EARLY SCREENING, BETTER OUTCOMES:

Developmental Screening & Referral Toolkit for Family Serving Agencies

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

INTRODUCTION

What is the Purpose of this Toolkit?
This toolkit is designed as a practical guide to support family serving agencies in accurately implementing or refining a high-quality approach to developmental screening and linkage. 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 agencies that focus on providing services to young children and their families, such as early care and education, infant and early childhood mental health, home visiting, and foster care services. It would be suitable for agencies that are implementing a new developmental screening initiative, as well as for those that already conduct developmental screenings but want to review and refine their program.

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

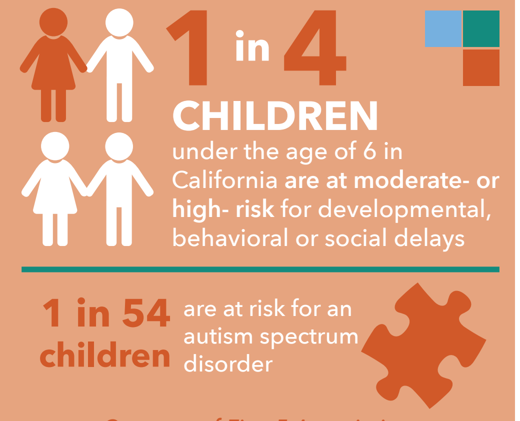
- Experience implementing screening programs for other domains
- Quality improvement process experience
- Knowledge of developmental screening guidelines and best practices
- Knowledge of local resources for early intervention and other common areas of need identified through developmental screening

Benefits of Developmental Screening and Linkage Practices
Developmental monitoring in the first five years of life provides a golden opportunity for developmental conversations between family serving agencies and parents[1] that can:

- Support developmental progress
- Enhance parent-child relationships
- Provide linkage to needed resources
- Strengthen connections between families and family serving agencies
- Aid in tailoring curriculum and/or service goals

Although the American Academy of Pediatrics (AAP) recommends routine developmental screening during well-child visits, the majority of young children do not get screened during routine medical sessions. For some families, the close relationships formed with staff members at family serving agencies provide an alternative opportunity for developmental conversations to occur. The Centers for Disease Control and Prevention's (CDC) *Learn the Signs. Act Early* and the U.S. Departments of Education and Health & Human Services' *Birth to 5: Watch Me Thrive!* are two federal programs that encourage early developmental and behavioral screening and identify the important and unique roles that early care and education providers, mental health providers, home visitors and child welfare workers have in screening and linkage.

- ***Learn the Signs. Act Early.* Program:** **www.cdc.gov/ncbddd/actearly/index.html**
- ***Birth to 5: Watch Me Thrive!*:** **www.acf.hhs.gov/ecd/child-health-development/watch-me-thrive**



Courtesy of First 5 Association

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.

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 that 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]

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.

[1] We recognize that various types of caregivers may be involved in the child's life. Throughout the toolkit, we use the term "parent" to refer to all primary caregivers.
[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] Campbell, H. (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.* childrennow.webfactional.com/files/3014/2617/8707/Dev-Screening-Policymaker_FactSheet_012414.pdf

DEVELOPMENTAL SCREENING, through the use of standardized tools, is recommended to identify and assess a recognized risk. For family serving agencies, conducting developmental screening at intake can help in establishing service goals and an intervention or educational plan. Follow-up developmental monitoring through repeat screening every 6 months can help to monitor progress or changes over time. In addition, some family serving agencies may have developmental screening requirements that are established by third parties (e.g., Head Start) that guide the timing and type of screening completed.

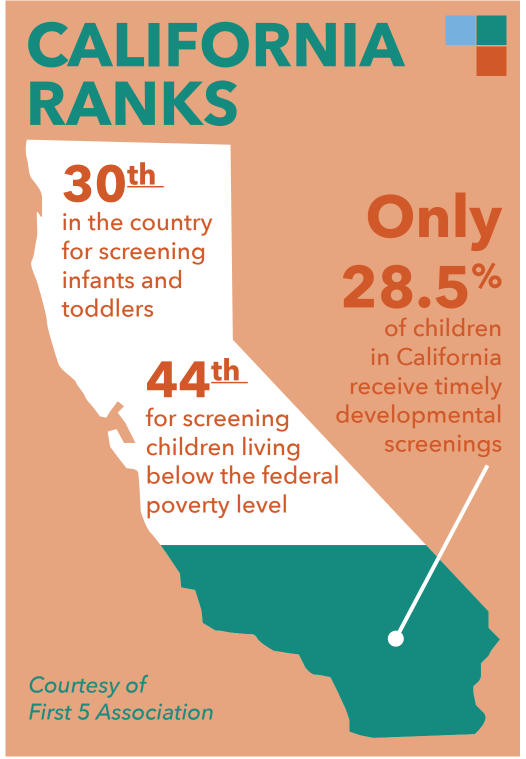
Screening tools are designed for specific domains (e.g., motor skills, communication or social-emotional) and for various delivery settings, ages and purposes. Quality screening tools are standardized on a large, representative population, and have been tested to determine their reliability, validity, sensitivity and specificity.

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.

Staff members may benefit as well from the use of standardized tools for developmental screening:

- When a staff member has less experience with child development, a standardized tool helps to identify subtle delays that might be missed and provides opportunities to talk about developmental milestones.
- Even when a staff member has extensive experience with recognizing developmental delays, a standardized tool helps to frame conversations with parents about those delays.
- The information obtained from a developmental screening tool can aid agency staff in tailoring the curriculum and goals to meet the child's individual needs.



Courtesy of First 5 Association

Despite established recommendations and benefits, most young children do not receive developmental screening, and many developmental delays go undetected at their 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, and between children living in different socioeconomic conditions, in terms of access to developmental screening, early intervention and diagnosis of developmental disabilities.

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

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

Statewide and Local Efforts Strengthening Early Identification and Intervention

In California, there has been growing recognition of the importance of early identification and intervention practices – encompassing routine surveillance, screening, developmental promotion and linkage to timely and appropriate services – to support a child's unique developmental needs. However, California's overall developmental screening rate remains low and the use of standardized screening tools is inconsistent.[7] Furthermore, data indicates many children with or at risk for a developmental delay are not screened, connected to, or accessing early intervention supports, including

[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

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

the Individuals with Disabilities Education Act (IDEA) Part C and behavioral health intervention services.[8,9,10,11,12]

Developmental screening has been incorporated into standard practice for many family serving agencies across California and within Los Angeles County, providing a range of models to reach families in varied settings where young children receive care.

- **Home visitation:** Home visitation programs for pregnant mothers and families with infants and young children are designed to enhance parent-child relationships, expand parenting knowledge and skills, optimize children's early health and development, promote universal access to comprehensive family health care, build strong family-friendly communities, and promote a safe and healthy home.[13] Most home visitation programs target high-risk groups, while others are universal (i.e., open to all families in a community). Many home visitation program models include developmental screening as either a required or recommended best practice. For example, programs implemented in L.A. County that support implementation of screening include Early Head Start (eclkc.ohs.acf.hhs.gov/programs/article/early-head-start-programs), Healthy Families America (www.healthyfamiliesamerica.org), Parents as Teachers (www.parentsasteachers.org), and Welcome Baby (www.labestbabies.org/welcome-baby).
- **Early care and education:** Quality Start LA is a voluntary program that assesses California State Preschool Programs and provides ratings of quality that assist families in identifying high-quality settings. Early education programs receive higher quality ratings if they conduct routine developmental and health screenings, with the highest rating in this domain going to those programs that work with families to ensure screening of all children using the Ages and Stages Questionnaire-3 (ASQ-3) and Ages and Stages Questionnaire: Social-Emotional-2 (ASQ:SE-2), and that use the screening results to make referrals, implement intervention strategies and adaptations, as appropriate. Head Start programs are also required to provide developmental screening for all children at enrollment.
- **Mental health:** Community mental health agencies funded by the Los Angeles County Department of Mental Health (LAC-DMH) provide evidence-based mental health care for infants and young children. LAC-DMH recently revised its intake assessment protocol for children birth to age 5 to include developmental screening and incorporate the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)*[14] which includes an assessment of developmental competencies.

First 5 Commissions have invested in building and strengthening early identification and intervention efforts locally. Many counties have adopted the Help Me Grow model to better coordinate and connect existing systems of early care and education, mental health, home visitation and physical health 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 LA (HMG LA). For more information, visit: www.first5la.org/help-me-grow/.

This toolkit was tested across two family serving agencies that provide an array of services to young children, including preschool, child care, foster family services, home visiting and mental health services. It is a compilation of best practices and learnings for implementing high-quality developmental screening and linkage practices within a community-based family serving agency that aids young children and families. It is our hope that the toolkit will be a guide to further support local, state and national partners in raising the bar on developmental screening and linkage practices and standards.

[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. (2007). *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. (2007). *Need for early intervention services among infants and toddlers in child welfare.* Research Brief, National Survey of Child and Adolescent Well-Being, No. 8. www.acf.hhs.gov/opre/report/nscaw-no-8-need-early-intervention-services-among-infants-and-toddlers-child-welfare
[12] Department of Health Care Services. (2016). *Performance outcomes systems report.* California Department of Health Care Services, Mental Health Services Division. www.dhcs.ca.gov/services/MH/Documents/LosAngeles_CtyAggRep.pdf
[13] LA Best Babies Network (n.d.). *About home visitation.* LA Best Babies Network. www.labestbabies.org/home-visitation
[14] ZERO TO THREE (2016). DC:0-5. *Diagnostic classification of mental health and developmental disorders of infancy and early childhood.* Washington, DC: ZERO TO THREE.

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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 them and their families with culturally and linguistically appropriate services as early as possible. The *First Connection* grantees include two family serving agencies (Allies for Every Child and Foothill Family), three Federally Qualified Health Centers (AltaMed Health Services, Eisner Health and Northeast Valley Health Corporation) and one regional center (South Central Los Angeles Resource Center) co-located 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 Technical Assistance 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 HMG LA by First 5 LA and the Los Angeles County Department of Public Health. HMG 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) at Children's Hospital Los Angeles 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 health care needs. For more information visit www.uscucedd.org.

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Contributors:
We gratefully acknowledge the contributions of the following agencies that participated in *First Connections* and contributed to the development and testing of these toolkit materials.

- **Allies for Every Child** (www.alliesforeverychild.org) invests in healthy childhoods so that every child has a life filled with opportunity. Allies is a child-centered, family-focused organization with a more than 30-year history of delivering on the promise of childhood for Los Angeles' most vulnerable and underserved children and families. Allies offers high-quality early education programs, intensive family strengthening interventions and innovative foster care and adoption services, as well as a range of critical multidisciplinary supports that all Allies families can access, including infant-early childhood mental health services, pediatric health consultations, disability screenings/advocacy, community events, etc. With a deep understanding of how adversity can impact the developing brain, Allies' team of experts design and deliver these services using a neurobiologically-informed, trauma-sensitive and relationship-focused approach. Special thanks to Adriana Cuestas, PsyD, Infant and Early Childhood Clinical Director, for her contributions to the toolkit.
- **Foothill Family** (www.foothillfamily.org/) empowers children and families to achieve success in relationships, school and work through community-based services that advance growth and development. Foothill Family sees brighter futures in which individuals and families thrive, communities are strengthened, and generations are enriched. Programs offered for young children include mental health care; early childhood development programs, including preschool preparedness and parent education; child abuse prevention and treatment; and preschool programs.

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 an existing screening program. Each phase is comprised of a series of steps that are identified below and correlate to additional details and materials found within the toolkit.

I. Plan

1. Assemble implementation team
2. Set goals
3. Establish developmental screening plan
   a. Determine which agency programs will provide screenings
   b. Select and obtain screening measure(s)
   c. Determine screening schedule
   d. Integrate screening tools into the client chart
   e. Determine agency processes, workflow and staff roles
4. Provide developmental conversations and developmental guidance
5. Develop referral and linkage plan/workflow
   a. Customize referral resources
   b. Customize referral algorithm
6. Pilot workflow and screening
7. Draft implementation timeline

II. Launch

8. Develop training plan and conduct training
9. Launch implementation

III. Evaluate, Refine, Spread, Sustain

10. Track quality improvement
11. Spread to other agency programs (if applicable)

PHASE 1: PLAN

STEP 1: Assemble Implementation Team

Successfully introducing and sustaining a developmental screening program relies on the Implementation Team's structure and governance. The team is collectively responsible for advancing the initiative from planning through post-analysis. While the team's ultimate composition depends on the size, staffing pattern and work roles of each agency, key roles to emphasize include the project's champion, leader, and subject matter experts who understand the needs of the agency, its staff members and its clients.

The following team roles have been found helpful in the family serving agencies 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 manager 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; talk with staff who may be less confident about administering screening tools or talking to parents; assist staff in utilizing screening results to inform curriculum development and goal setting; and provide feedback to the rest of the implementation team about barriers, process gaps, user input and suggested solutions. Some agencies may have an overall champion for the project to help build momentum and provide motivation, and have leads assigned to each agency program that will be implementing the screening project.

Lead
Like the champion, the lead for the initiative may already be familiar with developmental screening and/or have some previous exposure to developmental screening tools. In some smaller 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 in all programs within the organization as well as with families about the goals, benefits and timing. In some agencies, there may be separate leads for each program that will be implementing the screening protocol (for example, different leads for the preschool program, mental health program and foster care program).

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

- **Case Manager:** A person who is knowledgeable about resources within the agency and the larger service system for young children with developmental delays and is skilled at linking families with services.
- **Staff to conduct screening and discuss results with parents such as:**
    - Education staff (e.g., child developmental specialists, preschool teachers, daycare providers)
    - Home visitors
    - Mental health clinicians
- **Project Coordinator** to manage tasks such as tracking screenings, providing data about screening outcomes, and ensuring screening tools are available.

STEP 2: Set Goals

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 screening process as needed.

Gather Baseline Data

The first step of goal setting is to gather baseline data on developmental monitoring practices in the agency and consider how the developmental screening initiative fits within the agency's other related practices or policies. Sample questions that might help the team gather data include:

Staff and Program Readiness

- How familiar are staff members with developmental screening?
- Are any agency programs currently using developmental screening tools?
- What views do staff members have regarding how developmental screening fits in with existing practices and requirements?
- Are staff members prepared to incorporate developmental screening in the work they do with children and families?
- What might be some of the challenges or barriers? The benefits or strengths?

Approximately **25%** of young children are at risk for a developmental or behavioral delay.

Current Screening Practices

- Describe each program in which children birth to age 5 are served.
    - What does the intake process look like for new clients?
    - Who completes the intake?
    - How is intake data gathered and stored?
- Do current practices involve developmental monitoring in some form? Are there existing agency or funder requirements related to developmental monitoring or screening?
    - If so, how are those screening practices working?
    - Are there programs serving young children that are not implementing screening, but would benefit from screening?

Tracking

- What kind of documentation is tracked regarding the children receiving services at the agency? Can the results of developmental screening and linkage process be integrated with the existing charting system?
- How can the results of developmental screenings be tracked in order to support monitoring, as well as related referral and linkage?
- What system needs to be set up to ensure that children are screened at the planned intervals and that duplicate screenings are not done?

Funding

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

Identify 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. Questions to consider include:

Screening Domains

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

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

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

Screening Rates and Procedures

- What percentage of children will be screened?
- Which agency programs will conduct screenings?
- When and how will children be screened?
- Who will conduct the screenings?
- How will best practices be defined and shared across the agency?

Effectiveness of Implementation

- How will the experiences of parents and staff members 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.

Ideally, implementation goals will be measurable and include benchmarks for progress. For example, goals might include:

1. 85 percent of children birth to age 5 at the agency will complete a developmental screening at intake.
2. 85 percent of children will complete developmental screenings every 6 months after the initial intake screenings.
3. 85 percent of children with possible delays will be linked with resources to address their developmental needs.

STEP 3: Establish Developmental Screening 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. Determining which agency programs will provide screenings
2. Selecting and obtaining screening measures
3. Determining the timing for screening
4. Determining the method and location of screening administration
5. Designing process, workflow and staff roles within each program that will be implementing screening

The focus of this toolkit is on implementation of developmental screening, which is one step in the process of identifying developmental delays and disabilities and ensuring that children are linked to appropriate services when concerns are identified. If the screening indicates an area of concern, children will need to be linked to providers for a comprehensive assessment in order to document if there is a delay or disorder and to design an intervention plan. In some family serving agencies, there may be staff with the expertise to conduct comprehensive assessments. However, in most cases, children identified with concerns on the screening will be linked to outside agencies for further assessment.

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

Determine which agency programs will provide screenings

Family serving agencies often provide an array of programs across age groups. Developmental screening is most highly recommended for children from birth to age 5. Therefore, agencies may want to review all programs that provide services to this age group when collecting baseline data in Step 2. Based on that data, decisions can be made about whether to:

- Launch developmental screening designed to reach all children birth to age 5 in any agency program
- Focus on one or more programs that are most ready to start a screening program (possibly expanding to other programs later)
- Work to refine and improve an existing screening program
- Provide outreach through community screening events, and/or screenings for siblings of agency clients

A Closer Look:

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

Centers for Disease Control and Prevention:

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

Administration for Children & Families:

- *Birth to 5: Watch Me Thrive!*: www.acf.hhs.gov/ecd/child-health-development/watch-me-thrive
- *Infant/Toddler Development, Screening and Assessment*: childcareta.acf.hhs.gov/resource/infanttoddler-development-screening-and-assessment

Head Start Early Childhood Learning & Knowledge Center:

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

American Academy of Pediatrics:

- Healthy Child Care America: Developmental Screening: www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-child-care/

Select and Obtain Screening Measures

When selecting developmental screening measures, consider:

- Which developmental screening tools are most familiar to staff members in the agency?
- Which tools are a good fit for the population the agency serves (including ensuring that validated translations are available for the chosen tool if the agency serves families who speak languages other than English)?
- Which tools are standardized and validated on populations similar to those the agency serves?
- What will be the cost of the screening measures?

EXAMPLES OF RECOMMENDED TOOLS FOR DEVELOPMENTAL SCREENING:

	ASQ-3 and ASQ:SE-2 Ages and Stages Questionnaire-3 and Ages and Stages Questionnaire: Social-Emotional-2 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
Domains Measured	Communication, motor, problem solving, adaptive skills, social-emotional	Broad developmental domains	Autism symptoms
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

Birth to 5: Watch Me Thrive! developed a compendium of screening measures for young children that can be found here: eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/screening-compendium-march2014.pdf. All measures included in the compendium meet the following criteria:

- The tool is designed for the purpose of screening (not child assessment).
- The screening tool is appropriate for use with children between birth and age 5.
- The screening tool covers multiple developmental domains (e.g., physical/motor, cognitive, linguistic, social and emotional development).
- The screening tool is available for use by early childhood practitioners (early care and education providers, primary care practitioners, behavioral health service providers, home visitors, early intervention specialists, etc.).
- Information about the screening tool's administration, training, reliability and validity (i.e., sensitivity and specificity) is readily available.
- The tool covers the domain of social and emotional development.
- The tool includes family input.
- The tool has a sensitivity and specificity of 0.7 or greater.

After selecting the screening measures, the agency 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 and Stages Questionnaire-3* (ASQ-3), *Ages and Stages Questionnaire: Social-Emotional-2* (ASQ:SE-2), and *Modified Checklist for Autism in Toddlers, Revised* (M-CHAT-R) 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.

Integrate Screening Tools into the Client Chart

As part of the planning process, it is recommended that agencies include the screening measures in the client chart. Advantages include:

- Easy access for staff to review prior screening results and observe the child's developmental trajectory over time
- Higher likelihood that measures will be completed as planned
- Increased efficiencies in scoring by using approaches that enable the parent to complete the screening electronically

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. The TA team compared scores on the *Ages and Stages Questionnaire-3* and the *Ages and Stages Questionnaire: Social-Emotional* for 608 children (more than 50 percent in Spanish). Findings show that 14 percent had a positive screen on the ASQ:SE, suggesting that they should be referred for further mental health evaluation. Less than half of these children would have been identified as needing additional assessment or intervention if only the ASQ-3 had been administered. Therefore, it is recommended that developmental screening include the social-emotional domain.

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

Determine Screening Schedule

Family serving agencies may choose to complete all screening measures at intake, and then every 6 months thereafter. For reference, The *Ages and Stages Questionnaires-3rd Edition* (ASQ-3) manual, a developmental screening system that is included in the *Birth to 5: Watch Me Thrive!* compendium of screening measures for young children, recommends the following screening schedule:

- ☑ Screen children at regular intervals, from 2 months to 5 years, 6 months, if possible.
- ☑ Ideally, children should be screened initially at 2 and 4 months, then at 4-month intervals until they are 24 months old, and then at 6-month intervals until they are 5 years, 6 months old.
- ☑ Screening children more frequently than every 4-6 months (except at the 2- and 4- month intervals) is not recommended unless there is some reason to suggest that more frequent screening would be useful.

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 agency site?
- Will a paper back-up be available in case of technical challenges? If so, how will results from paper questionnaires be included in the client chart?

If a fully electronic interface is not feasible, then alternative methods for including the information in the client chart need to be considered. 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.

Determine Agency Processes, Workflow and Staff Roles

Developing and pilot testing a detailed workflow is essential to successfully integrating developmental screening into agency procedures.

Suggested questions to address when developing agency screening processes are listed below. The specific questions to consider would vary depending on the size of the agency, programs within the agency, staff roles, client volume, and other screening tools already in use or planned.
Agencies can determine if they want to have the same processes across programs or modify the workflow to fit each setting/program.

Identification

- What are the needs of the children and families being served?
- Who will be screened?
- 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 for completion at home or provided in person when the parent comes to the agency for services?
- If the screening tool is provided to the parent to complete at home, will help be offered over the telephone if the parent has questions about completing the measure?

- If the parent will complete the screening tool in person, 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 client'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 client outcomes be tracked?

Birth to 5: Watch Me Thrive! offers screening guides tailored to different staff members to promote early developmental and behavioral screening. The guides focus on why developmental and behavioral screenings matter, how to talk to parents, where to go for help, and how to select the most appropriate screening tool for the population served as well as the staff member implementing the screening.

- **Behavioral Health Providers:** www2.ed.gov/about/inits/list/watch-me-thrive/files/behavioral-health-guide-march2014.pdf
- **Child Welfare:** www2.ed.gov/about/inits/list/watch-me-thrive/files/child-welfare-guide-march2014.pdf
- **Communities:** www2.ed.gov/about/inits/list/watch-me-thrive/files/communities-guide-march2014.pdf
- **Early Care and Education Providers:** www2.ed.gov/about/inits/list/watch-me-thrive/files/ece-providers-guide-march2014.pdf
- **Early Intervention Service and Early Childhood Special Education Providers:** www2.ed.gov/about/inits/list/watch-me-thrive/files/early-intervention-guide-march2014.pdf
- **Home Visitors:** www2.ed.gov/about/inits/list/watch-me-thrive/files/home-visitors-guide-march2014.pdf
- **Housing and Homeless Shelter Providers:** www2.ed.gov/about/inits/list/watch-me-thrive/files/shelter-screening-guide.pdf
- **Primary Care Providers:** www2.ed.gov/about/inits/list/watch-me-thrive/files/pcp-screening-guide-march2014.pdf

Telehealth and Developmental Screening

Developmental screening can be conducted virtually, either in addition to in-person visits or as part of regular telehealth care. Agencies 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; parent can scan or take a photograph of completed questionnaire and send it back to the agency
- Conducting a telephone or virtual session that includes time to help the parent complete the questionnaire

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

A Closer Look: Sample Workflow

The following workflow sample is utilized at one of the *First Connections'* participating family serving agencies as part of their Early Care and Education Program that completes all screening measures at intake and repeats every 6 months.

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

Sample Workflow Algorithm

Before Appointment

Educational staff provides all new intake clients with a parent handbook, which describes screening procedures

Educational staff selects the appropriate screening measures for the child's age and language of parent, and provides them to parent to complete

Parent completes screening measures at home before appointment

Day of Appointment

Educational staff collects completed screening measures, and gives parent *Milestones Moments* booklet and encourage parent to download *Milestones Moments* app

Educational staff scores screening measures and gives them to case manager for review

Case manager determines if referral is needed [note that referral may also occur before completion of screening measure if a prior concern(s) is specified]

After Appointment

- Educational staff initiates developmental conversation with parents and discusses screening results
- If case manager recommends referral, educational staff discusses recommendation with parents and provides guidance on process
- Case manager generates a feedback letter that includes developmental guidance activities
- Screening results are added to child's record
- Screening is repeated every 6 months

Before Appointment

Educational staff (e.g., child developmental specialists, teachers, home-based educators) provides all new intake clients with a parent handbook which describes screening procedures. Educational staff selects appropriate screening measures for child's age and language of parent. Screening measures must be completed within 45 days of intake.

During Appointment

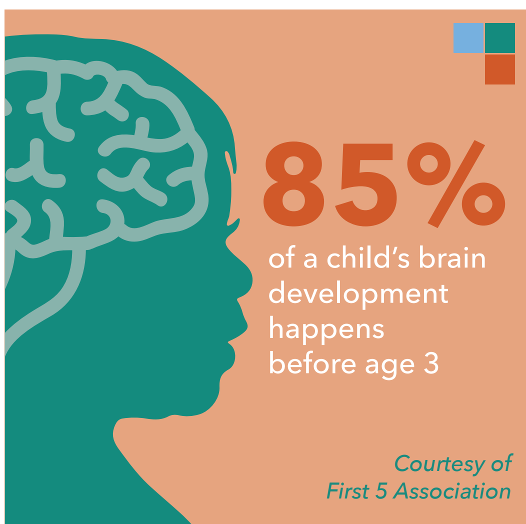
Parent completes screening measures at home during appointment. Educational staff collects and scores screening measures, provides parent with a *Milestones Moments* booklet and encourages parent to download the *Milestones Moments* app, retains measures to give to the case manager for review. Educational staff gives measures to case manager for review, to determine if referral is needed. However, referral may also occur prior to the completion of screening measure if a concern(s) is specified beforehand.

After Appointment

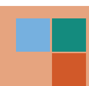
Educational staff initiates developmental conversation with parents and discusses screening results. If case manager recommends referral, educational staff then discusses recommendation with parent(s). Case manager also generates a feedback letter that includes developmental guidance activities. Screening results are retained in the child's record to support ongoing developmental monitoring. Screening is repeated every 6 months.

STEP 4: Provide Developmental Conversations and Developmental Guidance

Parent's completion of developmental screening measures creates an opportunity for the staff member to have open developmental conversations with parents and provide them with guidance. Beyond identification of delays, discussions about child development and developmental milestones are also 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 staff members.



A program's cultural and linguistic competence depends on a thoughtful and sensitive approach to families, from first contact and through all aspects of program delivery, including screening. Throughout the screening process, it is essential that parents are provided opportunities to ask questions and discuss their values and cultural beliefs, and that staff are open to engaging parents as full partners in the screening process. (See 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 skills or behavior or the parent-child relationship.
- 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 agency screens all children, 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. When raising 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).
- Discuss ways that the agency program helps to support the child's development.

STEP 4: Provide Developmental Conversations and Developmental Guidance

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 beliefs, and can successfully engage them in the linkage and intervention process. It is important to schedule enough time for the staff member to share the screening findings with the parent and provide them with information about next steps in the linkage and referral process. Sometimes parents will not be ready to accept a referral. In family serving agencies, staff usually have multiple opportunities to discuss the child's developmental progress. Therefore, if a parent expresses reluctance to follow through with a referral, the staff can discuss ways that the agency program can continue to support and monitor the child's development. The staff member can leave the door open for ongoing discussions and questions from the parent about their child's development. Sometimes the first conversation "plants the seed," and parents then begin to notice more examples of their child's developmental competencies and difficulties. The staff person can provide follow-up discussions as needed as the parent seeks more information.

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 (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 the ASQ-3 materials.
- After-Screening Letter – Appendix B has a sample letter that can be used to briefly summarize the results of the screening evaluation. The letter may assist families in navigating 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 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 process covers how to refer and link children and families to additional community resources to support the child's development, including comprehensive assessments, early intervention and special education services. **Referral and linkage** follows screening, and is indicated when a child has an at-risk or clinical presentation, and/or a family requests additional resources.

As part of the developmental screening workflow, it is important to identify which staff members 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, depending on staff roles and training, and agency resources. The first step is to determine which staff will identify the appropriate referral resource(s) and which staff will discuss the referral recommendations with the family. Two examples follow:

1. Staff who work directly with the child and family (e.g., teacher, home visitor, mental health provider) determine what referral is appropriate and review the referral recommendations with the parent. Families often appreciate having a familiar person provide them information about the recommended referral; they may then be more open to hearing the information, and to extend the trust they have in the agency to the service that is recommended. This approach depends on the direct service staff being knowledgeable about the service system and skilled in assisting families to navigate the service system when they encounter barriers.

2. A central person, such as the developmental screening project lead or a trained case manager, assists direct service staff with the linkage process. In the *First Connections* initiative, case managers dedicated to helping link families with services were an important component to successful linkage. They provided guidance to the direct service staff to understand the service system; identified the most appropriate referral to meet the child's needs; discussed the referrals with families; and assisted families who encountered barriers.

Regardless which staff member provides the referral information, the following steps are important components:

1. Written information: A summary of the results of the developmental screening and written contact information for the referral is helpful to families. This enables parents to reflect on the information again after the developmental conversation, and to review it with other family members as part of the process of learning about their child's developmental needs and the resources available. The following types of written information may be helpful:
   a. Signed releases of information/exchanges of information: The staff member should ask the parent to sign a release of information form, allowing the staff member and the agency to which the child is referred to communicate about the referral outcome. This will allow the staff member to request records documenting any evaluations that were completed and any services to be offered, which can be saved to support ongoing developmental monitoring.
   b. After-Screening Letter (see above under Developmental Conversations and Developmental Guidance, page 17)
   c. List of referrals: Appendix B contains a referral handout, based on a resource letter developed by the Early Developmental Screening and Intervention (EDSI) Initiative,[15] which can be

[15] From 2005-2010, the Early Developmental Screening and Intervention (EDSI) Initiative goal was to identify children with developmental and behavioral delays as early as possible and to connect them with appropriate and effective services and interventions that would optimize their potential for success. EDSI was comprised of these core components: 1) empower physicians in early care and education settings; 2) connect communities so that providers can work together; and 3) create sustainable change. First 5 LA supported the EDSI initiative, administered by the UCLA Center for Healthier Children, Families and Communities.

customized by each agency 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: child care, early education and special education; mental health services; and other family supports.

d. 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), agencies 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.

2. Preparation and support: Parents often appreciate assistance in preparing to contact a referral source, or having support during the actual phone call or first visit to the agency. 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 an early intervention resource 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. Examples of a warm handoff may include:
   - ☑ Giving the parent additional information about the agency where their child is being referred, including what to expect in terms of intake or further assessment;
   - ☑ Helping the parent prepare their questions to ask the agency where they are being referred;
   - ☑ Offering to call the agency together with the parent;
   - ☑ If the call is made together, helping the parent to ask their questions and supporting them in ensuring they understand what will happen next; and
   - ☑ Debriefing with the parent after the call.

3. Follow-up: It is recommended that staff reach out to the parent about two weeks after the referral is made to find out whether the linkage was successful and to help the parent with next steps if there have been any barriers.

Lesson from the Field:

The family serving agencies that participated in First Connections found that the role of the case manager to support families in linking with services was essential. When hiring and training a case manager, it is important to ensure a high level of knowledge about the special education and early intervention system in that community. For example, the case manager who was part of the First Connections team at Allies for Every Child collectively had 20+ years of experience in special education and early intervention. 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. The First Connections team at Allies for Every Child also reported that it was incredibly helpful to provide families with a roadmap or sequencing when discussing linkage to special education and early intervention. This roadmap of "what comes next" allowed families to better understand the process, and helped to reduce anxiety and potential barriers.

Customize Referral Resources

Many family serving agencies will have internal resources to meet some or all of the needs identified through the developmental screening process. Families often appreciate being able to access additional services within the same agency they have grown to trust. Therefore, it is helpful to start with gathering information about all resources within the agency that may be useful to young children with developmental delays or concerns. Next, review the most common referral sources in the community that are currently used for young children.

This toolkit provides guidance about common referral resources (focused on early intervention, preschool/special education/early education, and behavioral health). However, individual agencies will need to customize the referral resource materials to fit their community and population. This includes determining which resources are provided internally, which community resources the agency already has a relationship with, and what gaps exist that may need additional outreach. As resources are identified, gather information about the referral-making

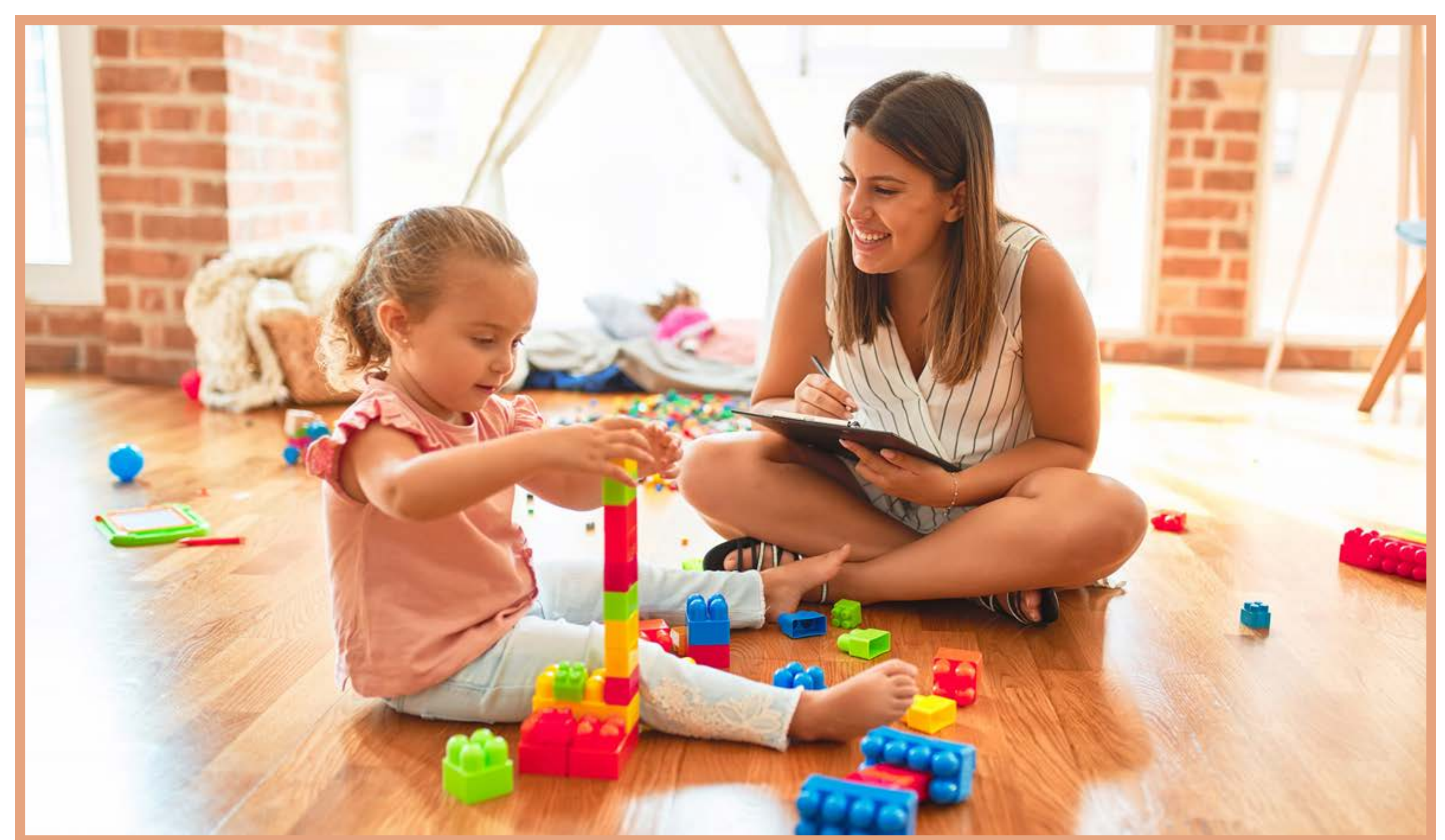
procedures. For frequently used external resources, it may be helpful to establish a formal memorandum of understanding (MOU).

The following common referral sources were frequently used in the *First Connections* initiative, some of which were internal agency resources and others provided through the community:

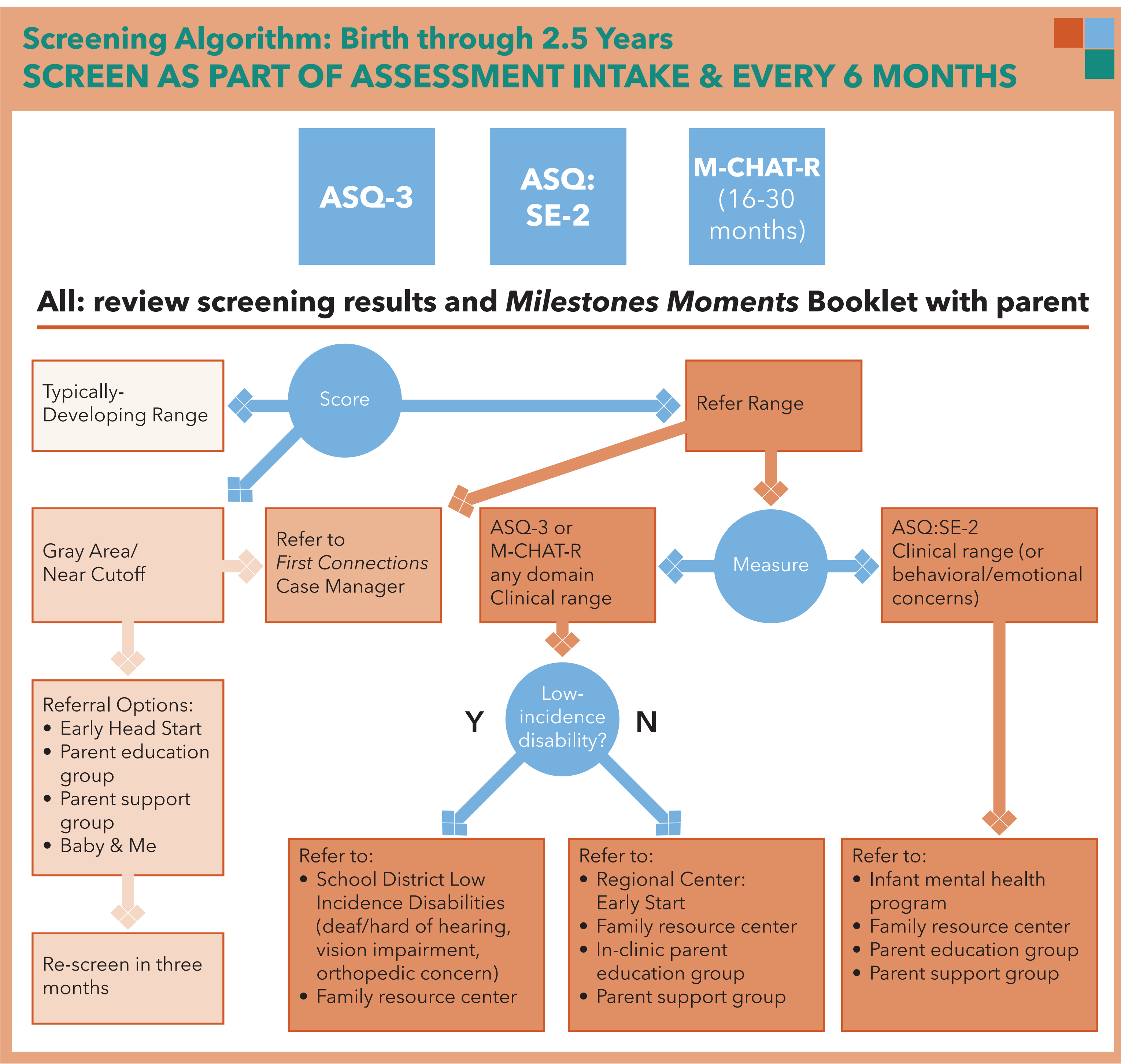
- Early intervention (services through the Individuals with Disabilities Education Act [IDEA] Part C for children from birth to age 3)
- Special education (services through IDEA Part B for ages 3 through 21)
- Preschool/early education for children who may not be eligible for special education, or in addition to special education services
- Head Start (ages 3-4) and Early Head Start (ages 0-2)
- Infant and early childhood mental health services/ behavioral health services
- Family support programs, including family resource centers (FRCs) and ethnic-specific family support organizations

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

Lesson from the Field:
At Allies for Every Child, the *First Connections* team shared that they followed an individualized protocol for children falling in the "gray zone" in a developmental domain. That is, if a child was in the gray zone, they would consult with the parent(s) to determine if developmental guidance and a plan for follow-up screening was appropriate, or if linkage to special education or early intervention services was needed at that time. In addition, if a child was in the gray zone, this information was considered when developing their school readiness goals. This ensured that development was being addressed in multiple settings with multiple staff members (e.g., center-based program, home-based setting, child care providers).



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



Screening Algorithm: 2.5 through 5 Years

SCREEN AS PART OF ASSESSMENT INTAKE & EVERY 6 MONTHS

ASQ-3

ASQ: SE-2

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

Score

Typically-Developing Range

Refer Cutoff

Gray Area/ Near Cutoff

Refer to *First Connections* Case Manager

Referral Options:
- Head Start
- Preschools
- Parent education group
- Parent support group

Re-screen in three to six months

Measure

ASQ-3 or M-CHAT-R any domain Clinical range

Refer to:
- School District: Special Education
- Family resource center
- In-clinic parent education group
- Parent support group

ASQ:SE-2 Clinical range (or behavioral/ emotional concerns)

Refer to:
- Mental health program
- In-clinic parent education group
- Parent support group

The sample screening referral algorithm is divided by age to guide referrals for children birth through age 2.5, and children ages 2.5 through 5. It is based on results from agencies administering the ASQ-3, ASQ:SE-2, and M-CHAT-R. The top of the algorithm summarizes the screening schedule (intake and every 6 months) and measures used for the agency. Results of the screening measures are categorized on the algorithm into three color ranges to represent different levels of risk: white ("Typically Developing Range"); gray ("Gray Area/Near Cutoff"); and black ("Refer Range").

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 programs also may provide developmental guidance (including, but not limited to, ASQ Activities Sheets).

Gray Area/Near Cutoff: 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 Sheets); and 4) more frequent re-screenings (3 months instead of 6). In addition, depending on the concerns, the staff member may refer to agency and/or community resources that are available to all children and do not require documentation of developmental delays. Examples include Early Head Start or Head Start, a Baby & Me group, or a parent support group. These resources tend to vary more by community and thus, referral sources need to be established through exploration of available child and family supports in each community.

Refer Range: When one or more of the scores is in the refer range, parents receive: 1) feedback about screening results; 2) written information about child development (such as the CDC's *Milestones Moments* booklet and/or *Milestones Moments Tracker* app); and 3) a referral for agency and/or community resources 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 (see additional information about referrals for children scoring in the "refer" range below).

Birth through age 2.5 referrals for scores in the "refer" range – Early Intervention Referrals
When one or more of the scores in each of the domains from the ASQ-3 are within the "Refer Range," or identified as high risk on the M-CHAT-R, an early intervention referral is recommended. In most cases, the primary cause for referral for children 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 regional centers.

Follow this link to locate the Part C program in your state: 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 "refer" range – Special Education Referrals
When one or more of the scores in each of the domains from the ASQ-3 are within the black "Refer Range," a special education referral is recommended. IDEA Part B ensures that children ages 3-21 with disabilities receive free appropriate public education to accommodate their needs and access the educational curriculum. Follow this link to locate information about the Federal IDEA Part B program: www2.ed.gov/parents/needs/speced/iepguide/index.html

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

Birth through age 5 – Family Support/Family Resource Center Referrals
In addition to the primary referral to early intervention or special education, it is recommended to refer families to a family support organization, such as a family resource center. Depending on the agency, additional internal resources may be available. Additional information about family resource centers is provided in Appendix A.

Both age groups referral for scores in the "refer" range – Mental Health referrals
When scores are in the refer range on the ASQ:SE-2 (or behavioral/emotional concerns are identified), a referral for infant/early childhood mental health services is recommended. These services may be available within the family serving agency, 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 agency-wide, a pilot of the screening process with a small number of clients is recommended. The focus of the pilot depends on whether the agency plans to implement in multiple programs or to start with one program. Because programs differ in their staffing patterns and workflows, it is recommended to pilot first in each program where screening is planned to occur.

During the pilot, a member of the implementation team will shadow each participating family to determine if any changes are needed to the workflow based on the parents' experiences and observations. At the end of the screening session, 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 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 staff member who was involved in the pilot.

STEP 7: Draft 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 program. The timeline should include:

- Plans to identify and invite pilot test clients and their parents, gain agreement for their participation in pilot, and conduct pilot
- Post-analysis of pilot test and development of amended workflow
- Schedule for training staff (see Step 8)
- Date and program location(s) to begin screening implementation
- Date to expand to additional programs, if the program will be phased in gradually

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.

Appendix E includes training materials for four developmental screening training topics (see below). 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 agencies. A sample evaluation form also is included to assess the effectiveness of the teaching style and content.

> The one-hour webinar, *Empowering Developmental Monitoring* (from CDC's *Learn the Signs. Act Early.* program) features a parent, a health care provider and an early care and education provider discussing the importance of tracking developmental milestones and working together to effectively monitor child development. This webinar may be helpful in promoting overall provider readiness: **www.aucd.org/template/event.cfm?event_id=8439&id=740&parent=740**

The following training sequence was found to be effective among the family serving agencies of the *First Connections* initiative. Technical Assistance can support the delivery and evaluation of the training sessions as well as individualize the support needed by the agency staff.

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

2. Case manager and any other staff who will discuss screening results with parents (e.g., child developmental specialists, preschool teachers, home visitors, mental health clinicians)
   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.
   Goals: Provide guidance for framing developmental conversations with parents.

3. Staff who will administer and score measures
   Time: Approximately 45 minutes
   Title: Screening Measures: Administration, Scoring, and Interpretation
   Topics: Administering and scoring screening measures, with a focus on ASQs and M-CHAT-R.
   Goals: Ensure entire staff is familiar with their roles in using the correct measure/form, presenting the measure to parents effectively, and scoring the measure.

4. Case manager and/or other staff who will assist families with linkage to resources
   Time: Approximately 45-60 minutes
   Title: Developmental Screening: Linkage to Resources
   Topics: Referral algorithm and helping parents navigate the referral process
   Goals: Provide guidance about referral pathways and process for making referrals.

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

Training Considerations

The following recommendations are based on the First Connections Training and Technical Assistance team's family serving agency 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 plays, case study material and small group discussion. For example, when training on developmental screening, administration and scoring, case study material is always utilized to provide staff with hands-on scoring practice.
- **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, facilitate further discussion or follow up if additional clarification is needed. The trainers should also communicate continued availability by e-mail or phone, and provide additional resources to the staff member, as requested.
- **Offer refresher training:** It is important to provide refresher sessions, opportunities for follow-up discussion, 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 programs approach training and screening. For example, one agency'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 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 services; 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, Sustain," introduces train the trainer model information for agencies interested in developing their own capacity to conduct staff trainings.

Lesson from the Field:

Through the *First Connections* initiative, Foothill Family and Allies for Every Child 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 protocol for screening at intake and every 6 months, screening rates can be maintained or improved over time. The *First Connections* team at Allies for Every Child also reported that offering a fixed group-training schedule, as well as flexible one-on-one trainings, ensured competency. In addition, the train the trainer model was identified as key to spreading and sustaining training efforts.

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 members who will administer them to families
- ☑ Protocol for screening schedule and workflow has been disseminated to all relevant staff
- ☑ Staff members have been trained in their screening and linkage roles
- ☑ Plan for recording screening results and linkage recommendations has been developed

In the first month of implementation, a meeting at the end of each week is recommended to review and address any challenges that arose in implementing the program.

PHASE 3: EVALUATE, REFINE, SPREAD, & SUSTAIN

STEP 10: Track Quality Improvement

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

- Examples of QI approaches in early care and education: www.researchconnections.org/childcare/resources/27882/pdf
- Examples of QI approaches in child care: childcareta.acf.hhs.gov/topics/quality-improvement
- Examples of QI approaches in home-visiting: mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting/home-visiting-program-technical-assistance/performance-reporting-and-evaluation-resources

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. Tracking methods will depend on the type of charting used by the agency and the screening tool(s) implemented.

System-wide tracking of completion rates

Collecting data for particular programs or at particular points in time can be helpful for tracking specific components of the developmental screening initiative to determine if it is working as planned. For example, an agency may start by tracking one program at a time (e.g., home visiting) before moving to track another program, or ensure that data is being collected sufficiently by implementing data checks at particular time points (e.g., every 6 months). A tracking sheet could be prepared and included in the child's chart; data to check for may include:

- A note indicating the date on which the measure was completed
- The developmental screening tool used
- Evidence of a screening result or screening score
- Outcome, such as referral and linkage details

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 member practicing the workflow with another staff member who is assuming the role of a parent; staff members would then swap roles. This would be followed by a process debrief and analysis of each step.
2. Consider the screening process from the perspectives of each staff member involved. This could include providing opportunities for staff members to pair up and shadow each other for at least one meeting in order to discuss steps that went well as well as areas for growth.
3. If the screening measure requires scoring, spot-check scored questionnaires to ensure they are being scored correctly.
4. Check to ensure that screening results are being logged correctly in the child's chart or other tracking system.
5. Consider the workflow from an efficiency perspective: Is every staff member working at the top of their skill set? Are there any functions that could be streamlined?

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. A subset of children's charts could be reviewed to gather the data for a small sample 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.

Lesson from the Field:

Allies for Every Child confirmed that connecting with referral organizations was critical to assisting families of those children found to be at risk for or with developmental delays. Regular communication with local regional centers and school districts ultimately helped to facilitate linkage and foster relationships between the First Connections team and the referral organizations.

Variables to Track Outcome of Referrals	
Demographics	• Child's age • Ethnicity • Preferred language
Results of Screening	Scores or ranges on each domain area assessed
Outcome of Screening	• No referral needed/no concerns • 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?

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 preschool-aged child had developmental concerns based on the ASQ-3 and had been referred for school special education services. The questions could be modified to fit other populations of interest.

STEP 11: Spread to Other Agency Programs

If an agency has multiple programs or sites, a developmental screening initiative should be implemented in one program 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 or programs. Guidelines for successful dissemination across sites or programs follow.

Dissemination Guidelines

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

- Conduct training of all staff
- Conduct close monitoring of site/ program for six months

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

Train the Trainer

When spreading the initiative to new sites or programs, 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 when there is turnover at the agency.

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 agency needs. Below is a sample list of ways in which the *First Connections* Train the Trainer Model may be utilized. Two worksheets, an Observation of Presentation Outline and Presenter's Reflection, were included as tools to support the development of the trainers (see Appendix F).

Identify Trainer

- Identify an individual in the agency 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 agency trainer, or provided to the agency 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 agency; the trainer-in-training either co-teaches with the lead trainer or observes. Additional support is available to the agency'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 agency 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 is provided to discuss the feedback from the audience as well as detailed observations and suggestions from the TA and reflections from the presenter.
- Additional consultation sessions are offered based on the trainer-in-training's and agency's needs.

APPENDIX A:

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

Date:______________________________

Dear Parent,

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.

Child's name:______________________________

Parent's name:______________________________

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.

Category	Service	Contact
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*
Child Care, 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 child care 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 to age 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, Infants & Children 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

Categoría	Servicio	Contacto
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*
Servicios de Intervención Temprana	**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*
Cuidado Infantil, Educación Temprana y Educación Especial	**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*
Cuidado Infantil, Educación Temprana y Educación Especial	**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*
Cuidado Infantil, Educación Temprana y Educación Especial	**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*
Servicios de Salud Mental	**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*
Otros Servicios de Apoyo a la Familia	**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*
Otros Servicios de Apoyo a la Familia	**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***
Otros Servicios de Apoyo a la Familia	**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, coordinate with 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/lookup-rcs-by-county) 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 screening questions over the phone.
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 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-emotional or adaptive)
    c. High risk of having developmental disabilities due to a combination of two 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).

Age 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/site/default.aspx?PageType=3&ModuleInstanceID=1097&ViewID=7b97f7ed-8e5e-4120-848f-a8b4987d588f&RenderLoc=0&FlexDataID=6119&PageID=403

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 (prenatal to age 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

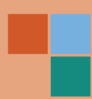
Behavioral Health, Applied Behavioral Analysis (ABA) and Specialty Mental Health Services

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 evidence-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.

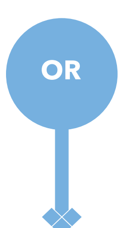
5 Assessment (FBA) is then authorized by L.A. Care and is to be completed by ABA provider in a period of three months.

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 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.



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

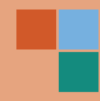
1. Any psychological evaluation other than a regional center.
   - If a member does not have a psychological evaluation, L.A. Care can provide linkage for a psychological assessment.

***Caregiver is able to submit a psychological evaluation and ABA recommendation from 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

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 meeting, 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 a licensed provider recommending evidence-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 Shied 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.

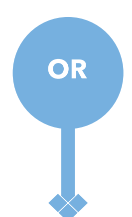
6 Assessment (FBA) is then authorized by Care 1st and is to be completed by ABA provider for a period of two months.

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.



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

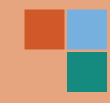
1. Any psychological evaluation other than that of a regional center.
   - If a member does not have a psychological evaluation, Blue Shield of California Promise can provide linkage for a psychological assessment.

***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.

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.

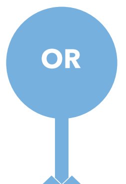
6 Assessment (FBA) is then authorized by MHN and is to be completed by ABA provider for a period of 2 months.

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.

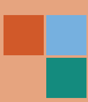


If a psychological evaluation from the regional center is **not available**, the following are options that can be used or taken:

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

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

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: 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 Blue Shield of California Promise. Once denial is received, Blue Shield of California Promise 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 evidence-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.

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 health care 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:
  - Relationship-based and family-focused, including the parents or caregivers as an integral part of the intervention
  - Developmentally appropriate
  - Culturally appropriate and fitting with the family's values
  - Trauma-informed

APPENDIX D:

Parent Phone Survey

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

My name is [*xx*] and I am calling from [*name of agency*]. May I speak with the parent of [*child's name*]?
We are calling to learn about parents' experiences when their child's development is screened, and when children are referred for extra help.

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

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

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

    a) Do you remember completing a screening at [*name of agency*] about your child's development?

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

    c) Did the screening show that your child might have a delay in [*his/ her*] development?

    d) After the screening, was it recommended for your child to get further evaluation?

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

   Do you know what school district the school is in?

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

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

    b) Did you have any problem with transportation to get to the evaluation?

    c) Did you have any problem scheduling the evaluation at a time that would work for you?

    d) How long did it take to get an appointment for the evaluation?

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

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

    a) Where did the evaluation take place?

    b) Were you there while your child was being evaluated, or did they work with your child alone?

    c) How many evaluators were present or conducted your child's assessment?

    d) Did the person (s) who did the evaluation speak your home language?

   [***If no:***] Did they use a translator?

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

f) Did you feel that the evaluator (s) understood you and your child and got accurate information?

g) How much time did the evaluator (s) spend with you and your child?

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

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

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

5. Now I'd like to ask about your experience during the IEP meeting.

   a. Did you meet with a team at the school to talk about what services your child would need or about the results of the evaluation (such as an IEP meeting)?

   b. Was the meeting in your home language?

   c. Did you have an opportunity to get all your questions answered about your child's learning and development, or to review the results of the evaluation?

   d. Did you understand the results of the evaluation?

   e. Did you feel you had opportunities to ask questions about anything you did not understand?

   [***If no: Ask why not***]

   f. Did you understand your child's eligibility?

   g. Did you understand what to do next to get help for your child after the meeting?

   h. Was your child found eligible for school services?

6. Now I'd like to ask about your experience getting educational services and supports for your child.

   a) Did your child start receiving school services yet?

   [***If yes:***] What kind of services? How are the services are going?

   [***If no:***] What are the barriers that you have encountered getting services started?

   b) Do you feel that the school services have been helping your child with [*his/her*] learning and development?

   c) How do you feel about the person or persons that are working with your child?

7. Did your child receive early intervention services before age 3?

   a) [***If yes***]: Did you have any challenges making the transition from early intervention services to getting services for your child at school?

8. Are there any other experiences (positive or negative) that you experienced during this linkage for school services that you would like to share with us?

We really appreciate you answering all of these questions. This is very helpful to us in understanding how to help families support their children's learning and development.

Do you have any questions before we end?

Thank you for participating!

APPENDIX E:
Training Materials

Topic	Audiences	Activities / Handouts
Developmental Screening Overview	All agency staff	PowerPoint: Developmental Screening Overview Handout: 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/Dev-Screening-Infographic (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)
Developmental Screening: Developmental Conversations with Parents	Case manager, and any other staff who will discuss screening results with parents (e.g., child developmental specialists, preschool teachers, home visitors, mental health clinicians)	PowerPoint: Developmental Screening: Developmental Conversations with Parents Resource: Guidelines for Talking to Families (www.firstsigns.org)

APPENDIX E: Training Materials

Topic	Audiences	Activities / Handouts
Screening Measures: Administration, Scoring and Interpretation	Staff who will administer and score measures	PowerPoint: Screening Measures: Administration, Scoring, and Interpretation Resources: Training DVDs for ASQs 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	Case manager, and/or other staff who will assist families with linkage to resources	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 www.disabilityrightsca.org/system/files/file-attachments/504001Ch12.pdf 5 Steps for Brain Building Serve and Return www.youtube.com/watch?v=KNrnZag17Ek&feature=emb_logo

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?

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.