveillance/Screening Tool *Psychosocial/Behavioral Assessment *Physical Examination *Reach out and Read (ROAR) Program – if available in your area
(Early Childhood) 3 – 5 year old Well Child Check	**CLINICAL SUPPORT STAFF:** *Completed referrals should have notes available. Follow up on incomplete referrals. *Order immunizations	*Appropriate age packet *Length, Height and Weight *Body Mass Index *Blood Pressure *Immunization *State Immunization Data base check *Tobacco Screening *Vision screening *Hearing screening *Fluoride Varnish *Discuss empanelment and assign PCP – if modeling Medical Home	*Discuss empanelment and assign PCP – if modeling Medical Home *Developmental Surveillance/Screening Tool *Psychosocial/Behavioral Assessment *Physical Examination *Reach out and Read (ROAR) Program – if available in your area
(Middle Childhood) 6 – 12 year old Well Child Check	**CLINICAL SUPPORT STAFF:** *Completed referrals should have notes available. Follow up on incomplete referrals. *Order immunizations	*Length, Height and Weight *Body Mass Index *Blood Pressure *Immunization *State Immunization Data base check *Tobacco Screening (if 12 y/o, include Alcohol, Domestic Violence, Depression Screen) *Vision screening *Hearing screening *Discuss empanelment and assign PCP – if modeling Medical Home *Fluoride Varnish *8 yo and older and BMI >= 85th percentile – Order Set "CMP/A1C/Lipid Profile (Obesity)"	*Discuss empanelment and assign PCP – if modeling Medical Home *Developmental Surveillance/Screening Tool *Psychosocial/Behavioral Assessment *Physical Examination *If 12 y/o Depression Screening *Obesity/Overweight labs as indicated (CMP, Lipid Panel, Hgb A1C) per BMI for 8 y/o and up *Screening lipid panel once for all patients 9 – 11 years of age
(Adolescence) 13 - 15 year old Well Child Check	**CLINICAL SUPPORT STAFF:** *Completed referrals should have notes available. Follow up on incomplete referrals. *Order immunizations	*Length, Height and Weight *Body Mass Index *Blood Pressure *State Immunization Data base check *Immunization *Vision screening *Hearing screening *Tobacco, Alcohol, Domestic Violence, Depression Screen	*Discuss empanelment and assign PCP – if modeling Medical Home *Developmental Surveillance/Screening Tool *Psychosocial/Behavioral Assessment *Physical Examination *Depression Screening *Obesity/Overweight labs (CMP, Lipid Panel, Hgb A1C) as indicated

Age/Type of Visit	Pre-visit Planning	Visit Elements for Clinical Support Staff	Provider
		*Discuss empanelment and assign PCP – if modeling Medical Home *Fluoride Varnish *If BMI >= 85th percentile: Order Set "CMP/A1C/Lipid Profile (Obesity)"	*HIV testing *RPR testing *GC/Chlamydia testing
(Adolescence) 16 – 17 year old Well Child Check	**CLINICAL SUPPORT STAFF:** *Completed referrals should have notes available. Follow up on incomplete referrals. *Order immunizations	*Length, Height and Weight *Body Mass Index *Blood Pressure *Vision screening *Hearing screening *Immunization *State Immunization Data base check *Tobacco, Alcohol, Domestic Violence, Depression Screen *Vision and hearing screen *Discuss empanelment and assign PCP – if modeling Medical Home *If BMI >= 85th percentile: Order Set "CMP/A1C/Lipid Profile (Obesity)"	*Discuss empanelment and assign PCP – if modeling Medical Home *Developmental Surveillance/Screening Tool *Psychosocial/Behavioral Assessment *Physical Examination *Depression Screening *Obesity/Overweight labs (CMP, Lipid Panel, Hgb A1C) as indicated *HIV testing *RPR testing *GC/Chlamydia testing (sexually active teens male and female)
(Adolescence) 18 years old – 21 years old	**CLINICAL SUPPORT STAFF:** *Completed referrals should have notes available. Follow up on incomplete referrals. *Order immunizations	*Length, Height and Weight *Body Mass Index *Blood Pressure *Vision screening *Hearing screening *Immunization *State Immunization Data base check *Tobacco, Alcohol, Domestic Violence, Depression Screen *If BMI >= 85th percentile: Order Set "CMP/A1C/Lipid Profile (Obesity)" *Discuss transitioning to adult care at 20 years of age	*Developmental Surveillance/Screening Tool *Psychosocial/Behavioral Assessment *Physical Examination *Depression Screening *Discuss transitioning to adult care at 20 years of age *RPR testing *HIV testing *GC/Chlamydia testing (sexually active teens male and female) *Obesity/Overweight labs (CMP, Lipid Panel, Hgb A1C) as indicated
Sports PE's – **ALL AGES**	**CLINICAL SUPPORT STAFF:** *Completed referrals should have notes available. Follow up on incomplete referrals. *Call parent to complete for prior to appt. (forms can be downloaded from internet)	*Nurse Screening note (age appropriate questions) *Sports PE form ***Forms are filled out completely** by parents and vitals by nursing/MA's *If WCC needed (none in last year) please give appropriate forms *Discuss empanelment and assign PCP – if modeling the medical home *Fluoride varnish appropriate for age	*Discuss empanelment and assign PCP. If has outside provider assign as Provider, Elsewhere. *WCC appropriate for age if not already performed (within the last year) *HIV if indicated per age *Obesity/Overweight labs (CMP, Lipid Panel, Hgb A1C) as indicated

Revised on 12/6/2024 - CN

General Developmental Surveillance/Screening Tool Examples:

1. Parents' Evaluation of Developmental Status (PEDS Tool)
2. Ages and Stages Questionnaire (ASQ)
3. Car Relax Forget Friends Trouble (CRAFFT)

Electronic Health Records (EHR) templates for WCC, by age

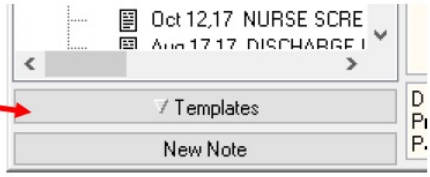
Please use links below or email IHSMCH@ihs.gov to request templates

WCC by age	EHR Template
Newborn and 2 Weeks	Newborn/2 Weeks Template
1 month	1 Month Template
2 months	2 Months Template
4 months	4 Months Template
6 months	6 Months Template
9 months	9 Months Template
12 months	12 Months Template
15 months	15 Months Template
18 months	18 Months Template
24 months	24 Months Template
30 months	30 Months Template
3 years	3 Years Template
4 years	4 Years Template
5 to 6	5 to 6 Years Template
7-10 years	7 to 10 Years Template
11-12 years	11 to 12 Years Template
13 years and up (adolescent)	13 Years and Older Template

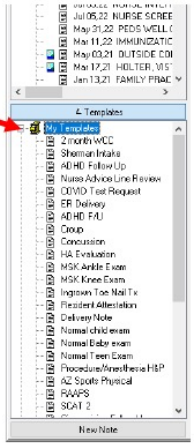
How to make your own Templates in E.H.R.:

1. Select a demo patient in EHR.

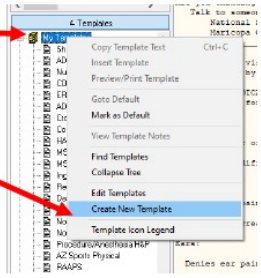
2. Select Template option on the bottom left-hand side of the screen



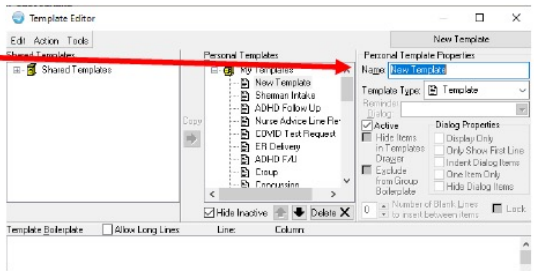
3. Select "My Templates."



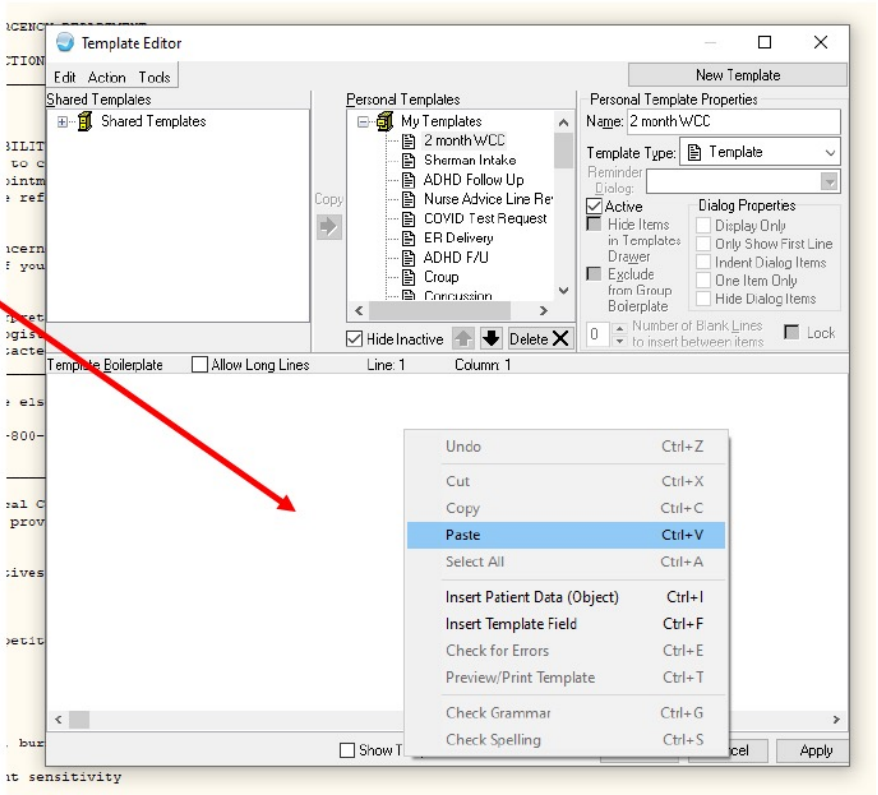
4. Right click on "My Templates."
5. Scroll down to "Create New Template."



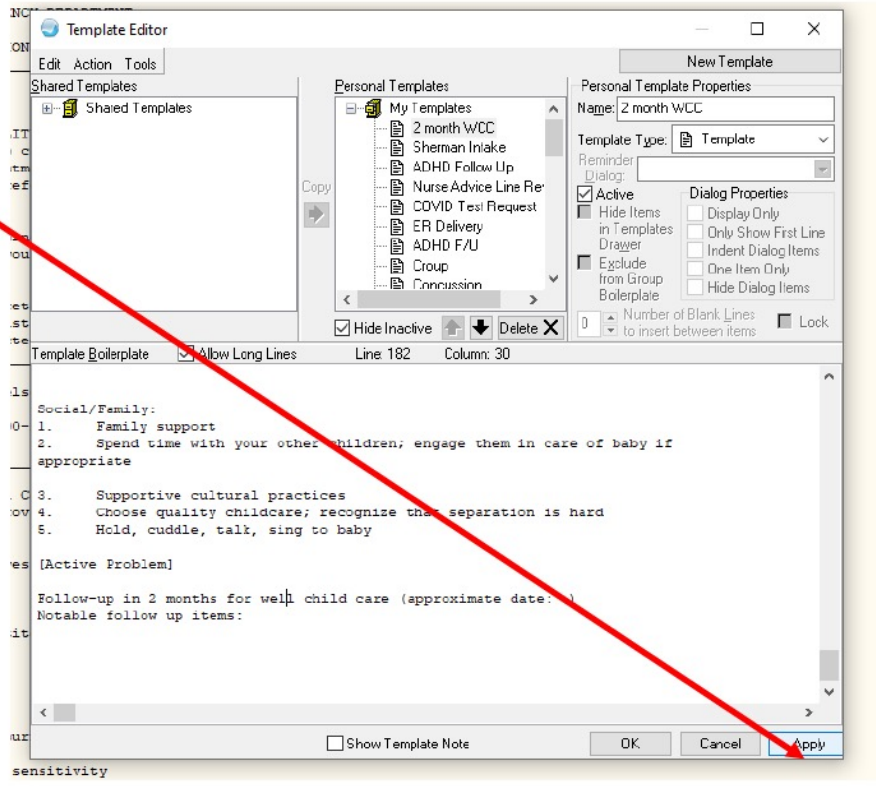
6. Name your Template.
   a. (Example will be shown for 2 month WCC)



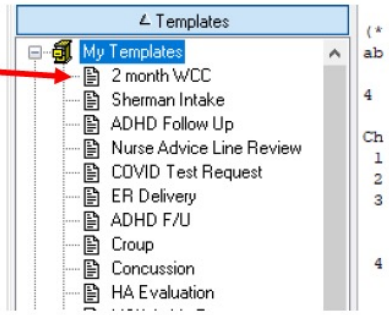
7. Copy well child check template from the Bright Futures word document templates and then RIGHT Click in the white box and PASTE the template.



8. Click APPLY. This will save the template.



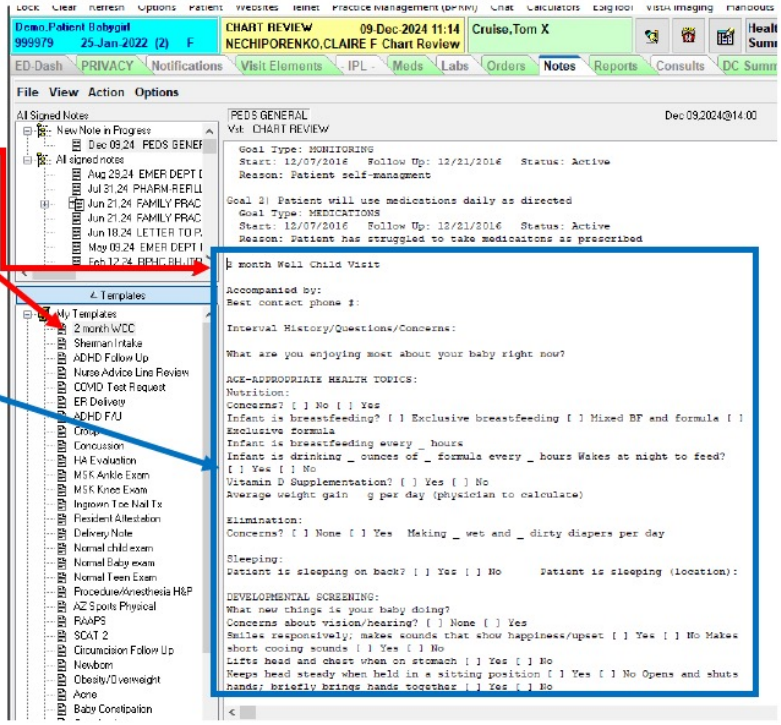
9. Document should now be seen under the My Templates list.



10. To use your template, open your note (each service unit will have different note titles)

11. Place your cursor in the body of the note where you want the template, highlight the template you want and then double click.

12. The template will be pasted to the body of your note where you placed the cursor.



Bright Futures Parent & Patient Educational Handouts

Link to Bright Futures website

Well-Child Visit Handouts

Parent and patient handouts from the *Bright Futures Tool and Resource Kit*, 2nd Edition, address key information for health supervision care from infancy through adolescence. Bright Futures is a national health care promotion and disease prevention initiative that uses a developmentally based approach to address children's health care needs in the context of family and community.

Parent Handouts

Bright Futures Parent Handout: First Week Visit (3 to 5 Days)
English PDF | Spanish PDF
Bright Futures Parent Handout: 1 Month Visit English PDF | Spanish PDF
Bright Futures Parent Handout: 2 Month Visit English PDF | Spanish PDF
Bright Futures Parent Handout: 4 Month Visit English PDF | Spanish PDF
Bright Futures Parent Handout: 6 Month Visit English PDF | Spanish PDF
Bright Futures Parent Handout: 9 Month Visit English PDF | Spanish PDF
Bright Futures Parent Handout: 12 Month Visit English PDF | Spanish PDF
Bright Futures Parent Handout: 15 Month Visit English PDF | Spanish PDF
Bright Futures Parent Handout: 18 Month Visit English PDF | Spanish PDF
Bright Futures Parent Handout: 2 Year Visit
English PDF | Spanish PDF
Bright Futures Parent Handout: 2½ Year Visit English PDF | Spanish PDF
Bright Futures Parent Handout: 3 Year Visit
English PDF | Spanish PDF
Bright Futures Parent Handout: 4 Year Visit
English PDF | Spanish PDF

Bright Futures Parent Handout: 5 and 6 Year Visits
English PDF | Spanish PDF
Bright Futures Parent Handout: 7 and 8 Year Visits
English PDF | Spanish PDF
Bright Futures Parent Handout: 9 and 10 Year
Visits English PDF | Spanish PDF
Bright Futures Parent Handout: 11-14 Year
Visits English PDF | Spanish PDF
Bright Futures Parent Handout: 15-17 Year
Visits English PDF | Spanish PDF

Patient Handouts
Bright Futures Patient Handout: 7 and 8 Year Visits
English PDF | Spanish PDF
Bright Futures Patient Handout: 9 and 10 Year
Visits English PDF | Spanish PDF
Bright Futures Patient Handout: 11-14
Year Visits English PDF | Spanish PDF
Bright Futures Patient Handout: 15-17
Year Visits English PDF | Spanish PDF
Bright Futures Patient Handout: 18-21
Year Visits English PDF | Spanish PDF

Reach out and Read

Reach Out and Read – Literacy promotion model

Link to Reach Out and Read website

"A Critical Window: More than 80% of a child's brain is formed during their first three years, and what they experience during this window can irreversibly affect how their brain develops. Attention and nurturing from a loving parent or caregiver support healthy brain development—and one of the best ways to engage young children is to read books together."

Reach Out and Read model of literacy promotion and family engagement:

- Primary care providers (Doctors, NPs and PAs) are trained to deliver anticipatory literacy guidance to parents and caregivers of children from infancy through 5 years of age during each well-child visit. This age-appropriate guidance centers on the importance of elements such as: frequent and early exposure to language, looking at board books and naming pictures with infants, rhyme and repetition for gaining phonemic awareness during toddlerhood, and reading interactively (such as asking open-ended questions) when reading with preschoolers. Providers also use this opportunity to model reading aloud and introduce it as another way to support positive, language rich interactions between caregiver and child.
- Additionally, the provider introduces a new, developmentally appropriate book into the visit for the child to take home, building a child's collection of 10-14 new books before kindergarten. Books are given at least from the 6-month visit, but also earlier visits, in some places.
- Reach Out and Read sites also create literacy-rich environments that may include community resource information, artwork, and gently used books for waiting room use or for siblings to take home. In some waiting rooms where possible, Reach Out and Read volunteers model for parents the pleasures and techniques of reading aloud with very young children.

Reach Out and Read AI/AN Initiative

- Established in 2007
- Collaboration between American Academy of Pediatrics (AAP) and IHS
- More than 200 I/T/U sites participate
- Outcomes: improved caregiver and child bonding and child language development, improved clinician morale, and improved family-clinician relationships

To learn more about participating in Reach Out and Read, visit the Start a Site page on the Reach Out and Read website or contact your local Reach Out and Read Affiliate office.

Part 4

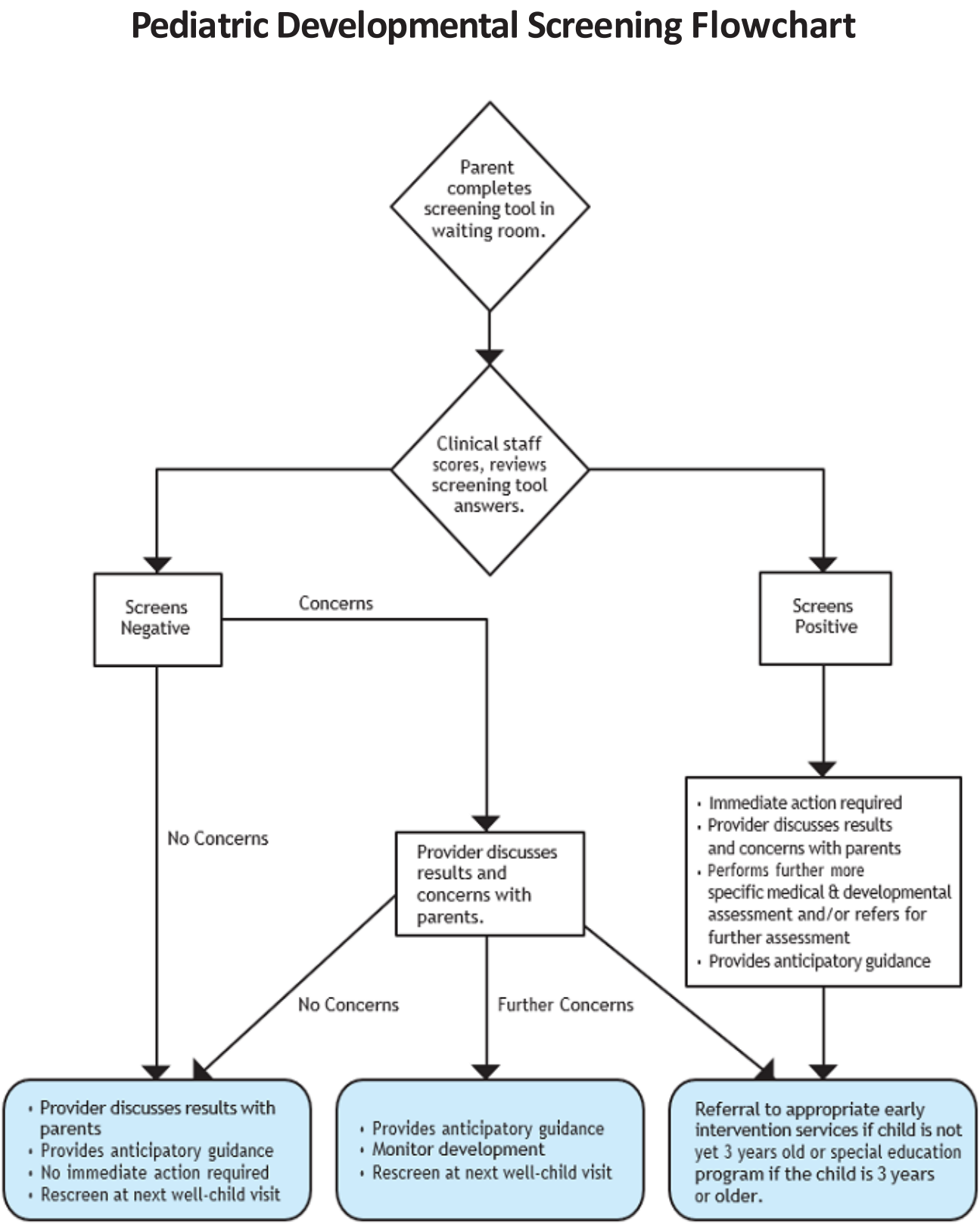
SCREENING TOOLS OVERVIEW

Screening Tools

Validated screening tools listed in this section can be used to monitor behavioral health, development and youth risk behaviors. While this is not an exhaustive list of all available or validated screening tools, they are some of the most commonly used tools and are referenced in the American Academy of Pediatrics' Bright Futures (Fourth Edition) guidance. **Choice of tools should be made by clinic staff based on feasibility and acceptability within the context of the local community.**

Screening Test	*Website Link*	*Who*	*When*
Maternal/Caregiver Depression			
Edinburgh Postnatal Depression Scale (EPDS)	https://downloads.aap.org/AAP/PDF/Postnatal%20Depression%20Scale.pdf	Mothers, Fathers, Caregivers (CG)	2 wk, 2 mo, 4 mo & 6 mo visits
Early Childhood Development			
Parents' Evaluation of Developmental Status (PEDStest)	https://pedstest.com/	CG response about child; *validated for 0-8 years*	Atleast 3 times by 3 yrs (ideally 9mo/18mo/30mo) and more often as indicated
Ages & Stages Questionnaire (ASQ)	https://agesandstages.com/	CG response; *validated for 1 mo-5 years*	Same as above
Survey of Well-being of Young Children (SWYC)	https://pediatrics.tuftsmedicalcenter.org/the-survey-of-wellbeing- of-young-children/overview	CG response; *validated for 2mo-5 years*	Same as above
Autism			
Modified Checklist for Autism in Toddlers, Revised (MCHAT-R)	https://www.mchatscreen.com/	CG response about child; *validated for 16-30 mo*	18 mo & 24 mo
Youth Risk/Behavioral Health			
Patient Health Questionnaire-9 (PHQ 9)	https://www.phqscreeners.com/select-screener	Youth self report; *validated for 12-18 yrs*	
The CRAFFT 2.1 Manual	https://crafft.org/wp-content/uploads/2021/10/CRAFFT_2.1_Provider-Manual_2021.10.28.pdf	Youth self report; *validated for 12-21 yrs*	
Pediatric Traumatic Stress Screening Tool	https://ce.childrenscolorado.org/sites/default/files/media/2022-06/Peds%20Trauma%20Stress%20Care%20Process%20Model.pdf	Youth self report; *validated for 6-18 yrs*	

Job Aid 1: Developmental screening flowchart



Job Aid 2: Sample patient tracking tool

Patient ID	**Well Child Visit**	**Date of Screen (MM/DD/YYYY)**	**Screening Result** (screen used, score and areas of concern)	**Referral Made?** (Y/N)	**Date of Referral (MM/DD/YYYY)**	**Date of Follow-up on Referral** (MM/DD/YYYY)	**Confirmed Referral Uptake?** (Y/N)	**Notes**
Ex.	*24 month*	*8/5/2020*	*ASQ, speech delay*	*Y*	*8/5/2020*	*8/20/2020*	*N*	*Follow up on where referral got stuck*
Ex.	*30 month*	*9/5/2020*	*MCHAT, high risk*	*Y*	*9/6/2020*	*9/30/2020*	*Y*	*Follow up with caregivers on Autism evaluation appt*

Job Aid 3: Sample scoring sheet for MCHAT

Scoring Sheet

M-CHAT-R™

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

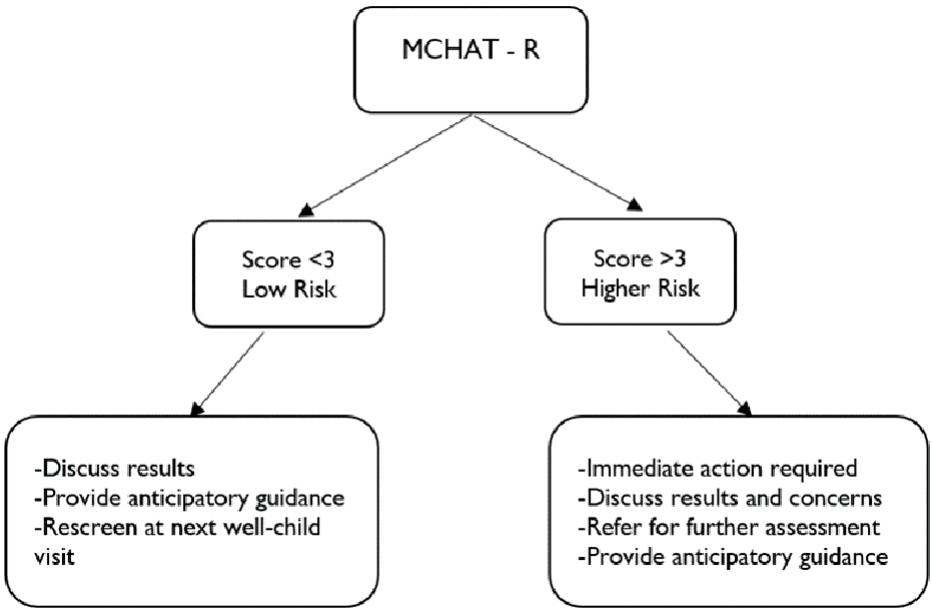
1. If you point at something across the room, does your child look at it? (**FOR EXAMPLE**, if you point at a toy or an animal, does your child look at the toy or animal?)	(Yes)	No
2. Have you ever wondered if your child might be deaf?	Yes	(No)
3. Does your child play pretend or make-believe? (**FOR EXAMPLE**, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	(Yes)	No
4. Does your child like climbing on things? (**FOR EXAMPLE**, furniture, playground equipment, or stairs)	(Yes)	No
5. Does your child make unusual finger movements near his or her eyes? (**FOR EXAMPLE**, does your child wiggle his or her fingers close to his or her eyes?)	Yes	(No)
6. Does your child point with one finger to ask for something or to get help? (**FOR EXAMPLE**, pointing to a snack or toy that is out of reach)	(Yes)	No
7. Does your child point with one finger to show you something interesting? (**FOR EXAMPLE**, pointing to an airplane in the sky or a big truck in the road)	(Yes)	No
8. Is your child interested in other children? (**FOR EXAMPLE**, does your child watch other children, smile at them, or go to them?)	(Yes)	No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (**FOR EXAMPLE**, showing you a flower, a stuffed animal, or a toy truck)	(Yes)	No
10. Does your child respond when you call his or her name? (**FOR EXAMPLE**, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	(Yes)	No
11. When you smile at your child, does he or she smile back at you?	(Yes)	No
12. Does your child get upset by everyday noises? (**FOR EXAMPLE**, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes	(No)
13. Does your child walk?	(Yes)	No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	(Yes)	No
15. Does your child try to copy what you do? (**FOR EXAMPLE**, wave bye-bye, clap, or make a funny noise when you do)	(Yes)	No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	(Yes)	No
17. Does your child try to get you to watch him or her? (**FOR EXAMPLE**, does your child look at you for praise, or say "look" or "watch me"?)	(Yes)	No
18. Does your child understand when you tell him or her to do something? (**FOR EXAMPLE**, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	(Yes)	No
19. If something new happens, does your child look at your face to see how you feel about it? (**FOR EXAMPLE**, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	(Yes)	No
20. Does your child like movement activities? (**FOR EXAMPLE**, being swung or bounced on your knee)	(Yes)	No

Job Aid 4: MCHAT implementation

Autism Screening

Recommended Tool: MCHAT-R
Who: Children ages 16-30 months
When: 18 and 24 month Well Child Checks
Protocol: Parent/caregiver written responses to 20 Yes/No questions
Training Video: M-CHAT-R/F Training Video (15 minutes) https://tnaap.org/programs/start/modified-checklistfor-autism-in-toddlers/

Scoring:



Follow up:
After a positive screen, then what?

- Discuss next steps
- Refer for a diagnostic evaluation and concurrent early intervention services
- Prepare family for diagnostic evaluation process (advise re: potentially long wait times)
- Provide resources: handouts, websites, online forums

Job Aid 5: Example template for locally developed Adolescent screening tool

We care about your health. We're asking these questions so that we can help you be as healthy as possible. Your answers are CONFIDENTIAL. Please DO NOT WRITE YOUR NAME, and HAND THIS FORM DIRECTLY TO YOUR DOCTOR OR NURSE PRACTITIONER.

	Yes	No	Not Sure
Do you know at least one person who you trust and can talk to about problems?			
Do your parent(s) or guardian(s) usually listen to you and take you seriously?			
Have you ever thought seriously about running away from home?			
Have there been any recent changes in your family? (births, deaths, divorce)			
Do you spend a lot of time wishing you looked differently?			
Have you ever been in a physical fight where you or someone else got hurt?			
Have you ever been in trouble with the police?			
Have you ever seen a violent act take place at home?			
Are you worried about violence, your safety, or someone else's safety?			
Are you worried about bullying?			
Do you always wear a seatbelt when you ride in a car, truck, or van?			
Have you ever smoked cigarettes, vaped, or chewed tobacco?			
Have you ever smoked marijuana/pot/weed?			
Have you ever done other drugs? (cocaine, meth, huffing or others)			
Have you ever drunk beer, wine, or other alcohol?			
Do any of your close friends drink or do drugs?			
Have you ever been in a car when the driver had been drinking or using drugs?			
Does anyone in your family drink or use drugs?			
Do you have a boyfriend/girlfriend?			
Have you ever had sex? (oral, vaginal, anal)			
Are you thinking about having sex?			
Have you ever felt pressured by anyone to do something sexual when you did not want to? (sex, kissing, oral sex, touching, anal sex)			
Have you done something fun during the past 2 weeks?			
When you get angry, do you do violent things?			
During the past few weeks, have you felt very sad or down as though you have nothing to look forward to?			
Have you ever thought about killing yourself or tried to kill yourself?			
Is there something you often worry about or fear?			
Have you ever been physically, emotionally, or sexually abused?			

What two words best describes you? 1)_____ 2) _____
What would you like to do when you finish high school? _____
If you could have three wishes come true, what would they be? 1) _____ 2) _____ 3) _____

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Part 5

RESOURCES FOR FAMILIES & HEALTHCARE PROVIDER

The resources listed below are suggestions, and not endorsements. They are resources often referenced by the AAP and the AAP Committee on Native American Child Health (CONACH) and do not comprise an exhaustive list. It is recommended that each clinic develop an additional resource list with culturally appropriate and locally available resources for families.

Early Childhood Development Resources

Providers

- AAP resources
  - 2019 Technical Report: Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice
  - Article in Pediatrics with Family Resources
  - Communicating with Families
  - Evidence Based Interventions for Children 5 Years and Under
- Family Strengths resources
  - AAP Early Brain Well Child Grid
  - Protective Factors: Action Sheets
- Early Relational Health (ERH)
  - Article in Pediatrics with Family Resources
  - Center for the Study of Social Policy: Building Relationships: Framing Early Relational Health
  - Centering Parenting: strategy for advancing Early Relational Health
- Tribal home visiting programs
  - https://nhvrc.org/about-the-nhvrc/

Families

- Vroom Brain Builder
- CDC's Learn the Signs. Act Early.
- CDC's Milestone Tracker App
- Baby Navigator/Autism Navigator

Reproductive Health Resources

Providers

- Bedsider.org
- https://providers.bedsider.org/
- Contraception educational materials
- ACOG's resource for Long-Activing Reversible Contraception (LARC)

Families

- Bedsider.org
- Contraception educational materials

Behavioral Health Resources

Providers

- Maternal Mental Health
  - National Maternal Mental Health Hotline: 1-833-TLC-MAMA (1-833-852-6262)
  - AIM Perinatal Mental Health Conditions Implementation Resources
  - Postpartum Support International
  - Centering Pregnancy
  - CDC: *Hear Her* Campaign
  - CDC: Identifying Maternal Depression
  - CDC: Pregnancy Risk Assessment Monitoring System
  - 2016 Perinatal Depression Medicaid Bulletin
  - Medicaid Postpartum Coverage Extension Tracker
  - ADHS Maternal Health Resources
  - ITCA: Improving Maternal Health Outcomes

Families

- Maternal Mental Health
  - Canopie app for mental health support
  - National Maternal Mental Health Hotline: 1-833-TLC-MAMA (1-833-852-6262)
  - CDC: *Hear Her* Campaign
  - NIH: Emotional Wellness Toolkit
  - Postpartum Support International

Local Community Resources for Families

Template for sites:

- Cultural Resources
- Food Insecurity
- Housing insecurity/utilities
- Unemployment
- Childcare

IHS Mission: To raise the physical, mental, social, and spiritual health
of American Indians and Alaska Natives to the highest level.