Educational & Developmental Intervention Services (EDIS) Personnel Development

KIT

Keeping In Touch

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DEVELOPMENTAL SCREENING QUALITY PRACTICES

Resource Article

The American Academy of Pediatrics (AAP) endorsed standardized developmental screenings as part of well-child care for all children in 2001. Implementation, however, was slow and in a follow-up 2002 survey, the AAP found that only 23% of pediatricians were complying with this proposal. This is a concerning percentage given that early identification of delays can be crucial in changing the developmental trajectory of young children. In 2006, the AAP revised their policy statement. Not only did they restate the need for standardized developmental screenings, the AAP made their policy statement more explicit stating that the use of a "good" (sensitive and specific) standardized developmental screening tool should be administered at 9, 18 and 30 month visits. With this recommendation in mind, Radecki, L., Sand-Loud, N., O'Connor, K. G., Sharp, S & Olson, L. M (2011) examined data from pediatricians between the years of 2002 and 2009 to determine whether and how the use of standardized screenings was implemented.

Data were collected via surveys sent out by the AAP's Division of Healthy Services Research. Roughly 1600 surveys were sent out both in 2002 and in 2009 to health care providers who provide health supervision/preventative care to children younger than 36 months: 894 and 927 responses were collected respectively. Providers who were developmental in nature (e.g., Developmental Pediatricians) and/or those with sub-specialties (e.g., Neurology, Neonatology, Genetics, etc.) were excluded from the surveys. Potential participants received up to 7 follow-up mailings to promote participation. A number of questions were raised, but one question in particular was included on surveys, "How often do you or your staff use the following methods or tools to identify children birth through 35 months of age at risk for developmental or problems?" A number of possible screening options were then included (e.g., informal checklists vs formal checklists such as the Ages & Stages, Denver II, Parents' Evaluation of Developmental Status [PEDS], Modified Checklist for Autism in Toddlers [MCHAT], etc.).

Results suggested the use of standardized screening tools doubled between 2002 (23%) and 2009 (47.7%). Yet, approximately half of all pediatricians reported "they did not routinely use the recommended formal screening tools with patients younger than 36 months." Many of these providers relied upon parent

Resource Article (continued)

report, informal checklists completed by parents, pediatrician and/or office staff. Physicians who are not completing developmental screenings provided a number of reasons: reimbursement issues, time constraints, lack of staff to perform screenings, and lack of confidence in their ability to screen. There are, however, efforts being made to increase physician comfort with the screening process as well as providing further reimbursement guidance (i.e., 96110 is the Current Procedural Terminology code for developmental testing) for Medicare. Programs started to increase developmental screenings, some of these include: Assuring Better Child Health and Development, Bright Futures, Child Find Demonstration Projects and Healthy Steps for Young Children Program and the TRACE program.

Additional findings suggested that as use of formal instruments increased in child care settings, the use of informal screenings decreased (from 71% in 2002 to 60.5% in 2009); this trend may be a direct result of the AAP's explicit policy of the use of "good" standardized screening tools. The Ages and Stages Questionnaire was listed most often (22.5%) as the formal tool used, followed by the Denver II (18.3%) and then the PEDS (15.9%). In 2009, 42.7% of physicians reported they "always" completed a developmental screening compared to 29.2% who claimed they "never" completed one.

While use of standardized developmental screenings at a rate of almost half during well-child visits is a positive trend, it is still lower than expected for quality comprehensive well-child care for our infants and toddlers. Given these results and the recommendations from the AAP, Early Intervention (EI) Child Find efforts are especially poignant. EI programs may want to evaluate their selection of screening tools, keeping in mind that tools must be both sensitive and specific to yield optimal results. Programs may want to target their Child Find efforts at facilities that provide well-child care with a particular emphasis on providing developmental screenings for the suggested age groupings (9, 18, and 30 months). EI providers are encouraged to share these recommendations with other community agencies working with young children and families (e.g., New Parent Support Programs, community play groups, etc.). By making standardized developmental screening tools readily accessible to parents of young children is encouraged and regarded as a proactive way for parents to advocate for their little ones both between and during well-child visits.

Radecki, L., Sand-Loud, N., O'Connor, K. G., Sharp, S & Olson, L. M. (2011). Trends in the Use of Standardized Tools for Developmental Screening in Early Childhood: 2002-2009. *Pediatrics, 128(*14), pp. 14-19.

What do the data say?

What is ***"Birth to 5: Watch Me Thrive!"***?
http://www.acf.hhs.gov/programs/ecd/child-health-development/watch-me-thrive

"As many as one in four children birth through the age of five are at risk for a developmental delay or disability" (National Survey of Children's Health, 2011 -12). This staggering statistic has the attention of several federal agencies that have joined together in a coordinated effort to encourage healthy child development, universal developmental and behavioral screening for children, and support for the families and providers who care for them. The Administration for Children and Families, Administration for Community Living, Centers for Disease Control and Prevention, Centers for Medicaid and Medicare, Health Resources and Services Administration, Eunice Kennedy Schriver National Institute of Child Health and Human Development, Substance Abuse and Mental Health Services Administration, and the Office of Special Education Programs at the Department of Education make up the federal partners contributing to this initiative.

The goals of this initiative are to help families and providers (Birth to 5: Watch Me Thrive):

- **Celebrate milestones.** Every family looks forward to seeing a child's first smile, first step, and first words. Regular screenings help raise awareness of a child's development, making it easier to expect and celebrate developmental milestones.
- **Promote universal screening**. Just like hearing and vision screenings assure that children can hear and see clearly, developmental and behavioral screenings track a child's progress in areas such as language, social, or motor development.
- **Identify possible delays and concerns early**. With regular screenings, families, teachers, and other professionals can assure that young children get the services and supports they need, as early as possible to help them thrive alongside their peers.
- **Enhance developmental supports.** Combining the love and knowledge families have of their children with tools, guidance, and tips recommended by experts can make the most of the developmental support children receive.

This exciting initiative recognizes the critical importance of early identification and intervention. By intervening early children and families can receive needed support before a child's concerns become greater and potentially longer lasting. Earlier intervention has the added benefit of more effective and less expensive services rather than costly and possibly enduring special education services as the child gets older.

In support of the goals this cooperative has issued a collection of research-based screening tools for young children. The collection is organized for a variety of stakeholders including early care and education providers, early intervention and early childhood special education providers, families, primary care providers, communities, child welfare, home visitors, behavioral health providers, and housing and homeless shelter providers. The Compendium of Screening Measures for Young Children is for stakeholders to use to raise community awareness about the importance of early screening and healthy child development. Included in each publication are additional resources and links to ultimately assist communities in helping to achieve the four goals of Birth to Five: Watch Me Thrive!

The guide developed for early intervention includes Child Find resources, for helping primary referral sources improve their screening and referral efforts, resources for building community partnerships and cooperative screening and referral efforts. This guide is online at: https://www.acf.hhs.gov/sites/default/files/ecd/early_intervention_guide_march2014.pdf

Also available are online collections of resources that providers and families can use to help children develop and reach their full potential. This collection is growing and is regularly updated as new resources are available. The link to this collection of resources is at: http://www.acf.hhs.gov/programs/ecd/child-health-development/watch-me-thrive/resources#Early-Intervention

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."

Accurately Interpreting ASQ-3 & ASQ:SE Results

Scoring and determining results for the ASQ-3 and the ASQ:SE is fairly straightforward. Both tools use cutoff scores to determine whether a child's score indicates that the child is developing typically or if he or she should be referred for a more comprehensive evaluation. By definition, most children are typically developing and making decisions about next steps is relatively simple. However, when children are identified by the ASQ-3 (i.e., scores below the cutoff) or the ASQ:SE (i.e., scores above the cutoff), decisions about next steps can be more complicated and require professionals' thoughtful interpretation. As the ASQ-3 and the ASQ:SE address different aspects of development, issues professionals should consider when interpreting results are different. The following guidelines are taken directly from the ASQ-3 User's Guide (Squires, Bricker, Twombly, & Potter, 2009)* and the ASQ:SE User's Guide (Squires, Bricker, & Twombly, 2003)**. Both are excellent resources for comprehensive information regarding the ASQ-3 and the ASQ:SE.

Guidelines for interpreting ASQ-3 results

After the child's questionnaire has been scored and the Overall section has been reviewed, several follow-up options should be considered on the basis of the child's screening results.

Results above the cutoff point: Children whose scores are well above the cutoff points are considered typically developing and do not require further evaluation. Children can be re-screened at 4- to 6-month intervals and parents can be provided suggestions for developmental activities, such as the intervention activities in the ASQ-3 User's Guide.

Results in the monitoring zone: If the child's score is in the monitoring zone, the professional should discuss any concerns addressed by the family in the overall section and can offer suggestions for activities, resources, or referrals as appropriate. The ASQ-3 Learning Activities book (Twombly & Fink, 2014) provides easy-to-use suggestions for learning activities that parents and caregivers can use to provide additional opportunities for children to practice particular skills. Areas of concern can be rescreened after providing children with opportunities to practice skills and can occur anywhere from a few hours up to two months later.

Results below the cutoff: For children whose scores fall below the cutoff score(s), some level of action should be taken. A referral for further evaluation in early intervention (EI) or early childhood special education (ECSE) should be considered for any child who scores in one or more developmental areas below the established cutoff point. Parents should inform and direct the referral process and should decide specific next actions to be taken as well as the timeline for taking these actions.

However, before making the decision to refer for further evaluation, it is important to consider what factors may have affected a child's performance on the ASQ-3, as other referral considerations or follow-up actions may be warranted. Below are *four factors* that should be considered to assist in the referral decision-making process:

Consultation Corner (continued)

Opportunity: Did the child have the opportunity to try the items or the time to practice the skills? If not, it may be appropriate to provide the child further opportunity to try the items before making a referral.

Health/biological factors: Does the child have a health condition or medical factors that may have affected his or her performance? If so, a referral to the primary healthcare provider may be appropriate as part of a referral for further assessment.

Cultural factors: Are there cultural reasons that the child's performance on the questionnaire was not optimal? For example, does the family feed the toddler, leaving the child with a little opportunity to use a spoon or fork? The practice of feeding a young child may have benefits to the parent–child relationship that outweigh the benefits of the child's learning how to use utensils. It may be clear from looking at other skills in the fine motor area that the child's fine motor development is on target and that the utensil–use item should be omitted.

Environmental factors: Are there environmental factors that may have affected the child's performance? For example, has there been a recent stressful event in the child's life that may have caused a developmental regression?
When interpreting results it is important to keep in mind that the purpose of the ASQ-3 is to identify children who may be experiencing a developmental delay and should receive further evaluation to see if they qualify for EI/ECSE. Good referrals are based on thoughtful consideration of information gathered during the screening process and the accumulation of compelling evidence that suggests enough concern to warrant further evaluation.

Guidelines for interpreting ASQ:SE results

After totaling the scores and considering parent comments, a decision related to referral or follow up preventative interventions will need to be made. ASQ:SE referral criteria are as follows:

Total score is below the cutoff: Scores below the cutoff indicate that the child does not have a problem in the social-emotional area. If program resources permit, monitor the child over time using the ASQ:SE. Provide the family with information and support on any behaviors that are of concern.

Total score is near the cutoff: Scores that are near but below the cutoff indicate the child may have a problem. In addition to the scoring range indicated on the ASQ:SE Information Summary, programs may designate their own "questionable" range to indicate that the child's score is close to the cutoff and/or that there is a substantial parental concern. Possible referral decisions may include making a referral for further EI/ECSE evaluation, refer for diagnostic social-emotional assessment, or provide the parent with information and support and monitor the child using the ASQ:SE.

Total score is above the cutoff: Scores above the cutoff indicate the child may have a problem in the social-emotional area. Possible referral decisions include refer to EI/ECSE, refer for diagnostic social-emotional or mental health assessment, or provide the parent with information, support and monitoring using the ASQ:SE.

Consultation Corner (continued)

Questionnaire cutoff points provide an index that separates children who require referral from those who do not. However, when assessing social-emotional delays, it is often difficult to look at assessment results as "black and white." While ASQ:SE referral criteria provide program staff with guidelines for how to interpret scores, staff must look at the larger picture when making decisions.

It is always important to look at assessment information in the context of other factors that may influence a child's life. The ASQ:SE is designed to gather information about a child's social-emotional development and to help guide referral decisions, but it is not the only information that should be considered prior to making decisions. Consider the following variables prior to making referrals for a further evaluation:

Setting/Time: Does the child act the same way at home and in child care? How long have the problem behaviors been occurring? Is the setting unfamiliar to the child/family? Is the child being reinforced for the problem? Where, when, and under what environmental conditions does the behavior occur?

Development: Can the behavior be attributed to a developmental delay? Are the child's skills at age level? Is the behavior related to a developmental stage? Are individual factors (e.g., temperament) related to the child's behavior?

Health: Is the child's behavior related to health or biological factors? Has the child had a recent medical check up? Have the influences such as hearing/vision loss, lack of sleep or hunger, medications or allergies, child born addicted to drugs been considered as behavioral influences?

Family/cultural factors: Are the "problem" behaviors within the cultural norm for this child's family? Is the parent–child relationship influencing the child's ASQ:SE scores? Has the child been affected by stressful or traumatic events, such as witnessing violence in the home or in the community, or recently moving homes, or placement into foster care?

When interpreting screening results, it is always important for professionals to consider other variables that may be influencing a child's behavior before making a referral for further evaluation. It is also important to address any concerns that the parent may have indicated. In many cases it may be possible that addressing these other variables first can alleviate many of the problem behaviors or concerns and the child's (actual or perceived) behavior problems will diminish. When other options are selected for children whose scores are above the cutoff, it is always good to monitor their behavior by rescreening with the age-appropriate ASQ:SE, often within two or three months to see if the selected strategies or intervention are having the desired effect.

References:

Squires, J., Bricker, D., Twombly, E. (2003). The ASQ:SE User's Guide for the Ages & Stages Questionnaires®: Social-Emotional: A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors. Baltimore: Brookes Publishing Co.

Squires, J., Twombly, E., Bricker, D., & Potter, L. (2009). ASQ-3™ User's Guide. Baltimore: Brookes Publishing Co.

Twombly, E., & Fink, G. (2013). ASQ-3™ Learning Activities. Baltimore: Brookes Publishing Co.

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
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