Educational & Developmental Intervention Services (EDIS) Personnel Development

KIT

Keeping In Touch

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Inside this edition DEVELOPMENTAL SCREENING QUALITY PRACTICES

Resource Article

Developmental screenings are often used to identify children at risk for developmental delay, but these screenings may also be used to track children's progress in early intervention. Greenwood, Carta and McConnell take this idea a bit further and propose using the Individual Growth and Development Indicators (IGDIs) to provide empirical data about specific developmental areas to help guide intervention decisions.

The authors explain, "IGDIs for infants and toddlers use direct observational measurement to record the frequency of responding during a short 6 minute semistructure play situation with a familiar adult." The infant and toddler IGDIs include: Early Communication Indicator (ECI), Early Social Indicator (ESI), Early Movement Indicator (EMI), Early Problem solving Indicator (EPSI) and Indicator of Parent-Child Interaction (IPCI).

To illustrate how the IGDIs are used let's look at the ECI, which examines a child's growth in abilities such as being able to express oneself through gestures, vocalizations, words and sentences. This tool is administered to a child by an adult play partner using toys. The play partner is trained to follow the child's lead by commenting and playing with objects that interest the child. Communicative acts are recorded and the totals are converted to scores.

Once the data are collected, the decision making process begins. The authors suggest using the Tilly model (Tilly, 2008) of data-based decision making to determine whether or not a positive response to intervention (RTI) has been made. This decision making process uses the following guiding questions: 1) Is there a problem – the use of the IGDI suggests whether or not a score falls below a benchmark; 2) What is causing the problem? – consideration of causes such as weak home language environment, hearing problems, etc.; 3) What intervention should be used – parents are taught/ coached in strategies that naturally fit their style and daily routines to help promote their child's development; 4) Is the intervention being implemented? – consulting with parents to see if the strategies are doable in day to day life; and 5) is the intervention working? – monitoring progress with parents.

Using IGDIs is one way interventionists can monitor the response to intervention for young children and their families participating in early intervention. To learn more visit the website at (http://www.igdi.ku.edu/

Greenwood, C. R., Carta, J. J. & McConnell, S. (2011). Advances in measurement for universal screening and individual progress monitoring of young children. *Journal of Early Intervention,* 33(4),

What do the data say?

Does the Duration of the well-baby visit matter?

Yes, according to the American Academy of Pediatrics the length of well-baby visits is an important factor on the content covered and quality of care. In fact, a recent study by Halfron, Stevens, Larson, and Olson (2011) found that longer visits were associated with higher quality of care with respect to content covered and parent satisfaction. Unfortunately, pediatricians often face time constraints that interfere with their ability to complete developmental screenings, deliver anticipatory guidance, listen to family questions, and develop follow-up plans. Balancing these important components is a challenge, and doing so in shorter periods of times creates an even greater challenge.

Using the data from the 2000 National Survey of Early Childhood Health (NSECH) Halfron and colleagues examined the association of well-baby visit time, content, and parent satisfaction. Specifically they analyzed the visit length to four factors, anticipatory guidance content, psychosocial assessment of risk, developmental assessment, family-centered care, and parent satisfaction. The NSECH data included 1691 children ages 4-35 months who had a well-baby visit in the past 12 months.

Regarding length of visit, 33.6% of the parents reported the visit lasting less than or equal to 10 minutes, 47.1% reported the visit lasting 11-20 minutes, and 20.3% said the visit lasted longer than 20 minutes. Interestingly, non-college educated mothers had visits lasting longer than 20 minutes more often than college educated mothers (28.3% vs. 15.9%). Care at community health care centers versus physician's offices or hospitals were also associated with lengthier visits (> 20 minute visits at 27%, 18.5% and 23.4% respectively). There were few differences in visit length across family demographics such as race/ethnicity, age of child, socioeconomic status, and health insurance coverage. Yet, the male healthcare providers were more likely than female providers to have visits lasting less than or equal to 10 minutes (38.1% vs. 23.2%).

The results indicated parents reporting longer visits received more anticipatory guidance, psychosocial risk assessment, greater family-centered care, and developmental assessment. Anticipatory guidance was based on the parents' receipt of guidance on 9-12 topics depending upon their child's age. The psychosocial risk assessment was based on the provider asking the parent about use of alcohol/drugs, community violence, smoking, parent health, emotional support, spousal support and difficulty paying for basic needs. The family-centered scale addressed how providers took time to understand the needs of the child, respected the parent as the expert on the child, asked how the parent was feeling, and understood the family and how they preferred to raise children. Developmental assessment was determine by asking parents whether the provider performed a developmental assessment. When comparing visits of 1-10 minutes with visits of greater than 20 minutes there were higher points on the anticipatory guidance scale (17.9 points higher), psychosocial risk assessment scale (16.9 points higher), and the family-centered scale (19.5 points higher). Additionally, longer visits were associated with greater odds of having a developmental assessment (70% in visits >20 minutes and almost half in visits lasting $\leq$10 minutes.

Looking closer at anticipatory guidance, discussion about immunizations and breastfeeding was delivered to 80% or more of the parents regardless of visit duration. As the length of the visit increased so too did the amount of anticipatory guidance. Yet, fewer than 50% of all the parents included in the study received guidance about emotional support, childcare, toilet training, finance, and violence.

These results reinforce that well-baby visit time does matter. Yet, the challenge remains to find the optimal time-content balance and implement it effectively. Communities must also additional ways to extend preventive guidance, resources, and services beyond time constrained well-baby visits. Community based efforts including screening systems such as the ASQ may be viable options worth exploring.

Halfron, N., Stevens, G. D., Larson, K., and Olson, L. M. (2011). Duration of a well-child visit: Association with content, family-centeredness, and satisfaction. *Pediatrics, 128*(4), 657-664. Accessed from: http://pediatrics.aappublications.org/content/128/4/657.full.pdf+html

Consultation Corner

From May through December 2014 we are excited to have Jantina Clifford, Jane Farrell, and Suzanne Yockelson as our consultation corner experts addressing the topic "Developmental Screening Quality Practices; Using the ASQ and ASQ-SE."

How To Use And Not Use The ASQ And ASQ-SE?

The ASQ-3 and ASQ:SE are designed to screen and monitor children from 0-5 years of age using parent observations, concerns and report. One of the most unique characteristics of the ASQ system is the flexibility in how , when, and where it can be used!

HOW? The ASQ-3 and ASQ:SE can be administered in a variety of ways including mail-out, online, telephone interview, home visit, and on site. It can be completed by parents, other caregivers, teachers or evaluators. Yet, it is recommended that a familiar caregiver (one who spends at least 20 hours per week with the child) completes the ASQ and makes time to observe the child's skills over a few days in a familiar setting to maximize accuracy of report and capture a child's optimum performance, including emerging skills. It is of course imperative that parents are involved in the ASQ completion and given assistance as needed.

When selecting administration methods programs should consider the population served and be open to using various methods to meet the diverse needs of the population. Considerations such as reading level, language and cultural differences, mental health status and involvement with protective services and/or corrections are variables that may influence the level of assistance caregivers need. Mail out and/or online methods work nicely to share the resource with as many parents as possible. Adding a phone interview or follow up call can help reach parents who have not completed the ASQ or those who need further assistance. ASQ Family Access is another ASQ resource that provides a secure website for parents to complete the ASQ, get quick and accurate results, and receive timely follow up. Using various methods of administration facilitates program efficiency by sharing the ASQ with as many as possible and reserving personnel time to provide face to face support as needed.

It is important to note that ASQ accuracy improves when answers are based on observable skills. If a caregiver is not sure about a skill, they should be encouraged or assisted to try it out. The ASQ:SE, on the other hand, should be completed by the caregiver with as much independence as possible. The ASQ:SE includes questions about a caregiver's *perception* of the child and their responses help providers tailor relational support to the caregiver and child. For these reasons providers should refrain from sharing their own perceptions of a child's behavior, which might influence caregiver's true perceptions. Assistance on the ASQ:SE should be limited to translation, item reframing, reading assistance, or interview. The ASQ:SE can also be used with multiple caregivers for different perceptions of the child's functioning in a variety of settings.

Responsive action plans include personal communication about results. The ASQ summary page guides decision making based on the scores. Follow up actions may be: trying activities and rescreening, sharing results with a primary care provider, referring for further evaluation. The ASQ-3 Learning Activities contain more than 400 easy-to-use learning activities, specially developed to complement ASQ-3. The ASQ:SE also includes parent activities to promote social emotional development.

RECCOMMENDATIONS:

Do present ASQ completion as a celebration of child development and positive parenting practice.

Do assess reading, language, cultural differences and prepare to assist in parent completion.

Do use a variety of completion methods to best meet the needs of individual families served.

Do encourage parents to try out items when a child is well rested, fed, and healthy.

Do include multiple caregivers in the ASQ completion process when appropriate.

Consultation Corner (continued)

Do design responsive follow-up action with every ASQ provided to a family.
Do collaborate with other community programs invested in ASQ implementation.

WHEN? Programs can choose the intervals to use the ASQ. Variables to consider include frequency of contact with families, personnel, and program budget for screening and monitoring efforts. The ASQ-3 questionnaire intervals include 2, 4, 6, 8, 9, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, and 60 months of age. The ASQ:SE questionnaire intervals include 6, 12, 18, 24, 36, 48, and 60 months of age. Programs can use either ASQ-3 or ASQ:SE, however it's designed as a complimentary system and ideally they are used together.

RECOMMENDATIONS:
Do consider program goals, resources, and child risk factors in selecting intervals to administer.
Do remember that parents become more confident and competent observing and reporting on their child's development with the ASQ over time!
Do calculate the child's age at administration accurately (including correcting for prematurity) and choose the correct interval.
Do provide ASQ-3 and ASQ;SE at separate times to avoid overwhelming caregivers.
Do use the Child Monitoring Sheet to track a child's screening results over time.
Do coordinate with other community programs using the ASQ to avoid duplication.

WHERE? The ASQ is often used by healthcare, education, and social services. These agencies offer natural opportunities to engage parents in screening of their young children. Pediatric practices use specific ASQ intervals corresponding with well child checks as a reliable tool for developmental surveillance and to bridge communication with parents about their child's development.

Screening clinics are often joint community efforts that provide screenings to large numbers of children. Parents can complete ASQ independently with appropriate materials available. Parents and children might rotate through "stations" completing items for each developmental area. Staff provides assistance to score, summarize results and share information about referrals and resources.

Child care settings are also effective places for screening children. Childcare providers are valuable reporters of child development. The ASQ has an additional benefit of reminding paraprofessionals of age expected skills. However, parents should always be invited to complete the questionnaires for their child. Conferences are effective ways to review results and discuss skills seen at childcare and at home. Many childcare businesses integrate ASQ completion as a "service" provided, assuring parents of their focus on developmental progress of all children. This positive approach helps build parent partnerships and builds trust in the ASQ process.

Center-based educational settings are another setting for screening children. Public programs like Head Start are mandated to screen children. Private programs are often motivated to screen children to meet their educational goals. Enrollment is a logical time to introduce ASQ to families and parents can take it home to complete and return.

Home visiting programs commonly use the ASQ system to involve parents in developmental monitoring, identify learning activities, and structure home visits. Home visits provide a context for maximum support during ASQ completion, encouraging parent child interactions and raising awareness about appropriate developmental expectations.

Early Intervention and Early Childhood Special Education programs often use the ASQ to screen new referrals and gather initial developmental information. This information can guide next steps in the process. The ASQ is also useful in monitoring to assure development is on schedule or trigger further evaluation if other concerns arise.

Protective Services use the ASQ for Child Abuse Prevention and Treatment Act (CAPTA) requirements. It is also helpful for monitoring children's adjustment to foster placement and identify developmental concerns. Early detection of social emotional challenges may help prevent or minimize the long term impacts of early maltreatment.

RECOMMENDATIONS:
Do design creative projects to engage parents in screening and monitoring.
Do provide ASQ training/coaching to community programs.

On the WWW

Our www resource this month is a national health care promotion and prevention initiative that uses a family-centered developmental approach to address children's health care needs. Bright Futures has resources for all providers and families. The website includes a host of resources on recommendations to promote and enhance children health and development. It helps providers from many different disciplines and services as well as families to understand children's development and what should happen at well-child visits with young children. In essence the work of Bright Futures informs people about the explicit nature and best practice expectations for well-child visits. Information included can be very helpful for interventionists helping families.

http://brightfutures.aap.org/

Continuing Education for KIT Readers

The Comprehensive System of Personnel Development (CSPD) is offering a continuing education opportunity for KIT readers.

In line with the focus on *Developmental Screening Quality Practices,* readers are invited to receive continuing education contact hours for reading the monthly KIT publications (May through November 2014) and completing a multiple-choice exam about the content covered in these KITs,.

KIT readers will receive the exam in December 2014. There is no need to register for the CEUs. Rather, if you are interested complete the exam online at www.edis.army.mil

Upon successful completion of the exam, you will receive a certificate of non-discipline specific continuing education contact hours.

KIT Newsletters are available online at **www.edis.army.mil**

Thank you for your continued interest in the KIT.
Please share your KIT questions/ideas via email to
EDISCSPD@amedd.army.mil