Putting Together the Pieces of the Puzzle: Improving Developmental Screening at the Practice and System Level

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Maine Quality Counts
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Muskie School of Public Service, USM

Agenda

• Developmental Screening: Why it is Important
• Quality Improvement Efforts to Raise Developmental Screening Rates
• First STEPS Phase 2 Evaluation
• Moving from Practice Innovation to System Transformation- Putting the Pieces of the Puzzle Together
• Resources Available for Practices
IHOC Maine
CHIPRA Quality Demonstration Grant
(Feb 2010-Feb 2015)

Improving Health Outcomes for Children (IHOC) Focus:
Building a public-private framework and system for measuring and improving the quality of child healthcare services and outcomes.

Collaborating with health systems, Pediatric and Family Medicine providers, associations, state programs and consumers to:

- Select and promote a set of child health quality measures
- Build a health information technology infrastructure to support the reporting and use of quality measurement information
- Transform and standardize the delivery of healthcare services by promoting a patient centered medical home model
- Create a Maine Child Health Improvement Partnership
Maine Child Health Improvement Partnership (ME CHIP)

Mission
To optimize the health of Maine children by initiating and supporting **measurement-based** efforts to enhance child health care by fostering public/private partnership.

Vision
All practices providing health care to children will have the skills, support, and opportunities for collaborative learning needed to deliver high quality health care.

ME CHIP is part of the National Improvement Partnership Network (NIPN)
Why is Developmental Screening in Children Ages 0-3 years Important?

• Pop Quiz:
  
  • What % of kids are affected by developmental delays and conditions?  **10%**
  
  • According to information published on March 30, 2012**, 1 out of how many kids have Autism Spectrum Disorder (ASD)?
    
    A. 1 out of 250
    B. 1 out of 150
    C. 1 out of 88
    D. 1 out of 68

Costs to Society

• In 2012-2013; approx. 28.2% of students in Maine needed special education services in kindergarten, but had not been identified by CDS prior to kindergarten entry (Kids Count data, Dec 2013)

• Public Spending on Disability Programs in the United States totaled over $600 billion in 2008- or 12% of the total federal, state, and local gov’t spending that year*

• People with cognitive limitations have total medical expenses 4.8 times higher than those with no disability*

• There is growing evidence that people with intellectual and other developmental disabilities experience poorer health outcomes than people without a developmental disability*

(*Maine Primary Care Association White Paper- Leverage Points in Delivery System Reform: Improving Care for Complex Patients (First Edition-April 2013)
AAP Recommendations


- Recommends addressing child development by including routine developmental surveillance;
- Periodic screening using standardized tools; and
- If a developmental concern is identified, referral and further evaluation to identify specific developmental disorders.
- Early identification of children with developmental delays and subsequent intervention can improve outcomes for young children.

**AAP Focus on Early Brain and Child Development (EBCD): 2013**

- Focus on ecobiodevelopmental framework
- Will demand a public health approach to prevent, mitigate, and treat toxic stress
- Protect the brain and build new skills
Definition of Screening

- Developmental screening is the administration of a brief tool that assesses 5 domains of development (communication, physical/gross motor, problem solving/cognition, social-emotional skills and fine motor/adaptive skills) to aid in the early identification of children at risk for a developmental disorder or delay.

- A clear action step needs to be identified if a child does not meet the criteria for passing in one of the five domains.

- Screening should be completed, minimally, at critical ages or when a concern arises.
Periodicity Schedule and Tools

Developmental Surveillance: at every well-child care visit
  • Bright Futures
  • Survey of the Well-Being of Young Children (SWYC)

Developmental Screening: at 9, 18, 24 or 30 month visit
  • Ages and Stages Questionnaire-3 (ASQ-3)
  • Parent’s Evaluation of Developmental Status (PEDS)

Autism Screening: at 18 and 24 or 30 months
  • Modified Checklist for Autism in Toddlers (M-CHAT-R)
Our Challenge

In 2011, MaineCare rates that lead to a focus on developmental screening: 1-6% for children ages 1, 2, and 3.

Source: MaineCare claims data, 2011

First STEPS Learning Initiative

First STEPS (Strengthening Together Early Preventive Services): *First STEPS is a four year Quality Improvement Initiative focused on improving children’s health care & improving preventive health (EPSDT*) screenings:*

- Phase 1: Introduce Bright Futures 3rd Ed and Childhood Immunizations
- Phase 2: Developmental, Autism, and Lead Screening
- Phase 3: Healthy Weight and Oral Health
- First STEPS 2014: Spread lessons learned on developmental screening
- Each 8 month phase: 2 Learning Sessions; Monthly Practice Calls and PDSA Cycles
- First STEPS Learning Initiative targeted to practices serving high volume of children (>1000) covered by Maine’s Medicaid program; 28 practices collectively serving 33,985 kids enrolled in MaineCare (26%)* (based on 2010 MaineCare data)

*First STEPS promotes the use of the American Academy of Pediatrics (AAP) Bright Futures Guidelines and the Principles of the Patient Centered Medical Home (PCMH)*
First STEPS Phase II Developmental, Autism and Lead Screening

- Practice Teams from 12 child-serving outpatient practices, including 45 physicians collectively serving 20,000 children covered by MaineCare

- Goal for developmental, autism, and lead screening rates:

  Between May 2012 and December 2012, improve the rate of all these screenings by 50% with a target screening rate of 75%

  - Learning Sessions in May 2012 and Sept 2012
  - Monthly Practice-level Plan-Do-Study-Act Cycles
  - Monthly Calls for Practice Coaches
  - Practice Improvement Coaching Calls Every 4-6 Weeks
  - Monthly Data Reports Apr 2012 to Dec 2012
Practices also piloted New MaineCare modifiers for Developmental and Autism Screening Tools

- 96110: General Developmental Screening Tool- PEDS/ASQ ($8.99)
- 96110HI: Autism Specific Screening Tool – MCHAT 1/MCHAT-R ($8.99)
- 96111HK: Autism Specific Screening Tool- MCHAT 2/MCHAT-F ($86.59)
First STEPS Phase II Evaluation Overview

- Conducted by the Muskie School of Public Service as part of Maine’s Improving Health Outcomes for Children CHIPRA quality demonstration grant.

- Methods/Data Sources –
  - Pre/post office systems surveys,
  - Monthly chart review data and program data
  - Interviews with practices and stakeholders,
  - Administrative data (e.g. claims and referral data).
Most practices focused on integrating developmental screening into well child visits; one quarter focused on autism and lead screening.

Most practices adopted the ASQ general developmental screening tool/ two adopted PEDS.

For autism, practices either expanded use of MCHAT-I or added the M-CHAT II.

Examples of practice change: adopted decision rules to implement at specific ages, pre-visit planning, incorporating completion of parent questionnaires into workflow, instituting EMR reminder systems, improving referral and follow-up for positive screens.
First STEPS Phase II Evaluation Highlights

Percent documented use of a developmental screening tool (PEDS or ASQ).

Autism screening with M-CHAT* I or II increased for kids under 3 years old, from 56% to 82%

*Modified Checklist for Autism in Toddlers

Data source: First STEPS Phase II Chart Review
First STEPS Phase II Evaluation Highlights

MaineCare claims-based rates improved with increased billing and more consistent coding

<table>
<thead>
<tr>
<th>Age</th>
<th>First STEPS Practices</th>
<th>Statewide</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Before Phase II</td>
<td>During/After Phase II</td>
</tr>
<tr>
<td></td>
<td>(5/1/11-4/30/12)</td>
<td>(5/1/12-4/30/13)</td>
</tr>
<tr>
<td>1yo</td>
<td>5.3%</td>
<td>17.1%</td>
</tr>
<tr>
<td>2yo</td>
<td>1.5%</td>
<td>13.3%</td>
</tr>
<tr>
<td>3yo</td>
<td>1.2%</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

Data Source: MaineCare paid claims, developmental screening measures based on CHIPRA #8 2012 measure specifications

Billing for Autism Screening (MCHAT-1*) for 1 & 2 year olds has also increased since Phase II, although at a lower rate than developmental screenings.
Using new screening tools helped identify developmental delays earlier and increased tracking, follow-up and referrals for treatment

- More practices had systematic approaches for monitoring and tracking children identified at risk for developmental delays or autism

- While statewide referrals to CDS declined slightly between May-Dec 2011 and May-Dec 2012, for Phase II practices the average number of referrals to CDS increased by 40%

- Referrals from Phase II practices to one particular pediatric developmental specialist group increased from 27 prior to Phase II to 35 after Phase II.
First STEPS Phase II Evaluation Highlights: System-level Changes

- Success in piloting new developmental screening billing codes in Phase II practices led to MaineCare implementing changes statewide.

- Phase II identified the need for greater standardization of developmental screening between primary care and other educational and social service programs.

- Phase II provided opportunity for direct provider feedback on implementation of a new state law to increase lead testing for children.

First STEPS Phase II Initiative Final Report: Improving Developmental, Autism and Lead Screening for Children is available at:

MaineCare Billing Increased Post Phase II

Developmental Screening Rates Among MaineCare-enrolled Children
FFY 2011 - 2013

Percent of Eligible Children

- Age 0 - < 1:
  - FFY 2011: 2%
  - FFY 2012: 3%
  - FFY 2013: 13%

- Age 1 - < 2:
  - FFY 2011: 3%
  - FFY 2012: 6%
  - FFY 2013: 17%

- Age 2 - < 3:
  - FFY 2011: 1%
  - FFY 2012: 2%
  - FFY 2013: 12%
Developmental Screening added to Maine Care UR Report

Primary Care Utilization Report - CHILDREN to 21 years

Quality Metrics - Prevention - Children to 21 Years

Children Aged 1-3 who had a Development Screening during the Measurement Year

<table>
<thead>
<tr>
<th>% Members</th>
<th>PCCM</th>
<th>FFS</th>
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<tbody>
<tr>
<td>1.5</td>
<td>1.5</td>
<td>0.0</td>
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<tr>
<td>7.0</td>
<td>891</td>
<td>118</td>
</tr>
<tr>
<td>16246</td>
<td></td>
<td>1797</td>
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</table>

Quality Metrics - Practice Statistics

Follow-up after hospitalization for mental illness

<table>
<thead>
<tr>
<th>% Members - 7 day follow-up</th>
<th>Actual Value</th>
<th>Graphical Results</th>
<th>Denominator</th>
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<tbody>
<tr>
<td>PCCM</td>
<td>94.2</td>
<td>83.3</td>
<td>69</td>
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<tr>
<td>FFS</td>
<td>94.0</td>
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Diabetic HbA1c Testing

<table>
<thead>
<tr>
<th>% Members with 1 or more tests</th>
<th>Actual Value</th>
<th>Graphical Results</th>
<th>Denominator</th>
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<tbody>
<tr>
<td>PCCM</td>
<td>100.0</td>
<td>88.2</td>
<td>8</td>
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<tr>
<td>FFS</td>
<td>100.0</td>
<td>82.1</td>
<td>8</td>
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Diabetic Eye Exams

<table>
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<tr>
<th>% Members</th>
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<tr>
<td>12.5</td>
<td>12.5</td>
<td>8</td>
</tr>
<tr>
<td>47.3</td>
<td>47.3</td>
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Diabetic Care LDL Measured within previous 12 months

<table>
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<tr>
<th>% Members</th>
<th>PCCM</th>
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<tbody>
<tr>
<td>25.0</td>
<td>25.0</td>
<td>8</td>
</tr>
<tr>
<td>25.4</td>
<td>25.4</td>
<td>279</td>
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Diabetic Care - Members receiving Hypertrophy Treatment

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<th>% Members</th>
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<tbody>
<tr>
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<td>33.5</td>
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Chlamydia Screening Ages 15 - 20

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<th>% Members</th>
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<td>46.1</td>
<td>46.1</td>
<td>1038</td>
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</table>

Appropriate Testing for Children With Pharyngitis

<table>
<thead>
<tr>
<th>% Members</th>
<th>PCCM</th>
<th>FFS</th>
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<tbody>
<tr>
<td>81.1</td>
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<td>53</td>
</tr>
<tr>
<td>82.1</td>
<td>82.1</td>
<td>1038</td>
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</table>

Children Aged 1-3 who had a Development Screening during the Measurement Year

<table>
<thead>
<tr>
<th>% Members</th>
<th>PCCM</th>
<th>FFS</th>
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<tbody>
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Moving from Practice Innovation to System Transformation - What does it take?

• Clear goals with committed practice and organization leadership
• Align metrics across initiatives
• Capture population based data that is available to practices
• Align billing/coding across payors
• Provide ongoing training to practices
• Work across all sectors that work with children
• Develop common terminology
• Align policy across early childhood sectors and payors
• Understand how the social determinants of health like poverty and Adverse Childhood Events (ACES) affect the issue
• Include families and parents and develop messaging about importance of goal
• Make it Fun!
Aligning Metrics Across Initiatives

- 2010 CHIPRA Core Set Metric on Developmental Screening by age 1, 2, and 3
- CHIPRA metrics used by First STEPS Practice QI Project in 2012
- CHIPRA metric included in Health Homes Pilot
- CHIPRA metric added to MaineCare UR Reports
- CHIPRA metric included in MaineCare ACI metrics
Capturing Data and Aligning Payment

• Currently hard to capture data from EMRs consistently
• If practices are not billing for developmental screening, we are not able to capture population based metrics for CHIPRA measure
• In 2012, MaineCare issued guidance on 96110 code for developmental screening including use of modifiers to help distinguish data between general developmental screening and autism
• Per practice reports- commercial payors not consistently covering 96110 or issuing initial denials
• Billing/coding inconsistencies make it hard to scale up and spread- if patients are getting bills or it is applied to co-pay/deductible-practices get a lot of complaints and get frustrated
• Looking into Modifier-33-(new since 2011) for preventive services-plans cannot impose cost-sharing (co-pays, deductibles, coinsurance) with respect to specified preventive services if primary reason for office visit is preventive services
Resources to Help Practices Implement Developmental Screening in their Office

- First STEPS 2014 Regional Trainings/Webinars
- QC First STEPS Developmental Screening Change Package
- QC for Kids Website- Provider Resources Page
- AAP Autism Toolkit: MaineCare has purchased a license for Maine practices to use online (password protected)
# First STEPS 2014: 3 Regional Trainings on Developmental Screening (March-April) and Monthly Webinars

<table>
<thead>
<tr>
<th>DATE</th>
<th>TOPIC</th>
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<tbody>
<tr>
<td>April 10, 2014</td>
<td>Making the Connection with the Medical Home and Child Development Services, Part C, and other Early Childhood Partners doing Developmental screening in the Community - Dr. Bob Holmberg and Cindy Brown</td>
</tr>
<tr>
<td>May 8, 2014</td>
<td>What is Next? When a Child Doesn’t Pass Initial Autism Screening, Review of the MCHAT 2 Interview - Dr. Carol Hubbard</td>
</tr>
<tr>
<td>June 12, 2014</td>
<td>Planned Coordinated Care in Patient and Family-Centered Medical Home - Dr. Bob Holmberg and Nancy Cronin</td>
</tr>
<tr>
<td>July 10, 2014</td>
<td>Management of Behavioral Issues in Children with Autism Spectrum Disorders - Dr. Carol Hubbard</td>
</tr>
<tr>
<td>August 15, 2014</td>
<td>Translating Developmental Science into Healthy Lives: Realizing the Potential of Pediatrics and the Science of Early Brain and Child Development (EBCD) - Dr. Andrew Garner, National AAP <strong>Note the only day that is a Friday and not Thursday.</strong></td>
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<tr>
<td>October 9, 2014</td>
<td>Considering Culture in Developmental and Autism Screening - Nan Simpson, MSW</td>
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Improving Care for Children with Developmental Delays and/or Autism Spectrum Disorder

**Global Aim:**
Promote healthy development for young children and achieve earlier identification and intervention for children with developmental delays and/or autism spectrum disorder (ASD).

**Specific Aims**
From August 2013 to August 2016, we will increase the number of children enrolled in MaineCare receiving general developmental screening by primary care providers by 3 percentage points a year using MaineCare claims data as the source.

By 2016: MaineCare claims data will show 11.1% of children by age 1 (from 2.1%) 12.4% of children by age 2 (from 3.4%), and 9.5% of children by age 3 (from 0.5%) received a general developmental screening. (Baseline data is from 2011 MaineCare claims).

**Measures**
- # Screened
- Referrals
- Follow up Plans

QC 2014 April 2, 2014

QC for kids
Maine Quality Counts

(DRAFT Updated 11.4.13)
Practices Can Test Readiness with 20 Question Quiz

- **Yes or No.** Have you identified a physician champion and an office manager or nurse champion to improve developmental screening rates?

- **Yes or No.** Are staff clear on the difference between surveillance and screening?

- **Yes or No.** Have clinicians in your practice agreed upon, documented, and posted a standard schedule for developmental and autism screening?

- **Yes or No.** Are staff knowledgeable about developmental milestones?

- **Yes or No.** Does your practice provide information to families around developmental milestones (e.g., Bright Futures)?

- **Yes or No.** Do you use Bright Futures or some other tool (e.g., Tufts) for purposes of surveillance?

- **Yes or No.** Do you currently perform routine evidence-based screening for developmental delays and ASD in your practice using a standard tool?

- **Yes or No.** Does the practice have a standard process in place for next steps when a concern is noted during the development screening process?

- **Yes or No.** Do you have a standard process in place for when a child needs a referral to a developmental pediatrician?

- **Yes or No.** Are referrals for children identified at risk for or with developmental and timely—they are able to get the follow up they need in a timely fashion?

- **Yes or No.** Do you have a tracking system in place to track children at risk for or with a positive developmental or autism screening result?

- **Yes or No.** Do you have a care coordinator that assists families through the referral and treatment process for developmental delay and autism?

- **Yes or No.** Do you involve parents or patients in improving your office’s care for children with developmental delay or autism?

- **Yes or No.** Does your practice integrate quality improvement efforts in your office procedures to monitor the effectiveness of surveillance and screening tools (e.g., assessment, work flows, etc.)?

- **Yes or No.** Does your practice provide ongoing training and orientation to staff on how to conduct developmental surveillance, diagnostic screening and on how to communicate concerns and screening results?

- **Yes or No.** Have you made changes/improvements in your office space to design the optimal experience for children with ASD and developmental delays?

- **Yes or No.** Is your practice billing and coding properly for screening for developmental delays and ASD (e.g., familiarity with MaineCare codes)?

- **Yes or No.** Is your practice reliably collecting and reviewing data on the number of children getting developmental screenings (e.g., via claims based through utilization reports, registry reports)?

- **Yes or No.** Do you have systems in place to connect patients and parents with community resources and supports?

- **Yes or No.** Does your practice direct families to resources around care and treatment for children with developmental delays and/or ASD?
Work on Process Maps with Practices: Starting with a Block Diagram

**Patient checks in**
- Ask family if they have had screening done recently by another group and if they have a copy of the results.
- Screening form given to patient by front clerical staff.

**Screen completed**
- Screen completed by parent in wait room.
- MA collects and includes w/ check out sheet.

**Screen scored**
- Provider enters encounter, reviews and scores w/ pt.
- Provider scores form on enclosed scoring sheet using laminate score instructions posted in room.

**Results reviewed w/ Family**
- Provider reviews screen w/ pt.
- Provider discusses interventions as needed and signs Screen.
- Provider puts quick text in EMR indicating screen complete.
- Provider documents assessment & clinical impression.

**Referrals made as necessary**
- Follow up visits and/or referrals made at point of care via EMR.
- *Results shared with other early childhood sectors.

**Patient checks out**
- Patient checks out with plan of care.

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**Step 2:** Hang specific steps related to the bigger “buckets” of work underneath appropriate step, vertically.

QC 2014 April 2, 2014
Develop PDSA cycles and then test them...

- Using Plan-Do-Study-Act cycles.
- Relatively small, multiple tests of change.
- What can we test with one patient, one screening, one well child visit, on provider, for the next 30 minutes, etc.
AAP Autism and Bright Futures Toolkits
Now Available Online Statewide

Tools and Resources

- AAP Autism Toolkit and AAP Bright Futures Toolkit, 3rd Ed
  Providers can download the Toolkit and install it on their practice’s computer system: [http://www.maine.gov/dhhs/oms/provider/childrens.html#epsdt](http://www.maine.gov/dhhs/oms/provider/childrens.html#epsdt)
- New Parent/Patient Education Forms Available
  - 18 new handouts addressing key topics for Well Child Visits are now available: [http://www.maine.gov/dhhs/oms/provider/childrens.html#epsdt](http://www.maine.gov/dhhs/oms/provider/childrens.html#epsdt)
  - Based on the Bright Futures 3rd Edition guidelines
  - Revised to meet MaineCare health literacy requirements for members
  - Include Maine-specific informational links
- Revised Well Child Visit Forms Available
  - Updated to follow the Bright Futures 3rd Edition guidelines
  - Also include additional MaineCare priority elements
MOVING FROM PRACTICE IMPROVEMENT TO SYSTEMS CHANGE: DEVELOPMENTAL SYSTEMS INTEGRATION (DSI) PROJECT
DSI Goals

The goal of the initiative is to improve developmental screening across the early childhood system for children ages 0-3 and their families by generating:

• Acceptance of a set of standardized developmental screening tools used by child health and early care and education providers: Decided in Nov 2013 to use Ages and Stages Questionnaire (ASQ-3) and Parents Evaluation of Developmental Status (PEDS) across sectors

• Protocols for training requirements and administration of developmental screening tools that promote reliable and valid results;

• Mechanisms for sharing and communicating results efficiently and securely among child health and early care and education providers; and

• Cross-departmental policies in support of the coordinated system, including Health Home (HH) and Patient Centered Medical Home (PCMH) initiatives.
Developmental Systems Integration (DSI)/SAIEL Partners

Maine SAIEL
Developmental Screening Integration Team Partners

Maine Children’s Alliance

MIECHV (Maine Families Home Visiting)

Early/Head Start

Department of Education
  - PreK
  - SLDS
  - Early Childhood

Maine AAP Chapter

SAIEL (Maine DOE and DHHS)

Maine Children’s Growth Council
  - Health Accountability Team
  - Communications Coor

Office of Child and Family Services
  - CCDF
  - Children’s Behavioral Health

Child Development Services

Maine Children’s Alliance

Muckie School of Public Service, LSM (HRDC)

Quality Counts/MS CHIP

Maine CDC
  - CSIN
  - FINC

Office of MaineCare Services
  - HMO

Maine Children’s Families Home Visiting

Developmental Disabilities Council

Circle of Strength

QC 2014 April 2, 2014
Are we all speaking the same language?

DSI: Developing common terminology across the early childhood education and medical sectors
### Maine Early Childhood 0-3 Developmental Screening, Identification and Assessment Terminology Summary

<table>
<thead>
<tr>
<th>DEVELOPMENTAL SURVEILLANCE</th>
<th>DEVELOPMENTAL SCREENING</th>
<th>DEVELOPMENTAL EVALUATION (Diagnostic)</th>
<th>DEVELOPMENTAL ASSESSMENT (Ongoing)</th>
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<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td>The administration of a brief standardized tool aiding the identification of children at-risk of a developmental disorder in one or more domains (cognitive, communication, adaptive, social-emotional, physical).</td>
<td>Identifies/diagnoses the existence of a delay or disability, identifies the child’s strengths and needs in one or more areas of development (cognitive, communication, adaptive, social-emotional, physical) and determines the scope, intensity and duration of a therapeutic service(s) should a delay be identified.</td>
<td>Collects, synthesizes and interprets information about children from several forms of evidence of the child’s learning, growth, and development on an ongoing basis, over a period of time. The assessment process identifies a child’s unique strengths and needs in developmental domains (cognitive, communication, adaptive, social-emotional, physical) and the child’s unique approach to learning and development. Assessment methods can be both formal and informal and typically include standardized testing, observations and parent input.</td>
</tr>
<tr>
<td><strong>Instrumentation</strong></td>
<td>Performed/facilitated by medical practices, CDS/Part C, PHN/CHN, Maine Families, Early Head Start, early care and education teachers with informed, active parental input and participation.</td>
<td>Conducted on a periodicity schedule using a standardized tool such as the ASQ PEDS and MCHAT-RF</td>
<td>An ongoing process that is conducted initially and periodically after that to determine a baseline of skills and as an on-going process to measure child growth and development. Examples include AEPS, HELP, IDA, Gesell, MSEL, TPBA, Teaching Strategies GOLD</td>
</tr>
<tr>
<td><strong>Administrator</strong></td>
<td>Conducted by medical practices during well child care, PHN/CHN, Maine Families, Early Head Start, early care and education teachers with informed, active parental input and participation.</td>
<td>Conducted on an inter-periodic basis utilizing a standardized or norm-referenced instrument (e.g., BDIST, CDI, HELP, PPVT-IV, GFTA-2, ASQ-SE)</td>
<td>Conducted by CDS/Part C, Early Head Start, medical sub-specialists, SLP, OT, PT, Social Workers, Behavioral Health with informed, active parental input and participation and contributes to individualized curriculum planning and parent support/education services. If eligible for CDS, information is used to develop the Individualized Family Service Plan (IFSP) that defines and guides early intervention services across all developmental domains.</td>
</tr>
<tr>
<td><strong>Periodicity</strong></td>
<td>Ideally conducted for all children 0-3 in multiple settings in partnership with parents and other caregivers on an inter-periodic basis according to the AAP Periodicity Schedule minimally.</td>
<td>Conducted for all children 0-3 minimally according to the AAP Periodicity Schedule or on an inter-periodic basis when concerns are expressed by a parent/caregiver or indicated by surveillance. For EHS, must be completed within 45 calendar days of enrollment.</td>
<td>Conducted for children 0-3 who have been referred as a result of screening and/or parental or medical practice concerns. For CDS-Part C, must be completed within 45 calendar days of referral</td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
<td>Newborn, 3-5 Days, 1 mo, 2 mo, 4 mo, 6 mo, 12 mo, 15 mo, 24 mo, 3 years</td>
<td>Developmental: 9 mo, 18 mo, 24/30 mo MCHAT-RF: 18 mo, 24/30 mo</td>
<td>Conducted in early care and education settings including Early Head Start and child care programs as part of curriculum and individualized planning as well as for children who may have been identified as having developmental concerns and are eligible for CDS. Frequency varies by program and purpose for the developmental assessment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Initial and at least every 3 years or more frequently as determined by clinical judgment</td>
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</tr>
</tbody>
</table>
Coordinating with other Sectors around Developmental Screening

Maine Families Home Visiting
- Conduct developmental screening using ASQ-3 following the ASQ-3 periodicity schedule starting at 2 months
- Conduct social-emotional screening at least once between ages of 6 and 12 months using ASQ-SE

Early Head Start
- Conduct developmental screening using ASQ-3 within 45 days of enrollment and then follow the periodicity with the ASQ-3
- Conduct social-emotional screening using ASQ-SE

Public and Community Health Nursing
- Will begin using the ASQ-3 following the AAP periodicity schedule in 2014

Child Development Services (CDS)
- Uses a variety of tools but mainly the ASQ and Battelle
Recommendations from
Fall 2013 DSI Survey (300 respondents)

• Build awareness of the importance of developmental screening in children ages 0 to 3.
• Create a coordinated system of referring children
• Design a standard 0 to 3 screening process, which includes standardized tools, to use across all early childhood settings.
• Improve communication and a way of sharing information which honors the family’s privacy, yet at the same time connects them to timely, appropriate resources.
• Connecting developmental screening results and referrals to electronic records help with improved communication, tracking and data collection.
• Carefully look at developmental services across a continuum from the standpoint of surveillance, screening, and formal evaluation.
Outstanding Issues for Developmental Screening and DSI Project

- Ensure access to screening for all children
- Decide what is the role of each sector in surveillance and screening and how to improve training and coordination across groups
- Develop common release form and referral form to coordinate work across sectors and work to get forms into policy across organizations and practices
- Define metrics across early childhood sectors to evaluate impact
- Collect data across early childhood sectors
- Ensure consistent payment across payors
- Consumer Engagement: Defining a common message about why developmental screening is important to families that is used across sectors such as “Birth to 5: Watch Me Thrive” and “Learn the Signs, Act Early”
Your Child’s Early Development is a Journey
Check off the milestones your child has reached and share your child’s progress with the doctor at every visit.

6 MONTHS
- Copies sounds
- Begins to sit without support
- Likes to play with others, especially parents
- Responds to own name
- Strings vowels together when babbling (“ah,” “eh,” “oh”)
- Uses simple gestures such as shaking head for “no” or waving “bye bye”
- Copies gestures
- Responds to simple spoken requests

12 MONTHS (1 YEAR)
- Says “mama” and “dada”
- Pulls up to stand

18 MONTHS (1½ YEARS)
- Says several single words
- Walks alone
- Knows what ordinary things are for; for example, telephone, brush, spoon
- Plays simple pretend, such as feeding a doll
- Points to show others something interesting

2 YEARS
- Follows simple instructions
- Kicks a ball
- Points to things or pictures when they’re named
- Says sentences with 2 to 4 words
- Gets excited when with other children

3 YEARS
- Carries on a conversation using 2 to 3 sentences
- Climbs well
- Plays make-believe with dolls, animals and people
- Shows affection for friends without prompting
- Hops and stands on one foot for up to 2 seconds

4 YEARS
- Would rather play with other children than alone
- Tells stories
- Draws a person with 2 to 4 body parts
- Plays cooperatively

These are just a few of many important milestones to look for. For more complete checklists by age visit www.cdc.gov/ActEarly or call 1-800-CDC-INFO.
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For more information, please contact the IHOC Project Director, Joanie Klayman at jklayman@usm.maine.edu or 207-780-4202.

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