

Adolescent Depression Screening and Follow-Up Playbook

*For Quality Improvement Leads at Federally
Qualified Health Centers*



Aliados Health
Quality Improvement Team
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This work reflects the Aliados Health Population Health Improvement Framework. Thank you to our health centers and funder the California Improvement Network for your collaboration

Background

Adolescent depression remains a significant population health concern in Sonoma County and across the region. Depression in adolescents has been linked to long-term anxiety disorders, increased risk of substance use, and increased risk of suicide attempts. During the COVID-19 pandemic, more adolescents and young adults reported symptoms of anxiety and/or depression, and even prior to the pandemic, young people were at higher risk for poor mental health. Local data also show that suicide deaths per 100,000 population are higher in Sonoma County than California and U.S. rates. (CDC 2008)¹

National clinical guidance reinforces the importance of routine adolescent depression screening when adequate systems are in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. The USPSTF recommends screening adolescents ages 12 to 18 years for major depressive disorder when these supports are available. (Siu on behalf of USPSTF, 2016)²

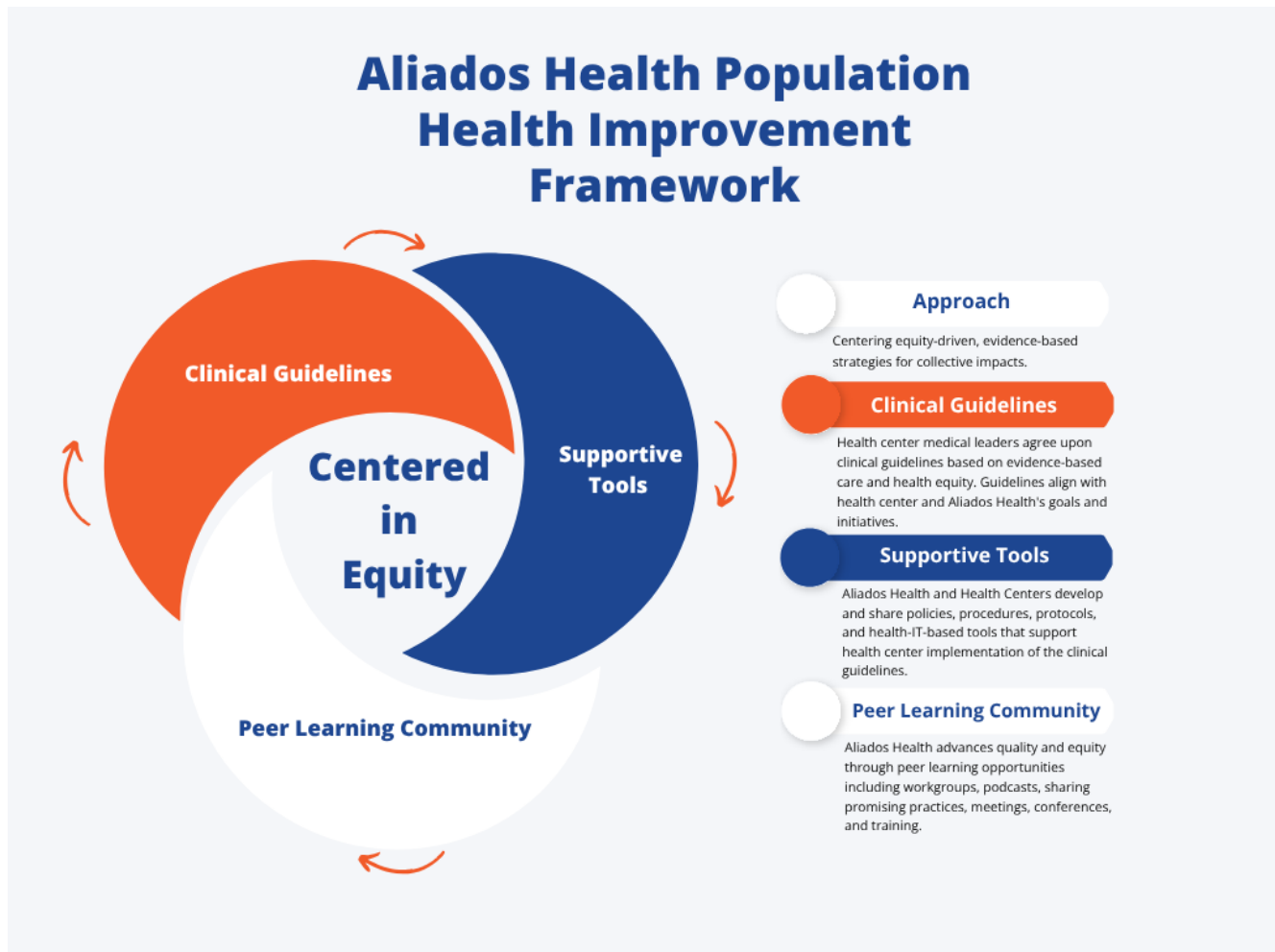
In early 2023, Aliados Health identified an age-based disparity through analysis conducted for the Performance Improvement Program administered for health centers participating in a primary care contract with Partnership HealthPlan of California. Adolescents ages 12–17 had lower depression screening and follow-up rates compared with adults ages 18 and older. In response, Aliados Health added a UDS adapted measure, adolescent depression screening and follow-up to the PIP Clinical Quality Measure Set, strengthening networkwide focus on routine screening, timely follow-up, and standardized documentation for this population.

This work reflects Aliados Health’s quality improvement approach: using data to identify disparities, aligning health centers around shared measures, supporting workflow and EHR standardization, and spreading practical strategies through peer learning and supportive tools. The Aliados Health Population Health Improvement Framework packages this QI approach into a practical improvement continuum, with the playbook serving as a supportive tool to help teams move from disparity identification to testing, spread, and sustainment.

¹ Centers for Disease Control and Prevention (2008). CDC Wonder. Retrieved from <https://wonder.cdc.gov/ucd-icd10.html>

² [Preventative Care and Screening: Screening for Depression and Follow-Up Plan | eCQI Resource Center](#)

Aliados Health Population Health Improvement Framework



This playbook functions as a quality improvement supportive tool within the Aliados Health Population Health Improvement Framework.

Playbook Purpose

The purpose of this playbook is to help health centers strengthen adolescent depression screening and follow-up through a barrier-focused structure that helps teams assess local data, identify the most pressing gaps, and select the play or combination of plays that best fits their context.

The plays are designed to address five common barriers identified across adolescent depression screening and follow-up workflows: missed adolescent depression screenings; inconsistent follow-up after positive screens; EHR documentation and reporting variation; unclear roles and handoffs across care teams; and the need for equitable youth and family engagement.

How to Use This Playbook

- **Start with the workflow pathway.** Use the workflow appendix, if needed, to understand the full screening and follow-up process before selecting a play. ([See Appendix: Example Adolescent Depression Screening and Follow-Up Workflow](#))
- **Identify the top barrier and select the relevant Play.** Use local data, team feedback, workflow observations, and equity stratification to identify the main gap, then use the [Barrier-to-Play Table](#) to choose one play, combine several plays, or return to a play as new barriers emerge.



Pro Tip: Start with screening reliability For health centers that are struggling with low rates of screening and referral for treatment, consider interventions that increase screening rates first.

- **Use the standard play structure.** Each play describes the barrier, when to use it, practical strategies, roles, EHR/data considerations, examples from the field, adaptation questions, implementation tips, and measures to monitor.
 - a. **Purpose:** Use this section to quickly understand which barrier the play addresses and why it matters.
 - b. **Core Strategies:** Select one or two practical actions to test first rather than trying to implement every strategy at once.
 - c. **Examples from the Field:** Use these as starting ideas and adapt them to your health center's staffing, EHR, and workflow context.
 - d. **Adaptation Questions:** Discuss these questions with the care team to decide what needs to be changed locally before testing the play.
 - e. **Implementation Tip:** Use this as a quick reminder to avoid common pitfalls and support reliable implementation.
- **Adapt and test locally.** Use the strategies, scripts, EHR tips, and examples as starting points, then adapt them to local workflows, staffing, EHR tools, and youth/family needs.
- **Monitor results and return to the plays as needed.** Use routine QI review and stratified data to assess progress, identify remaining gaps, and decide which play to test or revisit next.

This playbook is designed to be used flexibly. Health centers can begin with the workflow pathway to understand the full screening and follow-up process, then select the barrier-focused plays that best match their current performance gaps, operational challenges, staffing model, EHR capacity, equity priorities, and adolescent engagement needs.

Barrier-to-Play Table

Review the table below to match each top barrier with the plays most likely to help address it.

Top Barrier	Description	Related Plays
Missed adolescent depression screenings	Screening is not consistently completed due to workflow gaps, inconsistent use of PHQ-2/PHQ-9 tools, or lack of reliable visit-based prompts.	Plays 1 , 3 , 4 , 5
Inconsistent follow-up after positive screens	Positive PHQ-9 or self-harm responses require clear, timely next steps, but follow-up actions, referrals, and care coordination are not always standardized or documented.	Plays 2 , 3 , 4 , 5
EHR documentation and reporting variation	Health centers use different EHRs, templates, alerts, SmartPhrases, dashboards, and reports, creating variation in how screening and follow-up are captured and tracked.	Plays 3 , 4 , 7
Unclear roles and handoffs across care teams	Responsibilities among MAs, providers, behavioral health staff, care coordinators, front desk teams, and QI teams need to be clearly defined so screening, referral, and follow-up workflows do not break down.	Plays 1 , 2 , 5 , 7
Equitable youth and family engagement	Adolescents and families need culturally and linguistically responsive outreach, education, and staff communication scripts to improve trust, participation, and completion of screening and follow-up.	Plays 5 , 6 , 7

Barrier-Focused Improvement Plays

Play 1: Build a Reliable Screening Workflow

Purpose: Address missed adolescent depression screenings by creating a reliable workflow for identifying, screening, and documenting eligible adolescents during routine care.

Core Strategies

- All adolescent visits should trigger a screening opportunity.
- Embed PHQ2, PHQ9, or adolescent depression screening into standard visit workflows.
- Use visit planning, care gap reports, or EHR prompts to identify when screening is due.
- Clarify whether screening is completed by front office, MA, provider, care coordinator, or other staff.
- Build same-day workflows so screening can be completed before the patient leaves.
- Train staff on when screening is due, how to complete it, and where to document it.

Examples from the Field

Takeaways From Health Centers
Embed screening and outreach workflows into all adolescent visit types, including well visits, sick visits, and telehealth encounters. Every visit is an opportunity to screen or close a care gap, especially when the next touchpoint is uncertain.
Use morning huddles and EHR health maintenance tools to make screening needs visible before the visit begins and clarify who will complete screening.
Recalling adolescents who are due for care (Due for well child exams, vaccines or have not been seen in a year) is essential for closing missed screening and follow-up gaps, helping teams re-engage adolescents who may not return soon and ensuring overdue care is not missed.

Adaptation Questions

- Who completes the initial screen?
- Where is the screening result documented?
- What happens if the screen is not completed during the visit?
- How will the team identify adolescents who are overdue for screening?



Implementation Tip

Start by mapping the current screening workflow from appointment scheduling through visit close. Identify where screening is most likely to be missed and test one workflow change, such as an EHR prompt, visit template update, or MA checklist.

Play 2: Close the Loop on Positive Screens

Purpose: Address inconsistent follow-up after positive screens by creating a reliable process for assessment, referral, follow-up, and documentation.

Core Strategies

- Define what constitutes a positive screen and what response is required.
- Create a clear escalation pathway for positive PHQ9 scores or self-harm responses.
- Use warm handoffs to behavioral health when available.

- Schedule follow-up assessment, counseling, or intake before the adolescent leaves when possible.
- Document referral, counseling, safety planning, outside services, or follow-up action in a standardized way.
- Track whether follow-up was completed after a positive screen.

Examples from the Field

Takeaways From Health Centers
Reserving behavioral health capacity for same-day warm handoffs so positive screens can lead to timely engagement, rapport-building, assessment, and follow-up. Example: Assign a behavioral health provider for each four-hour shift with blocked time to support warm handoffs.
Schedule the next step during the initial encounter whenever possible to reduce drop-off after a positive screen.
Use standardized documentation tools to ensure follow-up actions are consistently captured, reportable, and visible to the care team.
Use clinical decision support to make positive screens and self-harm responses visible at the point of care and prompt timely provider action. Example: Implement an EHR practice alert that appears when a PHQ-9 is positive or Question 9 is positive, prompting providers to document follow-up.
Track the reason for referral or follow-up so teams can understand demand, improve workflow design, and distinguish measure-driven follow-up from other behavioral health needs.

Adaptation Questions

- What score or response triggers follow-up?
- Who reviews positive screens before the visit ends?
- What is the escalation process for self-harm responses?
- How is behavioral health or care coordination involved?
- How is follow-up documented and tracked?



Implementation Tip

Create a simple positive-screen response pathway that defines next steps by risk level. Include who is responsible, what documentation is required, and how follow-up completion will be monitored.

Play 3: Optimize EHR Documentation and Clinical Decision Support

Purpose: Address EHR documentation and reporting variation by using EHR tools and clinical decision support to support consistent screening, follow-up, documentation, and reporting.

Core Strategies

- Embed PHQ tools into adolescent visit templates.
- Use EHR prompts, alerts, reminders, or hard stops to identify when screening is due.
- Use SmartPhrases, templates, or structured fields to standardize documentation.
- Configure alerts for positive PHQ9 results or self-harm responses.
- Use care gap reports, dashboards, and QA/QI reports to track screening and follow-up.
- Validate EHR configuration and reporting logic to ensure accurate measure capture.

Examples from the Field

Takeaways From Health Centers
Use required EHR workflow steps by building mandatory work/ hard stops and visit-template prompts when missed screening or incomplete documentation is a persistent gap.
Standardize follow-up documentation so common actions are captured consistently and can be reported accurately.
Make screening history and results easy to find within the visit workflow so providers can act before the encounter ends.
Use structured EHR tools to capture the full range of clinical and follow-up actions in consistent, reportable fields.

Adaptation Questions

- What EHR prompt or template identifies when screening is due?
- Where are PHQ results documented?
- What documentation captures follow-up after a positive screen?
- What alert is triggered by a positive PHQ9 or self-harm response?
- What report or dashboard will be reviewed routinely?
- Who validates measure capture and reporting logic?

Implementation Tip

Prioritize one high-value EHR improvement first, such as a screening reminder, follow-up documentation phrase, or care gap dashboard. Test it with one team before scaling.

Play 4: Use Data to Drive Improvement

Purpose: Address missed screening, follow-up, and performance gaps by using routine data review to identify variation, monitor progress, and guide improvement efforts.

Core Strategies

- Review screening and follow-up data routinely.
- Use care gap reports, dashboards, and monthly QA/QI reports to monitor performance.
- Identify variation by site, provider, team, clinic, or population where data are available.
- Use reports to support outreach for adolescents overdue for screening or follow-up.
- Share performance trends with clinical, behavioral health, operational, and QI teams.
- Use data findings to guide workflow changes and staff training.

Examples from the Field

Takeaways From Health Centers
Connect routine reporting to clear action ownership so data review leads to follow-up, not just awareness. Example: QA/QI team sends monthly reports to Behavioral Health, triggering response activation by the Site Supervisor and Coordinator.
Stratify performance by site, campus, team, or provider to identify where targeted workflow support is needed. Example: Created a report to identify site and provider-level variation resulting in identification of school-based sites as a key performance opportunity.
Assign routine dashboard review to a defined role so care gap data are used consistently to identify trends and retraining needs. Example: Develop a Care Gap Monitoring Dashboard and require Medical Assistant Supervisors to review it monthly as part of a Quality Watch.
Use performance trends and data validation of EHR health maintenance care gaps to drive retraining, recognize progress, and distinguish workflow gaps from reporting or configuration issues. Downward trends trigger retraining and process improvement activities.
Combine point-of-care alerts with population health tools to monitor completion, identify missed opportunities, and support outreach.

Adaptation Questions

- Which screening and follow-up measures will be reviewed?
- How often will the team review data?
- Who owns dashboard or report review?
- How will data findings be shared with care teams?
- What action is taken when gaps are identified?
- Can data be stratified to identify disparities?

Implementation Tip

Create a standing monthly review process that includes measure trends, care gaps, follow-up completion, and one agreed-upon action item for the next improvement cycle.

Play 5: Clarify Team Roles and Handoffs

Purpose: Address unclear roles and handoffs across care teams by defining responsibilities and creating reliable workflows for screening, referral, follow-up, and care coordination.

Core Strategies

- Define staff roles for screening, documentation, provider review, referral, scheduling, and follow-up.
- Clarify handoffs between front office, MAs, providers, behavioral health, care coordination, and QI teams.
- Use huddles to review workflow issues.
- Train staff on their role and how to escalate concerns.
- Create role-based checklists or workflow maps.
- Establish ownership for care gap follow-up and dashboard review.

Examples from the Field

Takeaways From Health Centers

Define and distribute ownership across QI, medical, behavioral health, care coordination, and outreach roles so screening and follow-up are treated as shared population health work. Clarify each role. Create regular cross-team forums to troubleshoot handoffs, role clarity, and workflow barriers.

Adaptation Questions

- Who identifies that screening is due?
- Who administers and documents the screen?
- Who reviews positive results?
- Who completes referral or warm handoff?
- Who schedules follow-up?
- Who monitors unresolved care gaps?



Implementation Tip

Develop a simple role matrix that lists each workflow step and the staff responsible role. Review it during team huddles and update it when workflows change.

Play 6: Strengthen Outreach and Youth/Family Engagement

Purpose: Address equitable youth and family engagement by using culturally and linguistically responsive strategies to improve participation in screening and follow-up.

Core Strategies

- Use youth- and family-friendly language to explain the purpose of screening.
- Normalize depression screening as a routine part of adolescent care.
- Use scripts to support staff conversations with teens and families.
- Offer culturally and linguistically responsive materials.
- Use multiple outreach modalities, including text, portal, phone, telehealth, and outreach lists.
- Extend screening and follow-up beyond in-person visits when appropriate.

Examples from the Field

Takeaways From Health Centers
Protect confidential time for screening explaining that rooming alone creates space to discuss things they may not otherwise feel comfortable sharing. Clearly explain the purpose of rooming alone and while giving adolescents choice and reassurance that a parent or caregiver can rejoin at any time.
Equip staff with communication approaches that explain the “Why” behind screening, normalize behavioral health conversations, reduce stigma, and help adolescents feel safe answering honestly. Use empathy, motivation interviewing and provide brief education to support adolescent engagement.
Strengthen youth engagement by connecting clinic workflows with trusted community partners that can support referral, follow-up, and ongoing care. Example partners include schools, wellness centers, Boys & Girls Club, and community-based organizations.
Use pre-visit education and consistent messaging such as a “What to Expect” handout and a “No Questions Asked” approach to normalize screening, reduce stigma, and prepare adolescents and families for confidential care conversations.

Adaptation Questions

- What message will staff use to introduce screening?
- What languages and formats are needed for materials?
- Which outreach channels are most effective for adolescents and families?
- How will screening be handled during telehealth or outreach encounters?
- How will staff explain follow-up after a positive screen?



Implementation Tip

Develop a short, plain-language staff script that normalizes screening and explains confidentiality, purpose, and next steps. Pair the script with youth- and family-facing materials.

Play 7: Support Spread and Sustainability

Purpose: Address training and sustainability needs by turning successful workflows into practical tools that can be adapted, spread, and sustained across teams and sites.

Core Strategies

- Package workflows into templates, checklists, scripts, and quick-reference tools.
- Use peer learning to share what is working across sites.
- Document promising practices in a format that others can adapt.
- Build training and retraining into routine operations.
- Monitor screening and follow-up performance over time.
- Create sustainability plans for ownership, data review, and workflow maintenance.

Examples from the Field

Takeaways From Health Centers
• Use existing leadership and quality structures to communicate workflow changes, lessons learned, and retraining needs across teams.
• Document successful local interventions in a format that other teams can adapt, especially when a workflow addresses a specific setting or population. Partner with your consortium to document a promising practice or podcast that can be shared with network stakeholders.

Adaptation Questions

- Which tools should be standardized for spread?
- What should remain customizable by each health center?
- Who owns training and retraining?
- How will promising practices to be shared?
- What data will be monitored over time?
- How will workflows be maintained during staffing or EHR changes?



Implementation Tip

Create a sustainability checklist that includes workflow owner, training plan, EHR/reporting owner, dashboard review cadence, and process for updating tools as workflows evolve.

Appendix: Staff Script Examples

Situation	Staff Role	Sample Language
Introducing routine screening	MA	<i>"We ask all teens these questions because emotional health is part of overall health. Your answers help the care team know how to support you."</i>

Explaining confidentiality	Provider / MA	<i>"Some parts of your visit are private. If you share something that makes us worried about your safety or someone else's safety, we may need to bring in support to keep you safe."</i>
Normalizing screening	Provider	<i>"Many teens experience stress, sadness, or anxiety. These questions help us check in early, even if things seem okay on the outside."</i>
Addressing caregiver questions	Provider / MA with support of provider if needed	<i>"This screening is a routine part of adolescent care. It helps us understand how your teens are doing emotionally and whether they need additional support."</i>
When a teen is hesitant	MA / Provider	<i>"You can take your time. There are no right or wrong answers. The goal is to understand how things have been going for you."</i>
After a positive screen	Provider / BH	<i>"Thank you for answering honestly. Your responses show that you may benefit from extra support, (if you are not already receiving it-provider portion). We'll talk together about next steps and make sure you are not handling this alone."</i>
Introducing behavioral health support	Provider / BH	<i>"We have someone on our team who works with teens on stress, mood, and coping. I'd like to introduce you today so we can support you right away."</i>
Outreach message	Care Coordinator / Front Desk	<i>"Hi, this is [Health Center]. We are reaching out because your teen may be due for a routine health screening. Please call us at [phone number] to schedule or ask questions."</i>

Appendix: Adolescent Depression Screening and Follow-Up Workflow Example

Use this checklist as a quick-reference guide for the overall adolescent depression screening and follow-up workflow. Health centers can adapt the steps to fit local staffing models, EHR tools, and visit types.

Workflow Phase	Key Actions	Decision Point	Lead Roles
1. Identify adolescents due for screening	Review scheduled visits, care gap lists, dashboards, or EHR prompts. Confirm age, eligible visit type, preferred language, and contact information.	Is the adolescent due for screening at this visit or through outreach?	Front desk, MA, care coordinator, QI/population health staff
2. Prepare for the visit	Flag screening is needed during huddle, chart prep, rooming note, or EHR prompt. Confirm who will introduce and administer screening.	Is screening clearly assigned before the visit begins?	MA, front desk, care coordinator, provider
3. Introduce and complete screening	Explain screening as routine adolescent care using youth-friendly language. Administer PHQ-2, PHQ-9, PHQ-A, or local screening tool according to protocol.	Is the result negative, positive, incomplete, or refused?	MA, provider, care coordinator

4. Review results before the visit ends	Ensure the provider or designated clinical team member reviews the results, including any self-harm response or elevated score.	Do the results require follow-up, risk assessment, warm handoff, or safety planning?	Provider, MA, behavioral health staff
5. Respond to positive screens	Assess risk, determine next steps, involve behavioral health or care coordination when indicated, and complete warm handoff, referral, counseling, safety planning, or follow-up plan.	Has the follow-up action been completed or scheduled before the patient leaves?	Provider, behavioral health staff, care coordinator
6. Track follow-up and unresolved gaps	Monitor referrals, pending follow-up visits, outreach tasks, and adolescents who did not complete screening or follow-up.	Is follow-up completed, scheduled, declined, or still unresolved?	Care coordinator, front desk, behavioral health team, QI lead
7. Review data and improve workflow	Review screening completion, positive screen follow-up, missed opportunities, no-shows, and equity stratification. Identify where the workflow is breaking down and test one improvement action.	What workflow change should be tested next?	QI lead, supervisors, care team, leadership
8. Update and sustain the workflow	Update scripts, workflow maps, role assignments, EHR tools, and training when gaps, staffing changes, or EHR changes are identified.	What needs to be standardized, retrained, or adapted locally?	QI lead, supervisors, leadership, EHR/HIT support

Appendix: Key Roles in the Example Workflow

A reliable adolescent depression screening and follow-up workflow depends on clear role ownership across the care team. Front desk and registration staff can help identify eligible adolescents and support scheduling or outreach. MAs and rooming staff introduce and complete screening, while providers review results and determine next steps. Behavioral health staff, care coordinators, and outreach teams help close the loop after positive screens through warm handoffs, referrals, follow-up scheduling, and tracking. QI, EHR/HIT, supervisors, and leadership support the infrastructure needed to monitor performance, improve workflows, and sustain changes over time.

Role / Team	Primary Role in the Example Workflow
Front Desk / Registration	Tracks appointments, including missed appointments. Conducts missed appointment calls and recalls.
Medical Assistants / Rooming Staff	Identifies adolescents due for screening, introduces screening as routine care, administers the screening tool, documents results, and flags positive screens.
Providers	Reviews screening results before the visit ends, assesses positive screens or safety concerns, determines the care plan, and documents clinical follow-up. Refer to Behavioral Health, if needed.

Behavioral Health Staff	Supports warm handoffs, risk assessment, brief intervention, safety planning, counseling, referral coordination, and youth/family engagement after positive screens.
Care Coordinators / Outreach Staff	Tracks unresolved screening and behavioral health follow-up gaps.
QI / Population Health Team	Reviews performance data, validates reports, identifies workflow breakdowns, supports PDSA testing, and monitors equity-focused trends.
EHR / HIT Support	Builds or optimizes EHR prompts, templates, structured fields, alerts, dashboards, and reports to support reliable documentation and tracking.
Supervisors / Operations Leaders	Clarifies role assignments, reinforces training, supports staffing and coverage, reviews workflow barriers, and helps sustain standard work.
Executive / Clinical Leadership	Sets priorities, allocates resources, monitors progress, supports behavioral health access, and sponsors spread and sustainability.

Resources

West County Health Center Promising Practice: [Raising the Bar: Improving Depression Screening and Follow-Up Rates at School Sites](#)

Sonoma Valley Community Health Center Podcast, Episode 51: [The QI Chat Room Podcast – Aliados Health](#).