~Developmental Screening Community Initiative
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Report of Lessons Learned from Three Maine Communities

December 2015
Executive Summary

Background
Documenting the needs of Maine’s infants and young children has been a priority of the Maine Early Childhood Comprehensive Systems Initiative since its inception in 2004. Beginning in 2013, Maine Quality Counts for Kids (QC) started to partner with the State Agencies Interdepartmental Early Learning Team (SAIEL), the interdepartmental sub-agency established by the Maine Department of Education and the Maine Department of Health and Human Services commissioners. Together, QC and SAIEL lead the Developmental Systems Integration (DSI) initiative in order to improve general developmental screening rates for children so that early identification and referral can occur statewide more seamlessly for all children ages 0-3 years. Recognizing that many disciplines, including medical practices, Child Development Services (Maine’s Early Intervention provider), Maine Families Home Visiting, Public/Community Health Nursing and Early Head Start all have a goal to ensure that children in need of services are identified and receive services early, the DSI initiative was committed to testing ways in which to promote best practices between disciplines to enhance communication and coordination in order for this goal to be achieved. It was from this desire that the Developmental Screening Community Initiative was created.

Approach
The Developmental Screening Community Initiative (DSCI) was promoted to communities in January 2015 to implement and test best practices for improving developmental screening efforts at the local level. Three DSCI mini-grants were provided to multi-disciplinary teams in the Bangor, Waterville and Midcoast regions to implement and test developmental systems integration. The mission of the developmental screening community initiative was to provide support to a multi-disciplinary community team in testing and implementing best practices for coordination to improve developmental screening efforts at critical ages for children ages birth to three. The overarching vision of the initiative was to result in better health outcomes and school readiness, through early identification, for Maine children ages birth to three.

In order to improve care and coordination, the DSI: SAIEL Steering Committee proposed to test ways to better communicate and coordinate in the aforementioned communities in Maine over a period of eight months. This included involvement in the completion of a pre- and post-developmental systems survey, monthly meetings, monthly data collection requirements, an initial team training, four webinars and two gatherings of all teams to learn from one another. The partners in these communities served as demonstration sites, testing the recommendations of the DSI: SAIEL Steering Committee collectively as a local team. They provided continuous feedback and updates on their progress, sharing lessons learned with other stakeholders.

Results
Results from the monthly data collection on the DSI metrics rendered the following results.

Rates of Developmental Screening
The overall goal related to the rates of developmental screening was that 75% of children will have a developmental screening using a validated tool at 9, 18, and 24 or 30 months. In aggregate, compared to the sample size of children, approximately 35% of children were screened at least once.
during the critical ages. The average rate of screening for children by eight months of age was 9.5%\(^1\); for children on or by their first birthday, the average rate was 37.5%; for children on or by their second birthday, the average rate was 38.7%; and for children on or by their third birthday, the average rate was 17.2%. While rates of developmental screening did not meet the intended goal of 75%, the DSCI rates were higher than the FY 2014 MaineCare developmental screening rates, which were 18.5% for one year old children; 25.6% for two year old children and 19% for three year old children. The highest number of screenings was conducted in the months of July and March, respectively. The Midcoast region had a developmental screening rate of 55%; the Waterville region had a rate of 31%; and the Bangor region had a rate of 19%.

**Information Sharing Across Disciplines**

The goal for information sharing across disciplines was 75% of developmental screening results are shared with the child’s medical home and other community organizations upon parental consent. By sharing information, the aim was to reduce duplicate screenings for children and to get children to referrals efficiently if necessary. Also, organizations were encouraged to share screening information, despite the results, whenever a screening was completed. The average rate of sharing information with the medical home in aggregate was 20.5% compared to a baseline rate in the beginning of the project at 1.2%. The rate of information sharing with the medical home in the Waterville region was 32.1%; 17.5% in the Bangor region; and 11.9% in the Midcoast region. Aggregate rates of information sharing with Child Development Services was 3.9% and aggregate rates of sharing information with other community-based organizations was 2%.

**Referrals and Referrals to Service**

The goal for referrals was that 75% of children would be referred to appropriate services as indicated by the developmental screening results. In total, approximately 505 children were referred for further evaluation; a rate of 42.1% of children screened required a referral for further evaluation. The month with the highest rate of referrals was August. The Bangor team had a referral rate of 41.5% and the Midcoast region had a referral rate of 30.5%. Rates of referrals to screenings in Waterville were skewed in that the rates of referrals that CDS received over the eight month time frame exceeded the rates of screening reported. The goal for referrals to service was that 75% of children referred to services are followed to determine if services are in place and if not, why not. The average rate of children receiving services after a referral is 70.8%. The average rate of children not receiving services due to ineligibility or family decline\(^2\) was 29.2%. Midcoast had the highest rate of children referred then getting into service at 81.3%; Waterville had a service rate of 53.2%; and Bangor had a rate of 46.4%.

Results were also provided through the pre- and post-developmental systems integration survey given at the beginning and end of the initiative. In total fifteen individuals completed the pre-survey from across the three DSCI sites. Thirteen individuals who completed the pre-survey then completed the post-survey. The changes seen from pre- to post-survey are based on these thirteen responses and are not necessarily generalizable to the entire DSCI project or future DSCI-like projects but rather should be viewed as opportunities for continuous quality improvement. The

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\(^1\) Developmental screening rates of children less than eight months of age was not collected until mid-way through the project in April 2015.

\(^2\) The rate of ineligibility and family decline were combined. The rates of ineligible clients compared to family decline were not separated.
survey examined: 1) the developmental screening process; 2) family involvement in the developmental screening process; 3) information sharing; 4) referrals; and 5) follow-up.

The Developmental Screening Process
Positive change was noted from pre- to post-survey in the developmental screening process. Positive areas of change include:
- clarity on the difference between surveillance and screening;
- staff training on how to conduct developmental screening;
- and ways in which to check fidelity of screenings.

Family Involvement in the Developmental Screening Process
There was little change from pre- to post-survey in the area of family involvement in the developmental screening process. Practices that were changed from pre- to post-survey included:
- completing screenings in advance (decrease in practice from pre to post);
- completing screening like an interview (decrease in practice from pre to post);
- use of probing questions to increase understanding during the screening process (decrease from pre to post);
- and use of toys and materials to demonstrate developmental milestones (increase from pre to post).

Information Sharing
Sharing information practices did change from pre- to post-survey. Changes were mostly seen in these areas:
- Child Development Services—decreased practice of sharing information from pre to post
- Medical Practices—increased practice of sharing information from pre to post
- Public Health/Community Health Nursing—increased practice sharing of information from pre to post
- Child Care—decreased practice of sharing information from pre to post
- Behavioral Health—decreased practice of sharing of information from pre to post
- Specialty Care—decreased practice of sharing information from pre to post
- Obtaining parental consent less of a problem from pre to post
- Increased staff training on the consent process from pre to post

Referral Practices
Referral practices basically remained unchanged from pre- to post-survey. Some slight changes were noted in the following practices:
- perception that families do not follow-up on referrals was decreased from pre to post;
- report that families decline referrals decreased from pre to post;
- and children ineligible for services decreased from pre to post.

Follow-Up Practices
A positive area of change in the follow-up questions was reports of organizations reviewing data on the developmental screening process more from pre- to post-survey. However, there was a decrease in tracking children receiving developmental screening from pre to post.
During the final DSCI gathering, all teams shared their successes, challenges, plans for sustainability that were both easy and harder to sustain over time and recommendations to the DSI Steering Committee.

Accomplishments
At the end of the DSCI project, members were asked to reflect on team accomplishments over the course of the DSCI project from January to August 2015. Noted themes of accomplishments reported included:

- sharing of ASQ screening results more; an increase in overall screenings at the critical ages;
- less duplication;
- improved communication across disciplines;
- improved developmental screening, information sharing and referral workflows in all settings;
- development of scripts for families to normalize developmental screening and to make reporting results less threatening;
- improved connection to child health care providers;
- quick and more responsive services for young children;
- timely sharing of results; increased staff training around developmental screening;
- incorporating the parent perspective in the DSCI work;
- closing feedback loops with Child Development Services;
- development of family outreach materials on the importance of developmental milestones and screening;
- and more awareness of resources available to families, including expectations related to eligibility requirements.

All teams noted that developing relationships through monthly meetings really helped to improve coordination and communication.

Challenges
The teams also noted challenges along the way. Themes around challenges were:

- having a limited timeframe to truly implement all the changes necessary to really make a difference in practices around developmental screening;
- shifts in team members (lost some team members along the way);
- difficulty in scheduling meetings with busy individuals who really needed to be at the DSCI meetings;
- some communities admittedly did not have a strong family voice to help inform the work;
- data collection was time-consuming and required more hand-counting of data than originally expected;
- best use of ASQ on-line and getting ASQ on-line up and running;

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3 Magnets and brochures were adapted from materials provided by, “Learn the Signs. Act Early” website (http://www.cdc.gov/ncbddd/actearly/pdf/parents_pdfs/trackchildsdevmilestoneseng.pdf) and can be download off the DSI website at: https://www.mainequalitycounts.org/image_upload/Dev.%20Milestones%20Magnet%20Template.pdf (developmental milestones magnet) and at: https://www.mainequalitycounts.org/image_upload/Tracking%20Milestones%20Brochure.pdf (developmental milestones brochure)
• incorporating developmental screening in established workflows so that it is a routine practice;
• family understanding of the importance of early identification and intervention;
• getting staff buy-in;
• improving understanding of the full range of services available to young children and their families;
• and technology (i.e., ASQ on-line implementation, incorporating results into EMR, databases that capture developmental screening data without the need for hand-counting).

Plans for Sustainability
Team members were asked to reflect on DSCI activities they felt they could sustain in the future. Reflections were reported on: 1) those activities important and easy to sustain and then 2) those activities that are important but harder to sustain. Activities which were reported to be easier to sustain included:

• maintaining flow of data between group members (e.g., e-mail; sharing printed materials; quarterly meetings);
• using health services advisory meeting through Early Head Start as a conduit to continue conversations;
• continuing to fax screening results to providers;
• promoting higher engagement of families about ASQ and more family outreach in general on the importance of developmental milestones;
• and child health care provider engagement.

The activities that are important but harder to sustain are:

• financial pieces (i.e., printing of outreach materials; maintaining ASQ online)
• long-term data submission and analysis;
• keeping a consistent group going;
• community education, including patients and providers
• continuous improvement of communication systems as there is still a need to bolster communication to improve coordination;
• keeping the momentum going;
• and working on consent to make the process more aligned for families.

Recommendations to the DSI Steering Committee
DSCI team members were asked to reflect on recommendations for the DSI Steering Committee moving forward with developmental system integration. Recommendations from the teams included periodic follow-up meetings/exchanges with community teams (e.g., email check-ins with DSI Program Manager); developing communication links between local communities and DSI Steering Committee to inform teams of latest work and to get input on practices; help with messaging to families regarding the importance of developmental milestones and screening; looking at ASQ on-line implementation as a statewide initiative in order to sustain and build on the ASQ effort; use of generated data to educate partners and stakeholders involved in developmental systems integration; universal process and consent to release information form; creation of a “passport” of services system; systematic developmental screening training when on-boarding staff; and assistance with promoting clarity on early intervention process and eligibility. DSCI teams also voted on priorities
for next steps which were (in priority order): 1) universal consent process and form; 2) improving feedback loops or responses to referrals; and 3) improving information sharing efforts.

Moving Forward

The greatest lesson to be learned from the DSCI work was that while a lot was accomplished in eight months, it also felt like the work was just getting started. Realistically, the testing phase of the DSCI could have been extended into a year or eighteen months. An important lesson to be learned was not to underestimate the importance of building relationships within a team. During the eight month period building trusting relationships across disciplines in order to increase understanding of eligibility and program requirements and to build a system of coordination improvement was a noted accomplishment.

As other communities consider a DSCI, the following should be considered based on lessons learned from the original DSCI teams:

1) Designate a leader who acts as the convener of the group and can provide information as well as follow-up in between meetings. The leader can enlist support from others to bring stakeholders to the table. Personal invites explaining the initiative is helpful to bringing stakeholders to the table for the initial meeting.

2) Consider having a facilitator help with agenda development, follow up and documenting decisions. The community leader will more than likely want to participate in the DSCI team meetings, so having a separate facilitator is important to the process.

3) Establish a DSCI work plan that considers the overarching goal of the project and then strategies to reach the goal with realistic timelines. Once a work plan has been developed, building in metrics or using established metrics should be a part of the plan to evaluate success.

4) Begin with strategies that lend themselves to a small or quick “win”. For example, beginning with family outreach messaging and materials are tangible and allow all disciplines a chance to test change.

5) Initial meetings should include opportunities to better understand the strength of the relationships necessary for coordination and communication of DSCI strategies. Beginning with a community eco-map allows for a visual representation of the strength of relationship and clearly shows areas where relationships can be fostered.

6) Allow time at each meeting for members to check-in with one another on any program or community changes that may affect the strategies within the DSCI work plan. Time for team members to better understand program and eligibility requirements should be built into agendas as well.

7) Build in small tests of change using quality improvement methodologies throughout the project and review these tests to document lessons learned. Quality improvement methodology training may be necessary if partners are not familiar with ways in which to test quality improvement.

8) Collect and review data often throughout the initiative to examine trends and the need for mid-course program adjustments. This includes any data or lessons learned from small tests of change using PDSA cycles.

9) If strategies include additional technological requirements, develop a separate work plan around implementing technology into the DSCI.

10) Celebrate and document successes along the way. Systems change is hard and significant work.
Next Steps in Developmental Systems Integration
The DSI: SAIEL Steering Committee is committed to using the lessons learned from the DSCI teams to plan for systems of change that incorporate plans for improvement in developmental systems integration. Importantly, the DSI: SAIEL Steering Committee is committed to meeting monthly to work on expanding developmental screening efforts, engaging partners to increase linkages and referrals, utilizing and promoting cross-disciplinary information sharing and referrals and enhancing systems (policy, data, funding) and workflow processes. Specific strategies include: creating a universal process and form for sharing information; exploring a Help Me Grow model of improving linkages and coordination for families with children ages birth to eight; examining statewide data on developmental screening rates, information sharing, referrals and services to determine areas of improvement and areas that need more focused attention; improving family outreach and messaging around the importance of developmental milestones and screening; supporting DSCI replication; and developing a feedback mechanism for articulating progress out to those working within the disciplines that the DSI: SAIEL Steering Committee represents.