EARLY SCREENING, BETTER OUTCOMES:

Developmental Screening & Referral Toolkit for Pediatric Medical Clinics

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 pediatric medical clinics in accurately implementing or refining a high-quality approach to developmental screening and linkage for young children. Although developed for California, the majority of information provided in this toolkit is relevant to other states and can be adapted to fit a range of settings. The toolkit is designed to be useful to clinics that are implementing a new developmental screening initiative, as well as for clinics that already conduct developmental screenings but want to review and refine their practices.

The pilot test of the toolkit included guidance by a Training and Technical Assistance (TA) team. Clinics will need to determine if they have sufficient internal resources to implement the program without TA, or whether contracting with a TA provider is necessary. Areas of expertise and experience needed (either internal or through TA) include:

- Experience implementing screening programs for other domains
- Quality improvement process experience
- 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
- Support developmental progress of the child(ren)
- Enhance parent-child relationships
- Provide linkage to needed resources
- Strengthen connections between families and pediatric providers

1 in 4 CHILDREN under the age of 6 in California **are at moderate- or high- risk** for developmental, behavioral or social delays

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

Courtesy of First 5 Association

In California, approximately 25 percent of young children are at risk for a developmental and behavioral delay.[2] In Los Angeles County, it's estimated an even higher percentage of young children (30-40 percent) would benefit from prevention and early intervention services and supports.[3] However, many children do not receive developmental services until they reach kindergarten.[4]

Benefits of Developmental Screening and Linkage Practices
Well-child visits in the first three years of life provide a golden opportunity for developmental conversations between medical providers and parents[1] that can:

Developmental monitoring during these early years, including surveillance and standardized screening, is recommended by the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) and supports developmental conversations during well-child visits. For more information about the AAP guidelines visit: pediatrics.aappublications.org/content/118/1/405.full. For more information about the AAFP guidelines visit: www.aafp.org/afp/2017/0701/p36.html

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.

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

SURVEILLANCE includes soliciting and responding to parent concerns and, through informal observations, identifying and documenting risk factors.

DEVELOPMENTAL SCREENING, through the use of standardized tools, includes identifying and assessing a recognized risk. It is also recommended that screenings be administered at 9-, 18-, and 24- or 30-month well-child visits.

[1] We recognize that the parent will not always be the person bringing the child to the visit. Throughout the toolkit, we use the term "parent" to refer to all primary caregivers.
[2] Parma, A., Peña, C. J., & Green, K. (2019) *Issue Brief 2: Linkage to Services and the Referral Process.* First 5 LA. www.First5LA.org/uploads/files/linkage-to-services-issue-brief-2_417.pdf
[3] First 5 LA. (2012). *Early Developmental Screening and Intervention Initiative* (EDSI): *Lessons Learned 2005-2010.* First 5 LA. www.First5LA.org/files/EDSI_Report_final_10092012.pdf
[4] Children Now, First 5 Association of California, & Help Me Grow California. (2014). *Ensuring Children's Early Success: Promoting Developmental and Behavioral Screenings in California*.

All families 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 parents to learn about child development and support their child's continued developmental progress.

All pediatric providers benefit as well from the use of standardized tools for developmental screening:

- When a provider has less experience with child development, a standardized tool helps to identify subtle delays that might be missed through surveillance.
- Even when a provider has extensive experience with recognizing developmental delays, a standardized tool helps to frame conversations with parents about those delays.

Screening tools are designed for specific domains (e.g., motor skills, communication, social-emotional) and for various healthcare 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.

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

Universal Screening Reduces Racial and Ethnic Disparities

Research indicates that there are disparities between different racial and ethnic groups, children living in different socioeconomic conditions, and gender differences, in terms of access to developmental screening, early intervention, and diagnosis of developmental disabilities.

For example, early identification and access to early intervention can lead to better long-term outcomes for children with autism spectrum disorder (ASD), yet Black and Latino children and children living in poverty are diagnosed with ASD years later than white children and children with higher income levels.[5,6]

Rates of developmental screening are lower for children of non-white ethnic groups and for children without a medical home. Implicit bias may hinder the accuracy of developmental surveillance. Universal developmental screening is one way to ensure that all children have access to monitoring of their development and the opportunity to identify concerns and intervene early.

[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. journals.sagepub.com/doi/10.1177/0009922813501378

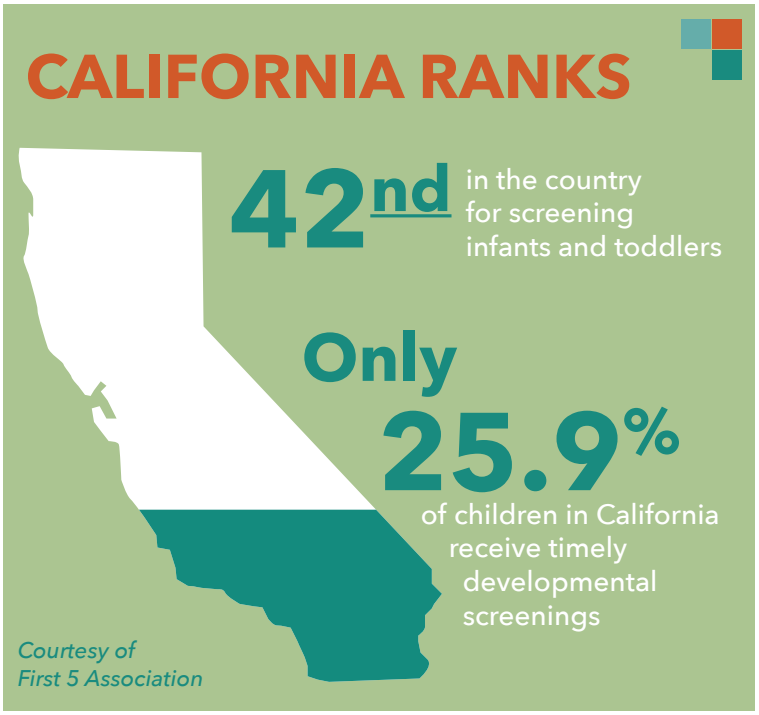
[6] Johnson, S., Riis, J., & Noble, K. (April 2016). *State of the Art Review: Poverty and the Developing Brain.* Pediatrics. 2016;137(4). pediatrics.aappublications.org/content/137/4/e20153075

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, which encompass 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.[7] Furthermore, data indicate many children with or at risk for a developmental delay are not screened, connected to, or accessing early intervention supports, including Individuals with Disabilities Education Act (IDEA) Part C and behavioral health intervention services.[8,9,10,11,12]

First 5 Commissions have invested in building and strengthening early identification and intervention efforts locally. Many counties have adopted the Help Me Grow (HMG) model to better coordinate and connect existing systems to support the developmental needs of young children and their families. For more information, visit: helpmegrowca.org/. 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, visit: First5LA.org/help-me-grow/.

Help Me Grow | LA



Effective 2020, California law clarified regulation and oversight requiring providers to screen children enrolled in the state's Medicaid program for developmental delays using standardized screening tools at 9 months, 18 months and 30 months as recommended by the AAP. The new law also created improved oversight and data reporting.[13]

Tested across three large Federally Qualified Health Clinics, this toolkit is a compilation of best practices and learnings for implementing high-quality developmental screening and linkage practices within a pediatric clinic setting. It is our hope that the toolkit is a guide to further support local, state and national partners in raising the bar on developmental screening and linkage practices and standards.

[7] California Legislative Information. Assembly Bill 1004 Developmental screening services (2019-2020). leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB1004

[8] 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.

[9] Early Childhood Technical Assistance Center. (n.d.). Part C national program data. ectacenter.org/partc/partcdata.asp

[10] Centers for Disease Control and Prevention. (2014). Screening for developmental delays among young children – National Survey of Children's Health, United States, 2007. www.cdc.gov/mmwr/preview/mmwrhtml/su6302a5.htm

[11] Administration for Children & Families. (n.d.). Need for early intervention services among infants and toddlers in child welfare. Research Brief, National Survey of Child and Adolescent Well-Being, 8. Retrieved from: www.acf.hhs.gov/sites/default/files/opre/early_intervention_0.pdf

[12] Department of Health Care Services. (2016). Performance outcomes systems report. www.dhcs.ca.gov/services/MH/Documents/LosAngeles_CtyAggRep.pdf

[13] California Legislative Information. Assembly Bill 1004 Developmental screening services (2019-2020). leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB1004

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The "Early Screening, Better Outcomes: Developmental Screening & Referral Toolkit for Pediatric Medical Clinics" was developed as part of the *First Connections* initiative, a First 5 LA-funded developmental screening and linkage effort in Los Angeles County.

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/.

Funded by First 5 LA and launched in January 2014, the *First Connections* initiative aimed to increase early developmental and behavioral screening for young children across six diverse agencies and connect children and their families with culturally and linguistically appropriate services as early as possible. The *First Connections* grantees include three Federally Qualified Health Centers (AltaMed Health Services, Eisner Health and Northeast Valley Health Corporation); two community-based organizations (Allies for Every Child and Foothill Family Services), and one regional center (South Central Los Angeles Regional Center) working in collaboration with a family resource center. 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 TA lead for *First Connections*.

Since its launch, *First Connections* grantees have conducted over 65,000 developmental and behavioral screenings at more than 120 locations. Given the success of the initiative, *First Connections* was extended to help further inform the planning and implementation of Help Me Grow Los Angeles (HMG LA) by First 5 LA and the Los Angeles County Department of Public Health. HMG LA is a national model that promotes cross-sector coordination and integration at the local level to strengthen developmental and behavioral screening and linkage to early intervention support.

The University of Southern California University Center for Excellence in Developmental Disabilities (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.

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Contributors:
We gratefully acknowledge the contributions of the following healthcare providers, all three Federally Qualified Health Centers (FQHCs) that participated in *First Connections* and contributed to the development and testing of the toolkit materials.

- AltaMed Health Services, the nation's largest independent FQHC, has delivered complete medical services to communities across Southern California since 1969. With more than 20 primary care clinics in Los Angeles and Orange Counties, AltaMed offers a full range of primary care, as well as dental, pediatrics, behavioral health, HIV/AIDS care and prevention, and Program of All-Inclusive Care for the Elderly to nearly 300,000 unique patients annually. AltaMed serves predominantly low-income, Latino and multi-ethnic individuals of all ages, 47 percent of whom are uninsured. With a team of qualified multicultural and bilingual professionals – from these same communities – AltaMed focuses on eliminating barriers to primary care services, senior care programs and essential community resources.
- Eisner Health is one of the largest providers of accessible, low-cost health care in Los Angeles County and the San Fernando Valley. Founded in 1920 as a small pediatric practice, it provides quality health care and supportive services to address the needs of the whole person. Eisner Health provides culturally competent, full life cycle medical care, OB/GYN and women's health services, dental care for the entire family, behavioral health care, speech and language therapy, optometry, dermatology, case management and care coordination. Programs include labor and delivery care at California Hospital and Medical Center and Martin Luther King, Jr. Community Hospital; the Eisner Health Family Medicine Center at California Hospital; high school-based community health centers; and a school-based portable dental program.
- Northeast Valley Health Corporation (NEVHC) provides comprehensive primary health care to medically underserved residents of L.A. County, particularly in the San Fernando and Santa Clarita Valleys. NEVHC provides primary and preventive health services to children, including developmental screening and age-specific education regarding child development and growth. The following staff from Northeast Valley Health Corporation provided invaluable input to the development of the toolkit:
  - o Alexandra Zamora, Program Coordinator
  - o Carolina Aguilar, Pediatric Development Care Coordinator

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PHASES OF SCREENING IMPLEMENTATION

The toolkit's three sections – Plan; Launch; and Evaluate, Refine, Spread, and Sustain – serve as a guide to implement a new developmental screening initiative, or to review and refine existing screening practices to help strengthen quality and effectiveness. Each phase is comprised of a series of steps which are identified below and correlate to additional detail and materials found within the toolkit.

I. Plan

1. Assemble implementation team
2. Set goals
3. Create developmental screening plan
   a. Select and obtain screening measure(s)
   b. Determine screening periodicity schedule
   c. Determine clinic processes, workflow and staff roles
4. Plan developmental conversations and determine developmental guidance
5. Develop referral and linkage plan/workflow
   a. Customize referral resources
   b. Customize referral algorithm
6. Pilot workflow and screening
7. Establish implementation timeline

II. Launch

8. Develop training plan and conduct training
   a. Determine who will conduct staff and medical provider training, and select or develop training materials
   b. Plan for training existing and new staff
   c. Implement training
9. Launch implementation

III. Evaluate, Refine, Spread, and Sustain

10. Implement quality improvement tracking
11. Spread to other clinic sites (if applicable)

PHASE 1: PLAN

STEP 1:
Assemble Implementation Team

Successfully introducing and sustaining a developmental screening practice relies on the implementation team's structure and governance. The team is collectively responsible for advancing the initiative from planning through continuous quality improvement. While the team's ultimate composition depends on the size, staffing pattern and work roles of each clinic, key roles to emphasize include the project's champion, leader and subject matter experts who understand the needs of the clinic, its medical providers and its users.

The following team roles have been found helpful in the FQHCs that participated in the *First Connections* initiative:

Champion
Support from the project champion is essential to the initiative's success. In many organizations, the champion will be a pediatric medical provider who is already familiar with developmental screening and has found standardized tools to be effective in framing developmental conversations with families. The role of the champion is to be a "cheerleader" for the project, to talk with medical providers who may be more reluctant or skeptical about the need for screening, and to provide feedback to the rest of the implementation team about barriers, process gaps, user input and suggested solutions.

Lead
The lead for the initiative often has a background in patient process and management, such as a nurse administrator or quality improvement director, and who has experience with project oversight and systems change implementation, tracking of results, and provider training. In some settings, the same person may be both the champion and the lead for the project. The lead is responsible for organizing the timeline for implementation, assembling the team as needed, tracking progress throughout, identifying and addressing barriers that arise, and communicating about the initiative with staff at all levels of the organization.

Key Work Role Representatives
Ideally, the implementation team includes one representative from each of the key work roles that will participate in the project. For example, representatives might include:

- **Pediatric medical provider** with a discipline different from that of the champion (i.e., if the champion is a pediatrician, family practice physicians should also be represented)
- **Medical assistant** (MA)
- **Front desk staff**
- **Technology lead** to address issues related to integration with electronic medical or health records
- **Communications specialist** to disseminate implementation news and progress internally and promotes screening purposes and benefits to educate patient families

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 developmental monitoring practices in the clinic and to consider how the developmental screening initiative fits within the clinic's other related practices or policies. Sample questions that might help the implementation team gather data include:

Provider Readiness:
- What are provider attitudes about developmental screening?
- Are any clinic providers currently using any developmental monitoring tools?

SCREENING IS COVERED

Developmental Screening can be billed using CPT billing code 96110 or ICD-10 Z13.4. This covers the time a health provider scores, reviews results, and interprets findings.

Federal health reform law requires insurance plans to cover developmental and behavioral screenings at no cost to children. Medicaid (Medi-Cal) also covers screenings as part of children's preventive services.

Courtesy of First 5 Association

Current Screening Practices:
- What is the current completion rate of standardized developmental screenings?
- If similar tools were used in the past, what was learned?
- What are the current linkage practices and referral sources available?
- What other types of screenings (e.g., social determinants of health or maternal depression), if any, are already implemented in the clinic?

Electronic Medical or Health Record (EMR/EHR) Tracking:
- How might the EMR/EHR support tracking of developmental screening (for medical provider and patient/family use)?

Funding:
- What funds are available to support purchasing developmental screening tools?

Set Goals
The implementation team will need to decide on the ultimate plan for screening. Decisions made at this phase will influence the rest of the plan, such as the training needed.

Ideally, goals will be measurable and include benchmarks for progress. For example, goals might include:
1. 85 percent of children will complete a broad developmental screening at their 9-, 18-, and 24- or 30-month well-child visits.
2. 85 percent of children will complete a social-emotional screening at their 24-month well-child visit.
3. 85 percent of children will complete an autism screening at their 18-month well-child visit.

Questions to consider to help set goals include:

Screening Domains:
- What types or domains of screening will be implemented? (e.g., broad developmental domains; signs of autism; social-emotional functioning)

Screening Rates and Procedures:
- What percentage of children will be screened?
- When and how will children be screened?
- How will best practices be defined and shared across the clinic(s)?

Effectiveness of Implementation:
- How will patient, parent and user experience be measured?
- How will initiative success be defined?

Although this toolkit focuses on developmental screenings, the same principles would apply to implementing additional screening domains.

It may be helpful to consider the following AAP recommended screenings when setting goals:
1. Developmental screenings
   a. Broad developmental screening (e.g., language, motor, adaptive, etc.)
   b. Social-emotional screening
   c. Autism screening
2. Maternal depression screening
3. Social determinants of health tools/questions

STEP 3:
Create Developmental Screening Plan

PHASE 1: PLAN

Results of the Set Goals step, including baseline quantitative and qualitative measures, future-state goals, and domains to be screened, will be instrumental in designing the 'Screening Plan' and reaching key implementation decisions, including:

1. Selecting and obtaining screening measures.
2. Determining screening periodicity schedule.
3. Integrating screening tools into the electronic medical or health record (EMR/EHR).
4. Designing clinic process, workflow and staff roles.

This planning approach has been pilot-tested in the *First Connections* initiative and can be customized to fit the needs of individual clinics.

A Closer Look:

Additional information about starting a developmental screening initiative can be found in the following documents developed by AAP's Screening Technical Assistance and Resource (STAR) Center.

- Developmental screening: www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/Early-Childhood-Development.aspx
- Practices: www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/For-Practices.aspx
- Screening recommendations: www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/Screening-Recommendations.aspx

1. Selecting and Obtaining Screening Measures

When selecting developmental screening measures, consider:

- Which developmental screening tools are most familiar to medical providers in the clinic?
- Which tools are a good fit for the population the agency serves (e.g.: if the clinic services families who speak languages other than English, the chosen tool must have validated translations available)?
- Which tools are standardized and validated on populations similar to those the agency serves?
- What will be the cost of the screening measures?
- How easily can the screening tools be integrated with the EMR/EHR?

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)™ 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

AAP has compiled a list of effective and validated developmental screening tools here: www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/Screening-Tools.aspx.

After selecting the screening measures, the clinic 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 Questionnaires*, *Third Edition* (ASQ-3), *Ages & Stages Questionnaires: Social-Emotional, Second Edition* (ASQ:SE-2), and *Modified Checklist for Autism in Toddlers, Revised* (M-CHAT-R) screener because these were implemented as part of the First Connections initiative. However, the toolkit's materials can be modified to fit the use of other screening tools.

2. Determining Screening Periodicity Schedule

AAP recommends the following screening schedule consistent with AAFP recommendations:

- Developmental monitoring at all well-child visits
- Developmental screening using a standardized parent-report tool at 9-, 18-, and either 24- or 30-month visits
- Psychological/behavioral health monitoring at all visits, including use of a parent-report social-emotional measure at 9-, 18-, and either 24- or 30-month visits
- Autism-specific screening at 18- and/or 24-month visit

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

As part of the *First Connections* initiative, the Children's Hospital Los Angeles Training and Technical Assistance team studied whether targeted social-emotional screening was worth the extra time involved. We compared scores on the *ASQ-3* and the *ASQ:SE-2* for 608 children (more than 50 percent in Spanish). We found that 14 percent had a positive screen on the ASQ:SE-2, 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. Therefore, we recommend that developmental screenings 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.

3. Integrating Screening Tools into the Electronic Medical or Health Record (EMR/EHR)

As part of the planning process, it is recommended that clinics include a goal of integrating the screening measures into the EMR/EHR. Advantages include:

- Easy access for providers to review prior screening results and observe the child's developmental trajectory over time.
- Higher likelihood that measures will be completed as planned, especially if the EMR/EHR has mechanisms requiring the screening to be completed in order to move forward in the medical chart.
- Some approaches enable the parent to complete the screening electronically which leads to efficiencies in scoring.

A Closer Look:

The availability of measures that can be integrated varies over time; the following are some examples as of the publication date of this toolkit.

- CHADIS (Comprehensive Health and Decision Information System) is a web-based screening, diagnosis, and management system. It offers many web-based developmental screening measures, including questionnaire completion, automatic questionnaire scoring, and time-based graphical displays. Current examples of questionnaires available include ASQ-3, ASQ:SE-2, M-CHAT-R, SWYC, among many others. www.site.chadis.com/pediatric-questionnaires
- ASQ Online management system and EMR/EHR system with Application Programming Interface. agesandstages.com/resource/asq-online-api-faqs/
- SWYC (Survey of Well-being of Young Children) is integrated with some EMR/EHRs (e.g., EPIC) and is seeking to expand to others. www.floatinghospital.org/The-Survey-of-Wellbeing-of-Young-Children/Overview
- Some clinics have developed their own software to create an electronic version of a screening tool that is integrated into the EMR/EHR. The challenge with this method is that it can be quite costly (and requires permission from the publisher of the screening tool) and can become obsolete as new versions of the screening tool are developed.

When considering electronic versions of screening tools, it is important to address the following issues:

- Does the publisher of the screening tool provide or allow electronic versions, and if so at what cost?
- If the measure will require Wi-Fi to complete, is Wi-Fi reliably available at each clinic site?
- Will a paper back-up be available in case of technological challenges? If so, how will results from paper questionnaires be imported into the EMR/EHR?

If a fully electronic interface is not feasible, then alternative methods for including the information in the EMR/EHR need to be considered. For example, these may include scanning and uploading the completed questionnaires, and/or creating a space in the record to input the final scores from the questionnaires.

4. Designing Clinic Processes, Workflow and Staff Roles
Developing and pilot testing a detailed workflow is essential to successfully integrating developmental screening into clinic procedures.

Suggested questions to address when developing clinic screening processes are listed below. The specific questions to consider would vary depending on the size of the clinic, staff roles within the clinic, patient volume, and other screening tools already in use or planned.

Identification

- How will children due for screening be identified?

Staff Roles: Administration

- Who will be responsible for identifying which screening tool is due, and ensuring it is provided in the parent's primary language?
- How will the screening tool get to the parent? Will it be mailed in advance of the child's health visit, emailed as a link for electronic completion, or handed to the parent at the time of the visit?
- If the screening tool is provided to the parent in advance of the visit, will there be a pre-visit reminder call, as well as help offered over the telephone if the parent has questions about completing the measure?
- If the parent will complete the screening tool during the visit, who will explain the screening tool to them and answer questions they might have?
- Can developmental tools (e.g., ASQ-3 Materials Kit) be provided to encourage parents as they attempt to elicit the child's response and observe skills they are unsure about?
- Who will be responsible for checking the screening tool for any missing items and helping parents with completion?

Staff Roles: Scoring, Interpretation and Linkage

- Who will be responsible for scoring the screening tool?
- Who will be responsible for interpreting the scores?
- How will the scores be input into the patient's chart?
- Who will provide feedback to the parent regarding screening results and next steps?
- Who will be tasked with follow-up to support family-to-services linkage?
- How will referrals and their outcome be tracked in the patient's chart?

Telehealth and Developmental Screening
Developmental screening can be conducted virtually, either in addition to in-person visits or as part of regular telehealth care. Clinics can explore options, including:

- 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, scan or photograph, and send back to the clinic
- Conducting a telephone or telehealth visit that includes time to help the parent complete the questionnaire

Telephone or telehealth visits can also be used to link families with needed resources and to follow up with families to find out if they needed help accessing the recommended resources.

The AAP worksheet, *Getting Started: Implementing a Screening Process* provides questions to consider when developing the workflow: www.aap.org/en-us/_layouts/15/WopiFrame.aspx?sourcedoc=/en-us/Documents/screening_getting_started_worksheet.docx&action=default

A Closer Look: Sample Workflow

The pre- through post-visit workflow affects clinic procedures, medical provider and parent/child experiences, completion rates and measurable outcomes. Because the workflow reflects comprehensive real-time implementation, all touch points and action items are accounted for, including roles and responsibilities.

The following workflow sample was pilot-tested at one of *First Connections'* participating FQHCs that mailed the paper screening tool ahead of well-child visits.

As illustrated in this diagram, the clinic implemented the following work roles and processes:

WORKFLOW: Roles of Care Team Members

Care coordinator uses EMR to identify which children have well-child visits scheduled and selects correct screening measures for child's age and language of parent

Day of visit: Registration staff collects completed screening or provides blank screening for parent to complete in the waiting area.

Care coordinator mails screening tool and instruction letter to parent two weeks prior to visit

MA collects completed screening measures from parent; if not done, helps parent to finish in exam room

Parent completes screening measures at home before well-child visit

MA scores screening measures and puts in folder for provider along with *Milestones Moments* booklet

Provider initiates developmental conversation with parents and discusses screening results

If referral is recommended, provider discusses recommendation with parents and provides guidance on process

If referral is recommended, MA assists in completing referral forms and provides family with written referral information

Provider documents screening results and follow-up plan in EMR

Front desk staff scans screening results and uploads into EMR

If referral is made, care coordinator assists family within one week with linkage to referrals

Pre-Visit

The care coordinator for developmental screening, using the EMR/EHR, identifies which children are at the ages for the periodicity schedule utilized by the clinic and have well-child visits scheduled within the coming two weeks. The care coordinator identifies the correct screening tool for the child's age and the language of the parent, mails the tool to the parent with a letter explaining the purpose of the screening, and requests that the tool be completed and brought to the clinic visit. The clinic has an automated call system that reminds patients of appointments and includes information about bringing in the completed screening tool. This FQHC monitored and determined that approximately 50 percent of parents remembered to complete the screening tool prior to the visit and bring it with them to the appointment. As a result, the FQHC determined that mailing the screenings in advance was worth the time and cost involved.

At-Visit

The FQHC's daily schedule indicates which patients are due for their developmental screening. The front desk staff requests the completed screening tool from the parent when they check in and then places it in the patient's visit folder. If the parent did not bring the screening tool, the front desk staff provides an age- and language-appropriate blank copy and asks the parent to complete it in the waiting room and return the completed form to the front desk staff to place in the patient's visit folder.

The MA collects the completed screening tool from the patient's folder or parent and reviews it for completeness. If there are missing items, the MA asks the parent to complete any omissions and offers to answer any screening tool questions the parent might have missed. The MA scores the screening tool, prepares the scores for the medical provider, and obtains a Centers for Disease Control and Prevention's (CDC) *Milestones Moments* booklet for the medical provider to give to the parent.

The healthcare provider reviews the scores and determines if the screening indicates parent concerns about development. The provider follows a screening algorithm (see toolkit section under "Referral Plans") to determine what type of referral is appropriate for any developmental concerns identified. The provider uses the screening results to initiate a developmental conversation with the parent. This includes discussing the results from the screening tool, answering any questions, reviewing the CDC *Milestones Moments* booklet and/or ASQ-3 Activities Sheet, and discussing referral recommendations if a referral is needed.

If a referral is made, the provider completes the referral paperwork, which is provided to the parent with instructions on how to initiate an appointment. In addition, the provider alerts the care coordinator that a referral is recommended.

After-Visit

The front desk staff electronically scans the completed screening results and uploads them into the EMR.

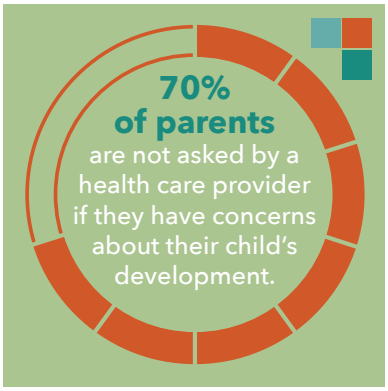
The medical provider documents the screening results and the follow-up plan in the EMR.

The care coordinator reaches out to the family by telephone within a week from the screening visit to answer questions about the referral and to assist with addressing any barriers to linkage.

If there are concerns about development, the child is scheduled for a one-month follow-up with the medical provider.

STEP 4: Plan Developmental Conversations and Determine Developmental Guidance

Parent completion of developmental screening measures creates an opportunity for the medical provider and parent to have an open and supportive conversation about the child's development and beneficial resources. Beyond identification of delays, discussions about child development and developmental milestones are helpful to parents when children are typically developing, and can be linked to other aspects of health, learning, and home routines that are recommended by medical providers.



A culturally and linguistically competent and successful program begins at the front desk. Throughout the process, it is essential that parents are provided opportunities to ask questions and discuss their values and cultural beliefs, and that medical providers are open to engaging parents as full partners in the screening process: nccc.georgetown.edu/documents/FrontDeskArticle.pdf.

When discussing the results of developmental screening, the following tips have been found helpful to 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, such as telling the parent that just as their child's height and weight are tracked, so is their development. Assure parents that the clinic screens all children at well-child visits, not just their child.
- 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).
- Provide an opportunity for the parent to respond to the information. Ask if this information fits with how they view their child. If the medical provider raises a 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, and instead talk about strengths and 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).

When potential developmental delays are identified, 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/cultural values, and can successfully engage them in the linkage and intervention process. It is important to schedule enough time for the medical provider, or a case manager, to share the screening findings with the parent and provide them with information about next steps in the linkage and referral process.

Information about making referrals to early intervention, special education, and additional services is provided in Step 5.

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 *Milestones Moments* booklet (written pamphlet) or CDC *Milestones Moments* Tracker (phone app). Both are free and available through the CDC's *Learn the Signs. Act Early.* campaign at www.cdc.gov/ncbddd/actearly/pdf/booklets/Milestone-Moments-Booklet_Reader_508.pdf and www.cdc.gov/ncbddd/actearly/milestones-app.html
- ASQ-3 Activities Sheets™. These age-appropriate and printable sheets come with the purchase of ASQ-3 materials.
- After-screening Letter. Appendix A has a sample letter that can be used to briefly summarize the results of the screening evaluation. The letter may assist families in navigating the next steps in referral and linkage. It is recommended that the letter be provided in person (rather than by mail), allowing the parent an opportunity to discuss the information and ask questions. The first sample letter corresponds with the categories of development in the ASQ-3 and ASQ:SE-2, and is available in English and Spanish.

STEP 5:
Develop Referral and Linkage Plan/Workflow

The referral and linkage plan covers how to refer and link children and families to additional community resources to support children's development, including early intervention and special education services. **Referral and linkage** follow screening and is indicated when a child has an at-risk or clinical presentation, and/or when a family requests additional resources.

As part of the developmental screening workflow, it is important to identify which staff/providers will share referral information with the family, and what kind of support and follow-up can be provided if parents have difficulty navigating the service system. Several approaches to linkage may be considered:

1. A primary care provider reviews referral recommendations: Families often appreciate the information about the recommended referral and this can also help extend the trust they have in their medical providers and clinic to the service that is recommended.

2. A case manager – an individual with a bachelor's or master's degree in social work or related field – assists with linkage/"warm hand-off": In the First Connections initiative, a case manager dedicated to helping link families with services was an important component to successful linkage. In some clinics, the case manager was on-site during well-child visits to meet with families after the medical provider shared the screening results and recommendations. In other clinics, a case manager followed up by telephone with families who had been referred to services by their medical provider.

Oftentimes, simply providing a referral is not sufficient to support families in successful linkage. A **"warm handoff"** is a family-centered approach that helps to ensure a child is directly linked to early intervention supports and services or transferred seamlessly from one provider to the next. In addition, the parent is provided with support in becoming an advocate for their child and learning how to navigate the service system for them.

In the case of a follow-up by telephone, the case manager:

- ☑ Gives the parent additional information on the agency where their child is being referred, including what to expect in terms of intake or further assessment
- ☑ Helps the parent prepare their questions for the agency/provider or answer questions asked by the agency/provider
- ☑ Offers to call the agency together with the parent
- ☑ Helps the parent, if the call is made together, to ask their questions, and supports them in ensuring they understand what will happen next
- ☑ Follows up with the parent in two weeks to find out whether the linkage was successful and helps the parent with next steps if there have been any barriers

In other cases, the referral is made in writing (rather than by phone), but the case manager still follows all other steps to support the parent in navigating any barriers. This approach is also helpful in ensuring that information about the referral outcome is provided to the medical provider and included in the child's EMR/EHR.

3. Written materials regarding the referral: Several types of written material may be helpful as part of the linkage process.

   - ☑ Signed releases of information/exchanges of information: The healthcare provider should ask the parent to sign a release of information form, allowing the provider and the agency to which the child is referred to communicate about the referral outcome. This will allow the healthcare provider to request records documenting any evaluations that were completed and any services to be offered, which can be saved in the child's EMR/EHR for review at future medical appointments.
   - ☑ "After-Screening Letter" (see Step 4: Developmental Conversations and Developmental Guidance)
   - ☑ List of referrals: Appendix B contains a referral handout, based on a resource letter developed by the Early Developmental Screening Initiative (EDSI), which can be customized by each clinic and provided to parents to summarize referral suggestions. The referral template, which provides space to write in details for early intervention services, is separated by category: childcare, early education and special education; mental health services; and other family supports.
   - ☑ Referral sheets tailored to individual agencies: When developing relationships with common referral sources (focused on early intervention, preschool/special education/early education, and behavioral health), clinics should obtain information about the preferred method for sending referrals. Many agencies providing early intervention services have their own referral forms, and completing the forms for the family (or assisting them in completing the form) can facilitate smooth linkage. In addition, a sample letter that can be provided to schools when requesting preschool special education services is found in Appendix C.

Lesson from the Field:

The FQHCs that participated in First Connections found that the role of the case manager or care coordinator to support families in linking with services was essential. One successful model was to use a care coordinator with lived experience; that is, a staff person who is a parent of a child with special needs and therefore had learned first-hand to navigate the service system. Sometimes this role is called a Parent Partner. Such a person may also help to reduce stigma and help families to feel more comfortable in accepting services through the early intervention or special education system.

When hiring and training a case manager or care coordinator, it is important to secure a person who has a high level of knowledge about the special education and early intervention system in that community. While this knowledge can be acquired on the job (and this toolkit includes resources to support that training), it can take considerable time to build up expertise about the nuances of the eligibility criteria, optimal ways of framing the request for services, and the array of services available in a local community for children and families with different types of needs. In some communities, a resource such as 211 or Help Me Grow may offer assistance in identifying referral options.

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 respective communities and populations. Start with reviewing the most common referral sources currently used for young children and gathering information about their referral-making procedures. In some cases, it may be helpful to establish a formal memorandum of understanding (MOU) with frequently-used referral sources. To determine comprehensive developmental resource materials for use with families of young children, the following common referral sources were frequently used in the *First Connections* initiative:

- Early intervention (services through the Individuals with Disabilities Education Act [IDEA] Part C for children birth to age 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
- Head Start (ages 3 and 4) and Early Head Start (birth to age 2)
- Infant and Early Childhood Mental Health/Behavioral Health services
- Family support organizations, including family resource centers (FRC) and other ethnic-specific family support organizations

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

Lesson from the Field:

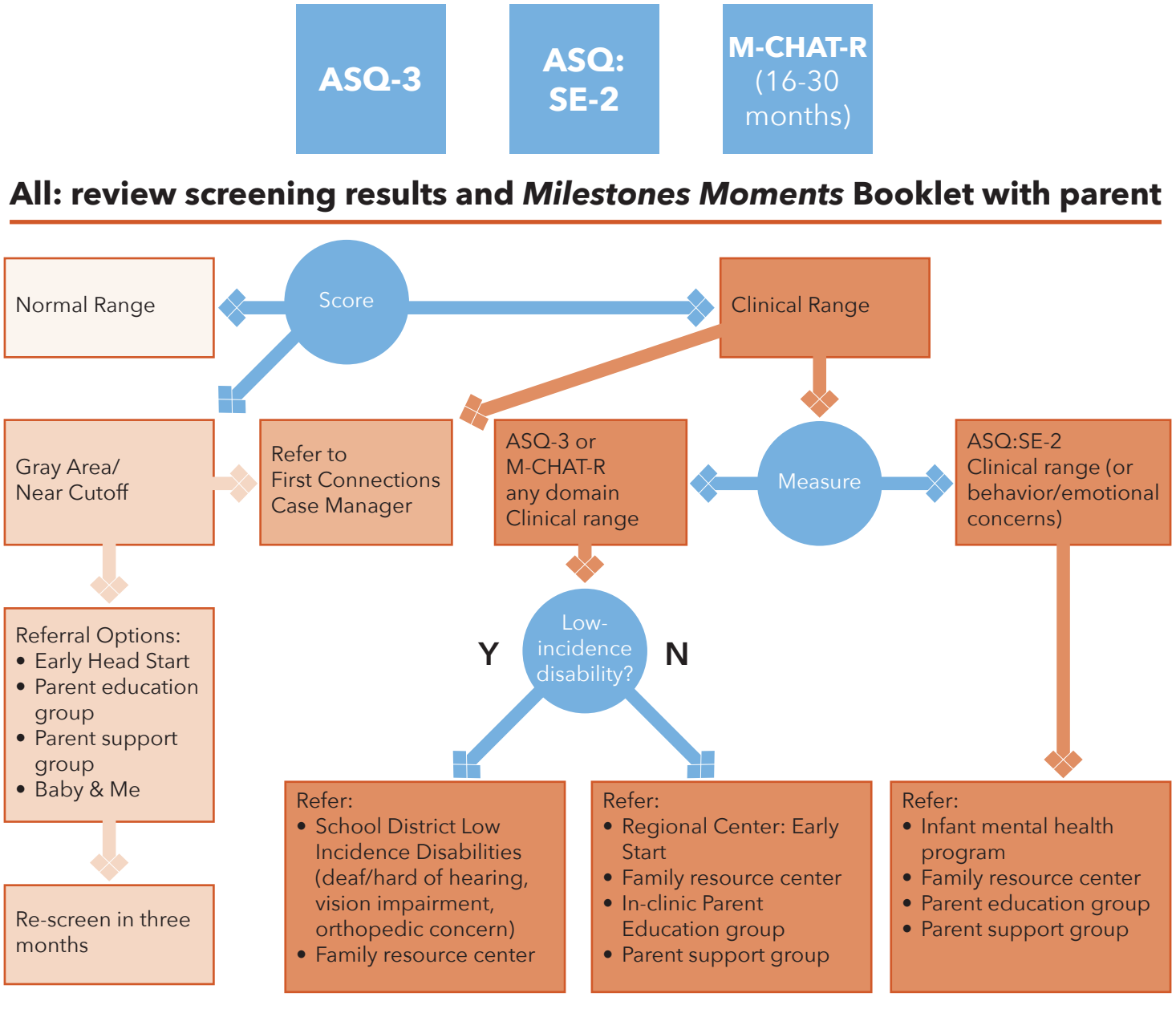
Both AltaMed and Eisner Pediatric identified a need specifically for children with screening results in the "gray zone" for communication. At AltaMed, the *First Connections* team launched a pilot project called Hablamos Juntos that specifically targeted parents of children with a potential speech delay. This was an internal resource that providers could refer their patients to, and that assisted with further linkage if deemed necessary.

At Eisner, one of the *First Connections* team members was a contracted speech-language pathologist, who developed an individualized parent training program. This co-located service was designed to meet the needs of young children who were either in the "gray zone" for communication or who had delays identified, but whose parents were reluctant to access early intervention services. These parents were open to receiving services at their medical home, where they trusted their provider and had an opportunity for exposure to what speech-language services would be like for their child. After exposure to the speech-language intervention in this setting, parents were able to then access early intervention services if needs remained.

Developmental Screening Referral Algorithm
For the *First Connections* initiative, we developed a screening referral algorithm to guide providers and care coordinators to identify the most appropriate referrals for children and families depending on the screening results. This algorithm should be customized to a clinic's referral sources and screening tools that are used.

Developmental Screening Referral Algorithm: Birth through 2.5 Years

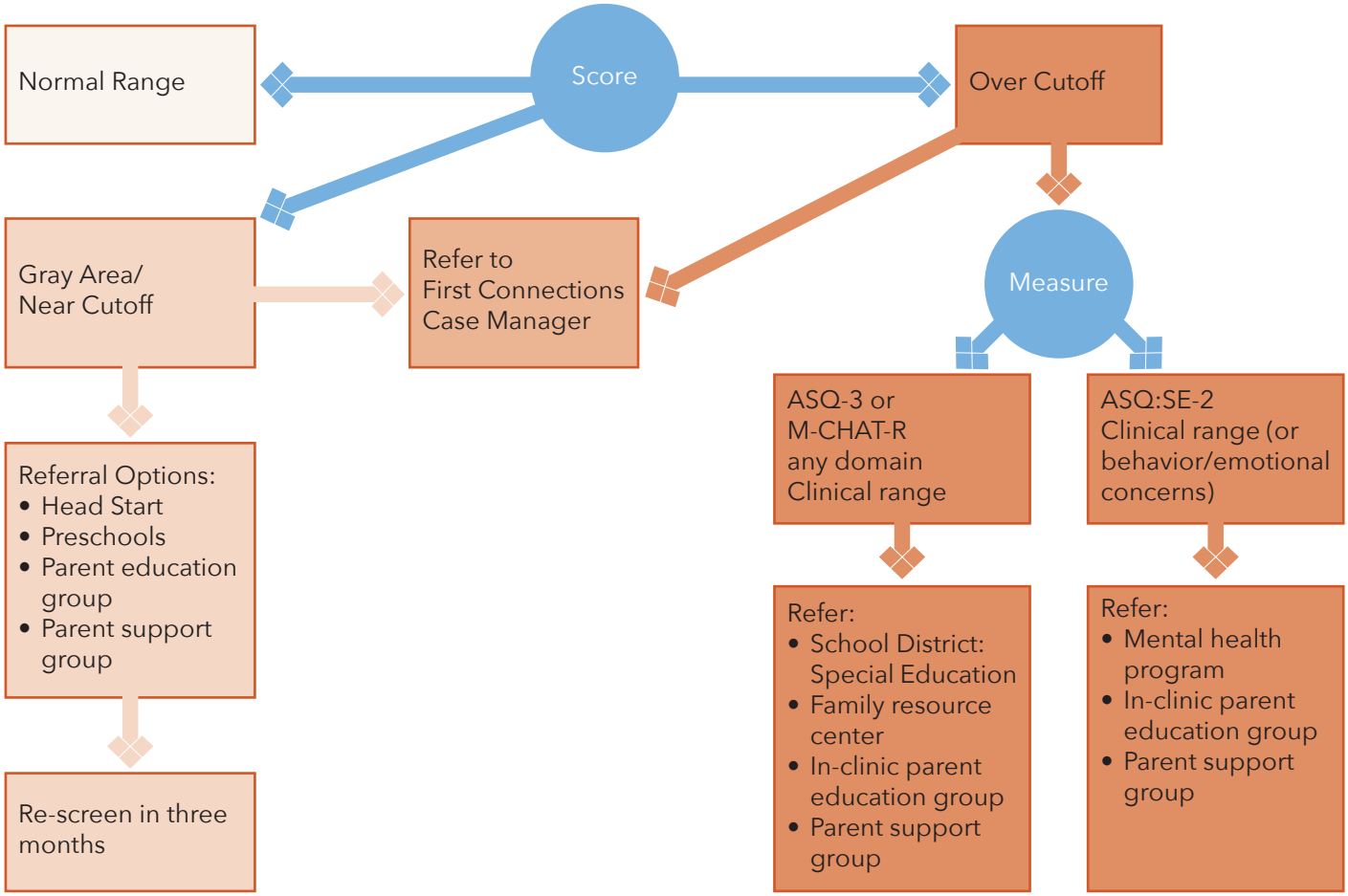
SCREEN AT 9, 18, AND 24 MONTHS



Developmental Screening Referral Algorithm: 2.5 through 5 Years
SCREEN AT 36, 48, AND 60 MONTHS

ASQ-3 **ASQ: SE-2**

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



The sample screening referral algorithm is divided by age to guide referrals for children birth to age 2.5, and children ages 2.5 through 5. It is based on results from clinics administering the ASQ-3, ASQ:SE-2, and M-CHAT-R. The top of the algorithm summarizes the periodicity schedule and measures used for the clinic. Results of the screening measures are categorized in the algorithm into three color ranges to represent different levels of risk: white ("Typically Developing Range"); gray ("Gray Area/ Near Cutoff"); and black ("Clinical Range").

White ("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 the CDC *Milestones Moments* booklet and/or CDC's *Milestones Moments Tracker* app. Some providers also may provide developmental guidance, including, but not limited to, ASQ Activities SheetsTM.

Gray ("Gray Area/Near Cutoff/Monitoring Range"): When scores are in the gray area, parents receive 1) feedback about screening results; 2) written information about child development such as the CDC's *Milestones Moments* booklet and/or CDC's *Milestones Moments Tracker* app; 3) developmental guidance (such as ASQ Activities SheetsTM); and 4) an appointment sooner than usual (e.g., one to three months) to re-screen. In addition, depending on the concerns, the medical provider may refer to community resources that do not require documentation of developmental delays. Examples include Early Head Start or Head Start, a Baby & Me group, or a parent support group. Because these resources tend to vary more by community, referral sources need to be established through the exploration of available child and family supports in each community.

Black ("Clinical Range"): When one or more of the scores is in the clinical range, parents receive 1) feedback about screening results; 2) written information about child development (such as the CDC's *Milestones Moments* booklet and/or CDC *Milestones Moments Tracker* app); and 3) a referral for a community resource appropriate to the area of concern, such as early intervention, special education, or mental health services, depending on the areas of concern and the child's age.

Birth Through Age 2.5 referrals for scores in the clinical range – Early Intervention Referrals
When one or more of the scores in each of the domains from the ASQ-3 are within the clinical range or identified as high risk on the M-CHAT-R, an early intervention referral is recommended. In most cases, the primary referral for children at this age who have a developmental delay or are at-risk for delay is determined by a state's early intervention program – IDEA Part C. California's Part C program is called "Early Start," and is managed by local regional centers.

To locate the Part C program in your state visit: ectacenter.org/contact/ptccoord.asp

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

Age 2.5 through 5 referrals for scores in the clinical range – Special Education Referrals
When one or more of the scores in each of the domains from the ASQ-3 are within the clinical range, a special education referral is recommended. IDEA Part B ensures that children ages 3 to 21 with disabilities receive free appropriate public education to accommodate their needs and access the educational curriculum.

To locate information about the Federal IDEA Part B program visit: 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 5 referrals for scores in the clinical and monitoring range– Family Support /Family Resource Center Referrals
In addition to the primary referral to early intervention or special education, it is recommended that families be referred to a family support organization, such as a family resource center. Depending on the clinic, additional internal resources may be available. Additional information about family resource centers is provided in Appendix C.

Birth through 5 referrals for scores in the clinical range – Mental Health Referrals
When scores are in the clinical 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, or through mental health agencies contracting to provide mental health services through the state or county. Additional information regarding navigating referrals for behavioral health in Southern California is provided in Appendix C.

STEP 6:
Pilot Workflow and Screening Process

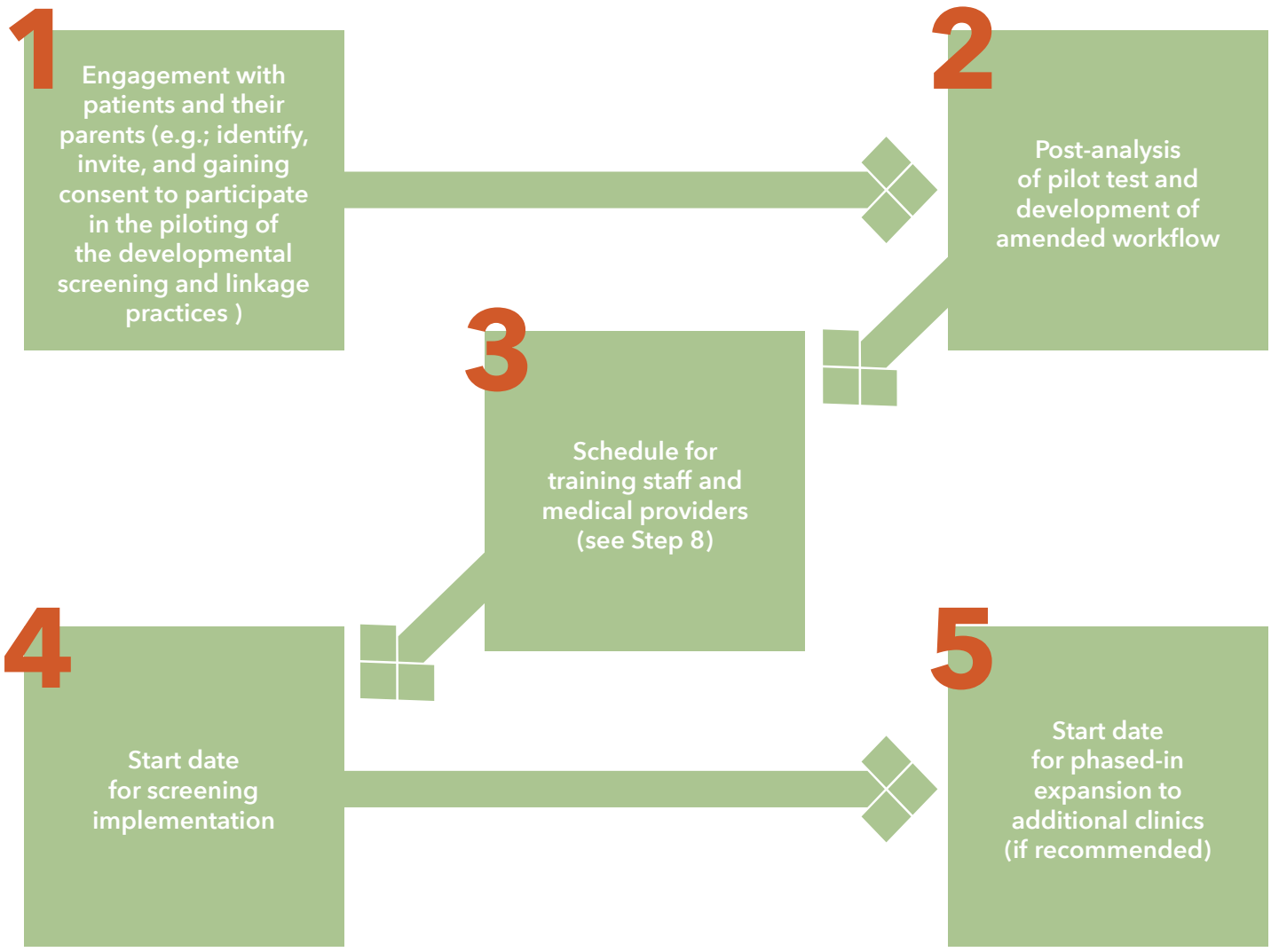
PHASE 1: PLAN

Before launching clinic-wide, a screening process pilot with a small number of patients is recommended to test out the clinic procedure. During the pilot, a member of the implementation team will shadow each participating patient through their visit to determine if any changes are needed to the workflow based on the parents' experiences and observations. At the end of the visit, immediate feedback would be gathered from the family about the screening process. A follow-up with the family should be scheduled three weeks after the appointment to assess whether any linkage procedures were effective in connecting them with recommended community resources. This toolkit includes sample questions (see Appendix D) that can be used to systematically gather parent feedback through a phone survey. In addition, it is helpful to obtain feedback from each clinic staff member and medical provider involved in the pilot.

STEP 7
Establish Implementation Timeline

PHASE 1: PLAN

After the screening plan is in place, the implementation team develops a timeline for launching the developmental screening and linkage practices. The timeline should include:



PHASE 2: LAUNCH

STEP 8:
Develop Training Plan and Conduct Training

The training plan includes determining who will conduct training, selecting or developing training materials, and scheduling training for the key groups of staff and medical providers.

Appendix E includes training materials for four developmental screening training topics (see box). The training materials include PowerPoint presentations, training guides, and handouts and/or activities needed to deliver each training topic. All of the materials created by the *First Connections* Training and Technical Assistance team have been pilot-tested and are customizable to meet the needs of diverse clinics. A sample evaluation form also is included to assess the effectiveness of the teaching style and content.

A Closer Look

The following training sequence was found to be effective in the FQHC *First Connections* initiative. Technical assistance can support the delivery and evaluation of the training sessions as well as individualize the support needed by the clinic staff.

1. Clinic-wide training (all staff)
   Time: Approximately 15 minutes
   Title: Developmental Screening Overview
   Topic: Importance of developmental screening and overview of the screening initiative, including workflow.
   Goals: Introduce the initiative, obtain buy-in, and set the stage for subsequent training sessions and implementation steps.

2. Medical providers (pediatricians, family practice physicians, nurse practitioners, physician assistants)
   Time: Approximately 45 minutes
   Title: Developmental Screening: Developmental Conversations with Parents/ Caregivers
   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.
   Goal: Provide guidance for framing developmental conversations with parents.

3. Front desk staff and medical assistants (and/or medical providers, if they will be administering and scoring measures)
   Time: Approximately 45 minutes
   Title: Screening Measure Administration, Scoring, and Interpretation
   Topic: Administering and scoring screening measures, with a focus on ASQ and M-CHAT-R.
   Goals: Ensure entire staff is familiar with their roles in using the correct measure, presenting the measure to parents effectively, and scoring the measure to ensure scores are ready for medical providers when the well-child visit begins.

4. Medical providers and/or case managers
   Time: Approximately 45-60 minutes
   Title: Developmental Screening: Linkage to Resources
   Topics: Referral algorithm and helping parents navigate the referral process
   Goal: Provide guidance about referral pathways and process for making referrals.

After all training sessions are delivered it is recommended that the staff receives ongoing implementation support or refresher sessions throughout the first few months of the screening initiative. Repeat trainings can be offered as new staff or providers join the team.

It is recommended that the four core trainings be delivered before launching the screening initiative.

Training Considerations
The following recommendations are based on the *First Connections* training and technical assistance team's FQHC 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 games, case study material, practice scoring and interpreting sample measures and small group discussion.
- **Increase relevance:** By communicating the importance of a training subject or specifically connecting the training subject to the work that the attendees do, the team is able to individualize training sessions and increase relevance.
- **Invite supervisors and champions:** Champions at each new training group actively participate in the trainings with enthusiasm; their presence helps to engage the audience and develop trust. Direct supervisors should be trained so they can support implementation.
- **Solicit feedback:** Asking for feedback from attendees helps to improve trainings over time.
- **Remain available:** Staying for a set 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 the staff member, as requested.
- **Offer refresher training:** It is important to offer refresher sessions, opportunities for follow-up discussions, or case examples to further advance the knowledge acquired during the training and to correct problems (e.g., incorrect scoring of measures).
- **Create connections:** In facilitating a model of sustainability and addressing barriers, it can be helpful to share information on how other clinics approach training and screening. For example, one clinic's initiative in promoting a needs assessment led another to similarly assess training gaps.
- **Highlight change:** It is essential for the groups to see the direct positive impact on the children they serve. Tracking data and sharing results with staff and providers can include: increases in the percentage of children screened; increases in the percentage of children found eligible for early intervention services; increased parent satisfaction with well-child visits; and stories from parents who had success in obtaining early intervention services and seeing progress in their child's development.
- **Train the trainer:** Step 11 of Phase 3, "Evaluate, Refine, Spread, and Sustain," introduces a train the trainer model for agencies interested in developing their own capacity to conduct staff trainings.

Lesson from the Field:

Through the *First Connections* initiative, AltaMed learned that continual trainings for staff are helpful, not just at the beginning of the project but also throughout. With staff turnover it is important to re-introduce both informational and technical topics to reinforce why and how we screen children for delays. Furthermore, by reinforcing the AAP guidelines for screening at 9, 18, and 24 months with the pediatric residents as well as the AltaMed providers, screening rates have improved over time.

STEP 9:
Launch Implementation

At this point the planning and training components of the initiative have been completed, and the site is ready to fully implement and launch. See checklist below to ensure implementation readiness:

- ☑ Screening measures are available for use and accessible to staff who will administer them to families
- ☑ Protocol for screening schedule and workflow has been disseminated to all relevant staff and providers
- ☑ Staff and providers have been trained in their screening and linkage roles
- ☑ Plan for recording screening results and linkage recommendations in the EMR has been developed

In the first week or month of implementation, it is recommended to have a morning huddle each day to confirm screening plan and roles, and a meeting at the end of each week to review and address any challenges that arose in implementing the program.

PHASE 3:
EVALUATE, REFINE, SPREAD, SUSTAIN

STEP 10:
Implement Quality Improvement Tracking

Ideally, the effort to implement a developmental screening initiative can follow similar procedures as other Quality Improvement (QI) efforts.

For examples of QI approaches in healthcare, see www.aafp.org/practice-management/improvement/basics.html.

Specific to developmental screening initiatives, the following recommendations for tracking data will help determine if the project is being implemented as planned and help identify areas for improvement. The tracking methods will depend on the type of medical record used by the organization and the screening tool(s) implemented.

Systemwide tracking of completion rates:
If an electronic screening tool is used and is integrated with the EMR, it is possible to track systemwide metrics before and after implementation of the developmental screening initiative. For organizations that do not have an electronic database for screening measures, it is helpful to sample a subset of well-child visits to check the same metrics for a sample of the total population served.

The screening metric is the rate of completion of screening measures according to the screening plan (e.g., out of the total number of well-child visits for the age group to be screened, what percentage of children were screened as planned).

Collecting data for subsets of the population or for a short time period can be helpful for tracking specific components of the developmental screening initiative to determine if it is working as planned.

Analysis of workflow:
After implementing the screening workflow, a multi-perspective walk-through of the process is recommended to evaluate how well it is working:

1. Consider the screening process from a parent perspective. This could include a staff person conducting a "mock" appointment or shadowing a parent as they go through the appointment, followed by a process debrief and analysis of each step.
2. Consider the screening process from the perspectives of each staff member and medical provider involved (e.g., front desk, MA, primary provider). This could include shadowing several patient visits and then asking each staff/medical provider contact for feedback.
3. If the screening measure requires scoring, spot-check scored questionnaires to ensure they are being scored correctly.
4. Spot-check medical records to ensure that scored questionnaires are being filed/uploaded as planned, and that referral information and referral outcomes are being documented as planned.
5. Consider the workflow from an efficiency perspective: Is every staff person and medical provider working at the top of their skillset? Are there any functions that could be streamlined?

Lesson from the Field:

In the First Connections initiative, one FQHC had a workflow that included mailing the screening questionnaire to parents in advance of their child's scheduled well-child visit, and a reminder phone call the day before. In order to determine if this approach was effective, they sampled for a two-week period the number of children arriving for their well-child visit with the questionnaire completed, versus those who forgot the questionnaire or said they had not received it. Based on this analysis, they found that more than 50 percent of the families brought the completed questionnaire with them to their appointment, and therefore concluded that it was worth the time and effort involved in mailing them in advance.

Analysis of linkage outcomes:
Another important metric is 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. In an electronic system, the data may be available for all children screened, and if not, a subset of charts could be reviewed to gather the data for a smaller group of children. If the following variables can be tracked, the program can reveal successes and barriers to linkage, and identify gaps where additional referral sources may be needed.

Variables to Track Outcome of Referrals	
Demographics	• Child's age • Ethnicity • Parent's preferred language
Results of Screening	Scores or ranges on each domain area assessed
Outcome of Screening	• No concerns identified/no referral needed • Monitoring and re-screening needed • Referral needed
Linkage	Where was the child referred?
Outcome of Linkage	• 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?

Lesson from the Field:

AltaMed learned that connecting with referral organizations was critical to assisting families of children found to have (or were at risk for) developmental delays. The team set up meetings with local regional centers and met with the intake coordinators there to get some insight into the referral process. This allowed the project team to troubleshoot and facilitate linkage to resources for the parents. From a case manager standpoint this was valuable as it allowed the case manager to provide tips for families that could facilitate linkage, such as specific information to provide when leaving a message for a regional center intake; reasons why an intake may be prematurely closed; and the ability to directly email an application to an intake coordinator to assist with linkage. Moving forward, these tips will be disseminated to providers to educate them on the process to better assist families should a case manager not be available.

Analysis of parent satisfaction:
Surveys of parents will help to identify successes and barriers from a more individual perspective and may highlight areas where changes are needed or where there are gaps in service availability. Appendix D contains the script for a sample parent phone survey that was conducted as part of the *First Connections* initiative. The survey's target population was parents whose child had at least two domains of concern (black/clinical range) on the ASQ-3, and had been referred for early intervention services.

If an agency clinic has multiple sites, a developmental screening initiative should be implemented at one site first, following the QI process outlined above, to troubleshoot any difficulties and ensure successful implementation. Then, the initiative can be rolled out at additional sites. Guidelines for successful dissemination across sites follow.

Dissemination Guidelines

Pre-Implemetation
- Development of workflow
- Identify champions for the site
- Meet with key people (champions, supervisors, etc.)

Implemetation
- Conduct training of all staff and medical providers
- Conduct close monitoring of site for six months

Post-Implemetation
- Maintain frequent phone contact with key administrative staff
- Conduct a site-visit (six to eight months post-implementation)

Example from the Field:
Northeast Valley Health Corporation successfully spread its developmental screening initiative from one site to all nine of its pediatric health centers. They created a standardized process for implementation of the program, which made it easier for medical providers working across multiple sites to follow the same protocol at each health center. In order to successfully spread to additional sites, it was important to have quantitative data that could be shared with providers on the impact the program had on our patients, such as the number of patients who had a screen indicating a concern, and the number successfully linked to early intervention services following screening. Also, qualitative data, such as feedback from parents (including a video of a parent talking about the positive impact of the screening and the early intervention services), was a very important step in getting staff buy-in. Rather than seeing the screening protocol as additional work, we used success stories of patients receiving services; this approach made a big impact on our staff and providers. In addition, maintaining contact with all sites and conducting regular site visits was important. It reminded staff that our team was available to answer questions and continue to provide support.

Train the Trainer
When spreading the initiative to new sites, it is important to identify staff qualified to conduct training based on their expertise within defined areas. This will ensure that the program is implemented as planned at new sites, and that staff are available to train new staff/providers when there is turnover at the clinic.

The *First Connections* Train the Trainer Model is a guide that helps to determine the appropriate level of training support needed based on training topic, existing level of expertise and clinic needs. Below is a sample list of ways in which the *First Connections* Train the Trainer Model may be utilized. Two worksheets, a *Presenter's Reflection and Observation of Presentation Outline*, were included as tools to support the development of the trainers (see Appendix F).

Identify Trainer
- Identify an individual in the clinic who has some interest, background or experience in the topic to participate in the Train the Trainer Model. This individual is supported through a collaborative process that includes consultation sessions, development of training materials and observation and reflections on the delivery of the presentations.

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

Presentation Plan
- An initial consultation session is held to develop the presentation plan.
- The TA provider/lead trainer provides initial training for clinic/site; the trainer in training either co-teaches with the lead trainer or observes. Additional support is available to the clinic's trainer in training during subsequent training sessions. Support could include live observation of the training session or video review of the training.

Feedback and Reflection
- The clinic/site trainer collects feedback from the audience after each training session.
- The trainer in training completes a *Presenter Reflection* worksheet (Appendix F).
- The TA provider completes the *Observation of Presentation* (Appendix F).
- After the training sessions are conducted, a consultation session provided to discuss the feedback from the audience as well as detailed observations and suggestions from the TA and reflections from the presenter.

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_RCMap.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)

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.

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,

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

1 Caregiver contacts L.A. Care Behavioral Health Department intake line at **888-347-2264** to begin screening process once all required documents have been gathered.

2 During initial call, caregiver answers intake questions (i.e., member ID, demographics, diagnosis information, prior assessments, etc.).

3 Eligibility criteria: Children under the age of 21, medically stable, with a letter from licensed provider recommending evidenced-based BHT services.

3 Caregiver faxes (**213-438-5054**) or emails (**ASDbenefit@lacare.org**) psychological evaluation and/or other documentation to be reviewed and to determine eligibility.

4 If found **eligible** and if caregiver has an ABA provider of their choice, provider is to send an authorization request to L.A. Care. If caregiver does not have a provider, L.A. Care can make available provider list and/or provide direct linkage.

***If found **not eligible**, recommendations will be made by L.A. Care to get second opinion from a contracted licensed psychologist.

5 Assessment (FBA) is then authorized by L.A. Care and is to be completed by ABA provider in a period of three months.

6 After clinician reviews the completed FBA assessment and services are deemed medically necessary, authorization for direct services is approved for a six-month period.

Documentation Needed for ABA Linkage Process

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

Caregiver will ideally provide a psychological evaluation that is less than two years old from regional center. The report must include the ABA recommendation in order for it to be accepted as the sole document; otherwise, member will be referred for re-evaluation.

OR

If a psychological evaluation from a regional center is **not available**, the following are options are available:

1. Any psychological evaluation other than a regional center.
   - If a member does not have a psychological evaluation, L.A. Care can provide linkage for a psychological assessment.

***Caregiver is able to submit a psychological evaluation and ABA recommendation from licensed provider (**Recommendation must be less than two years old**).

2. An ABA recommendation letter/referral from a primary care physician, psychologist, or medical doctor.
   Clinical notes can also be submitted as supporting documentation to recommend ABA.

3. EPSDT

Blue Shield of California Promise
Behavioral Health/ABA Linkage Process

1 Caregiver contacts Blue Shield of California Promise Behavioral Health Department intake line at **888-297-1325** to begin screening after all documentation is completed.

2 During initial meting, caregiver answers intake questions (i.e., member ID, demographics, ASD diagnosis information, prior assessments, etc.).

3 Eligibility Criteria: Children under the age of 21 years, medically stable, with a letter from licensed provider recommending evidenced-based BHT services.

4 Caregiver faxes psychological evaluation or other documentation provided to **844-283-3298** to be reviewed and to determine eligibility (**Please see Slide 2 for a list of documentation that can be provided to Blue Shield of California Promise.**).

5 If found **eligible** and after caregiver requests an in-network ABA provider, MCP reaches out to provider for availability/case acceptance.

***If found **not eligible**, recommendations are made by Blue Shield of California Promise to get a second opinion with a contracted licensed psychologist.

6 Assessment (FBA) is then authorized by Care 1st and is to be completed by ABA provider for a period of two months.

7 After services are deemed medically necessary, an authorization for direct services is approved for a six-month period. A progress report will be submitted every six months to continue determining eligibility.

Documentation Needed for ABA Linkage Process

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

Caregiver will ideally provide a psychological evaluation that is less than two years old from a regional center. The report must include the ABA recommendation in order for it to be accepted as the sole document; otherwise member will be referred for re-evaluation.

OR

If psychological evaluation from a regional center is **not available**, the following are options are available:

1. Any psychological evaluation other than that of a regional center.
   - If a member does not have a psychological evaluation, Blue Shield of California Promise can provide linkage for a psychological assessment.

***Caregiver is able to submit a psychological evaluation and ABA recommendation from a licensed provider (**Recommendation must be less than two years old**).

2. An ABA recommendation letter/referral from a primary care physician, psychologist, or medical doctor.
   Clinical notes can also be submitted as supporting documentation to recommend ABA.

3. EPSDT

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.**

Caregivers must have documentation mentioned in the next slide to begin screening process:

1 Caregiver contacts Autism Center Program at Managed Health Network (MHN) intake line at **888-232-7359** to begin screening process.

2 During initial call, caregiver answers intake questions (i.e., member ID, demographics, diagnosis information, prior assessments, etc.).

3 Caregiver faxes psychological evaluation or other documentation to **415-257-1484** for review and eligibility determination. **Please see Slide 2 for a list of documentation that can be provided to MHN.**

4 If found **eligible**, MHN provides parents with their in-network ABA provider list.

***If found **not eligible**, recommendations are made by MHN regarding treatment and other findings.

5 Once an MHN ABA provider has been selected, the referring MD or licensed psychologist must complete Part A of the **MHN Medi-Cal Applied Behavior Analysis Referral Form** and the ABA provider must complete Part B of the same form and fax to 855-427-4798.

6 Assessment (FBA) is then authorized by MHN and is to be completed by ABA provider for a period of 2 months.

7 After clinician reviews the completed FBA assessment and services are deemed medically necessary, authorization for direct services is approved for a six-month period and thereon. A progress report is to be submitted every six months to continue determining eligibility.

Documentation Needed for ABA Linkage Process

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

Ideally, Caregiver would provide a psychological evaluation from a regional center.

OR

If a psychological evaluation from the regional center is **not available**, the following are options that can be used or taken:

1. Any other psychological evaluation from a facility other than a regional center, if the member does not have a psychological evaluation.

***A caregiver can also submit the psychological evaluation and ABA recommendation as well if they have it.

2. An ABA recommendation letter/referral from a primary care physician, psychologist, or surgeon. ***A child can be approved for ABA therapy as long as one of providers mentioned above recommends ABA and the child is found eligible during the intake process.**

3. EPSDT

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.

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

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 in which delays were identified, and the child was referred for early intervention services. It can be modified to fit the needs of an individual agency. This survey takes approximately 30 minutes to complete.

This survey was developed to obtain information from parents who had participated in developmental screening in which delays were identified, and the child was referred for early intervention services. It can be modified to fit the needs of an individual agency. This survey takes approximately 30 minutes to complete.

Hello, 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 early intervention services.

1. How old is your child? (If more than one child, choose the child that is less than 3 years old).

2. Have you ever filled out a form at your child's doctor's appointment that asked questions about your child's development?

   [***If not sure:***] It asks about things like walking, talking, playing, dressing himself/herself, etc. Doctors use the results of the screening to learn about how your child is growing and to see if they might need more help with learning and developing.

   Do you remember filling out a form like that?

   [***If no:***] Do you have any concerns about your child's development?
   [***If no: survey is over. Thank parent for participating.***]
   [***If yes: skip to question #4***]

3. We would like to know about the results of your child's developmental screening. I'm going to read some questions to you, and please answer "yes," "no," or "not sure" for each one. You are welcome to share more information with me about any of these questions if you'd like.

   a) Did the screening help you understand your child's development?

   b) Did the doctor or another person in the office give you anything in writing to help you understand your child's development?

   c) After the screening, did the doctor tell you that your child might have a delay in his/her development?

   d) After the screening, did the doctor tell you that your child needed further evaluation?

   e) Did your child receive any further evaluation for developmental needs?

4. Was your child referred to a regional center for evaluation?

   [***If yes:***] Which one?

   [***If not sure: read list of regional centers and the street they are on to help parent remember***]

   - Eastern Los Angeles Regional Center on South Fremont in Alhambra
   - Harbor Regional Center on Hawthorne in Torrance
   - Frank D. Lanterman Regional Center on Wilshire in Los Angeles
   - North Los Angeles County Regional Center on Sherman Way in Van Nuys
   - San Gabriel/Pomona Regional Center on Rancho Camino Dr in Pomona
   - Westside Regional Center on Green Valley Circle in Culver City

5. Now I'd like to ask about your experience getting the evaluation for your child at the regional center.

   a) Did you have any problem making or scheduling appointments?

b) Did you have any problem with transportation?

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***]

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

a) Did the person who did the evaluation speak your home language?

[***If not:***] Did they use a translator?

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

c) Did you feel that the evaluator understood your child and got accurate information?

d) How much time did the evaluator spend with you and your child?

e) Did you feel that the evaluator spent enough time to do a thorough evaluation?

f) Did the evaluator get an accurate picture of your child, both strengths and concerns?

g) Did they talk to you about your child's social-emotional development and behavior?

h) Did you understand the results of the evaluation?

i) Did you have an opportunity to get all your questions answered about your child's development or to review the results of the evaluation?

j) Did you understand what to do next to get help for your child after the evaluation?

7. Now I'd like to ask about your experience getting early intervention services for your child.

a) After the evaluation, was your child eligible for early intervention services?

[***If no:***] How did you find out that he/she was not eligible?

(For example, did you receive a letter, or did the person doing the evaluation tell you in person?)

b) Did you meet with a team at the regional center to talk about what services your child would need or about the results of the evaluation?

c) Was the meeting in your home language?

d) Did you start receiving early intervention services yet?
(For example, this might include someone coming to the home to work with your child on their speech, walking, or other areas of development.)

e) Is the person (or are the people) providing early intervention services able to speak to you and your child in your home language?

f) Do you feel that the early intervention services have been helping your child with his/her development?

g) Do you feel that you are included in the early intervention services?
(For example, can you stay in the room, and is the early intervention staff helping you to work with your child on his or her development?)

We really appreciate you answering all of these questions. This is very helpful to us in understanding how to help families like yours to support their children's 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 clinic staff	PowerPoint: Developmental Screening Overview Handouts: Screening Algorithm: Birth through 2.5 Years Screening Algorithm: 2.5 through 5 Years Video: *Early Recognition of Child Development Problems* (4.5 minutes), produced by Centers for Disease Control: www.youtube.com/watch?v=KrUNBfyjlBk Resources: A Healthy Beginning for Young California Kids: Universal Developmental & Behavioral Screenings www.chs-ca.org/_docs/dev-screening-infographic.pdf Learn More About Your Child's Development www.zerotothree.org/resources/series/your-child-s-development-age-based-tips-from-birth-to-36-months Developmental Monitoring and Screening www.cdc.gov/ncbddd/actearly/pdf/Dev-Mon-and-Screen-English-and-Spanish-P.pdf Your Developmental Screening Toolkit docsfortots.org/toolkits/developmental-screening-toolkit/
Developmental Screening: Developmental Conversations with Parents/Caregivers	Medical providers: pediatricians, family practice physicians, nurse practitioners, and physicians assistants	PowerPoint: Developmental Screening: Developmental Conversations with Parents/Caregivers Resource: Guidelines for Talking to Families www.firstsigns.org

APPENDIX E: Training Materials

Topic	Audiences	Activities / Handouts
Screening Measures: Administration, Scoring and Interpretation	Healthcare providers involved in administration and scoring of screening measures	PowerPoint: Screening Measures: Administration, Scoring, and Interpretation Resources: Training DVDs for ASQ available from Brookes Publishing: Twombly, E. & Squires, J. *ASQ-3 Scoring & Referral* products.brookespublishing.com/ASQ-3-Scoring-Referral-DVD-P583.aspx Squires, J. & Twombly, E. *ASQ:SE-2 in Practice* products.brookespublishing.com/ASQSE-2-in-Practice-DVD-P949.aspx
Developmental Screening: Linkage to Resources	Medical providers & case managers	PowerPoint: Developmental Screening: Linkage to Resources Handouts: Screening and Referral Algorithm: Birth through 2 Years Screening and Referral Algorithm: 3 through 5 Years Resources: Learn the Signs: Act Early Milestone Moments Booklet and Tracker App Checklists www.cdc.gov/ncbddd/actearly/freematerials.html Vroom www.vroom.org/ Special Education Rights and Responsibilities-Information on Early Intervention Services serr.disabilityrightsca.org/serr-manual/chapter-12-information-on-early-intervention-services/ 5 Steps for Brain-Building Serve and Return www.youtube.com/watch?v=KNrnZag17Ek

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.