Developmental Screening: A practical approach

Clinical Advances in Pediatrics
Nov 18, 2009

Marilyn Augustyn, MD
Boston University School of Medicine

Sarah Soden, MD
Children’s Mercy Hospital and Clinics

Based on the Screening Tools And Referral Training or START Program via the generosity of Quentin Humbard, MD, FAAP and the Tennessee Chapter of the American Academy of Pediatrics

Disclosure

• I have no actual or potential conflict of interest in relation to this program.

Objectives

• Select standardized screening tools to identify children with potential developmental, behavioral, or emotional problems
• Score and interpret screening tools accurately
• Correctly code developmental screening practices to maximize reimbursement
• Identify efficient and cost-effective strategies for incorporating screening and surveillance into clinical practice

There is a better way

Workshop Components

1. Science of screening and surveillance
2. Practice with specific tools
3. Coding and implementation

Goal: Increase early identification and referral of children with potential developmental, behavioral or emotional problems using standardized screening tools
The Why

Meeting patients needs?

Did you know?

20% of all visits to the pediatrician's office are developmental or behavioral in nature.

80% of parental concerns are correct and accurate.

Olson AC. How to establish family professional partnerships. Presented at: International Family Centered Care Conference; September 5, 2003; Boston, MA

Why are Developmental Issues Important and to whom?

Importance of child behavior/parenting concerns has increased

• 1958: 2% of parents' concerns
• 1960’s: 45% more concerned about behavior than other issues
• 1984: 81% of questions concerned psychosocial issues
• 1998: 96% of the questions parents raised had to do with either development or behavior

Four Classical Streams of Development

• Motor
• Cognition
• Communication
• Emotional
AAP Council on Children with Disabilities recommends routine surveillance and standardized developmental and behavioral screening.

Surveillance

A flexible, continuous process, in which knowledgeable professionals perform skilled observations of children during child health care (in consultation with families, specialists, child care providers, etc).

SM Dworkin, A Shannon, and P Dworkin. ChildServ Curriculum. Center for Children’s Health and Development, St. Francis Hospital and Medical Center; 1999; Hartford, CT

Surveillance

• Eliciting and attending to the parent’s concerns
• Maintaining a developmental history
• Identifying the presence of risk and protective factors
• Making accurate and informed observations of the child
• Documenting the process and findings

AAP Policy - Pediatrics 2006; 118; 405-420

Screening

• Brief, objective, and validated test
• Goal to differentiate children that are "probably ok" vs. "needing additional investigation"
• Performed at set points in time (9, 18, 24/30 months) OR if a specific concern arises
• Autism specific screening is now recommended at 18 & 24 months

AAP Policy - Pediatrics 2006; 118; 405-420

We see the child through the lens of our expectations

Importance of Being Objective

Touch or take temp
A Typical Challenge

- Roger, new patient well visit, 2 years old
- Upset and crying when he checks in
- Mother reports he has limited words, does not listen, and has “temper tantrums” when he does not get his way

How is this currently handled in your practice?

Detection Rates

**Without Tools**
- 20% of mental health problems identified
  (Lavigne et al, Pediatrics, 1993; 91:649-655)
- 30% of developmental disabilities identified
  (Palfrey et al, JPEDS, 1994; 111:651-655)

**With Tools**
- 80-90% with mental health problems identified
  (Stamer, JOPP, 1991; 12:51-64)
- 70-80% with developmental disabilities correctly identified
  (Squires et al., JOPP, 1996; 17:420-427)

Detection Rates

- Only 15-20% of pediatricians use screening tests routinely
- Most rely on developmental milestones or prompting for parental concern.
- Only half of physicians in a national survey have a validated developmental screening instrument in their offices.
- The Denver-II continues to be the predominant choice.

Benefits of screening

- Screening works!
- Results in access to services
- Cost effective
- Improves patient/family satisfaction
- Delaying intervention has the potential to require more intensive interventions for longer periods of time.
- Early intervention means better outcomes at earlier ages and saves society $30,000-$100,000 per child.

Barriers to screening

- Time
- Knowledge of tools and methods
- Familiarity with coding and billing procedures
- Referral resources


Some final words on “why”?  
• The child’s development and behavior is a critical window to establish a lasting and productive relationship with the family.

• Investing the time and energy to get a true picture of the child early will pay off in the long run in patient and provider satisfaction

The What

Featured Tools

Developmental Screening/Surveillance Tools
- Parents’ Evaluation of Developmental Status (PEDS)
- Ages and Stages Questionnaire (ASQ)

Autism Screening Tool
- Modified Checklist for Autism in Toddlers (M-CHAT)

Emotional and behavioral screening
- Pediatric Symptom Checklist (PSC 35/PSC 17)
- NICHQ Vanderbilt ADHD Scales

Additional Screening Tools

Other Screening Tests
- Bayley Infant Neurodevelopmental Screen (BINS)
- Battelle Developmental Inventory
- Brigance Screens
- Denver Developmental Screening Tool
- PEDS-DM
- ASQ-SE

Preparing Parents/Caregivers

Explain tool and purpose to parents

Discourage assumption of a “problem”
  - addressing developmental and behavioral issues is an important part of your service

Assess ability to complete tool properly
  - with assistance?
  - in office or at home?
**PEDS**

**Parents’ Evaluation of Developmental Status**

- **Time:** About 2 minutes to administer as an interview and score; less if parent completes while waiting.
- **Cost:** $30 for 50 sets; or $500 for 1000 sets.
- **Features:** High sensitivity and specificity (70 to 80%).

**3 Components**

- **PEDS Response Form:** to elicit information from parents.
- **PEDS Score Form:** for the clinician to document the results of each screen in the medical record.
- **PEDS Interpretation Form:** to determine needed actions and to document specific decisions.

---

**PEDS Response Form**

- 10 questions which correspond to 10 domains or areas of concern.
- **Question 1:** What’s the BIG picture?
  - Can’t do what other kids can do.
  - Immature.
  - Learns slowly.
  - Takes a long time to get the hang of things.
  - Seems behind.
- **Questions 2-9:** No, Yes, A little, Comments.
- **Question 10:** Open-ended.
  - Often elicits questions about health, hearing or vision, psychosocial issues.
  - Good focus for patient education.

---

**What Parents Might Say.**

1. **Global/Cognitive (Learning, development):**
   - Can’t do what other kids can do.
   - Immature.
   - Learns slowly.
   - Takes a long time to get the hang of things.
   - Seems behind.
2. **Expressive Language (Talks/Makes Speech Sound):**
   - Doesn’t talk plain.
   - Nobody can understand him but me.
   - Sometimes doesn’t make sense when he talks.
3. **Receptive Language (Understands what you say):**
   - Doesn’t listen well.
   - Doesn’t understand what I say to him.
4. **Fine Motor (Uses hands & fingers):**
   - Holds his pencil funny.
   - Can’t get the spoon to his mouth right.
   - Can’t write his name.
   - Can’t draw shapes.
5. **Gross Motor (Uses arms & legs):**
   - Walks funny.
   - Can’t ride a tricycle or bicycle.
   - Falls a lot. Clumsy. Poor balance.
   - Hates sports.
6. **Behavior:**
   - Throws fits. Whines.
   - Stubborn. Only does what she wants.
   - Can’t pay attention.
   - Spoiled.
   - Never lets me have any peace. Clingy.
What Parents Might Say.

7. Social/Emotional (Gets along with others)
   - Whiny.
   - Clingy.
   - Acts mean.
   - Hits others.
   - Class clown.
   - Gets frustrated over nothing.
   - Too angry.
   - Stays in his room all the time.
   - Hates change.

8. Self help (Doing for self; independence)
   - Won’t do things for herself.
   - Still wants a bottle.
   - Won’t toilet train.
   - Can’t dress himself.

9. Preschool & School skills
   - Can’t write his name.
   - Can’t learn to read.
   - Doesn’t know colors or the ABCs.
   - Can’t remember his spelling words.

The PEDS Score Form

- COLUMNS for documenting responses across multiple age visits
- ROWS which correspond to the domains
- SHADED boxes indicate predictive concerns
- NON-SHADED boxes indicate non-predictive concerns

Score L. Mo’s Response Forms

Interpret Results

Scoring the PEDS

- Find appropriate age column (12-14 mo)
- Start with #2 on the Response form
- ‘Yes’ and ‘A little’ receive a check in the corresponding box on the score form
- ‘No’ responses are left blank
- Record the total number of small shaded boxes (predictive concerns) in the large shaded box at the bottom of the score form.
- Record the total number of small non shaded boxes (non-predictive concerns) in the large NON shaded box at the bottom of the score form

Case Example: L. Mo –12 Months

- PEDS Response Form
- PEDS Score and Interpretation Form

“Tool Time”: 5 Minutes

- Score L. Mo’s Response Form
- Interpret Results
The PEDS Interpretation Form

The number in large boxes at the bottom suggests which PATH of care to follow.

Look at the large SHADED box
- If 2 or more, follow Path A on the Interpretation Form
- If exactly 1, follow Path B
- If 0, move on to the large non-shaded box.

Look at the large non-shaded box
- If 1 or more, follow Path C
- If both boxes are 0:
  Follow Path D if you suspect a literacy barrier, otherwise follow Path E (child likely normal)

Significance of paths on PEDS interpretation form

• Path A
  - Are at highest risk of problems
  - 50 percent may have developmental problems
  - Need prompt referral for developmental diagnostic testing (further screening delays intervention)

• Path B
  - 30 percent may have developmental problems
  - Often needs a second stage developmental screen to determine the need for referrals

• Path C
  - Are at lower risk of developmental problems
  - Up to 5 percent may have developmental problems
  - 25 percent may have emotional and behavioral difficulties
  - May need parental counseling and close monitoring

• Path D
  - Determine if a literacy issue is present
  - May need screening in another language

• Path E
  - At low risk for problems
  - Less than 5 percent have delays or disabilities
  - Need only reassurance and ongoing monitoring
Case 2: Roger 2 yrs
- PEDS Response Form
- PEDS Score and Interpretation Form

“Tool Time”: 5 Minutes
- Score and Interpret Roger’s Response Form
- Review our Challenging Case

Scoring
- Find appropriate age column (2 years)
- Start with #2 on the Response form
- ‘Yes’ and ‘A little’ receive a check in the corresponding box on the score form
- ‘No’ responses are left blank
- Record the total number of small shaded boxes (predictive concerns) in the large shaded box at the bottom of the score form.
- Record the total number of small non shaded boxes (non-predictive concerns) in the large non shaded box at the bottom of the score form.

I’m worried about how my child talks and relates to us. He says things that don’t have anything to do with what’s going on. He is oblivious to anything but what he is doing. He’s not doing as well as other kids in many ways.

- "Yes, he just repeats things like "Wheel of Fortune"

He’s very coordinated and very fast!

We spend a lot of time playing and talking with him & this seems to be helping some. I do wonder about his hearing sometimes.

PEDS RESPONSE FORM

<table>
<thead>
<tr>
<th>Question</th>
<th>Circle: Yes</th>
<th>Circle: A little</th>
<th>Circle: No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>I’m worried about how your child talks and makes speech sounds?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>He has concerns about how you child understands what you say?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>He has concerns about how your child uses his or her hands and fingers to do things?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>He’s good with manipulatives but sometimes does lots of the same things over and over: flick lights, spin wheels on his cars</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PEDS SCORE FORM

<table>
<thead>
<tr>
<th>Skill Area</th>
<th>Yes</th>
<th>A little</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Cognitive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language and Communication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Memory and Learning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Engagement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self Help</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Teaching Sample**

He’s too young for that sort of stuff

He just doesn’t seem interested in even watching other kids.

Lots of tantrums

We spend a lot of time playing and talking with him & this seems to be helping some. I do wonder about his hearing sometimes.
The PEDS Interpretation Form
The number in large boxes at the bottom suggests which PATH of care to follow.

Look at the large SHADED box
If 2 or more, follow Path A on the Interpretation Form
If exactly 1, follow Path B
If 0, move on to the large non-shaded box.

Look at the large non-shaded box
If 1 or more, follow Path C
If both boxes are 0:
Follow Path D if you suspect a literacy barrier, otherwise follow Path E (child likely normal)

Advantages of the PEDS
• Can be used to focus the visit
• Enhances teachable moments
• Helps avoid “oh, by the way” questions
• Allows focus on patient needs as the parent sees them
• Improves patient flow
• Improves patient satisfaction

Ages and Stages Questionnaire (ASQ)
4 Months to 5 1/2 Years

• 21 color-coded questionnaires from 2 to 66 months
• Each questionnaire valid for 1 month before and after indicated age
• 30 - 35 items per questionnaire describing skills
• 5 domains of development

Adapted from: Michelle Macias MD FAAP, D PIP Training
**Ages & Stages™ Sample Item 48 Month Questionnaire**

**Fine Motor**

Using the shapes below to look at, does your child copy at least three shapes onto a large piece of paper using a pencil or crayon, without tracing? Your child’s drawings should look similar to the design of the shapes below, but they may be different in size.

- **Yes**
- **Sometimes**
- **Not Yet**

---

**ASQ Scoring & Interpreting**

- Check that all questions have been answered
- Assign a value of 10 to yes, 5 to sometimes, 0 to not yet.
- Add up the item scores for each area; record these totals in the space provided for area totals.
- Indicate the child’s total score for each area by filling in the appropriate circle on the chart.

---

**ASQ Scoring**

- Scores in the darkly shaded boxes are significant; definitive assessment is indicated
- Scores in the lightly shaded boxes indicate the need for guidance and close monitoring

---

**Information Summary: Overall Section**

1. Hears well?  
   - Yes
   - No
   - Comments:
2. Uses both hands equally?  
   - Yes
   - No
   - Comments:
3. Baby’s feet flat on the surface?  
   - Yes
   - No
   - Comments:
4. Family history of hearing impairment?  
   - Yes
   - No
   - Comments:
5. Vision concerns?  
   - Yes
   - No
   - Comments:
6. Recent medical problems?  
   - Yes
   - No
   - Comments:
7. Other concerns?  
   - Yes
   - No
   - Comments:

---

**Ages & Stages™ Questionnaire**

**Case Example: L.R.**

- 10 Month Questionnaire
- 10 Month ASQ Information Summary

**“Tool Time”: 2 Minutes**

- Score L.R.’s Screening Tool
- Interpret Results

---

**L.R.’s Score & Interpretation**

- **Total**
- **Communication**
- **Gross Motor**
- **Fine Motor**
- **Problemsolving**
- **Personal-social**
### Information Summary: Overall Section

1. Hears well?  
   - Yes  
   - No  
   Comments:

2. Uses both hands equally?  
   Comments:

3. Baby's feet flat on the surface?  
   - Yes  
   - No  
   Comments:  
     Likes to stand on toes.

4. Family history of hearing impairment?  
   Comments:

5. Vision concerns?  
   Comments:

6. Recent medical problems?  
   - Comments: Allergy/Asthma

7. Other concerns?  
   Comments: Growth

### Autism Spectrum Disorders

- 1 in 150 children
- Age of diagnosis falling
- Parent concerns ~18 months of age
- Early detection crucial
- AAP Autism Toolkit and CDC ALARM Initiative

### Modified Checklist for Autism in Toddlers (M-CHAT)

Robins, Fein, & Barton, 1999

- Administered at 16-30 months (rec. 18 & 24)
- 23 questions expanded and adapted from earlier CHAT (English or Spanish)
- Can be scored in five minutes by a professional or paraprofessional
- Yes/No responses convert to Pass/Fail responses

### Instructions & Permissions for Use of the M-CHAT

- Free for clinical, research, and educational purposes.
- Two authorized websites: www.firstsigns.org or http://www2.gsu.edu/~wwwpsy/faculty/robins.htm

1. Reprints of the M-CHAT must include the copyright at the bottom (© 1999 Robins, Fein, & Barton). No modifications can be made to items or instructions without permission from the authors.
2. The M-CHAT must be used in its entirety. There is no evidence that using a subset of items will be valid.
3. Parties interested in reproducing the M-CHAT in print (e.g., a book or journal article) or electronically (e.g., as part of digital medical records or software packages) must contact Diana Robins to request permission (drobins@gsu.edu).

### Critical Items

2, 7, 9, 13, 14, 15

A child fails the checklist when 2 or more critical items are failed OR when any three items are failed.

Yes/no answers convert to pass/fail responses. Below are listed the failed responses for each item on the M-CHAT.

<table>
<thead>
<tr>
<th>Item</th>
<th>Response</th>
<th>Item</th>
<th>Response</th>
<th>Item</th>
<th>Response</th>
<th>Item</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>NO</td>
<td>7.</td>
<td>NO</td>
<td>12.</td>
<td>No</td>
<td>17.</td>
<td>No</td>
</tr>
<tr>
<td>22.</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>No</td>
<td>9.</td>
<td>NO</td>
<td>14.</td>
<td>NO</td>
<td>19.</td>
<td>No</td>
</tr>
<tr>
<td>5.</td>
<td>No</td>
<td>10.</td>
<td>No</td>
<td>15.</td>
<td>NO</td>
<td>20.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Note: Items marked with an asterisk (*) indicate additional concerns.*
Modified Checklist for Autism in Toddlers (M-CHAT)

Case Example: T. Brooks

- T. Brooks M-Chat Form
- M-Chat Scoring Instructions

“Tool Time”: 2 Minutes
- Identify failed items
- Determine which are critical

Failed and Critical Items for T. Brooks

2. Does your child take interest in other children? Yes No (Critical)
11. Does your child ever seem oversensitive to noise? Yes No
13. Does your child imitate you? Yes No (Critical)

Total: 3 failed (2 critical) Results: Failed

Emotional-Behavioral Screening Tools

- Broad Band
  - Pediatric Symptom Checklist (PSC)
- Specific
  - CRAFFT/FRAMES
  - Edinburgh Postnatal Depression Scale (EPDS)
  - NICHQ Vanderbilt ADHD Scales

Pediatric Symptom Checklist- 35 (PSC- 35)

- Time: Can be completed by parents, or office staff in 5-10 minutes
- Cost: Free
- Features: Specificity and sensitivity of 0.95 using cutoff scores
Pediatric Symptom Checklist

- Designed to evaluate the psycho-social functioning of children ages 3-16
- Relies primarily on parent report of children's behavioral/emotional problems
- Tool is free
- Translations into Spanish and other languages
- There is a youth (>age 11) self-report version of the PSC

Cutoff Scoring (PSC 35)

- For school aged children 6-16 years, a total score of 28 or higher requires further evaluation.
- For children ages 2-5, the cutoff is 24 or greater, (see scoring procedure)

PSC-17 Cutoff Scoring

<table>
<thead>
<tr>
<th>Subscale Cutoff Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>The PSC-17 Internalizing Subscale (Cutoff 5 or more items)</td>
</tr>
<tr>
<td>The PSC-17 Attention Subscale (Cutoff 7 or more items)</td>
</tr>
<tr>
<td>The PSC-17 Externalizing Subscale (Cutoff 7 or more items)</td>
</tr>
</tbody>
</table>

Total Cutoff Score = 15

C. Jones' Score

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internalizing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Attention</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Externalizing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Total: 10 + 5 + 1 = 16

Recommendation: Further evaluation
ADHD Toolkit

• Developed (by AAP) to assist clinicians in providing quality care for children with suspect or diagnosed ADHD

• Norms based on over 10,000 children between the ages of 5 and 11 years in a suburban TN county

• Available through Members Only Channel at www.aap.org or www.nichq.org

Diagnosis Components

• Primary Care Initial Evaluation Form

• Assessment Scales - Parent & Teacher Informant
  - Symptom
  - Performance

• Assessment Follow-up - Parent & Teacher Informant

• Scoring Instructions for the Assessment Scales

Assessment Scales: Parent & Teacher

• Include measures for impairment in the home and classroom settings as well as academic performance

• Include symptom screening questions for 3 other co-morbidities:
  - Conduct Disorder (CT)
  - Oppositional Defiant Disorder (ODD)
  - Anxiety/Depression

• Should not be used alone for diagnosis

Scoring Assessment Scales: Symptoms

• Scoring is based on a 4 point rating scale (0-3)

• Scores of 2 or 3 on a single Symptom question reflect often-occurring behaviors

• To meet DSM-IV criteria the child must have at least 6 positive responses to either the 9 inattentive or 9 hyperactive core symptoms, or both.

Scoring Assessment Scales: Performance

• Scoring is based on a 5 point rating scale (1-5)

• Scores of 4 or 5 on Performance questions reflect problems in performance.

• There must be impairment, not just symptoms, to meet diagnostic criteria.

Discussing Screening Results

• Focus on positives

• Practice your language

• Stress the need for further evaluation and follow-up

• Offer parents activities they can do right away

• Help the parent to inform others
Encouraging Next Steps

- Acknowledge parent’s concerns
- Encourage communication, particularly when recommendations are not followed
- Provide parent with information on the referral process
- Set a follow-up appointment

Finding the Words

Providing Feedback to parents
- Vital to interpret and label behaviors in a constructive way
- Demystify the issues, avoiding jargon and explain the issues clearly
- Identify both the child’s strengths and weaknesses
- Parents need to know you have a concrete plan to deal with any issues

Maximizing Reimbursement

- Medicaid vs. Private insurers
- Coding Clues

CODING: 96110 is Nearly All You Need to Know!

96110 – used to report all limited developmental/behavioral screening tests
- Report with E/M or preventative services
- Can be performed by physician or staff
- Time to perform the test is included in the 96110 code
CODING: Modifiers and Multipliers

Modifier -25 should be added to the E/M or Well Visit (V20.2) code

Modifier -59 may be required by some MCO's to signify a “distinct procedural service”

Modifier -76 is put on the 96110 code if more than one is billed

Ex: Est. 18mo WCC + PEDS + MCHAT
   - 99392-25
   - 96110 x2 -76
   - Optional -59 if required by MCO

Early Intervention Services

- When do I refer
  - Whenever there is a concern about the development of an infant/toddler, and/or
  - When the family has a child with an “established condition” (a diagnosed physical or mental condition with a high probability of resulting in a developmental delay.)

Early Intervention Services

- What happens when I refer?
  - After referral, with parental consent, the multidisciplinary evaluation process is initiated to establish a child’s eligibility
  - Participation is voluntary; parents may refuse the evaluation and refuse services.

Early Intervention Services

Individualized Family Service Plan

Written plan to guide service coordinator, intervention service providers and family in the delivery of needed services.

Plan based on family assessment information and developmental evaluations.

Plan identifies outcomes and action steps to meet priorities and needs identified.

Transition at age 3 years

Intervention Services

Missouri
  - First Steps
  - Regional Center System

Kansas
  - Infants and Toddlers
  - Community Dev. Disability Organizations

3 yr+ School district’s Early Childhood Program

Getting Started with Screening Tools

“A journey of a thousand miles must begin with a single step.”

Lao-tzu
(604-531 B.C.)
How will your practice implement a screening protocol using standardized tools?

- Map the workflow for your practice situation.
- Develop a template for screening tools.

Critical Decisions

- Which tools at what intervals?
- How do you make time for screening?
- Who administers the screening, scores the tests, and communicates results?
- Who else needs to be involved in the screening and referral process?

Map the Flow

- How will the new workflow change what you are currently doing?
- What obstacles to implementing a screening and referral protocol do you see?
- What steps do you need to take to implement screening?

What Works for Your Practice?

Tools can be:

- Distributed at well child visits to be completed and brought back
- Mailed prior to well child visits
- Completed in waiting or exam rooms

A Happy Team

Potential Staff Roles

**Clinical**

- establish a physician/nurse “champions"
- choose and train others to use the tools
- score questionnaires
- provide feedback to parents
- distribute patient education

**Office**

- implement the screening process
- maintain and update referral lists
- organize and store tools
- restock and order materials
- assure accurate billing
Sample Screening Schedule

<table>
<thead>
<tr>
<th></th>
<th>2 weeks Edinburgh (as needed)</th>
<th>2 months Edinburgh PEDS</th>
<th>4 Months PEDS</th>
<th>6 Months PEDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 Months* ASQ</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24/30 Months* PEDS and M-CHAT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Scheduling Screening Tools: Example

<table>
<thead>
<tr>
<th></th>
<th>6 yrs PEDS/PSC</th>
<th>7 yrs PEDS/PSC</th>
<th>8 yrs PEDS/PSC</th>
<th>9 yrs PSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 yrs</td>
<td>PSC</td>
<td>11 yrs</td>
<td>PSC</td>
<td>13 yrs</td>
</tr>
<tr>
<td>14 yrs</td>
<td>PSC</td>
<td>15 yrs</td>
<td>PSC</td>
<td>17 and 18 yrs</td>
</tr>
<tr>
<td>16 yrs</td>
<td>PSC</td>
<td>17 and 18 yrs</td>
<td>PSC</td>
<td></td>
</tr>
</tbody>
</table>

*Per 2006 algorithm a screening tool is recommended at these visits. Per 2007 algorithm, an autism screening tool is recommended at 18 & 24 months.

The End
Parent Training Opportunities

Children's Mercy Hospital & Clinics’ Section of Developmental & Behavioral Sciences in conjunction with ABC'nD Autism Center are offering 6 different parent training opportunities. Please go to www.childrensmercy.org/autismparenttraining for more detailed information on each training module and how to register.

“Getting Ready to Learn”
Parents will learn common behaviors associated with Autism Spectrum Disorders, strategies for preventing and responding to challenging behaviors. Along with the basic concepts of Applied Behavior Analysis (ABA) and Treatment and Education of Autistic and related Communication-handicapped Children (TEACCH).

“Communication Made Simple for Home”
PECS (Picture Exchange Communication System), a research-based program focuses on a child learning to initiate communication. All six phases of PECS will be reviewed and strategies to teach verbal language will be introduced. Opportunities to observe children with ASD using PECS will be provided.

“ABC’s of Daily Routines”
Consistent routine is both helpful and important to children with ASD. Learn to identify and define daily routines that occur at home. Discussion will include routines involving eating, dressing, toileting, bathing and bedtime. Families will be assisted in improving a daily routine that might currently be challenging for their child.

“Home Makeover: Sensory Edition”
Many children with ASD have immature sensory systems that may affect his or her ability to learn and be successful. The areas that affect sensory processing will be reviewed and demonstrated. Sensory processing activities that can be implemented at home will be discussed.

“Ready, Set, Go: Community Outings”
Transitioning from one environment to another is often challenging for children with ASD. Strategies for successfully taking a child with ASD on community outings will be discussed such as grocery shopping, doctor/dentist appointments, church, hair-cuts, etc.

“Balls, Bubbles, Blocks: Important Early Interactions & Play Skills”
Early childhood development and developmentally appropriate practice for teaching play skills will be discussed. Learn to have fun playing with your child using easy to implement strategies.