

EARLY SCREENING, BETTER OUTCOMES:

Developmental Screening, Referral and Outreach Toolkit for Family Resource Centers



Developed by
University of
Southern California
University Center
for Excellence in
Developmental Disabilities
at Children's Hospital
Los Angeles
& First 5 LA



■ INTRODUCTION

What is the Purpose of this Toolkit?

This toolkit is designed as a practical guide to support family resource centers in implementing or refining a high-quality approach to developmental screening, outreach and linkage to services. The toolkit is designed to serve as a useful resource for agencies that provide supports to families who have young children with developmental delays or disabilities. For example, such agencies often offer parent-to-parent support, outreach and linkage to resources in their community. Although developed for California, most of the information provided in this toolkit is relevant to other states and can be adapted to fit a range of settings.

In California, the Family Resource Centers Network is an integral part of the early intervention system of care. Nationally, Parent to Parent USA and Easterseals implement models for helping families connect with other families, access community resources and navigate the system of care. The term “family resource center” will be used throughout this toolkit with the understanding that similar programs may employ different model names, such as family support centers.

The pilot test of the toolkit included guidance by a training and technical assistance (TA) team. Agencies will need to determine if they have sufficient internal resources to implement the program without TA or if contracting with a TA provider is necessary. Areas of expertise and experience needed (through either internal or external TA) include:

- Experience developing and implementing outreach programs
- Knowledge of developmental screening guidelines and best practices
- Knowledge of local resources for early intervention and other common areas of need identified through developmental screening

Benefits of Developmental Screening and Linkage Practices

Although the American Academy of Pediatrics (AAP) recommends routine developmental screening during well-child visits, many young children do not get screened during routine medical sessions. For some families, screening conducted by a staff member who is a parent

of a child with special needs – such as staff at family resource centers – provides an alternative opportunity for developmental conversations to occur that might help to reduce stigma and anxiety.

DEVELOPMENTAL MONITORING is the ongoing act of observing and tracking a child’s developmental milestones, noting how a child plays, behaves, learns, speaks and moves.

Approximately 25 percent of young children are at risk for a developmental or behavioral delay in California.¹ In Los Angeles County, it is estimated that an even higher percentage of young children (30-40 percent) would benefit from prevention and early intervention services and supports.² However, too many children do not receive developmental services until kindergarten.³

Identifying developmental concerns at the earliest age is vital so children and families can receive the prevention and early intervention services and supports they need as soon as possible.

DEVELOPMENTAL SCREENING with standardized screening tools is recommended to identify and assess a recognized risk. **Screening tools** are designed for specific domains (e.g., motor skills, communication, social-emotional) and for various delivery settings, ages and purposes. Quality screening tools are standardized on a large, representative population and have been tested to determine their reliability, validity, sensitivity and specificity. It is important to review the selected screening tool to make sure the population studies are representative of the population your program serves.

All families can benefit from the use of standardized tools for developmental screening:

- When a child’s development is delayed, screening leads to linkage to early intervention services that can change a child’s developmental trajectory.
- Even when development is typical, screening offers opportunities for parents⁴ to learn about child development and support their child’s continued developmental progress.

¹ Parma, A., Peña, C. J., & Green, K. (2019). Issue brief 2: *Linkage to services and the referral process*. First 5 LA. https://www.first5la.org/uploads/files/linkage-to-services-issue-brief-2_417.pdf

² Campbell, H. (2012). *Early Developmental Screening and Intervention Initiative (EDSI): Lessons learned 2005-2010*. First 5 LA. https://www.first5la.org/files/EDSI_Report_final_10092012.pdf

³ Children Now, First 5 Association of California, & Help Me Grow California. (2014). *Ensuring children’s early success: Promoting developmental and behavioral screenings in California*.

⁴ We recognize that various types of caregivers may be involved in the child’s life. Throughout the toolkit, we use the term “parent” to refer to all primary caregivers.



1 in 54
children are at risk for an
autism spectrum
disorder



Courtesy of First 5 Association

Despite established recommendations and benefits, most young children do not receive developmental screening. As a result, many developmental delays go undetected at their earliest stages when intervention can be most effective.

Universal Screening Reduces Racial and Ethnic Disparities

Research indicates access disparities – in terms of developmental screening, early intervention, and diagnosis of developmental disabilities – between different racial and ethnic groups and between children living in different socioeconomic conditions. For example, early identification and access to early intervention lead to better long-term outcomes for children with autism spectrum disorder (ASD). However, Black and Latinx children and children living in poverty are often diagnosed with ASD years later than White children and children from higher-income families.⁵

Rates of developmental screening are lower for children from non-White ethnic groups and children without a regular source of medical care. Universal developmental screening is one way to ensure that all parents have equal access to monitoring of their child's development and the opportunity to identify concerns and intervene early.

Statewide and Local Efforts Strengthening Early Identification and Intervention

In California, there has been growing recognition of the importance of early identification and intervention practices – encompassing routine surveillance, screening, developmental promotion and linkage to timely and appropriate services – to support a child's unique developmental needs. However, California's overall developmental screening rate remains low, and the use of standardized screening tools is inconsistent.⁶ Furthermore, data indicates many children with or at risk for a developmental delay are not screened, nor are they connected to or access early intervention supports such as the Individuals with Disabilities Education Act (IDEA) Part C and behavioral health intervention services.^{7,8,9,10,11}

Early intervention services in California are supported through IDEA Part C. States receiving Part C funds are required to have a comprehensive Child Find system to identify and evaluate all infants and toddlers with delays and disabilities, birth to age three, as soon as possible. A comprehensive Child Find includes public awareness, evidence-based screening, referral procedures and post-referral timelines of 45 days. Child Find is more effective when there is pre-referral education and information sharing with families to support their understanding of the importance of developmental milestones, screening and early intervention services.¹² In California, the early intervention program is called Early Start. This program is implemented at the local level by regional centers and local education agencies.¹³

⁵ Zuckerman, K. E., Mattox, K. M., Sinche, B. K., Blaschke, G. S., & Bethell, C. (2014). Racial, ethnic, and language disparities in early childhood developmental/behavioral evaluation: A narrative review. *Clinical Pediatrics*, 53(7), 619-631. <https://journals.sagepub.com/doi/10.1177/0009922813501378>

Johnson, S., Riis, J., & Noble, K. (2016). State of the art review: Poverty and the developing brain. *Pediatrics*, 137(4). https://www.researchgate.net/publication/297200483_State_of_the_Art_Review_Poverty_and_the_Developing_Brain

⁶ California Legislative Information. *Assembly Bill 1004 Developmental screening services (2019-2020)*. <https://legiscan.com/CA/text/AB1004/id/204534>

⁷ IDEA Part C, the Program for Infants and Toddlers with Disabilities, is a federal program that supports states in providing early intervention services for children birth through age 2. IDEA Part B is a law mandating that children and youth ages 3 to 21 with disabilities receive special education and related services.

⁸ Early Childhood Technical Assistance Center. (2007). *Part C national program data*. <http://ectacenter.org/partc/partcdata.asp>

⁹ Centers for Disease Control and Prevention. (2014). *Screening for developmental delays among young children - National Survey of Children's Health, United States, 2007*. <https://www.cdc.gov/mmwr/preview/mmwrhtml/su6302a5.htm>

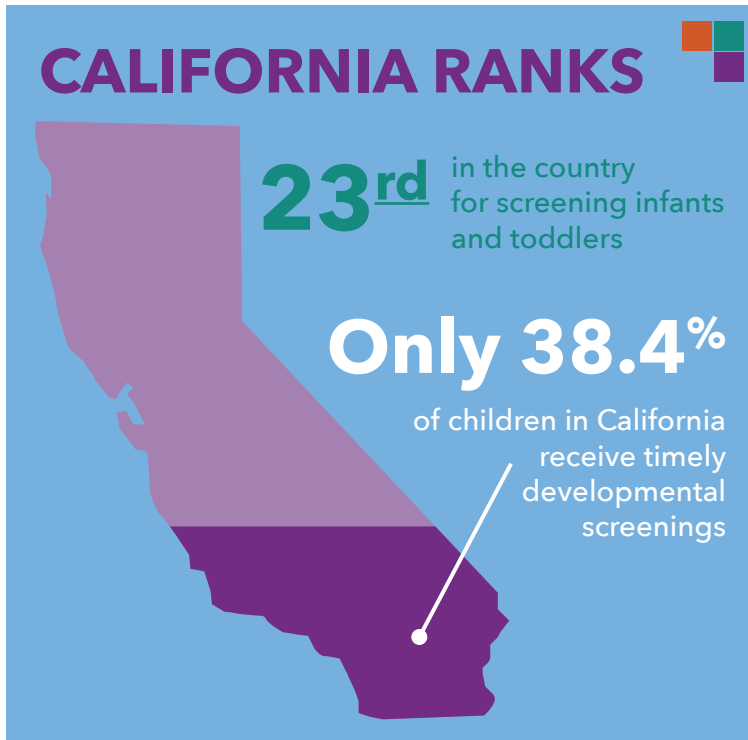
¹⁰ Administration for Children & Families. (2007). Need for early intervention services among infants and toddlers in child welfare. *Research Brief, National Survey of Child and Adolescent Well-Being, No. 8*. <https://www.acf.hhs.gov/opre/report/nscaw-no-8-need-early-intervention-services-among-infants-and-toddlers-child-welfare>

¹¹ Department of Health Care Services. (2016). *Performance outcomes systems report*. California Department of Health Care Services, Mental Health Services Division. https://www.dhcs.ca.gov/services/MH/Documents/LosAngeles_CtyAggRep.pdf

¹² ECTA Center. (n.d.). *Federal requirements for Child Find systems*. <https://ectacenter.org/topics/earlyid/overview.asp>

¹³ Department of Developmental Services. (2022). *Early Start*. <https://www.dds.ca.gov/services/early-start/>

- **Service Access and Equity Grant Program:** The significance of early intervention services is no longer being challenged. Research shows that approximately one in three infants and toddlers who receive early intervention services do not later require special education or disability services. However, the literature reports that inequities in accessing early intervention services exist for families with low household incomes, speak a language other than English, lack health insurance and/or access to primary health care services, and are Black, Indigenous and people of color.¹⁴



The California Department of Developmental Services (DDS) is committed to using the lens of cultural and linguistic competence to focus on disrupting social injustices and racial inequities. In response to inequities, the California legislature established the Service Access and Equity Grant Program, which provides \$11 million annually to the DDS to allow regional centers and community-based organizations to implement strategies that reduce disparities and promote equity in access to regional center services.

Program goals have included: a) building leadership capacity to increase representation and voice in the developmental services system for self-advocates and families; b) creating collaborative opportunities for connection and learning between individuals, families, service providers and regional centers; and

c) improving access to technology, including training for self-advocates and families. Programs funded have included community support for promotores and family navigators, workforce development, community outreach and engagement, education and training.

- **Help Me Grow:** First 5 Commissions have invested in building and strengthening local early identification and intervention efforts. Many counties have adopted Help Me Grow, a national model that promotes cross-sector coordination and integration at the local level to strengthen developmental screening and linkage to early intervention support. In Los Angeles County, First 5 LA and the Los Angeles County Department of Public Health are co-implementing Help Me Grow Los Angeles (HMG LA). For more information about the national Help Me Grow model, visit helpmegrowca.org. For more information on HMG LA, visit publichealth.lacounty.gov/mch/helpmegrow/es/index.html.



- **Family Resource Centers (FRCs):** In California, FRCs are part of Early Start, California's IDEA Part C program. Staffed by families of children with special needs, these organizations are dedicated to providing emotional support and resources to families that have children with or at risk for health care needs and/or other disabilities. FRCs actively work in partnership with regional centers and education agencies at the local level and often assist parents in obtaining information about early intervention services and/or navigating the Early Start system.

FRC services may include:

- Parent-to-parent family support
- System navigation
- Information about development and disabilities
- Referral to community resources
- Public awareness of systems and services
- Parent/professional education
- Assistance with a child's transition from Early Start at age 3 to Lanterman services
- Support services in various languages
- Translation assistance
- Support services in urban and rural communities.

FRCs typically have regular meetings designed to disseminate information about child development and provide parent support activities, discuss collaborative

¹⁴ Hebbeler, K., Spiker, D., Don, B., Scarborough, A. A., Sangeeta, M., Simeonsson, R. J. ... Nelson, L. (2007). *Early intervention for infants and toddlers with disabilities and their families: Participants, services, and outcomes. Final report of the National Early Intervention Longitudinal Study (NEILS)*. SRI International.

projects around family-centered care, and increase the effectiveness of early intervention services. Caregivers may also gain information via participation in an FRC listserv or other electronic or media platforms.

For more information on FRCs, please visit:

- **Family Resource Centers Network of California** (www.frcnca.org)
- **Early Start** (www.dds.ca.gov/services/early-start)

This toolkit was developed and tested by a regional center co-located with an FRC that coordinates both early intervention services and services for children and adults with developmental disabilities. It is a compilation of best practices and lessons in implementing high-quality developmental screening, linkage practices and outreach at an FRC that serve young children and families through parent partnerships. We hope that the toolkit will serve as a useful guide to further support local, state and national partners in raising the bar on developmental screening and linkage practices and standards.

**When linked to
early intervention
services before
kindergarten,
children are
more likely to
succeed in
school and life.**



■ ACKNOWLEDGEMENTS

Early Screening, Better Outcomes is a series of toolkits and auxiliary materials intended to help early childhood stakeholders implement or refine a high-quality developmental screening and linkage initiative in their community. The *Early Screening, Better Outcomes* series was developed as part of the *First Connections* initiative, a developmental screening and linkage effort in Los Angeles County funded by First 5 LA. This publication, entitled *Developmental Screening, Linkage & Outreach Toolkit for Family Resource Centers*, represents the third and final toolkit in the series. Previously published toolkits and materials focus on pediatric medical clinics and family-serving agencies and are available online at www.first5la.org/early-screening-better-outcomes-developmental-screening-referral-toolkits/.

First 5 LA is an independent public agency bringing parents, community members and diverse partners together so that *by 2028, all children in L.A. County will enter kindergarten ready to succeed in school and life*. As part of this vision, First 5 LA has invested in fostering healthy child development and supporting partners in early identification and intervention practices. For more information, visit www.First5LA.org.

First Connections is a First 5 LA-funded initiative that focuses on increasing early developmental and behavioral screening for young children across six diverse agencies by connecting these children and their families with culturally and linguistically appropriate services as early as possible. *First Connection* grantees included one regional center (South Central Los Angeles Regional Center) with a co-located FRC whose model serves as the foundation for this toolkit; three Federally Qualified Health Centers (AltaMed Health Services, Eisner Health and Northeast Valley Health Corporation); and two community-based organizations (Allies for Every Child and Foothill Family). In addition, the University of Southern California University Center for Excellence in Developmental Disabilities at Children's Hospital Los Angeles served as the training and technical assistance lead for *First Connections*.

From 2014 through 2019, *First Connections* grantees conducted over 65,000 developmental and behavioral screenings at more than 120 locations throughout Los Angeles County. Given its success, the initiative was extended to help further inform the planning and implementation of HMG LA by First 5 LA and the Los Angeles County Department of Public Health. For more information about *First Connections*, visit www.first5la.org/first-connections.

The University of Southern California University Center for Excellence in Developmental Disabilities (USC UCEDD) at Children's Hospital Los Angeles served as the training and technical assistance lead for *First Connections*. The USC UCEDD is a nationally recognized leader in developing and implementing quality services for infants, children, youth and adults with, or at risk for, behavioral, developmental, physical, and/or special health care needs and their families. The USC UCEDD collaborates in training, research and policy projects to improve the lives of individuals with developmental disabilities, develop more responsive systems of care, and increase access for children with special healthcare needs. For more information, visit www.uscucedd.org.

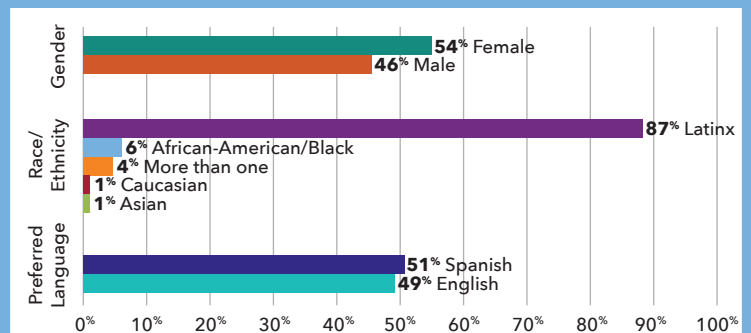
South Central Los Angeles Regional Center (SCLARC) and McClanay Family Resource Center serve as a central point of contact for consumers of all ages – including infants, toddlers and families of children with special needs – as well as service providers, community-based agencies and organizations.

McClanay FRC offers family-focused information, referrals, support and training to promote family empowerment. These services are responsive to the needs of a diverse community.

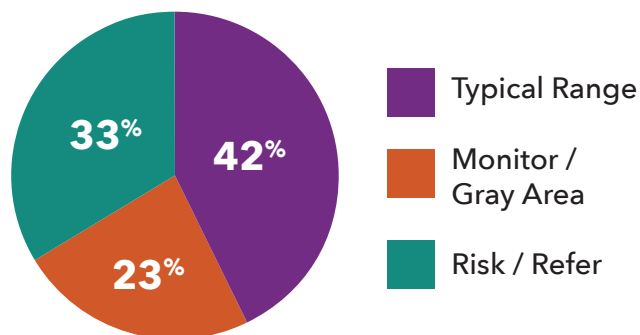
SCLARC contracts with the DDS to coordinate services for individuals with developmental disabilities and their families. One of their goals is to ensure that individuals eligible to receive services are assisted in living the highest quality life possible in their communities. As one of 21 regional centers serving communities throughout California, SCLARC is responsible for serving five districts in the County of Los Angeles, including Compton, San Antonio, Southeast and Southwest.

Over a two-year period, SCLARC served a diverse range of young children and their families through the *First Connections* developmental screening project that screened 2,162 children. The visuals below present information about who was served during this period, screening findings and outreach and referral activities.

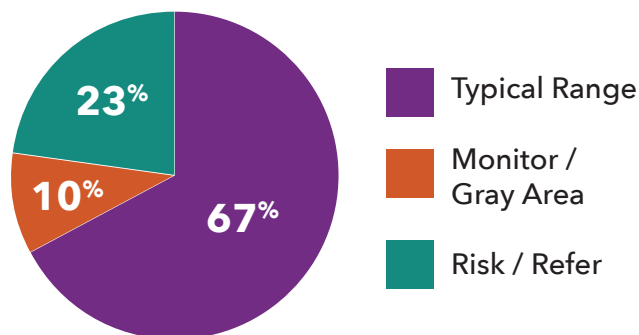
CHILD DEMOGRAPHICS



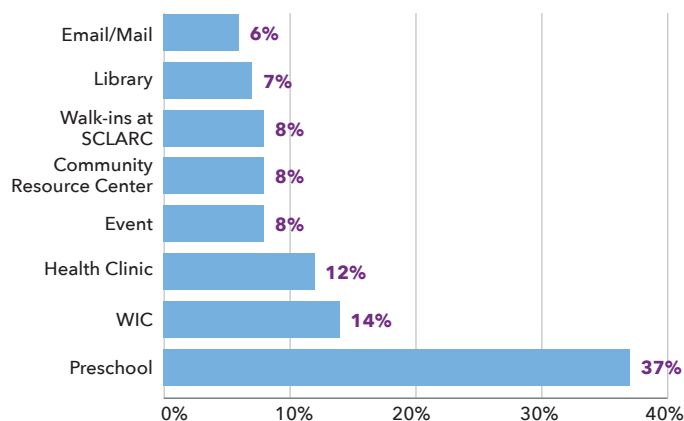
ASQ-3 RESULTS



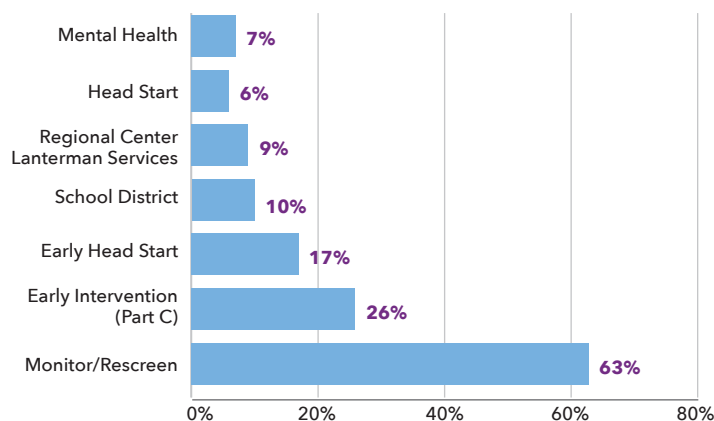
ASQ:SE-2 RESULTS



OUTREACH LOCATION



REFERRALS



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PHASES OF SCREENING AND OUTREACH PLAN

The toolkit's four sections – *Prepare, Screen, Link and Sustain* – serve as a guide for implementing a new developmental screening, linkage and/or outreach initiative or reviewing and refining an existing program. Each phase comprises a series of steps, identified below, which correlate to additional details and materials found within the toolkit. Agencies can select which elements to implement depending on their community's needs and resources.

I. Prepare

1. Assemble the implementation team
2. Set goals
 - a. Gather baseline data
 - b. Identify goals
3. Establish a developmental screening plan
 - a. Select and obtain screening measure(s)
 - b. Determine screening procedures
 - c. Hold developmental conversations
4. Develop an outreach plan and partnerships for outreach

II. Screen

5. Develop a training plan and conduct training
 - a. Determine who will conduct trainings
 - b. Select or develop training materials
 - c. Plan for training existing and new staff
6. Implement in-house screening
7. Implement outreach screening

III. Link

8. Develop a referral and linkage plan and customize referral resources
 - a. Customize referral resources
 - b. Customize referral algorithm
9. Develop a follow-up plan for children and families

IV. Sustain

10. Determine tracking metrics
11. Train for sustainability



PHASE 1: PREPARE

STEP 1: Assemble the Implementation Team

Successfully introducing and sustaining a developmental screening program relies on the implementation team's structure and governance. The team is collectively responsible for advancing the initiative from planning through post-analysis. While the team's ultimate composition depends on the size, staffing pattern and work roles of the agency, key roles to emphasize include the project's leader and subject matter experts who understand the needs of the families and agencies in the broader community.

The following team roles have been found helpful in the family resource center that participated in the *First Connections* initiative. For some programs, based on the number of staff available, one person may be able to serve in multiple roles.

Lead/Program Supervisor

The lead or program supervisor for the initiative is responsible for organizing the timeline for implementation of screening and outreach, assembling the team as needed, communicating the objectives, tracking progress throughout, identifying and addressing barriers that arise, and communicating about the initiative with staff at all

levels of the organization as well as with families and community partners. The lead should have experience working with parents, be knowledgeable about the service systems for young children, and be skilled at building collaborations with community partners. In addition, it would be helpful for the lead to have some prior experience with overseeing projects and staff training.

Family Support Specialist

In FRCs, these individuals conduct developmental screening with parents, discuss screening results, conduct parent education, and link families to services. FRCs are usually staffed by individuals who have lived experience as the parent of a child with special needs and who share the cultural perspectives and language of families served by the community. Individuals in this role may also have job titles such as Family Resource Specialist, Parent Mentor, Parent Partner, Family Support Liaison, or others, depending on the agency's mission or programs.

Administrative Assistant

This individual manages tasks such as tracking screenings and linkages, scheduling outreach events and ensuring the availability of screening tools.



STEP 2: Set Goals

PHASE 1: PREPARE

The implementation team sets measurable goals that will take effect once the developmental screening initiative is launched. This helps the team ensure shared commitment, track progress, recognize successes and challenges, and refine the process.

Gather Baseline Data

The first step of goal setting is to gather baseline data on current approaches to developmental screening, outreach efforts and parent education sessions. Sample questions to consider:

Screening Readiness

- What is the level of familiarity of the staff with screening tools?

Current Screening and Linkage Practices and Resources

- Are there any developmental screening approaches currently being used? If so, what are the current practices?
- What resources are available to families within your agency?
- What are the current linkage practices and referral sources available in the community for young children?
- Are there gaps in the available services needed to meet the needs of families of young children in the community your agency serves?

Current Outreach Efforts

- Does your agency currently conduct any outreach efforts to provide developmental screening or linkage in community settings?
- Does your agency have community partners who might be interested in hosting developmental screening and linkage events?
- What populations does your agency wish to reach with its outreach efforts? Are there any underserved areas of the community that are important to reach?

Data Tracking

- How does your agency currently track linkage efforts? How could it better track?
- How does your agency currently track outreach efforts? How could it better track?

Funding and Staffing Resources

- What funds are available to support purchasing developmental screening tools and early identification resources for parent?
- What funds are available to support outreach efforts,

such as marketing materials?

- Are there any staff members who can be assigned to the screening and outreach efforts?
- Are there parent volunteers who can assist with the project?

Identify Goals

The implementation team will need to decide on the ultimate plan for screening, linkage, outreach and parent education efforts. Decisions made at this phase will influence other aspects of the plan, such as the type of training and the changes to the program that might be needed. Questions to consider include:

Screening and Linkage Procedures

- When and how will children be screened? (e.g., Will screening be offered to families who walk into your agency? To those who phone requesting assistance? To families at community outreach events?)
- What is the age range of the children who will be screened?
- What types or domains of screening will be implemented (e.g., broad developmental domains, signs of autism, social-emotional functioning)?
- What follow-up services will be provided to help families navigate the system of care and overcome barriers to services?

It may be helpful to consider the domains included in the CDC's Learn the Signs. Act Early. program materials (e.g., *Milestone Moments* booklet, milestone checklists) when determining domains to screen:

1. Social/Emotional
2. Language/Communication
3. Cognitive (e.g., learning, thinking, problem-solving)
4. Movement/Physical Development

Outreach and Parent Education

- What geographic areas will be included in the agency's outreach efforts?
- When will outreach take place? How many screening events will be held during that period?
- What types of organizations will be invited to host screening and outreach events?
- What follow-up services will be provided to support families who participated in a screening event?



- What type of parent education sessions will be conducted? What venues will be used (e.g., community clinics, libraries, etc.)?

Effectiveness of Implementation

- How will parent experience be measured?
- How will initiative success be defined?
- How will the agency track whether or not linkages were successful?

The baseline data collected can help frame the selection of goals. Ideally, goals will be measurable and include benchmarks for progress. For example, an agency's set of goals might include:

1. All families with a child 5 years or younger who contact the FRC will be offered a broad developmental screening and a social-emotional screening for their young children.
2. All families with a child ages 18 to 24 months who contact the FRC will be offered an autism screening.
3. Developmental screening events will be held twice monthly, reaching 100 families at 20 community sites annually.
4. Following screening, all families will be offered parent education materials.
5. Following screening, all families who have a child with a possible delay will be provided with at least one community resource for follow-up.

STEP 3: Establish Developmental Screening Plan

PHASE 1: PREPARE

Results of the *Set Goals* step – including the baseline quantitative and qualitative measures, goals selected, and domains to be screened – will be instrumental in designing the screening plan and reaching key implementation decisions.

Select and Obtain Screening Measure(s)

When selecting developmental screening measures, consider the following questions:

- Which developmental screening tools are most familiar to staff in the agency?
- Which screening tools are a good fit for the population the agency serves (e.g., tools that have validated translations for families who speak languages other than English, tools that are easy to complete unassisted)?
- Which tools are standardized and validated on populations similar to those the agency serves?
- Which tools would be effective when conducting offsite screening events in the community? Consider whether administering measures on paper or electronically (such as using a tablet) would work best at outreach events. Also consider whether screenings at outreach events will be conducted in groups or individually.
- What will be the cost of the screening measures?

EXAMPLES OF RECOMMENDED TOOLS FOR DEVELOPMENTAL SCREENING:



ASQ-3

Ages and Stages
3rd Edition

brookspublishing.com/asq

PEDS

Parents' Evaluation
of Developmental
Status

PEDStest.com

M-CHAT

Modified Checklist
for Autism in
Toddlers, Revised
(M-CHAT-R)TM
M-CHAT.org

Number of Questions	30 (6 each area)	10	20
Variety of Survey	21 age-based forms	Single form, all ages	Single form, all ages
Age Range	2 months–5 years	0–8 years	16–30 months
Parent Completion	10–20 minutes	5 minutes	2–5 minutes
Provider Score & Interpret Time	1–5 minutes	2 minutes	5–10 minutes
Languages	English, Spanish, French; ASQ PTI also available in Somali and Hmong	English, Spanish, Vietnamese; Others with license	English, Spanish, Chinese, & Korean; Others with license

Proven Parent-Report Methodology. Research shows that parents are reliable reporters of their child's development.

EASY TO USE AND SCORE

Courtesy of First 5 Association

A Closer Look:

The following websites provide information on developmental monitoring and screening and may be useful resources when starting a developmental screening initiative.



Centers for Disease Control and Prevention:

- *Learn the Signs. Act Early.* Program: <https://www.cdc.gov/actearly>
- Developmental Monitoring and Screening: <https://www.cdc.gov/ncbddd/childdevelopment/screening.html>
- *Watch Me! Celebrating Milestones and Sharing Concerns* online continuing education: <https://www.cdc.gov/ncbddd/watchmetraining/index.html>

Administration for Children & Families:

- *Birth to Five: Watch Me Thrive!*: <https://www.acf.hhs.gov/ecd/child-health-development/watch-me-thrive>
- *Infant/Toddler Development, Screening and Assessment*: <https://childcareta.acf.hhs.gov/resource/infanttoddler-development-screening-and-assessment>

Head Start | Early Childhood Learning & Knowledge Center:

- Screening: The First Step in Getting to Know a Child: <https://eclkc.ohs.acf.hhs.gov/physical-health/article/screening-first-step-getting-know-child>
- Child Screening & Assessment: <https://eclkc.ohs.acf.hhs.gov/child-screening-assessment>

American Academy of Pediatrics:

- Healthy Child Care America: Developmental Screening: <https://www.aap.org/en/patient-care/developmental-surveillance-and-screening-patient-care/>

To help organizations identify the appropriate screening tools for the communities they serve, *Birth to 5: Watch Me Thrive!* developed a compendium of screening measures for young children. All measures included in the compendium meet the following inclusion criteria:

- The tool is designed for screening (not child assessment).
- The screening tool is appropriate for use with children between birth and age 5.
- The screening tool covers multiple developmental domains (e.g., physical/motor, cognitive, linguistic, social and emotional development).
- The screening tool is available for use by early childhood practitioners (early care and education providers, primary care practitioners, behavioral health service providers, home visitors, early intervention specialists, etc.).
- Information about the screening tool's administration, training, reliability and validity (i.e., sensitivity and specificity) is readily available.
- The tool must cover the domain of social and emotional development.
- The tool includes family input.
- The tool is accurate.

The full compendium can be found at <https://www.acf.hhs.gov/ecd/child-health-development/watch-me-thrive#Compendium>.

After selecting the screening measures to be used, the FRC will need to arrange to purchase the measures or obtain permission if the selected measures are free but copyrighted.

The training materials included in this toolkit are focused on the *Ages & Stages Questionnaire, Third Edition (ASQ-3)*, *Ages & Stages Questionnaire: Social-Emotional, Second Edition (ASQ:SE-2)*, and *Modified Checklist for Autism in Toddlers, Revised (M-CHAT-R)* screeners because these were the screening measures used as part of the *First Connections* initiative. However, the toolkit's materials can be modified to fit the use of other screening tools.

Birth to 5: Watch Me Thrive! offers a variety of screening guides tailored for different early childhood audiences – such as ECE providers, home visitors or primary care providers – who seek to promote early developmental and behavioral screening. These guides focus on topics such as the importance of developmental and behavioral screening, how to talk to parents, where to go for help, and how to select the most appropriate screening tool for the population served as well as the staff member implementing the screening. The following **communities** guide may be particularly helpful to family resource centers serving young children: <https://www2.ed.gov/about/inits/list/watch-me-thrive/files/communities-guide-march2014.pdf>.

Virtual Developmental Screenings

Developmental screening can be conducted virtually in addition to in-person visits or as part of regular telehealth care. Agencies can explore a range of screening options such as:

- Providing an electronic link to a screening questionnaire that parents can complete on their own.
- Mailing or emailing a screening questionnaire that the parent can complete, then scan or take a photograph of the completed questionnaire to send back to the agency.
- Conducting a telephone or virtual session that includes time to help the parent complete the questionnaire.

Lesson from the Field: Don't Forget Social-Emotional Screenings!

As part of the *First Connections* initiative, the Children's Hospital Los Angeles TA team studied whether targeted social-emotional screening was worth the extra time involved. The TA team compared scores on the ASQ-3 and the ASQ:SE-2 for 608 children, with more than 50 percent of the screenings conducted in Spanish. The findings showed that 14 percent of the children had a positive screen on the ASQ:SE, suggesting that they should be referred for further mental health evaluation. Less than half of these children would have been identified as needing additional assessment or intervention if only the ASQ-3 had been administered. Based on these and other similar studies, we recommend that developmental screening include the social-emotional domain.

Citation:

Williams, M. E., Zamora, I., Akinsilo, O., Hickey Chen, A., & Poulsen, M. K. (2017). Broad developmental screening misses young children with social-emotional needs. *Clinical Pediatrics*, 57, 844-849.

Phone conversations or virtual sessions can also be used to link families with needed resources and to follow up with families to find out if they need help accessing the recommended resources.

Hold Developmental Conversations

Parents' completion of developmental screening measures creates an opportunity for them to have an open and supportive conversation about their child's development and resources. Beyond the identification of delays, discussions about child development and developmental milestones are also helpful to parents when children are typically developing.

A program's cultural and linguistic competence depends on developing a thoughtful and sensitive approach toward families, from first contact and through all aspects of program delivery, including screening. Throughout the screening process, it is essential to offer parents opportunities to ask questions and discuss their values and cultural beliefs. Staff must be open to engaging parents as full partners in the screening process.¹⁵

When potential developmental delays are identified, it's important to talk openly with parents about the screening results, the linkage process and the importance of early

intervention. This direct approach encourages parents to open up about their concerns, questions and parental and cultural beliefs, and helps them recognize the value of

Determine Screening Procedures

The implementation team will need to finalize the decisions made in the *Identify Goals* step regarding what age range of children will be served, what locations will be used for screenings, and what screening tools will be used. The team will then develop and pilot a detailed workflow that includes identifying staff roles and responsibilities. A sample workflow is provided in Step 6.

¹⁵ Bronheim, S. (n.d.). *Cultural competence: It all starts at the front desk*. National Center for Cultural Competence, Georgetown University Center for Child and Human Development, Centers for Excellence in Developmental Disabilities. <https://nccc.georgetown.edu/documents/FrontDeskArticle.pdf>

STEP 3: Establish Developmental Screening Plan PHASE 1: PREPARE

resources and early intervention services and support to help their child's development.

When discussing the results of developmental screening (conducted either in-house or during outreach screening events), the following tips can be helpful in engaging parents:

- Use the parent's home language to ensure they understand the information (obtain an interpreter if needed).
- Begin discussions with the parent by recognizing something positive about the child's skill or behavior.
- Revisit the purpose of the screening tool; for instance, explain to the parent that, just as their child's height and weight are tracked, so is their development.
- Ask the parent if they have any questions about the screening measure they completed.
- Review the results of the screening tool, beginning with areas in which the child is developing typically or strongly, before moving to any areas of concern (if applicable). Emphasize that this is a screening tool and not a comprehensive assessment.
- Provide an opportunity for the parent to respond to the information. Ask if this information fits with how they view their child. If there is an area of concern, ask the parent if this is something they also have been concerned about or if other family members have expressed concern.
- Avoid using "pass/fail" language or diagnosis; talk instead about a child's strengths and the other areas where help may be needed.
- Provide written or online materials that can support messages about encouraging the child's development (even when typically developing).

Information about making referrals to early intervention, special education and additional types of services is provided in the section below.

Written or online materials should be provided to parents following developmental screening so they can continue to track and foster their child's development through helpful activities and tips. Materials that parents have found useful include:

- **CDC Milestone Moments** - Available as a booklet (written pamphlet) or phone app, these free tools are available through the CDC's *Learn the Signs. Act Early.* Campaign.
 - ◆ *Milestone Moments Booklet*: https://www.cdc.gov/ncbddd/actearly/pdf/booklets/Milestone-Moments-Booklet21_Eng_Sng_FNL-508.pdf
 - ◆ *Milestone Moments Tracker App*: <https://www.cdc.gov/ncbddd/actearly/milestones-app.html>.

- **ASQ-3 Activities Sheets** - These age-appropriate and printable sheets come with the purchase of the ASQ-3 materials.
- **After Screening Letter** - Appendix A features a sample letter that can be used to briefly summarize the results of the screening, with categories of development corresponding with those in the ASQ-3 and ASQ:SE-2 tools. The letter is available in English and Spanish and may assist families in navigating the next steps in referral and linkage. It is recommended that the letter be provided by staff in person (rather than delivered by mail) so that the parent will have an opportunity to discuss the information and ask questions.



STEP 4:

Develop Outreach Plan and Partnerships for Outreach

PHASE 1: PREPARE

Community outreach is one way that FRCs can reach populations that have traditionally been underserved in developmental screening efforts. For example, during the *First Connections* initiative, the FRC co-located at South Central Los Angeles Regional Center (SCLARC) provided regular community events that included developmental screening and linkage to both community resources as well as resources available within SCLARC's early intervention program.

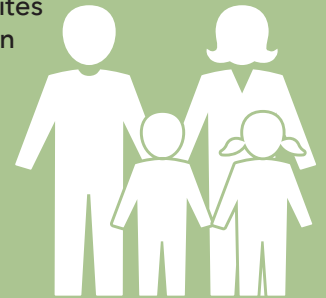
To develop a network of partnerships for outreach opportunities:

- Identify the population the program is trying to reach. This decision may be informed by sources such as:
 - ◆ The input and expertise of an FRC's stakeholders, which can be collected through surveys or focus groups of parents
 - ◆ A review of information from the local early intervention program about which populations of children are underserved in the existing program
 - ◆ Research literature on disparities in access to services
 - ◆ Local knowledge about the communities surrounding the FRC

- Identify agencies or programs that serve the populations to be reached
- Reach out to those agencies to discuss partnership opportunities for developmental screening events

The FRC co-located at SCLARC developed partnerships with the following types of community organizations for conducting developmental screening:

- Libraries
- Early learning/preschool sites
- Women, Infants, & Children Supplemental Nutrition Program (WIC) sites
- Health clinics
- Health plan community resource centers
- Health fairs and family festivals



PHASE 2: SCREEN

STEP 5:

Develop Training Plan and Conduct Training

When developing the training plan, the team will need to make several key decisions, such as determining who will conduct training, selecting or developing training materials, and scheduling training for staff members.

Determine Who Will Conduct Trainings

The implementation team must determine if there are FRC staff or volunteers who have the time and expertise to deliver trainings or if an outside trainer must be secured. Ideally, a train-the-trainer model is recommended to ensure that multiple people on staff become skilled in delivering the core trainings. This approach ensures that the program will have the internal capacity and expertise to train new staff members. During the *First Connections* initiative, the TA team delivered the initial trainings, and then a train-


the-trainer framework was adopted to develop in-house capability to deliver future trainings. The train-the-trainer approach is described further in Phase 3 of this toolkit.

Select or Develop Training Materials

Appendix E includes training materials covering four topics on developmental screenings. Each topic is sequenced and tailored for different audiences (see below), with training materials that include PowerPoints, trainer guides, handouts and/or activities. All of the materials created by the *First Connections* TA team have been pilot-tested and are customizable to meet the specific needs of your program. A sample evaluation form is also included to assess the effectiveness of the teaching style and content (see Appendix F).

A Closer Look

The following training sequence was found to be effective for participating FRCs in the *First Connections* initiative. Refer to Appendix E.

- 
- 1. Title:** [Developmental Screening Overview](#)
Who: Program-wide training (all staff in Family Resource Center)
Time: Approximately 15 minutes
Topics: Importance of developmental screening and overview of the screening initiative, including workflow and staff roles
Goals: Introduce the initiative, promote support and engagement, and set the stage for subsequent training sessions and implementation steps
 - 2. Title:** [Developmental Screening: Developmental Conversations with Parents](#)
Who: Family Support Specialists (or other staff who will discuss screening results with parents)
Time: Approximately 45 minutes
Topics: Developmental conversations with parents about screening results, benefits of screening and early intervention. Includes cultural considerations and information regarding screening bilingual children/bilingual development.
Goals: Provide guidance for framing developmental conversations with parents.
 - 3. Title:** [Screening Measures: Administration, Scoring, and Interpretation](#)
Who: Family Support Specialists (or other staff who will administer and score screening measures)
Time: Approximately 45 minutes
Topics: Administering and scoring screening measures, with a focus on ASQs and M-CHAT-R.
Goals: Ensure staff members are familiar with their roles in using the correct measures, presenting the measure to parents effectively, and scoring the measures correctly.
 - 4. Title:** [Developmental Screening: Linkages to Resources](#)
Who: Family Support Specialists (or other staff who will administer and score screening measures)
Time: Approximately 45-60 minutes
Topics: Referral algorithm and helping parents navigate the referral process
Goals: Provide guidance about the referral pathways and process for making referrals.

The four core trainings should be delivered before launching the screening initiative. After all training sessions are delivered, it is recommended that staff members receive ongoing implementation support or refresher training sessions throughout the first few months of the screening initiative. Repeat trainings can be offered as new staff join the team.



Recommendations

The following recommendations are based on the *First Connections* training experience:

- **Consider interactive methods:** Attention, involvement and overall learning can be augmented with the use of interactive methods, such as the inclusion of demonstrations or role-playing, case study materials and small group discussions. For example, when training on developmental screening, administration and scoring, case study material is always utilized to provide staff with hands-on scoring practice.
- **Emphasize relevance:** By communicating the importance of a training subject or specifically connecting the subject to the work that the attendees do, the team is able to personalize the training experience and underscore the relevance of the topic.
- **Solicit feedback:** Asking for feedback from attendees after a training session helps to improve trainings over time.
- **Remain available:** Staying for a period of time after the training allows attendees to approach the trainer with questions and facilitates further discussion or follow-up if additional clarification is needed. The trainers should also communicate continued availability by email or phone and provide additional resources to attendees if requested.
- **Offer refresher training:** Providing refresher sessions, opportunities for follow-up discussions, or additional case examples can help further advance the knowledge acquired during the training and help correct initial problems (e.g., incorrect scoring of measures).
- **Highlight change:** It is essential for staff to see the direct positive impact their work has on the children they serve. Tracking data and sharing results with staff can include: increases in the number of children screened; increases in the number of children found eligible for early intervention services; stories from parents who had success in obtaining early intervention services or who have seen progress in their child's development.
- **Build internal capacity:** Phase IV introduces the train-the-trainer model information for agencies interested in developing their own capacity to conduct staff trainings.

STEP 6: Implement In-House Screening

PHASE 2: SCREEN

After the screening tools have been selected and staff have completed training, the FRC is ready to conduct screenings for families coming to the center. The following workflow sample is designed for an FRC that intends to offer developmental screening and linkage for all children ages birth to 5 whose parents requested assistance at the FRC. In this example, the screenings provided included the ASQ-3 and ASQ:SE-2 (for all children ages 0-5) and the M-CHAT-R (for children ages 18-24 months).

Sample Workflow

Developmental Screening

The Family Support Specialist is available during regular business hours when the FRC is open. When the parent of a young child contacts the FRC requesting information on their child's development, they are encouraged to participate in a developmental screening for their child. If the parent walks in during business hours, the screening is offered to be completed at that time. If a parent calls requesting assistance, they are encouraged to visit the FRC during business hours.

If the parent agrees to the developmental screening, the Family Support Specialist obtains age- and language-appropriate screening measures and asks the parent to complete them. The Family Support Specialist provides the ASQ-3 Materials Kit to assist the parent and encourages them to try out any of the items on the questionnaire that they are unsure of. In addition, the Family Support Specialist offers to read the items to the parent and complete the tool together if the parent prefers.

The Family Support Specialist reviews the completed screening tool, looks for any missing items and asks the parent to complete any omissions. After scoring the screening tool, the Specialist either provides the parent with the *Milestones Moments* booklet or helps them download the *Milestones Moments* app onto their phone, and then reviews the screening results with the parent.

The Family Support Specialist uses the Developmental Screening Referral Algorithm (see Phase III, Step 8) to determine what referrals may be appropriate based on the screening measure scores. Depending on the type of referral, the Family Support Specialist may assist the parent in completing the referral paperwork, assists the parent in calling the agency to request an appointment, or provides the parent instructions on how to contact the agency to initiate an appointment.

The parent is provided with a copy of the screening measure and results, as well as contact information for the Family Support Specialist if questions arise.

Follow-up

The Family Support Specialist reaches out to parents who completed the screening to ensure connection to needed intervention services. Within a month, the Family Support Specialist will contact the parent to check on the status of the referral. If parents are experiencing barriers, the Family Support Specialist will offer to contact the service provider together with the parent to support access to services. If the child is found not eligible for the service, the Family Support Specialist will offer support in identifying additional resources.



STEP 7: Implement Outreach Screening

PHASE 2: SCREEN

Developmental screening may be provided in community settings through one-time events (such as a booth at a health fair), recurring events (such as weekly parent hours at libraries) or as a regular program (such as screenings conducted routinely for an early learning center or at a health clinic). The exact screening procedures may vary depending on the number of families participating, the number of FRC staff available and the physical site.

The following are two examples of approaches to outreach screening:

Library parent hours:

- **Outreach Activity:** Families are invited to an event at the library to learn about child development.
- **Screening:** After providing information to parents about developmental screening, the Family Resource Specialist invites those who are interested in completing the ASQ-3 and the ASQ:SE-2.
 - ◆ Parents are provided with the correct form depending on their child's age and their preferred language.
 - ◆ Toys are made available for parents to try out items on the questionnaire with their children.
 - ◆ The Family Resource Specialist circulates among the parents and answers questions about completing the questionnaire.
- **Scoring and Discussion:**
 - ◆ Parents turn in their questionnaires and engage in other library activities while the Family Resource Specialist scores the screening measures.
 - ◆ Parents return for one-on-one discussions about their child's screening results and recommended follow-up resources.
 - ◆ All parents are provided with developmental guidance tools such as the ASQ worksheets and the CDC *Milestones Moments* booklet or *Milestones Tracker* app.
 - ◆ For parents who have developmental concerns or whose developmental screening indicates a possible concern, the Family Resource Specialist uses the referral algorithm to identify an appropriate resource for further evaluation.
 - ◆ Parents are also encouraged to share the results of the screener with their child's medical provider.
 - ◆ Finally, parents receive information about the FRC where they can follow up for more intensive care coordination support as needed.

Early learning center or health clinic:

- Family Resource Specialists are available in the waiting room of the health clinic or the drop-off area of the early learning center to provide information about child development and opportunities for parents to complete developmental screening.
- Similar to the library events, the Family Resource Specialists assist parents in completing the measure, provide feedback about the results, and recommend resources.
- When events are held in a setting such as a clinic or preschool, parents can be encouraged to share the screening tool with the staff who know their child (e.g., the child's teacher or the primary care physician) and to discuss questions and developmental concerns in more depth after completing the measure.



PHASE 3: LINK

STEP 8: Develop Referral and Linkage Plan and Customize Referral Resources

Referral and linkage follow screening and are indicated when either a child has an at-risk or clinical presentation and/or when a family requests additional resources. This process covers how to connect children and families to additional community resources, including early intervention and special education services, to support the child's development.

After reviewing the screening results with parents and discussing their child's development across domains (see section on Developmental Conversations in Phase I, Step 3 and Appendix E), providing information about needed services and resources is recommended. During the referral and linkage process, FRC staff can improve outcomes for children and their families by incorporating the following elements:

1. Written information: Providing a written summary of the results of the developmental screening, as well as the contact information for the referral, is helpful to families. This enables families to reflect on the information again after the developmental conversation and to review it with other family members as part of the process of learning about their child's developmental needs and the available resources. The following types of written materials may be helpful:
 - a. Signed releases of information/exchanges of information: If the parent is expected to have an ongoing relationship with the FRC, the staff member can ask the parent to sign a form allowing the FRC and agency to which the child is referred to communicate with each other about the referral outcome. This will allow the staff member to request records documenting any evaluations that were completed and any services to be offered, which can be saved to ongoing support for the family if there are challenges with linkage.
 - b. After Screening Letter: Appendix A contains a sample letter that summarizes the results of the screening, with categories of development corresponding with those in the ASQ-3 and ASQ:SE-2 tools.
 - c. Referral list: Appendix B contains a referral handout, based on a resource letter developed by the Early Developmental Screening Initiative (EDSI), that can be customized and provided to parents to summarize referral suggestions.

The referral template provides space to write in details for local agencies that are categorized by service type: early intervention, child care, early education and special education, mental health services, and other family supports.

- d. Agency-specific referral sheets: When developing relationships with common referral sources (such as early intervention, preschool/special education/early education, and behavioral health), FRCs should obtain information about the preferred method for sending referrals. Many agencies providing early intervention services have their own referral forms; completing these forms for the family (or assisting them in completing them) can facilitate smooth linkage.
2. Preparation and support: Oftentimes, simply providing a referral is not sufficient to support families in successful linkage. Parents often appreciate assistance when preparing to contact a referral source, such as during their first phone call or visit to the agency. A warm handoff is a family-centered approach that helps ensure a child is directly linked to an early intervention resource or transferred seamlessly from one provider to the next. During a **warm handoff**, the parent also receives support that will help them become a better advocate for their child and more adept at navigating the service system. Examples of a warm handoff may include:
 - a. Giving the parent additional information about the agency where their child is being referred, including guidance on what to expect in terms of intake or further assessment;
 - b. Helping the parent prepare their questions to ask the agency where they are being referred;
 - c. Offering to call the agency together with the parent;
 - d. If the call is made together, helping the parent to ask their questions and supporting them in ensuring they understand what will happen next; and
 - e. Debriefing with the parent after the call.
3. Follow-up: If the family is open to it, it can be helpful to reach out to the parent about two weeks after the referral is made to find out whether the linkage was successful and to help the parent with additional next steps if there have been any barriers.

STEP 8: Develop Referral and Linkage Plan and Customize Referral Resources

PHASE 3: LINK

Customize Referral Resources

This toolkit provides guidance about common referral resources (focused on early intervention, preschool/special education/early education, and behavioral health). However, individual agencies will need to customize the referral resource materials to fit their community and population. This includes determining what common referral sources are currently used for young children and what gaps currently exist in the community that may necessitate additional outreach. As resources are identified, gather information about the referral-making procedures.

The following common referral sources were frequently used during the *First Connections* initiative:

- Early intervention (services through the IDEA Part C for children ages 0-3)
- Special education (services through IDEA Part B for ages 3 through 21)
- Preschool/early education for children who may not be eligible for special education, or in addition to special education services
- Head Start (ages 3-4) and Early Head Start (ages 0-2)
- Infant and early childhood mental health/behavioral health services
- Family support programs in addition to the FRC, such as ethnic-specific family support organizations

Additional information about these referral resources is found in Appendix C.



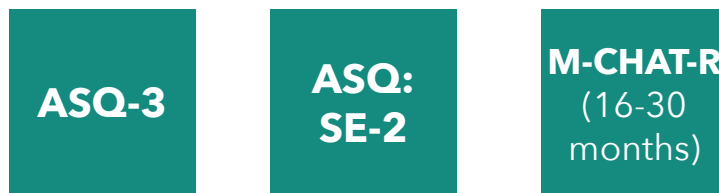
STEP 8: Develop Referral and Linkage Plan and Customize Referral Resources

PHASE 3: LINK

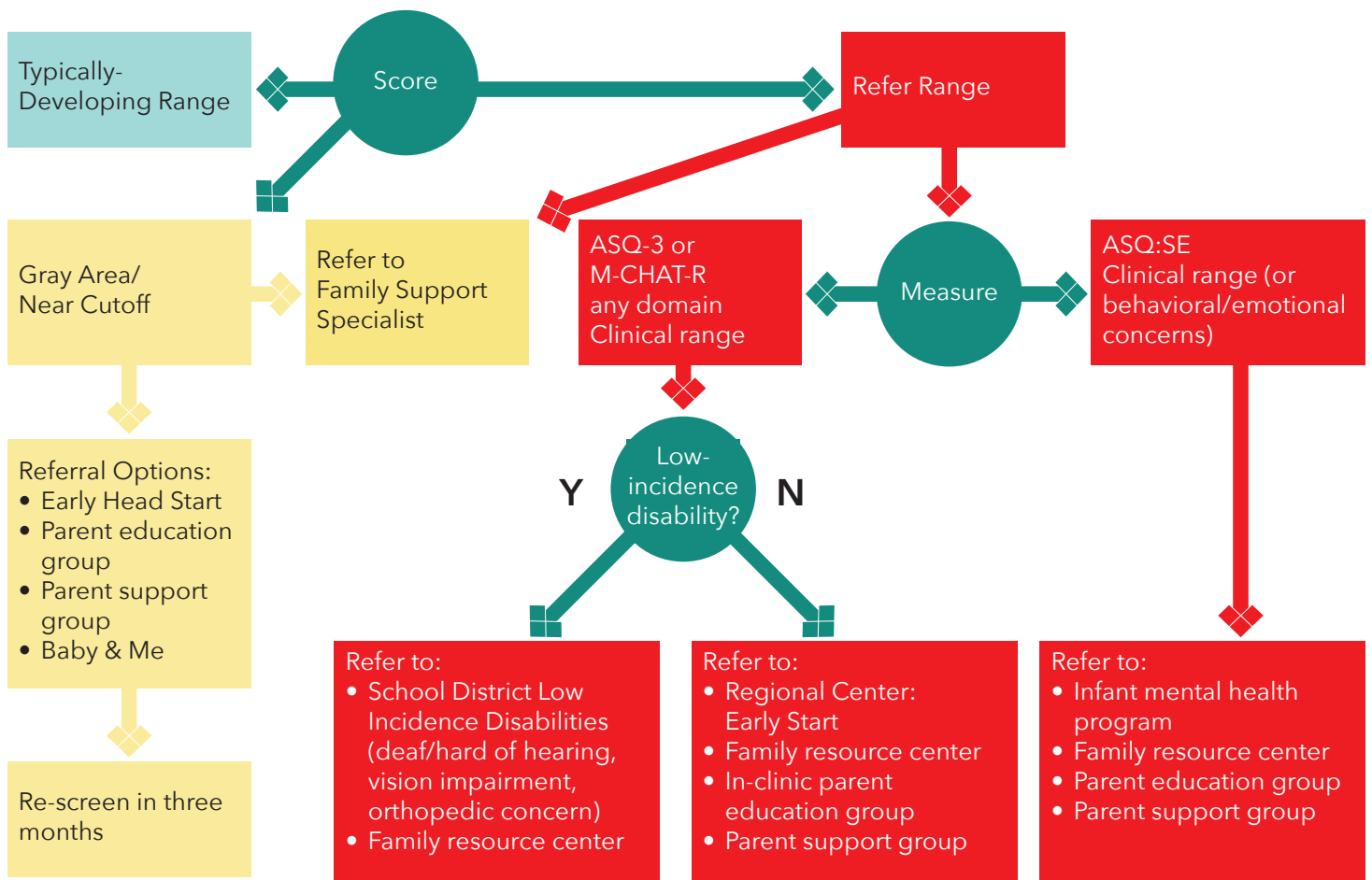
Customize Referral Algorithm

For the *First Connections* initiative, we developed a screening referral algorithm to guide staff in identifying the most appropriate referrals for children and families depending on the screening results. This algorithm should be customized to the agency's referral sources and screening tools that are used.

SCREENING ALGORITHM: BIRTH THROUGH 2.5 YEARS



All: review screening results and *Milestones Moments Booklet* with parent

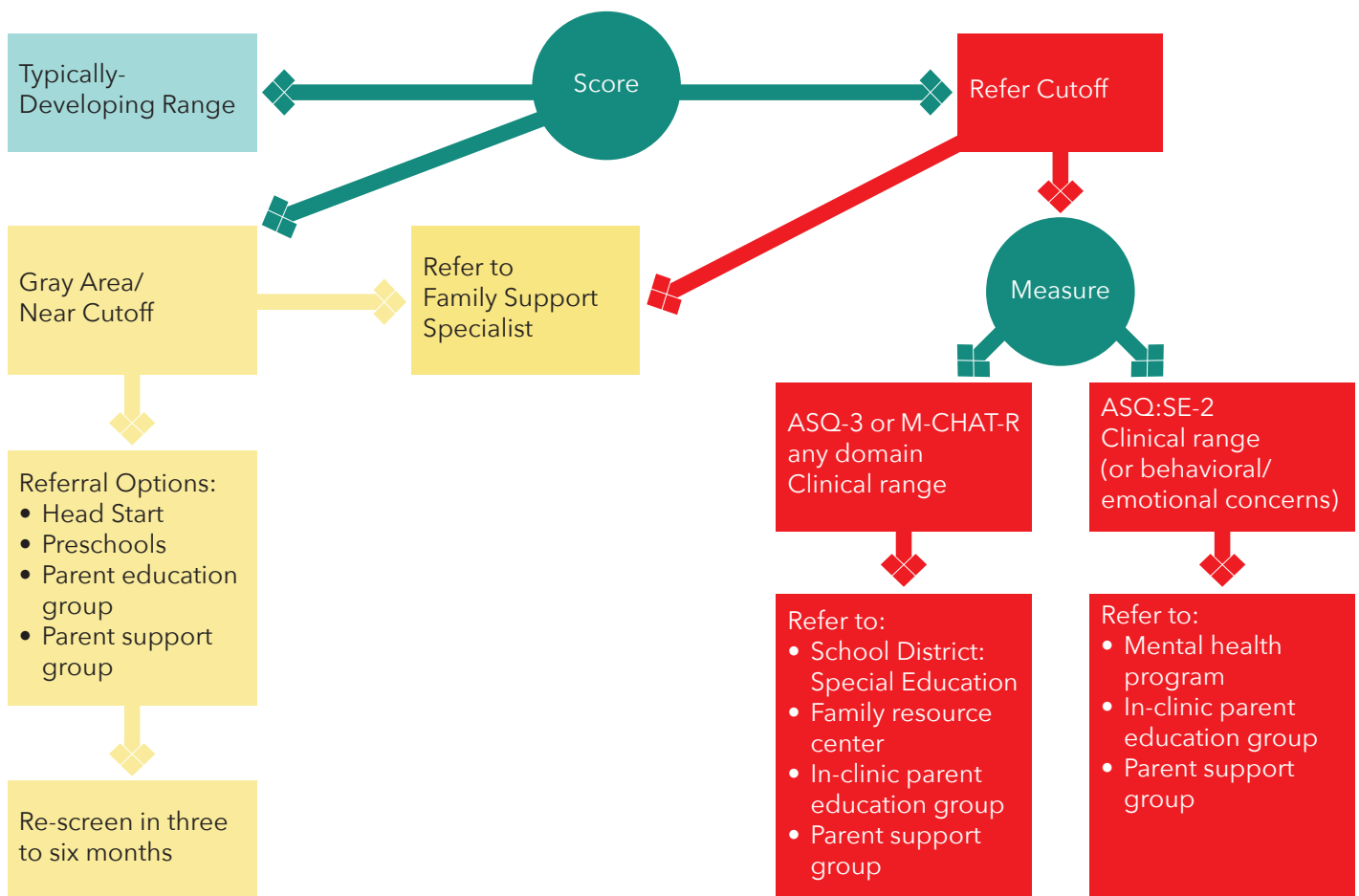


SCREENING ALGORITHM: 2.5 THROUGH 5 YEARS

ASQ-3

ASQ:
SE-2

All: review screening results and *Milestones Moments Booklet* with parent



STEP 8: Develop Referral and Linkage Plan and Customize Referral Resources

PHASE 3: LINK

The sample screening referral algorithm is presented for two different age ranges – children birth through age 2.5 and children ages 2.5 through 5 – so as to better guide referrals. Both versions are based on best practices developed by agencies administering the ASQ-3, ASQ:SE-2 and M-CHAT-R.

Results of the screening measures are categorized on the algorithm into three ranges representing different levels of risk:

Typically Developing Range: When all scores are within the Typically Developing range, parents receive: 1) feedback about screening results; and 2) written information about child development (such as CDC's *Milestones Moments* booklet and/or *Milestones Moments Tracker* app). Some programs may also provide developmental guidance (such as ASQ Activities Sheets) as well as resources that are available to all children and families (e.g., library enrichment programs, parent and me classes, recreational activities).

Gray Area/Near Cutoff: When scores are in the Gray Area/Near Cutoff range, parents receive: 1) feedback about screening results; 2) written information about child development (such as CDC's *Milestones Moments* booklet and/or *Milestones Moments Tracker* app); and 3) developmental guidance (such as ASQ Activities Sheets). Depending on the concerns, the Family Support Specialist may also provide other community resources that are available to all children and do not require documentation of developmental delays. Examples include Early Head Start or Head Start, a Baby & Me group, or a parent support group. The availability of such resources tends to vary by community; as a result, referral pathways will need to be established by the FRC through a comprehensive exploration of available child and family supports in each community.

Refer Range: When one or more of the scores is in the Refer range, parents receive: 1) feedback about screening results; 2) written information about child development (such as CDC's *Milestones Moments* booklet and/or *Milestones Moments Tracker* app); and 3) a referral for community resources such as early intervention, special education, or specialty mental health services, depending on the areas of concern and the child's age (see additional information about referrals for children scoring in the Refer range below).

Referrals by Age Range and Identified Risk

Birth through age 2.5 referrals for scores in the Gray Area/Near Cutoff range - Early Intervention Referrals

When one or more of the scores in each of the ASQ-3 domains are within the Gray Area/Near Cutoff range or if a child is identified as high risk on the M-CHAT-R, an early intervention referral is recommended. In most cases, the primary cause for referral of children at this age who have a developmental delay or are at risk for delay is determined by a state's IDEA Part C program. California's Part C program, Early Start, is managed by regional centers.

Follow this link to locate the Part C program in your state: <https://ectacenter.org/contact/ptccoord.asp>

Additional information on navigating the early intervention system is provided in Appendix C.

Age 2.5 through 5 referrals for scores in the Refer range - Special Education Referrals

When one or more of the ASQ-3 domains are within the Refer range, a special education referral is recommended. IDEA Part B ensures that children ages 3-21 with disabilities receive free appropriate public education that accommodates their needs and promotes access to the educational curriculum. Follow this link to locate information about the Federal IDEA Part B program: <https://www2.ed.gov/parents/needs/speced/iepguide/index.html>.

Additional information about navigating the preschool special education system is provided in Appendix C.

Birth through age 5 referrals for scores in the Refer range - Mental Health Referrals

When scores are in the Refer range on the ASQ:SE-2 (or if behavioral/emotional concerns are identified), a referral for infant/early childhood mental health services is recommended. These services may be available through behavioral health providers connected with the child's health insurance plan, through mental health agencies contracted to provide specialty mental health services through the state or county, or through a regional center if the child is under age 3. Additional information regarding navigating referrals for behavioral health in Southern California is provided in Appendix C.

Develop Follow-Up Plan for Children and Families

After developmental screening has been conducted and resources and referrals provided, it can be very helpful to follow up with parents, to ensure they are connected or to address any barriers they experience. For example, during a developmental screening outreach event, FRCs can ask parents in attendance for their contact information as well as permission for the Family Support Specialist to call them later to follow up. The Family Support Specialist can then perform follow-up phone calls later to help with the following:

- Address any concerns that may have arisen about the referral and may have prevented the parent from making the phone call to the agency. Such concerns may have arisen, for example, if the parent was discouraged by a family member or friend from following up or if they found information online that raised concerns.
- Address any barriers that have arisen when the parent attempted to access a resource.
- Provide information about advocacy resources available if the parent continues to encounter barriers.

As a parent with lived experience, the Family Support Specialist can help other parents work through any concerns by answering their questions or providing more information about the referral or resource that was recommended. This form of support and guidance can help move reluctant parents toward action and provide hope and guidance for those who have encountered barriers.

Another benefit of follow-up calls lies in helping FRCs ascertain whether families were successfully linked with services. Information collected can help identify barriers that come up regularly or services that are routinely difficult for families to access. This information can be used during Phase IV: Sustain and may also be used to inform the FRC's goals in future advocacy efforts to improve the service system.



PHASE 4: SUSTAIN

STEP 10: Determine Tracking Metrics

Tracking methods selected by the FRC will depend on the goals set for the project. The following recommendations for tracking metrics will help determine if the project is being implemented as planned and help identify areas for improvement:

Screening: Collecting data on the number of in-house and outreach screenings completed, as well as the demographics of those served, can help track specific components of the developmental screening initiative to determine if it is working as planned.

Successful Linkage: Another important metric is assessing whether children are effectively linked to needed services when developmental concerns are identified. This is a more complex task but is valuable if resources allow it. If FRCs are conducting follow-up contacts, they can create a database to track the outcomes for children who have been screened. If tracking all children is not possible, a subset of families could be contacted. The information collected can reveal both successes and barriers to linkage and identify gaps where additional referral sources may be needed.

Analysis of Parent Satisfaction: Surveys of parents will help identify successes and barriers from a more individual perspective and may highlight areas where changes are needed or gaps in service availability exist. Appendix D contains the script for a sample parent phone survey conducted as part of the *First Connections* initiative. The survey's target population was parents whose children had at least two domains of concern on the ASQ-3 and had been referred for early intervention services. Results of the survey indicated a high level of satisfaction and successful linkage.¹⁶ The questions can be modified to fit other populations of interest.

Variables to Track Outcome of Referrals

Demographics	<ul style="list-style-type: none">• Child's age• Ethnicity• Preferred language
Results of Screening	Scores or ranges on each domain assessed
Outcome of Screening	<ul style="list-style-type: none">• Typically developing/ no referral needed/no concerns• Monitoring range• Possible concern range/ referral needed
Linkage	Where was the child referred?
Outcome of Linkage	<ul style="list-style-type: none">• Did the child have an evaluation?• Was the child found eligible for services?• Were there any barriers accessing the evaluation or services?• What type of services is the child receiving?

¹⁶ Quebles, I., Perrigo, J., L., Bravo, R., Patel Gera, M., Poulsen, M. C., Wheeler, B. Y., & Williams, M. E. (2022). Latinx mothers' experiences with linkage to early intervention. *Infants and Young Children*, 35(3), 189-204.

STEP 11: Train for Sustainability

PHASE 4: SUSTAIN

The *First Connections* Train the Trainer Model is a guide that helps to determine the appropriate level of training support needed based on the training topic, existing level of expertise and agency needs. Below is a sample list of ways in which the *First Connections* Train the Trainer

Model may be utilized. Two worksheets, an Observation of Presentation Outline and Presenter's Reflection, are included as tools to support the development of the trainers (see Appendix F).



Identify Trainer

- An individual in the FRC – someone with interest, background or experience in the topic of developmental delays – is identified to participate in the Train the Trainer Model. This individual will be supported through a collaborative process that includes consultation sessions, development of training materials, and observation and reflections on the delivery of the presentations.

Develop and Share Training Materials

- Resources (e.g., PowerPoint slides, notes) are either co-developed by the TA provider/lead trainer and agency trainer or provided to the agency and customized to their needs.

Create Presentation Plan

- An initial consultation session is held to develop the presentation plan.
- The TA provider/lead trainer provides initial training for the agency; the trainer-in-training either co-

teaches with the lead trainer or observes. Additional support should be made available for the agency's trainer-in-training during subsequent training sessions. Support may include live observation of the training session or video review of the training.

Collect Feedback and Reflection

- The agency trainer collects feedback from the audience after each training session.
- The trainer-in-training completes a *Presenter Reflection* worksheet (Appendix F).
- The TA completes the *Observation of Presentation* (Appendix F).
- After the training sessions are conducted, a consultation session is provided to discuss the feedback from the audience as well as detailed observations and suggestions from the TA and reflections from the presenter.
- Additional consultation sessions are offered based on the needs of both the trainer-in-training and the agency.

APPENDIX A:

After Screening Letter: ASQ-3 and ASQ:SE-2

Date: _____ Child's name: _____

Dear Parent, Parent's name: _____

Thank you for completing the
Ages & Stages Questionnaires about
your child's development. Please
review your child's results below.
We are here to answer any questions.

Date completed: _____

DOB: _____

Clinic: _____

Developmental Area:	Your child is doing well in these areas:	Your child might need help in these areas (please talk to your child's health provider for ideas):	Your child needs an evaluation in these areas:
Communication (how your child talks)			
Gross Motor (how your child moves his or her body)			
Fine Motor (how your child moves his or her hands)			
Problem Solving (how your child thinks)			
Personal-Social (how your child interacts and plays with others and learns to do things on his/her own)			
Social-Emotional (how your child feels and behaves)			

Please contact us with any questions: _____

Regards,



APPENDIX B:

Referral Handout

This handout can be individualized to an agency or parent by adding specific names of agencies and phone numbers.

Early Intervention Services	Regional Center: Early Start Program Provides services for children birth to age 3 with a significant delay, established risk or at high risk due to biomedical risk factors.	Phone Number Agency Name
	Early Start Family Resource Centers (FRCs) Provide free information, resources, referrals, parent training and education, and parent-to-parent/caregiver emotional support for families of infants and toddlers from birth to age 3 who are part of the Early Start Program (Some centers provide information for all ages).	Phone Number Agency Name
Childcare, Early Education and Special Education	Early Head Start/Head Start Programs Provide educational, health and social services to low-income children and children birth to age 5 with an Individual Family Service Plan or an Individualized Educational Program.	Phone Number Agency Name
	Special Education Services Provide educational services and designed instruction, at no cost to parents, to meet the unique needs of the child (ages 3-21).	Phone Number Agency Name
	Resource and Referral Agency (R&R) Provides free services to help parents find childcare that best fits the family needs. (This may include referrals to Head Start and/or Early Head Start if family meets income eligibility requirements or child has an Individual Family Service Plan or Individualized Educational Program.)	Phone Number Agency Name
	Special Education Support Services Help families navigate services, provided through local public schools, for students with special needs (ages 3-21).	Phone Number Agency Name
Mental Health Services	Mental Health Services Provide mental health services for children birth-5 and their families.	Phone Number Agency Name
	Los Angeles County Department of Mental Health Birth to 5 Representatives Answer questions about available services and programs and assist families with making referrals and linkages.	Phone Number Agency Name
Other Family Supports	Office of Clients Rights Advocacy (OCRA) Provides advocacy and legal services to consumers of all 21 regional centers throughout California. A Clients' Rights Advocate (CRA) is designated for each regional center catchment area. The CRA helps with legal problems, conducts trainings and investigates denials of rights.	Phone Number Agency Name
	Ethnic-focused Parent Education, Support and Advocacy Organizations Assist families experiencing barriers to accessing mainstream service systems and parent education and support groups. A number of parent organizations have emerged focusing on the needs of specific racial, ethnic and linguistically diverse families.	Phone Number Agency Name
	211 LA County Provides information about accessing health and human services programs throughout Los Angeles County 24/7.	2-1-1
	WIC - Women's, Infants & Children's Supplemental Food Program Provides breastfeeding and nutrition education and food vouchers to low-income pregnant or nursing women, infants, and children (birth to age 5).	Phone Number Agency Name



APPENDIX B: Referral Handout

Spanish Referral Handout

Servicios de Intervención Temprana	Centro Regional: Programa de Intervención Temprana Brinda servicios a los niños recién nacidos hasta los 3 años, que padecen de retraso considerable, tienen algún riesgo establecido o los que están en alto riesgo, debido a factores biomédicos.	Número de Teléfono Nombre de Agencia
	Centro de Recursos para Familias de Intervención Temprana (FRC) Ofrece información, recursos, referencias, capacitación y educación para padres y apoyo gratis de padre a padre, para las familias con niños recién nacidos hasta los 3 años que están en riesgo, o que forman parte del Programa de Intervención Temprana (algunos centros ofrecen información para todas edades).	Número de Teléfono Nombre de Agencia
Cuidado Infantil, Educación Temprana y Educación Especial	Programas Head Start, y Early Head Start Brindan servicios educativos, sociales y de salud, a los niños de bajos recursos, y a los niños menores de 5 años, que tienen un Plan de Servicio Familiar Individualizado o Programa de Educación Individualizado (IEP por sus siglas en inglés).	Número de Teléfono Nombre de Agencia
	Programa de Educación Especial Ofrece servicios especializados escolares, gratuitos para los padres, para ayudar a los niños con necesidades especiales (edad de 3 a 21 años).	Número de Teléfono Nombre de Agencia
	Servicios de Apoyo de Educación Especial Ayudan a las familias a navegar los servicios que ofrecen las escuelas públicas locales, para los estudiantes con necesidades especiales (entre los 3 y 21 años).	Número de Teléfono Nombre de Agencia
	Agencias de Recursos y Referencias (R&R) Ofrecen servicios gratuitos para ayudar a los padres a buscar cuidado infantil que mejor satisfaga las necesidades de su familia. Esto puede incluir las referencias a Head Start y/o Early Head Start, si la familia reúne los requisitos de ingresos, o si el niño tiene un Plan de Servicio Familiar Individualizado o Programa de Educación Individualizado (IEP).	Número de Teléfono Nombre de Agencia
Servicios de Salud Mental	Servicios de Salud Mental Brindan servicios de salud mental a familiares y niños recién nacidos hasta los 5 años.	Número de Teléfono Nombre de Agencia
	Representantes del Departamento de Salud Mental del Condado de Los Ángeles Para Niños Recién Nacidos Hasta Los 5 Años Contestan preguntas acerca de servicios y programas disponibles, y ayudan a las familias con referencias y facilitar el acceso a programas y servicios.	Número de Teléfono Nombre de Agencia
Otros Servicios de Apoyo a la Familia	Oficina de Defensa de los Derechos de los Clientes (OCRA, por sus siglas en inglés) Brinda defensa y servicios legales a los consumidores de todos los 21 centros regionales en California. Un defensor de derechos de los clientes es designado para cada zona geográfica. El defensor ayuda con los problemas legales, lleva a cabo entrenamientos e investiga las denegaciones de derechos.	Número de Teléfono Nombre de Agencia
	Organizaciones con Enfoque Étnico de Defensa, Apoyo y Educación a Los Padres Ayudan a las familias que enfrentan impedimentos para recibir servicios generales, y ofrecen grupos de educación y apoyo para los padres. Se han creado una cantidad de organizaciones para padres que se centran en las necesidades específicas de las familias de diversidad racial, étnica y lingüística	Número de Teléfono Nombre de Agencia
	211 Condado de Los Ángeles Ofrece información acerca del acceso a programas de salud y servicios humanos, a lo largo del Condado de Los Ángeles. Disponible las 24 horas al día.	2-1-1
	WIC - Programa Especial de Nutrición Suplementaria para Mujeres, Infantes y Niños Brinda educación sobre la lactancia y la nutrición, ofrece vales de comida a las mujeres embarazadas o lactantes, infantes y niños de bajos recursos (recién nacidos a 5 años).	Número de Teléfono Nombre de Agencia



APPENDIX C:

Resources for Navigating Service Systems for Young Children

Services in California for individuals with developmental delays/disabilities:

Regional Center Services

Regional centers are nonprofit agencies that are located throughout the state of California. They contract with the state's Department of Developmental Services (DDS) to provide diagnosis and assessment at no cost and, if eligible individuals, coordinate services and supports for individuals with developmental delays and/or disabilities. Regional centers, by law, can only pay for services that are not available through other sources, and so are considered the payor of last resort. www.dds.ca.gov/RC

Locating Regional Centers

The look-up zip code tool (www.dds.ca.gov/RC/regionMap.cfm?view=laCounty) and map (www.dds.ca.gov/wp-content/uploads/2019/09/DDS_RCMa.pdf) can be used to find the regional center that serves a specific area. Families can only access services through the regional center that serves their geographic area.

Birth to Age 3: Early Intervention Services in California

Early Start (Early Intervention under IDEA Part C) is the program in California that provides early intervention services to children birth to age 3. www.dds.ca.gov/services/early-start

In California, the early intervention system contracts with the regional centers. Anyone can make a referral, including parents, medical care providers, family members and day care providers. Each regional center has its own procedures for processing referrals, which may include a phone call, a paper form, and/or an online application. Within 45 days of receiving an initial application, the regional center will assign an Early Start intake specialist, schedule and complete evaluation and assessments to determine eligibility, develop an Individual Family Service Plan (IFSP) if eligible, or contact the family and provide a recommendation and referrals if the child is not eligible.

Enrollment and Eligibility Steps

1. Referral/Intake Request: Parents must first request an intake and may be asked to answer some phone screening questions.

2. Intake Assessment: The child will then be assigned a person or team to complete an intake assessment. According to federal guidelines, the assessment should be "comprehensive" and "multidisciplinary." Intake assessments may occur in the home, a regional center office or another location convenient to the family.
3. Determination: Children birth to age 3 may be deemed eligible if they have one of the following:
 - a. Established risk condition is known to cause developmental disabilities (e.g., Down Syndrome)
 - b. Developmental delay (33 percent or greater delay in one or more of the following areas of development: physical, cognitive, communication, social or emotional or adaptive)
 - c. High risk of having developmental disabilities due to a combination of 2 or more risk factors (e.g., low birth weight, premature birth, low Apgar scores, prenatal substance exposure, or any accident or illness likely to affect development)

After eligibility is determined, a service coordinator is assigned, and a meeting is held with the family to develop an Individual Family Service Plan (IFSP).

Ages 3 through Adulthood– Services for Children and Adults with Developmental Disabilities in California

Eligibility Criteria

Regional centers coordinate services for individuals ages 3 through adulthood with developmental disabilities under the Lanterman Act, a California law. An individual is deemed eligible under the Lanterman Act if they have a developmental disability, defined as:

1. Diagnosis of intellectual disability, autism, cerebral palsy, epilepsy or a "fifth category" (i.e., disabling condition similar to intellectual disability that requires similar intervention) disorder; and
2. Disorder began before age 18; and
3. Disorder causes functional impairment in domains of daily living.

Enrollment and Eligibility Steps (if a child is already enrolled in Early Start; enrollment occurs prior to age 3 to determine services after age 3)



APPENDIX C: Resources for Navigating Service Systems for Young Children

1. **Evaluation:** The child will be evaluated by a psychologist, either employed by or contracted with a regional center, to determine if the child meets the criteria for a developmental disability under the Lanterman Act.
2. **Transition Discussion:** Before the child is 33 months old, the child's Early Start service coordinator will hold an IFSP meeting that includes the child's parents and a school district representative. This meeting will start the process of determining eligibility for special education services for preschool, and appropriate school placement.

At age 3, Early Start services will end, and if eligible, most ongoing services will be provided through the school district (see below). If the child meets eligibility for Lanterman Act services through the regional center, a new service coordinator will be assigned. The regional center service coordinator will hold a meeting with the child's parents before the child turns 3 to develop an Individual Program Plan (IPP) that specifies non-educational services and supports that the regional center will provide. Parents should continue to have regular meetings with the child's service coordinator (at least annually), even if most needed services are provided through the school district. The regional center may provide additional services not covered by the school (e.g., those needed in the community or at home), and will resume primary responsibility for services after the child turns 22 and completes schooling.

If a child has not been in Early Start, is over age 3 and the medical provider suspects or diagnoses a developmental disability per the eligibility criteria above, they can refer the child to the regional center to determine eligibility for services. The timeline for completion of the psychological assessment and determining eligibility is 90 days for individuals older than 3 years.



Family Resource Centers in California

Family resource centers (FRCs) actively work in partnership with local regional centers and education agencies. They may assist parents with emotional support and in obtaining information about early intervention services and/or navigating the Early Start system. FRCs are part of Early Start and California's IDEA Part C program and some have additional funding to serve families of children older than 3. They are staffed by families of children with special needs that reflect the culture and languages in the communities they operate.

The aim of FRCs is to share available resources with families that have children with health care needs and/or other disabilities. FRCs may provide parent-to-parent family support, information and referral, public awareness, parent education, assistance with transition from Early Start at age 3, support services in various languages, and support services in urban and rural communities. FRCs typically have regular meetings which are designed to disseminate information and offer parent support activities (e.g.: support groups for parents, siblings, etc.). FRCs also seek to partner with professionals to support child find efforts, parent advocacy, and increase the effectiveness of early intervention services. Caregivers may also gain information via participation in an FRC group email list.

For more information:

- www.frcnca.org
- www.dds.ca.gov/services/early-start/family-resource-center/regional-center-early-start-intake-and-family-resource-centers

Special Education Services

The Individuals with Disabilities Education Act (IDEA) Part B is a federal law that ensures children with disabilities (ages 3-21) receive Free Appropriate Public Education (FAPE) to accommodate their needs and access the educational curriculum. sites.ed.gov/idea/statuteregulations/#statute

Enrollment and Eligibility Steps to develop an Individualized Education Program (IEP)

1. **Referral/Intake Request:** A referral or request for an assessment must be received by the school or district administration. The request can be made by a school professional or a parent through the child's local school. Parental consent is required before the child can be assessed.

Timeline: The school has 15 days to respond to the written request and develop an assessment plan. The parent has up to 15 calendar days to sign the assessment plan.



APPENDIX C: Resources for Navigating Service Systems for Young Children

2. **Assessment:** The assessment must include all areas related to the child's suspected disability. The assessment results will be used to decide the child's eligibility for special education services and to make decisions about an appropriate educational program. If the parents disagree with the assessment, they have the right to ask for an Independent Educational Evaluation (IEE). The IEE can be performed at the school system's expense.
Timeline: After the assessment plan is signed by the parent, the district has 60 days to complete assessments and hold the IEP meeting where results will be reviewed. The parent can request copies of reports in advance of the IEP meeting.
3. **Multidisciplinary Discussion:** During the IEP meeting, all team members from the district who are involved in the assessments and the parents will review the assessment results. The team will present their findings and will determine if the child is a "child with a disability" as defined by IDEA and eligible for special education services. The parent can request a hearing if they disagree with the eligibility decision.
Timeline: Parents should be given notice of the IEP meeting at least 10 days before to allow for planning – such as requesting an interpreter – and to inform the school of others planning to attend the meeting (parents can bring a friend, family member, advocate, other providers, etc.). Notifying parents within 10 days allows for rescheduling if they cannot participate on the scheduled date or at the scheduled time.
4. **Reaching Agreement:** The school team will work with the parent to write the plan to meet the child's individualized educational needs. The IEP, which is a legal document, includes goals, services and supports, and the placement offered. The parent must give consent before the school may begin providing the special education services as stated in the IEP. The child can begin receiving services as soon as possible after the IEP meeting and parental consent is given. Parents are provided with a copy of the IEP and can request that it be translated.

If the parent disagrees with the IEP and placement they can continue to discuss their concerns with the IEP team and try to work out an agreement. They also can agree with some parts of the IEP, while continuing to work on those parts with which they disagree. If an agreement is not reached between the parent and the IEP team, the parent can ask for, or the school may offer, mediation. The parent also can file a complaint with the state education agency and request a due process hearing, at which time mediation must be available.
5. **Services Provided:** The school must ensure that special education services are provided as stated in the IEP. Teachers and all other providers involved in delivering the services at school have access to the IEP and should know their specific service responsibilities as stated in the plan. This includes any accommodations, modifications and supports that must be provided to the child, in keeping with the IEP.
6. **Progress Measured:** The child's progress is measured annually based on the goals stated in the IEP. Parents of children receiving special education services must also receive reports on their child's progress at least as often as parents of nondisabled children are informed of their child's progress.
7. **Routine Review and Adjustments:** The child's IEP should be reviewed and updated by the team at least once a year and can be reviewed more often if requested by the parent or school.
8. **Reassessment:** The child must be reassessed at least every three years, known as a "triennial." This reassessment will help determine if the child continues to be a "child with a disability," as defined by IDEA, and identify the child's needs. A child can be reassessed more often if there is a change in their condition or if parents or teachers request it.

Resources within Los Angeles Unified School District (LAUSD)

The IEP Process Needs You is an informational guide for parents about the IEP meeting. The guide serves as a way for parents to understand special education programs available through LAUSD but also helps them prepare before an IEP meeting to better address their concerns and the child's area of needs.

achieve.lausd.net/cms/lib/CA01000043/Centricity/domain/168/brochures/IEP%20PROCESS%20NEEDS%20YOU.pdf

LAUSD Parent's Guide to Special Education Services explains parents' rights and procedural safeguards.

achieve.lausd.net/cms/lib/CA01000043/Centricity/domain/168/brochures/Parents%20Guide%20September%202018%20English.pdf

The Request for Special Education Assessment form can be completed by a parent and given to the child's local school to request an assessment for special education. It is recommended that the parent ask the receptionist to date-stamp the form both when the request is made and when a copy is provided to the parent. Alternatively,



APPENDIX C: Resources for Navigating Service Systems for Young Children

parents can prepare their own letter requesting an assessment.
achieve.lausd.net/cms/lib/CA01000043/Centricity/Domain/362//Serve/request_for_assess_eng_rev.pdf

If a child is younger than 5, LAUSD has a special intake process for special education:

- Early Childhood Special Education Intake/Referral Line
213-241-4713

Additional resources through LAUSD:

- Complaint Response Unit (CRU)
1-800-933-8133
- School and Family Support Services
213-241-6701
- IEP Access: Parent Access Support System Portal
achieve.lausd.net/Page/10470
- Parent Resources for Engagement and Student Success
achieve.lausd.net/site/default.aspx?PageType=3&ModuleInstanceID=36240&ViewID=7b97f7ed-8e5e-4120-848f-a8b4987d588f&RenderLoc=0&FlexDataID=57040&PageID=12578

Early Head Start (ages prenatal-3) and Head Start (ages 3-5)

Early Head Start is a national program serving infants and toddlers under age 3 and pregnant women. These programs are designed to nurture healthy attachments between parent and child by providing intensive comprehensive child development and family support services to low-income families. Services are usually provided in-home.
eclkc.ohs.acf.hhs.gov/programs/article/about-early-head-start-program

Head Start is a nationwide school preparedness program for children ages 3-5 coming from a low-income background. Services are provided in a preschool setting and include classroom learning, health screenings, nutritious meals, oral health and mental health support. Programs also support and strengthen parent-child relationships by engaging parents in classroom learning and providing parent education programs. www.acf.hhs.gov/ohs/about/head-start

Parents can look up their local Early Head Start or Head Start program by using the locator tool on the Head Start Early Learning & Knowledge Center website and entering their residential zip code: eclkc.ohs.acf.hhs.gov/center-locator. Eligibility is based on age and on family income that is at or below the poverty level based on U.S. Federal Poverty guidelines. For more detailed information on federal poverty guidelines, please view the tables on the U.S. Department of Health and Human Services website. aspe.hhs.gov/poverty-guidelines

If a child is enrolled in a Head Start program and identified or suspected to be a child with special needs under IDEA Part B, the child may be eligible for special education services through the IEP. These services can be provided within the Head Start preschool setting. eclkc.ohs.acf.hhs.gov/children-disabilities/publication/infographic-young-children-special-needs

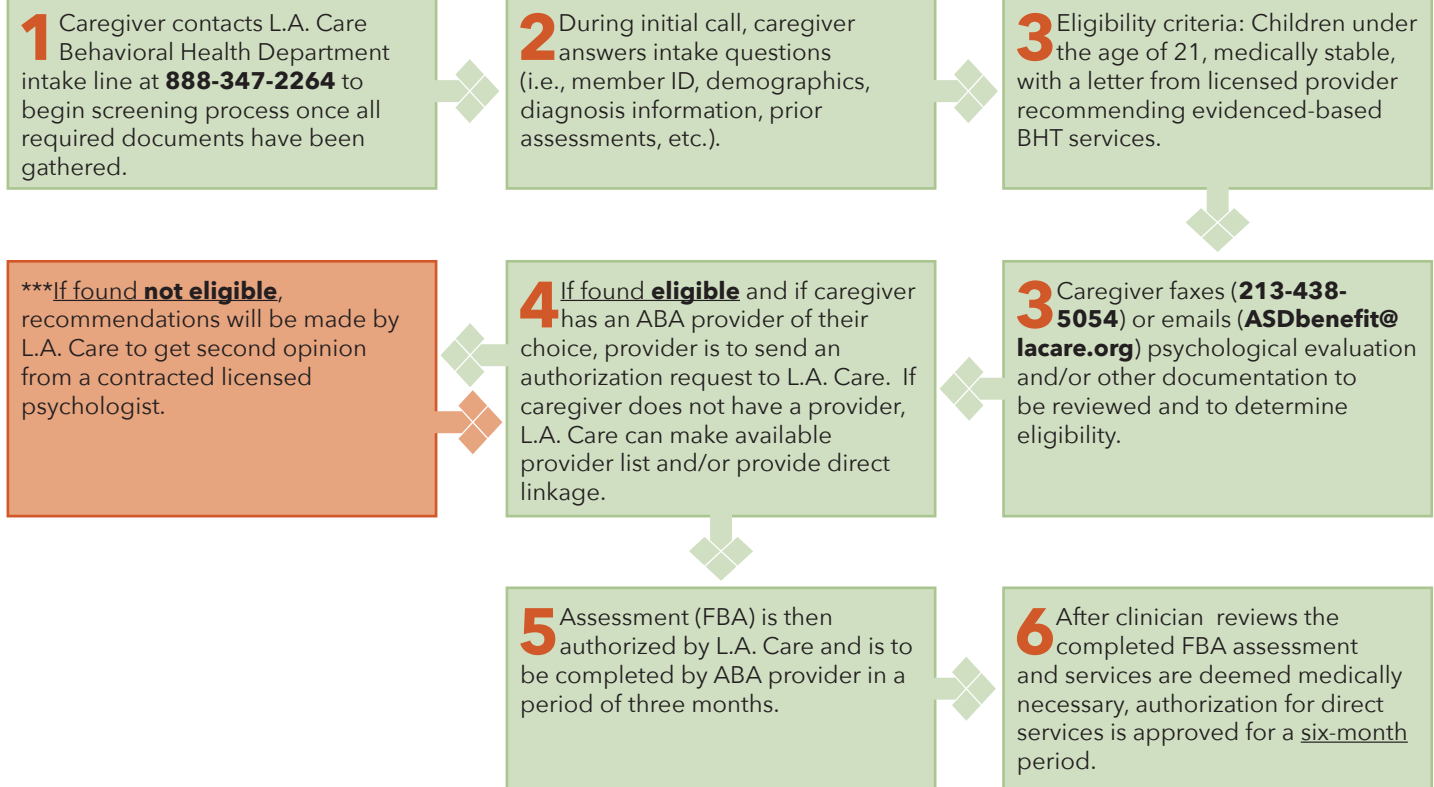
Behavioral Health, Applied Behavioral Analysis (ABA) and Specialty Mental Health Services

Young children with social-emotional or behavioral concerns, and young children with Autism Spectrum Disorders (ASD), may benefit from referrals for behavioral health/mental health services.

Behavioral Health or ABA Services for Children with Medi-Cal

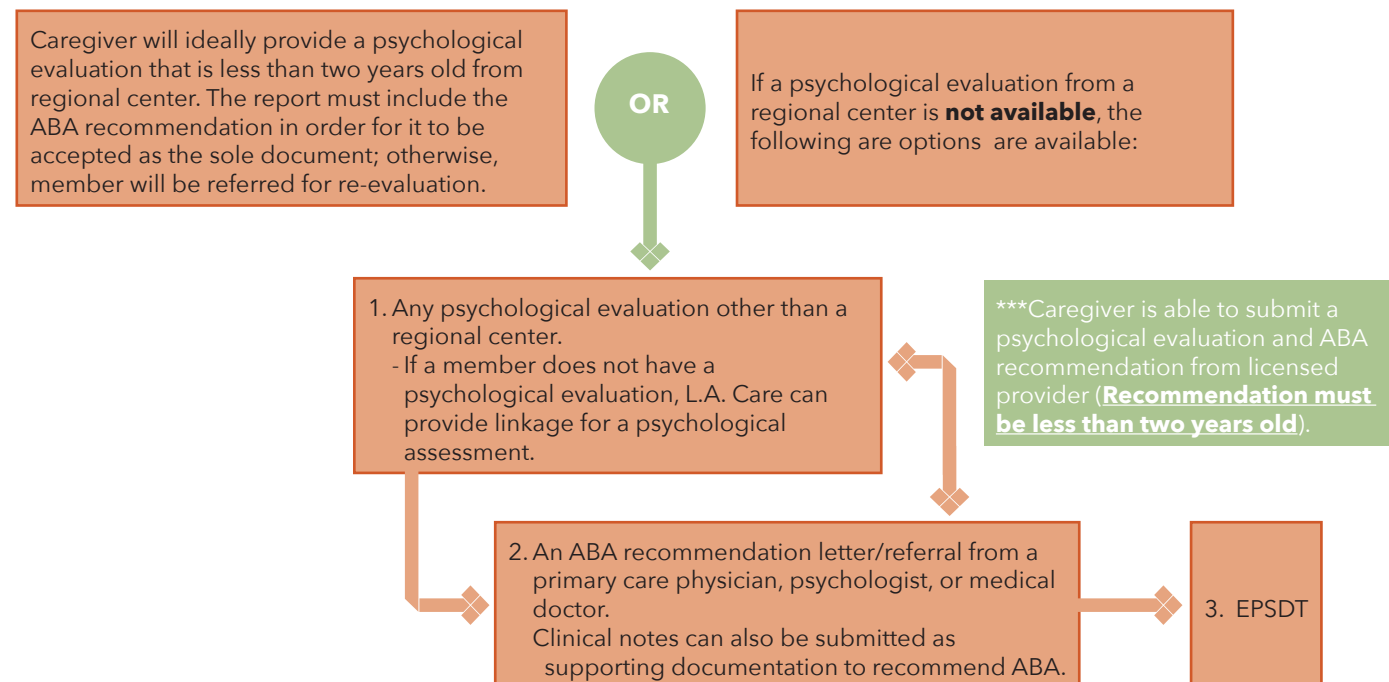
For the *First Connections* initiative, we created referral algorithms to guide medical providers and care coordinators as they assisted parents of children with Medi-Cal in accessing ABA or other behavioral health services through health insurance. These algorithms are customized to several managed care plans (MCPs) under Los Angeles County Medi-Cal. The algorithms for L.A. Care Health Plan, Blue Shield of California Promise (formerly Care1st) Health Plan, and Health Net in this toolkit were pilot-tested with families to confirm the linkage process. In addition, the algorithms for L.A. Care and Blue Shield of California Promise Health Plans were reviewed and approved by the MCPs. The algorithm for Health Net has been pilot-tested.

L.A. Care Behavioral Health/ABA Linkage Process

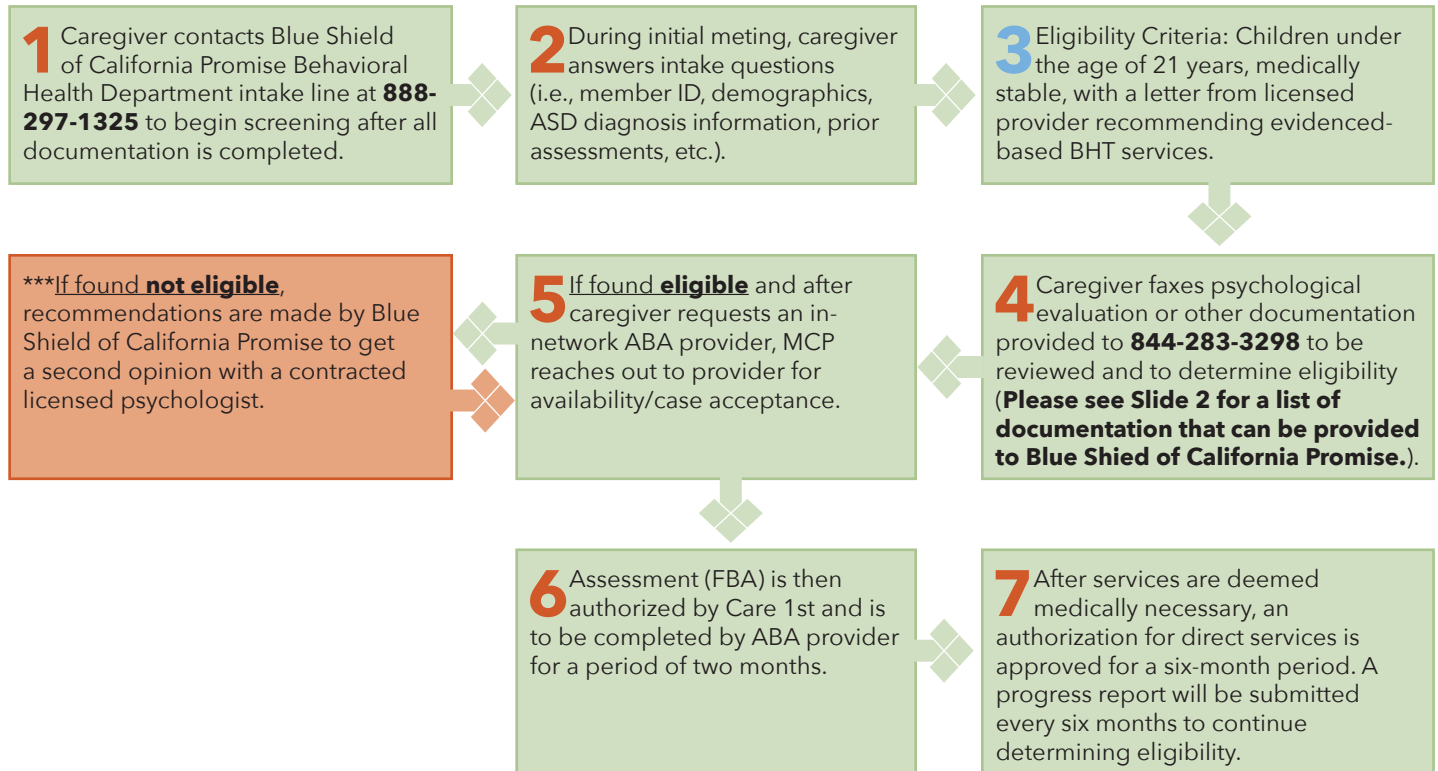


Documentation Needed for ABA Linkage Process

*****Documentation to be faxed to L.A. Care Behavioral Health Department at 844-283-3298**

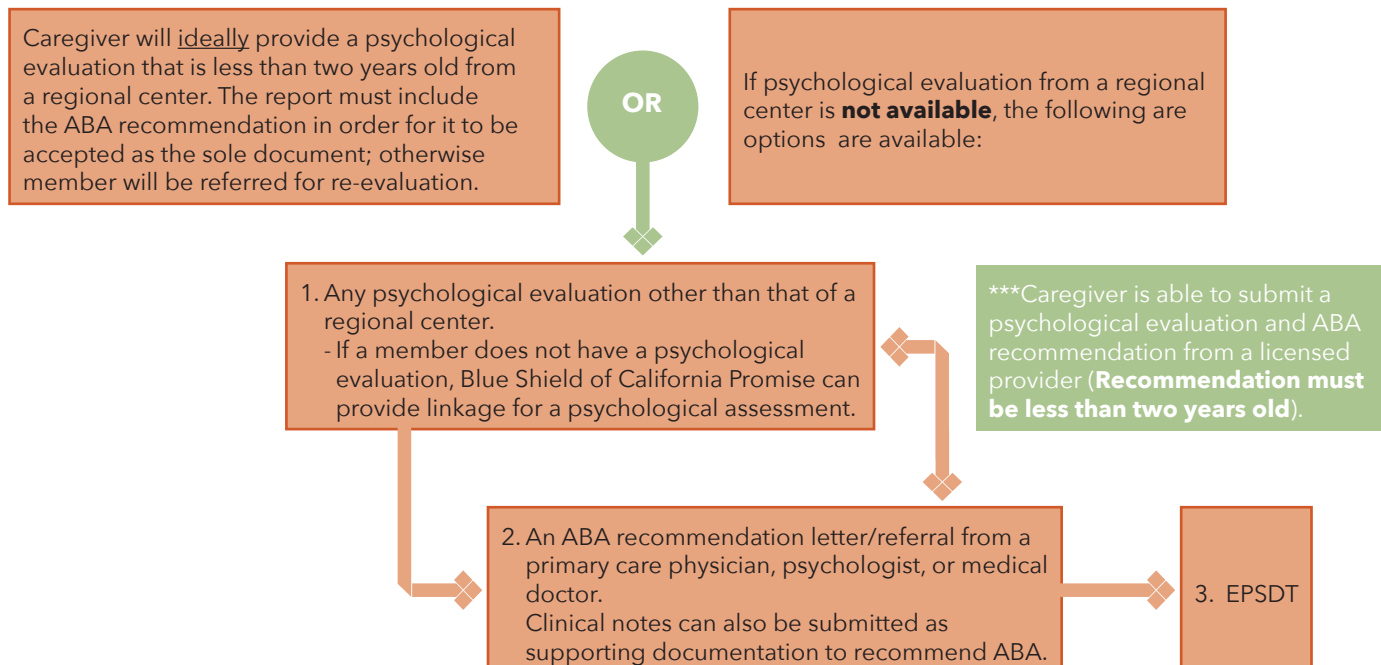


Blue Shield of California Promise Behavioral Health/ABA Linkage Process



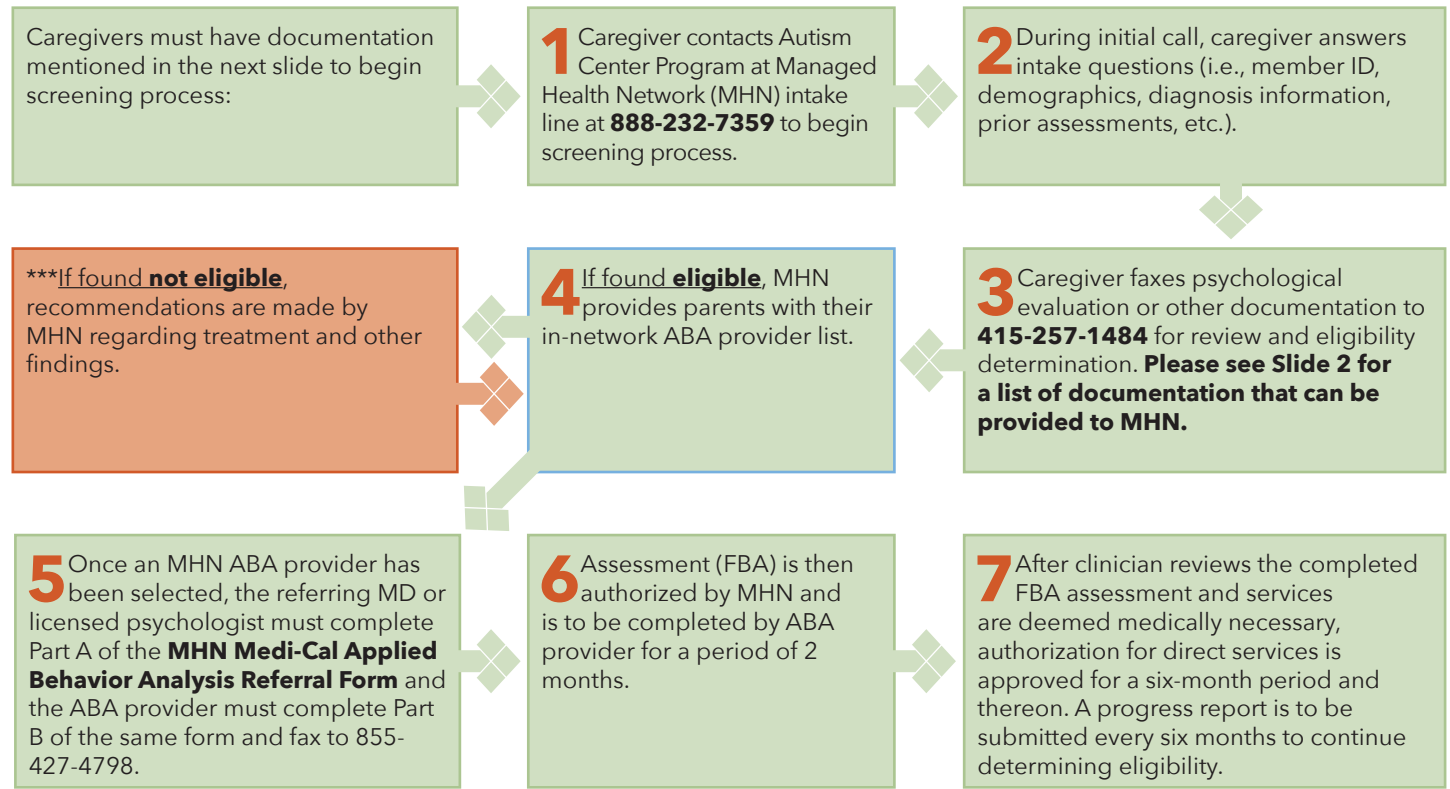
Documentation Needed for ABA Linkage Process

***Documentation to be faxed to Blue Shield of California Promise Behavioral Health Department at 844-283-3298



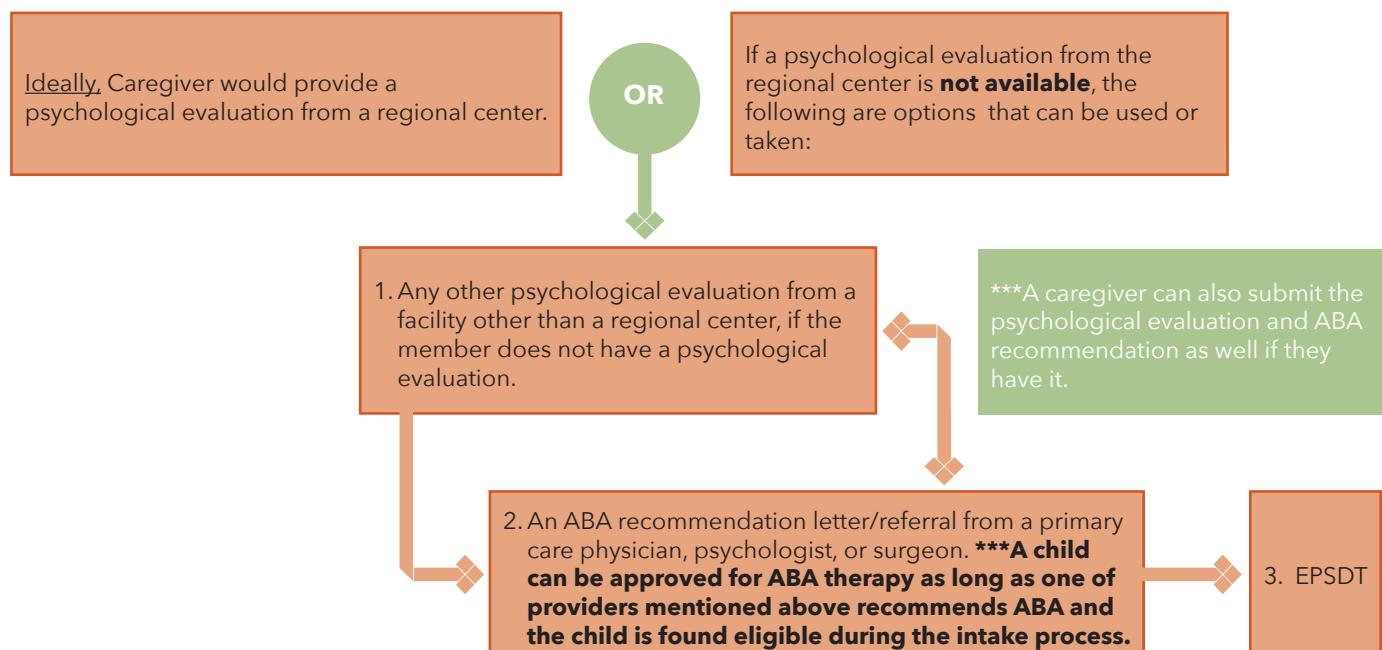
Health Net Behavioral Health/ABA Linkage Process

***Please note this information has not been confirmed by the MCP but has been pilot tested with families.



Documentation Needed for ABA Linkage Process

***Documentation to be faxed to Autism Center Program at Managed Health Network (MHN) at **415-257-1484**



Health Net Behavioral Health/ABA Linkage Process (Continued)



IMPORTANT INFORMATION

- Effective July 2018, an ASD diagnosis is no longer one of the requirements to qualify for ABA services. This information can be found in the All Plan Letter (APL) 18-006: <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-006.pdf>
- Caregivers should only contact the Autism Center Program at Managed Health Network (MHN) if Health Net is the primary managed care plan. For example:
 - For other types of primary insurance plans, caregivers should contact that insurance provider first.
 - ▶ If primary insurance **denies** services, caregivers should obtain a denial letter stating ABA is not a covered benefit and submit to CARE 1st. Once denial is received, Care 1st will begin the ABA eligibility process (ABA is not guaranteed).
- After 18 years of age, a conservatorship document is needed to continue services.
- Services can be provided up until 21 years of age. Once a member turns 21 years of age, member will be referred to a regional center.

State Criteria for a Medi-Cal member to be eligible for BHT Services as stated in the APL 18-006

- Be under 21 years of age.
- Have a recommendation from a licensed physician and surgeon, or a licensed psychologist, that evidenced-based BHT services are medically necessary.
- Be medically stable.
- Be without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities.
- ***MCPs must coordinate with other entities to ensure duplication of services does not happen.



APPENDIX C: Resources for Navigating Service Systems for Young Children

As noted in the State of California Department of Health Care Services All Plan Letter 18-006, Behavioral Health Treatment (BHT) can be an essential part of the federal Medicaid (Medi-Cal) program requirement under Early and Periodic Screening, Diagnostic and Treatment (EPSDT): www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-006.pdf.

In Fall 2014, the Department of Health Care Services (DHCS) included BHT services as a Medi-Cal benefit for individuals under the age of 21 with a confirmed diagnosis of ASD from a licensed psychologist, physician or surgeon. However, in 2016, DHCS shifted BHT services for Medi-Cal members with an ASD diagnosis from regional centers to MCPs, and as of July 1, 2018, DHCS no longer requires an ASD diagnosis for a child to be referred to BHT services. For children who are not enrolled in an MCP and have Fee-for-Service (FFS) Medi-Cal (also known as "regular Medi-Cal" or "straight Medi-Cal") DHCS states that those "who are eligible for regional center services receive BHT services coordinated through their local regional center." www.dhcs.ca.gov/services/medi-cal/Documents/BHT_FAQ_12-18-18.pdf.

ABA linkage criteria are dependent upon several factors outlined below under the state eligibility for BHT services:

Eligibility Criteria

1. Child is under age 21.
2. Child is medically stable and does not need 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities.
3. Parent must provide a recommendation from a licensed psychologist, physician or surgeon that demonstrates services are medically necessary. This recommendation can be presented in the form of a psychological evaluation from their regional center or another BHT facility. If the child does not have a psychological evaluation, the MCP can make a referral for the child to be evaluated by a contracted psychologist. If the parent has both a psychological evaluation and another form of documentation such as a letter or referral form making the recommendation from a licensed psychologist, physician or surgeon, both forms of recommendation can be submitted to the MCP. A child can be appropriate for ABA therapy as long as the provider recommends it and the client is found eligible during the intake process.

Please note that an ABA recommendation alone does not qualify a member for ABA services—eligibility must be confirmed by the MCP.

4. MCPs must then verify services being provided by other entities, to ensure that duplication of services does not happen.

Enrollment and Eligibility Steps:

1. Referral/Intake Request by Phone: The contact information to begin the screening and eligibility process depends on the member's MCP:

MCP	Department	Intake Line
L.A. Care	Behavioral Health Department	888-347-2264
Blue Shield	Behavioral Health Department	888-297-1325
Health Net	Autism Center Program at Managed Health Network	888-232-7359

2. Intake Assessment by Phone: During the initial call, parents will be asked to answer intake questions such as demographics, member insurance information (e.g., member ID) and information about the child's ASD diagnosis (if the child has been diagnosed).
 - a. Parents should begin the ABA linkage process by first *contacting their primary insurance provider (or MCP)*. It is important for parents to know that the MCP can provide this initial intake service. If L.A. Care Health Plan, Blue Shield of California Promise Health Plan or Health Net is not the family's primary MCP, parents should contact their primary insurance provider first.
 - b. If the primary MCP denies services, parents should request a denial letter that states ABA is *not a covered benefit*. Once the denial letter is received, the parent should submit it to either of the MCPs described in the algorithm (L.A. Care Health Plan or Blue Shield of California Promise Health Plan) for the secondary MCP to begin the ABA eligibility process.
3. Determination: When intake questions are completed and appropriate documentation (i.e., psychological evaluation) is submitted, one of the MCP clinicians will review the psychological evaluation or documentation to determine eligibility.



APPENDIX C: Resources for Navigating Service Systems for Young Children

- a. After the child is found eligible and the parent chooses a medical provider of their choice within the MCP network, the insurance provider will submit an authorization request for services to the MCP.
- b. If parents do not have a medical provider of choice, the MCP will provide a provider list and/or direct linkage to a specific provider.

After Authorization for Services is Approved:

4. **Evaluation:** After the authorization is approved by the MCP, the chosen medical provider will conduct a Functional Behavior Assessment (FBA). This assessment is usually completed in a period of two to three months (timelines vary depending on the MCP).
5. **Determination:** After the MCP reviews the completed assessment and services are deemed medically necessary, authorization for direct

services is approved for a six-month period. A progress report will be submitted by the provider of healthcare services every six months to determine continual eligibility.

6. **Services Provided:** If services are approved, they can be provided up until age 21; however, after age 18, conservatorship documentation is needed to continue services. After a member turns 21, they will be referred to their area's regional center for continued services.

The procedures outlined above apply to children with Medi-Cal who are enrolled in an MCP. For children with Fee-for-Service Medi-Cal who are eligible for regional center services, the process should be requested through the regional center.

Tips for Parents When Accessing ABA Services

- Consider receiving a referral for a specific ABA provider or agency.
- Ensure that the provider and supervisor are credentialed or licensed (i.e., board-certified behavior analyst, or BCBA).
- Consider a background check for the ABA provider; this should be common practice for most credentialed or licensed providers.
- Ask about and understand what ABA services entail (e.g., reinforcement, shaping, chaining or linking small behaviors together, etc.).
- Encourage communication and collaboration between your child's providers.
- Be present for ABA services in order to encourage learning and generalization.
- Establish a schedule that feels manageable and appropriate.
- Recognize that ABA services should be individualized.
- Collaborate with the ABA provider to establish appropriate goals.
- Observe the child/provider interaction.
- Encourage generalization of skills to other environments (e.g., community).
- Be aware of billing, business and insurance practices.
- Be aware of data collection methods and participate in regular review of progress.
- Request that common terms (versus clinical) are utilized or that clinical terms are explained, in order to maximize learning.
- Ensure that you understand your provider's beliefs about your child, as ABA providers hold both core and differing beliefs and philosophies (e.g., connections between sensory and medical conditions and behavior).

Adapted from: www.iidc.indiana.edu/pages/tips-for-choosing-a-provider-for-applied-behavior-analysis-aba

Specialty Mental Health Services

Los Angeles County provides specialty mental health services to children with Medi-Cal, from birth to age 21 who have a primary eligible mental health diagnosis and meet medical necessity guidelines. These services include infant and early childhood mental health services.

Considerations (when deciding whether to refer a child to mental health services through their MCP or through specialty mental health):

- If the primary concern is ASD, refer to the regional center and to the MCP for behavioral health services.
- If the primary concern is social-emotional symptoms, traumatic experiences or challenges in the parent-child relationship, a referral for specialty mental

APPENDIX C: Resources for Navigating Service Systems for Young Children



health services is recommended. In addition, for very young children (e.g., birth to age 2), specialty mental health agencies are more likely to have providers trained to provide infant mental health to this age group.

To identify a mental health provider through the L.A. County Department of Mental Health (DMH) contracted agencies, contact 800-854-7771 or search the provider directory at dmh.lacounty.gov/pd.

An intake assessment will be completed to determine if the child has an eligible mental health diagnosis and meets medical necessity. Then a treatment plan will be developed in collaboration with the family. Services may include home- and/or clinic-based mental health services or telemental health services, medication support (if indicated), and rehabilitation services to support children in developing daily living skills related to their mental health diagnosis.

For children from birth to age 5, services provided by the DMH agencies and contracted agencies include a range of evidence-based practices, including but not limited to:

- Child-Parent Psychotherapy (CPP): A dyadic model (parent and child together) designed for young

children exposed to traumatic events. The focus is on building the parent-child relationship, reducing trauma symptoms, and putting the child on a positive developmental trajectory.

- Parent-Child Interaction Therapy (PCIT): A parent-coaching model focused on reducing symptoms of disruptive behavior, improving parenting skills, and enhancing the parent-child relationship.
- Incredible Years: Parent coaching through a group format, including parent groups and child groups.

When choosing a provider for mental health services, consider the following guidelines:

- Look for a provider who has specialized training and experience working with young children. One way to identify such a provider is to confirm if they are endorsed as an infant mental health specialist through the California Center for Infant and Early Childhood Mental Health (or similar endorsement organization in other states): cacenter-ecmh.org/wp.
- Mental health services for young children should be:
 - o Relationship-based and family-focused, including the parents or caregivers as an integral part of the intervention
 - o Developmentally appropriate
 - o Culturally appropriate and fitting with the family's values
 - o Trauma-informed



APPENDIX D:

Parent Phone Survey

This survey was developed to obtain information from parents who had participated in developmental screenings where delays were identified and the child was referred for school special education services. It can be modified to fit the needs of an individual agency. This survey takes approximately 15 minutes to complete.

My name is [xx] and I am calling from [name of agency]. May I speak with the parent of [child's name]?

We are calling to learn about parents' experiences when their child's development is screened, and when children are referred for extra help.

The questions will take approximately 15 minutes. Is this a good time to talk or should we schedule this conversation at a more convenient time?

[Name of agency staff person who made referral] shared with me that you did a developmental screening in [month/year] and [name of staff person] tried to help you get services for [him/her]. Does that sound right? We wanted to ask some questions about the process of getting help for [him/her] and see what it was like for you. We are asking these questions to all the parents who have gone through this process. This will help us with ideas for helping other parents.

1. First, we'd like to know about the results of your child's developmental screening. The form that you filled out at [xx] that asked about your child's learning and development. It's called the ASQ [or substitute name of screening measure used]. You are welcome to share more information with me about any of these questions if you'd like.

- a) Do you remember completing a screening at [name of agency] about your child's development?
- b) Did the screening help you understand your child's development?
- c) Did the screening show that your child might have a delay in [his/ her] development?
- d) After the screening, was it recommended for your child to get further evaluation?

2. Was your child referred to a school or school district for evaluation, an IEP, or other help?
[if no: end survey]

Do you know what school district the school is in?

3. Now I'd like to ask about your experience getting an evaluation for your child for school services

- a) Did you have any problem making or scheduling appointments? _____
- b) Did you have any problem with transportation to get to the evaluation?
- c) Did you have any problem scheduling the evaluation at a time that would work for you?
- d) How long did it take to get an appointment for the evaluation?

[If no evaluation done: skip to question #8]

4. Now I'd like to ask about your experience when your child was evaluated.

- a) Where did the evaluation take place?
- b) Were you there while your child was being evaluated, or did they work with your child alone?
- c) How many evaluators were present or conducted your child's assessment?
- d) Did the person (s) who did the evaluation speak your home language?

[If no:] Did they use a translator?

- e) Did you have any trouble talking with the evaluator(s) about your child or understanding the evaluator's questions?



APPENDIX D: Parent Phone Survey

- f) Did you feel that the evaluator (s) understood you and your child and got accurate information?
- g) How much time did the evaluator (s) spend with you and your child?
- h) Did you feel that the evaluator (s) spent enough time to do a thorough evaluation?
- i) Did the evaluator get an accurate picture of your child, both strengths and concerns?
- j) Did you understand what to do next to get help for your child after the evaluation?
5. Now I'd like to ask about your experience during the IEP meeting.
- a. Did you meet with a team at the school to talk about what services your child would need or about the results of the evaluation? (such as an IEP meeting)
- b. Was the meeting in your home language?
- c. Did you have an opportunity to get all your questions answered about your child's learning and development, or to review the results of the evaluation?
- d. Did you understand the results of the evaluation?
- e. Did you feel you had opportunities to ask questions about anything you did not understand?
- [If no: Ask why not]**
- f. Did you understand your child's eligibility?
- g. Did you understand what to do next to get help for your child after the meeting?
- h. Was your child found eligible for school services?
6. Now I'd like to ask about your experience getting educational services and supports for your child.
- a) Did your child start receiving school services yet?
- [If yes:]** What kind of services? How the services are going?
- [If no:]** What are the barriers that you have encountered getting services started?
- b) Do you feel that the school services have been helping your child with *[his/her]* learning and development?
- c) How do you feel about the person or persons that are working with your child?
7. Did your child receive early intervention services before age 3?
- a) **[If yes:]** Did you have any challenges making the transition from early intervention services to getting services for your child at school?
8. Are there any other experiences (positive or negative) that you experienced during this linkage for school services that you would like to share with us?
- We really appreciate you answering all of these questions. This is very helpful to us in understanding how to help families support their children's learning and development.*
- Do you have any questions before we end?*
- Thank you for participating!*



APPENDIX E:

Training Materials

Topic	Audiences	Activities / Handouts
Developmental Screening Overview	All FRC staff	<p>PowerPoint: Developmental Screening Overview</p> <p>Resources: A Healthy Beginning for Young California Kids: Universal Developmental & Behavioral Screenings/Dev-Screening-Infographic: https://www.chs-ca.org/_docs/dev-screening-infographic.pdf</p> <p>Learn More About Your Child's Development: https://www.zerotothree.org/resources/series/your-child-s-development-age-based-tips-from-birth-to-36-months</p> <p>Developmental Monitoring and Screening: https://www.cdc.gov/ncbddd/actearly/pdf/Dev-Mon-and-Screen-English-and-Spanish-P.pdf</p> <p>Your Developmental Screening Toolkit: http://docsfortots.org/toolkits/developmental-screening-toolkit/</p>
Developmental Screening: Administration, Scoring and Interpretation	Staff involved in administering and scoring measures	<p>PowerPoint: Developmental Screening: Administration, Scoring and Interpretation</p> <p>Resources: Training DVDs for ASQs available from Brookes Publishing:</p> <ul style="list-style-type: none"> • Twombly, E. & Squires, J. ASQ-3 Scoring & Referral: http://products.brookespublishing.com/ASQ-3-Scoring-Referral-DVD-P583.aspx • Squires, J. & Twombly, E. ASQ:SE-2 in Practice: http://products.brookespublishing.com/ASQSE-2-in-Practice-DVD-P949.aspx
Developmental Conversations with Parents	Staff responsible for discussing screening results with parents	<p>PowerPoint: Developmental Conversations with Parents</p> <p>Resource: Guidelines for Talking to Families: www.firstsigns.org</p>



APPENDIX E: Training Materials

Topic	Audiences	Activities / Handouts
Developmental Screening: Linkages to Resources	Staff responsible for discussing screening results with parents	<p>PowerPoint: Developmental Screening: Linkages to Resources</p> <p>Handouts: Screening and Referral Algorithm: Birth through 2 Years Screening and Referral Algorithm: 3 through 5 Years</p> <p>Resources: Learn the Signs. Act Early. <i>Milestone Moments Booklet</i> and <i>Tracker App</i> Checklists: www.cdc.gov/ncbddd/actearly/freematerials.html Vroom: www.vroom.org/ Special Education Rights and Responsibilities-Information on Early Intervention Services: www.disabilityrightsca.org/system/files/file-attachments/504001Ch12.pdf 5 Steps for Brain Building Serve and Return: www.youtube.com/watch?v=KNrnZag17Ek&feature=emb_logo</p>



APPENDIX F:

Training Worksheets

Presenter's Reflections

- Was your presentation delivered as expected?
- Identify at least two areas of the presentation that you feel most proud of.
- Identify at least two areas that you want to focus on for next time.
- How was the pacing of the presentation? Did you feel that you were going too fast? Or did it seem to go too slowly?
- How did the audience respond to the presentation? What was their level of engagement?
- Was the material presented accessible to the audience and did it seem to be at about the right level of complexity? If not, what changes would you need to make for next time?
- Review any written feedback from the audience. What suggestions would you like to incorporate next time?
- What supports do you need before your next training?



APPENDIX F: Training Worksheets

Observation of Presentation

The presenter...	Comments
Maintained good eye contact with the audience.	
Used a voice loud and clear enough to hear easily.	
Presented the information in an organized manner.	
Posted a clear question or questions for the audience to consider during the presentation.	
Considered and included cultural factors related to the topic.	
Reflected on and/or answered the audiences' questions or comments.	
Involved the audience, invited questions and promoted discussion.	
Utilized visual supports (i.e., handouts and video) well to clarify the information presented.	
Provided the audience with information and resources to learn more about the topic if interested.	
Pacing of presentation fit the time allotted.	
Used person-first language and showed respect and compassion for the people being discussed.	

- What went well in this presentation? Please provide at least one area of strength.
- Which aspects of the presentation/presenter style could be improved? Please provide at least one suggestion.

