

Developmental Screening in the DC Primary Care Setting

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Title of Presenter

American Academy
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DEDICATED TO THE HEALTH OF ALL CHILDREN™

Why This Matters



Taking action to support a child's development from birth to 5 alters the trajectory of a child's academic career and life path.

Children who receive needed services before age 5:

- See their conditions fully treated or substantially mitigated
- Are better prepared for Kindergarten
- Achieve higher rates of educational attainment
- Live in families that have greater support and reduced stress

Objectives of this Presentation



1. Describe DC's early intervention services and process.
2. Summarize evidence regarding effectiveness of developmental screenings by primary care providers.
3. Discuss implementation of the American Academy of Pediatrics (AAP) recommendations.

DC's Early Intervention Services and Process



IDEA in Washington, DC



- The Individuals with Disabilities Education Act (IDEA) is the federal law that outlines the rights of children with special needs from birth through age 21.
- In DC, two programs serve children under age 5:
 - Strong Start (0 to 3) run by Office of the State Superintendent
 - Early Stages (3 through 5) run by DC Public Schools

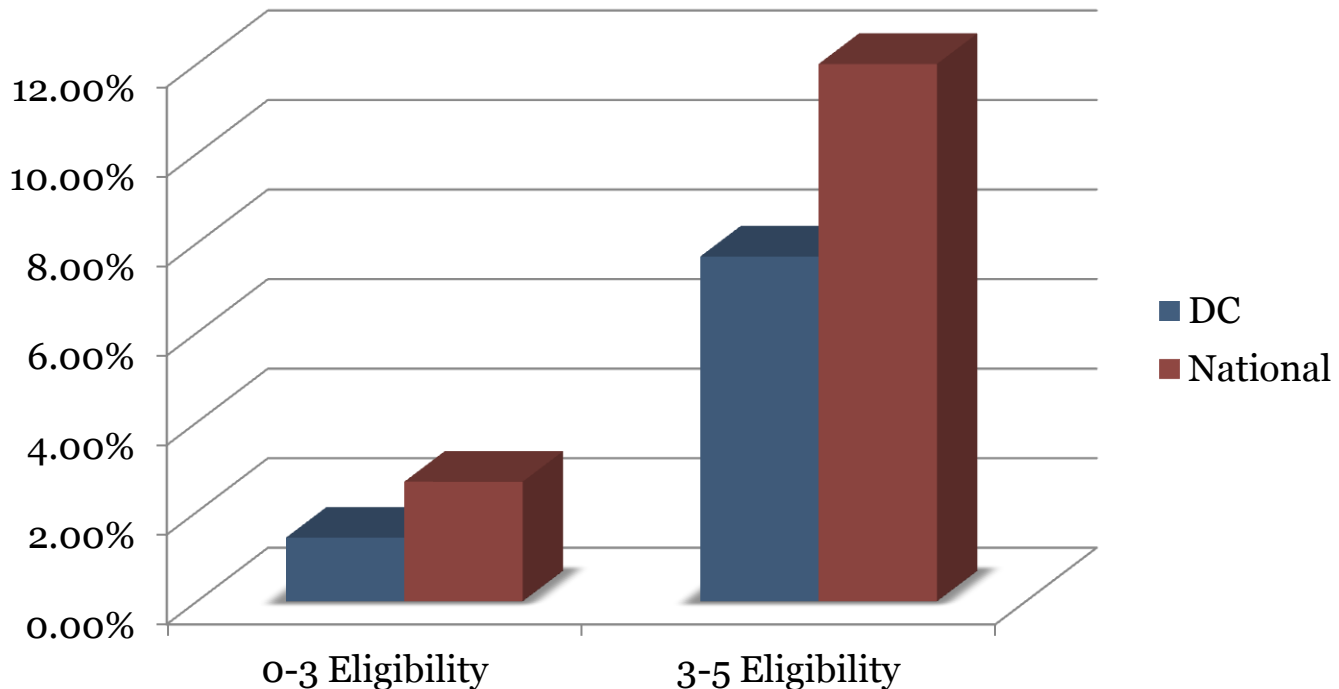
Making Referrals

	Strong Start	Early Stages
Age Range:	Birth to 2 years 8 months	2 years 8 months to 5 years 10 months
Reason:	<ul style="list-style-type: none"> • Developmental delay • Diagnosed condition or risk factor associated with developmental delay • Parental concern 	<ul style="list-style-type: none"> • Same as Strong Start • Concerns over school readiness and social-emotional issues
Examples:	Very low birth weight, genetic condition, prematurity, hearing or vision impairments, birth defects, delayed speech	Most common: speech delay, developmental delay, and behavioral concerns, as well as physical and fine motor concerns.

>> See handouts for information on how to refer <<

Early Intervention in DC: How are we doing?

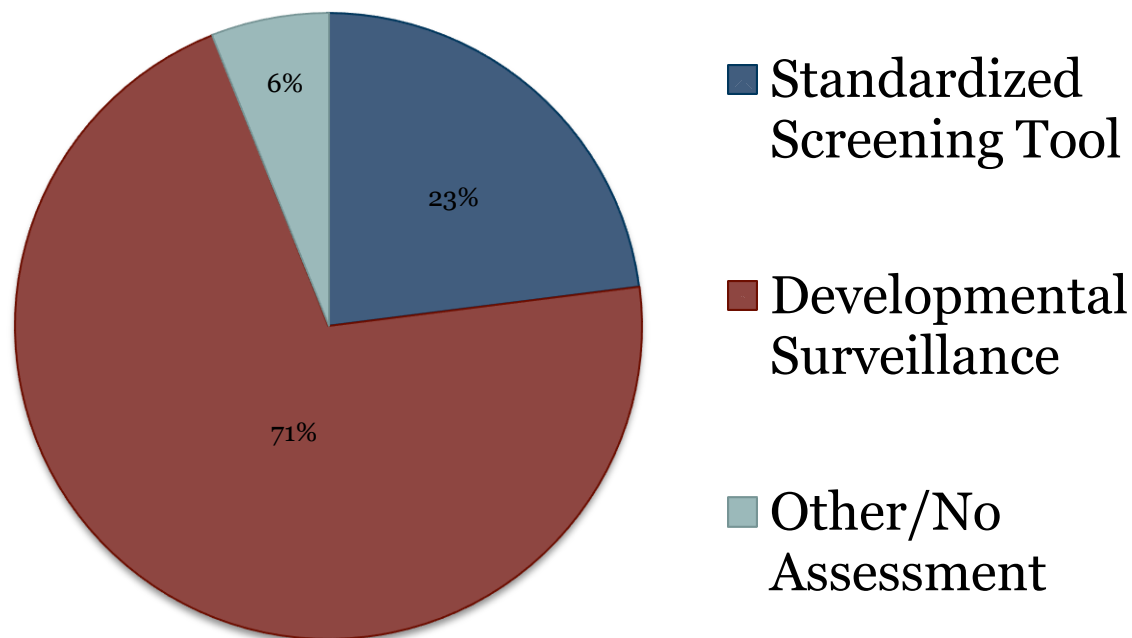
Percentage of children found eligible for services.



We need to find more children and find them earlier.

Evidence regarding developmental surveillance and screening in primary care settings

How Pediatricians Currently Assess Child Development



Sand, 2005

How Effective is Developmental Surveillance?



A LOOK AT TWO STUDIES:

Hollie Hix-Small, et.al. 2007

R. Christopher Sheldrick, et.al. 2011

Identification of Developmental-Behavioral Problems in Primary Care: A Systematic Review

R. Christopher Sheldrick, et.al. 2011

Context: a systematic review of 11 studies on the effectiveness of surveillance

Developmental surveillance has low rates of sensitivity

- Sensitivity: 14% to 54%
- Specificity: 69% to 100%

Impact of Implementing Developmental Screening at 12 and 24 Months in a Pediatric Practice

Hollie Hix-Small, et.al. 2007

Context: a study of 1428 children in private practices

Developmental surveillance missed 67.5% of children later identified by ASQ as needing referral

Why does developmental surveillance miss children?



- Inaccuracy of clinical judgment
 - Tends to identify most severe delays
- Non-standardized administration
 - Partial vs. complete administration
 - Targeted vs. universal screening
 - Parental report when direct observation was intended

How Effective is Standardized Developmental Screening?



A LOOK AT TWO STUDIES:

North Carolina ABCD Project 2004

Hollie Hix-Small, et.al. 2007

North Carolina ABCD Project, 2004



Context: Broad implementation of developmental screening (ASQ) during Medicaid well child visits

Result:

- Increase in referrals to early intervention from 3.9% to 7% of all children <36 months
- 70% of these children were found eligible for services

Hollie Hix-Small, et.al. 2007



Context: a study of 1428 children in private practices were screened at 12- and 24-month well-child visits.

Result:

- Referral rate increased 224% once developmental screening process was implemented.
- 94% of referred children were found eligible for services.

Implementation of the AAP Recommendations for Screening

AAP Recommendations

Key Points



The Screening Tool is Standardized

Screening is Universal

- All children screened, regardless of risk

Screening is Periodic

- Completed at 9, 18 and 30* months

*If 30-month visit is not routine, 3rd screening at 24 months

AAP Recommendations

Why?



The Screening Tool is Standardized

- Eliminates inconsistent surveillance techniques

Screening is Universal

- Eliminates problem of low sensitivity of surveillance

Screening is Periodic

- Ensures children are not missed
- Tracks developmental changes over time

AAP Recommendations: Response to Failed Screening



If a screening reveals a concern, providers should

- Refer to early intervention programs
(Strong Start/Early Stages: see Special Ed Cheat Sheet handout for details)
- Refer to medical subspecialists

Ages & Stages Questionnaire



- Well-validated
- One-time cost
 - Unlimited duplication
- Milestone/skill-based
 - Facilitates parent education
- Options: parent administration or parent self-report
 - Waiting room/exam room

Use of ASQ-3 in DC (FY 2011)



- Widespread use:
 - Used as intake tool by both Strong Start and Early Stages
 - DCPS screens all Head Start children (4,500) with ASQ-3
- Strong correlation to eligibility in DC:
 - Strong Start: 57% of ASQ-referred children were eligible.
 - Early Stages: 65% of ASQ-referred children were eligible.

Developmental Surveillance and Screening Policy Implementation Pilot



Established by the AAP to test the feasibility of implementing the 2006 AAP screening guidelines.

A 9-month project involving 17 practices using ASQ 3

Results: 85% of presenting patients were screened.

Lessons from the AAP Pilot



Practices struggled most in three areas:

1. Conducting screening at 30-month visit.
1. Administering a screening after surveillance suggested a concern.
1. Referring children to both medical subspecialists and local early intervention programs. (Only 61% of children with failed screenings were referred.)

King, Tandon et al. 2010

Models for Implementation

In all cases, screening is reviewed by physician during visit.



Parent completes ASQ in
waiting room.

(Currently being done at some CNMC clinics)

Parent completes ASQ in
exam room.

Nurse, medical assistant or
volunteer administers ASQ.

(Before appointment by phone or at visit.)

Parent completes ASQ
online.

(Before appointment, provider previews results)

Implementation Issues to Consider



- Acceptable sensitivity/specificity: 70%-80%
- Cost
- Time required
- Impact on clinic workflow/patient flow
- Parental language/literacy issues
- Other clinic missions (e.g. teaching)
- Knowledge of resources to which to refer

Implementation Cost Model



- Beers to update with billing data

Conclusion



1. Strong Start and Early Stages are working to dramatically increase the number of children under age 5 receiving early intervention services.
2. Routine and universal developmental screening is a crucial part of identifying children who will be eligible for services.
3. Medical practices have had success implementing the AAP guidelines for screening.

Next Steps



1. The DC Chapter of the AAP will be disbursing grants and technical assistance to practices interested in implementing the AAP screening guidelines.
1. Early Stages is available to provide training on administering the ASQ.

Supporting Documents on the Flash Drive



AAP Screening Algorithm
Referral Form for Strong Start
Referral Form for Early Stages
Early Stages FAQ
Early Stages Developmental Milestones Sheet
Supporting Literature

From the AAP Policy Statement: Successful early identification of developmental disabilities requires the pediatrician to be skilled in the use of screening techniques, actively seek parental concerns about development, and create links with available resources in the community.

AAP - Healthy People 2020 Partnering Agencies



D.C. Department
of Mental Health

