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Child Screening for Developmental, Health and Environmental Information

A Project for the Florida Cabinet for Children and Youth



The Policy Group for Florida's Families
and Children, on behalf of the Children's
Summit Workgroup

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Child Screening for Developmental, Health and Environmental Information

A Project for the Florida Cabinet for Children and Youth

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Executive Summary

Scope of Work

The issue: Currently, a variety of screening tools are in use by various state and local agencies and organizations. Not all children receive a screening that addresses the full range of developmental capacities, and often the individual administering the screening lacks sufficient knowledge of child development and skill in screening. In too many instances, screening information for children with findings is not referred to a qualified provider for further assessment and diagnosis. Furthermore, screening and assessment information, when produced, may not be shared between programs, services, and providers resulting in duplication of screenings, unknown or lost information as a child/family accesses more than one service, and/or delay in receiving needed interventions. This creates missed opportunities to build resiliency and optimal development in the child and family.

Proposed solution: Using a panel of experts, including professionals trained in screening and comprehensive assessment techniques and professionals representing programs/services throughout the state:

- Collect information on child screenings currently in use
- Identify facilitators and barriers to sharing screening information across services and agencies
- Recommend ways to make high quality screening and assessment information accessible to parents and all appropriate service providers
- Develop and/or recommend a screening methodology and frequency for children 0-18.

Background

The Children's Summit Workgroup accepted this recommendation and presented a proposal to the Florida Children and Youth Cabinet to convene a panel of experts and develop a set of recommendations for Cabinet consideration. With the Cabinet's approval of the proposal, the Children's Summit Workgroup contracted with The Policy Group for Florida's Families and Children for oversight of the project.

The work of The Policy Group for Florida’s Families and Children has been comprehensive. The Child Screening Project has included:

- Development of a survey regarding child screening and assessment
- Administration of the survey statewide to a wide range of child and youth professionals
- Analysis of 168 surveys
- A review of research and best practice evidence regarding child screening and assessment
- Identification and convening of a panel of developmental screening and assessment experts
- Interviews with child screening experts
- Development of recommendations

Phase 1: Child Screening Survey

The Policy Group for Florida’s Families and Children commissioned a survey to understand the types and uses of screenings and assessments across Florida. The survey, conducted by Florida State University graduate student Michelle Craig, was delivered electronically to 251 agencies or programs identified as possibly providing child screenings or assessments. Opportunities were also provided for completion and follow-up of the survey via telephone. One hundred and sixty-eight surveys were completed and analyzed. Findings addressed screening and assessment definition and purpose issues, use of tools, qualifications of staff providing screening, involvement of families, use and follow-up of screening information and barriers to screening.

Phase 2: Panel of Experts Review

The panel of experts convened by The Policy Group for Florida’s Families and Children began their work by participating in an interview process designed to collect additional information on current practices and issues in Florida specific to child screening. This information, along with the survey analysis summarized above and a collection of additional resources and information, served as the starting point for panel deliberations. Member work included agreement on definition of terms, guiding principles, and a vision statement.

This report also includes a description of a system approach to comprehensive screening based on best practice evidence and panel deliberations. At each juncture in the system description, information is provided as to the current practices in Florida. The report concludes with an overview of current system strengths and challenges and a set of short-, intermediate- and long-term recommendations.

Definition of Terms

The following definitions were adopted:

Child Screening is a brief procedure designed to identify children who should receive more intensive assessment or diagnosis

Child Assessment is a systematic procedure to identify the specific needs of a child for the purpose of intervention.

Limitations

This project focused primarily on child screening. Members recognize that child screening and assessment go hand-in-hand, and child screening is neither meaningful nor ethical without follow-up assessment and diagnosis when screening raises a red flag. Nonetheless, a detailed analysis of child assessment is not included. Assessment takes many forms, has multiple purposes and has different definitions based on setting. In order to narrow the focus of this effort, respond in a timely manner and develop reasonable recommendations for consideration, workgroup and panel members agreed to limit the primary focus on recommendations regarding child screening and the type of assessments that are required as follow-up to screening.

In addition, the primary focus of review was on screening protocols for young children. Members reviewed and discussed concerns relative to school-age and adolescent children, particularly those children in child welfare and juvenile justice programs, and have included some recommendations addressing these age groups. Nonetheless, the importance of identifying children early in order to intervene and prevent many of the concerns that are found in current populations of older children resulted in a stronger concentration on system development for screening of young children.

It is also noted that some forms of screening are not intended to identify a need for further assessment. For example, screening may be a mechanism to identify eligibility for services for children and families. Although this report does not address this type of screening, the development of child screening protocols should incorporate these types of screening in addition to developmental, health, and environmental screenings.

Guiding Principles

Workgroup and panel members identified the following guiding principles:

- All children in Florida should have access to uniform, high-quality comprehensive screening beginning at birth and continuing at regular intervals throughout childhood.
- All expectant mothers should have access to uniform, high quality comprehensive screening to identify protective and risk factors associated with child outcomes.
- Families with children should have access to uniform, high quality screening of the full spectrum of developmental capacities, in conjunction with child screenings in order to fully support optimal child outcomes.
- Families must provide consent for child screening and be recognized as essential partners in the child screening process.
- Child screening must be linked to child assessments and intervention services when there are indications that further information or services are needed.
- Screening results should be published in the aggregate by age, population group and type of suspected problem to advance understanding of the magnitude of issues.

Conclusions

There are a number of areas in Florida where families are afforded multiple opportunities to ensure that their children are screened and receive services if needed through exceptional programs and efforts. Coordination efforts across agencies and programs include numerous interagency agreements and memoranda of understanding. In addition, entities such as the Governor's Task Force on Autism, the Developmental Disabilities Council and the Department of Health Early Childhood Comprehensive Systems Grant provide important leadership and support for child screening coordination efforts. Strong leadership is often behind the collaboration efforts that occur across multiple local service providers to provide comprehensive screening, assessment and intervention protocols and services.

Unfortunately, however, child screening of the full range of developmental, health and environmental factors is not available for most of Florida’s children. Too many children miss out due to lack of health insurance, medical homes, policy and practice barriers to screening in medical settings or lack of trained and competent screeners. When screening is in place, too often it does not include attention to social-emotional needs, environmental hazards or family functioning. There is little consistency in the tools used by agencies and programs providing child screening, with differences even found in the same program offered in different parts of the State. Due to lack of comprehensiveness and training, many conditions are not identified early when treatment is most beneficial and cost effective. As children age, additional opportunities are missed for screening, assessment and intervention, particularly for children and adolescents in child welfare and juvenile justice programs. Furthermore, staff providing Part C and Part B services are overwhelmed in some areas of Florida resulting in delays in service provision – delays that have major consequences for children’s development and families’ functioning. Although there are many outstanding exceptions, too often families do not have the supports they need to navigate the referral and service provision process.

Recommendations

Goal 1: Create a system of standardized child screening tools, processes, and procedures.

- Identify a set of age-appropriate tools that capture demographic, developmental, health, and environmental information important to optimal development and develop a set of criteria and protocol (including commitment to informing and supporting families) for their use across programs and agencies statewide.
- Develop interagency agreements and procedures that ensure all agencies and programs receiving state or federal funding utilize the agreed-upon system of standardized child screening tools, processes and protocols.
- Develop staff and parent training regarding the system of standardized child screening and incorporate coordinated training in interagency agreements.
- Utilize the Florida Pediatric Society and *Docs for Tots* to identify mechanisms for improved communication and coordination between health providers and early intervention, early care and education and other service providers.

Goal 2: Increase the availability of and access to screening that is comprehensive across the range of development capacities, environmental factors and family functioning.

- Expand access to routine maternal mental health screening (through health department clinics, health care providers, birthing centers/hospitals, home-visiting programs, secondary and higher education school clinics).
- Develop awareness and outreach materials for use across state agencies adopting guidelines from the AAP/Bright Futures regarding screening frequency, identifying resources for families, and promoting the medical home concept.
- Expand the web-based Florida SHOTS™ Registry Program to include child screening information.
- Develop a plan to promote fuller and better utilization of Early Periodic Screening, Diagnosis and Treatment (EPSDT).
- Review Medicaid policies and practices to provide incentives for providers to conduct child screening, referral, and follow-up services.
- Review HMO and AHCA reimbursement policies to remove barriers to child screening by pediatricians and other health care professionals.
- Incorporate requirements regarding child screening and follow-up in a statewide quality rating improvement system for early care and education programs.

- Develop and implement community assessments designed to identify and build social capital (individual, family, and community strengths) and optimize child health and well-being.

Goal 3: Increase the effectiveness of screenings by increasing the knowledge and skills of those that administer screenings

- Utilize the Florida Pediatric Society and *Docs for Tots* to develop training and practice guidelines regarding child screening in medical settings.
- Assess and address cultural and linguistic appropriateness of screening instruments and protocols.
- Identify mechanisms and funding to support use of developmental specialists in partnership with pediatricians.
- Revise and mandate child care training module on Observation, Screening and Assessment (see a description of *Screen for Success* in this report as a possible model for consideration in the revision process).
- Develop policies and supports to train and utilize skilled developmental specialists to screen in early care and education programs.
- Develop policies and supports to provide continuing education for child welfare and juvenile justice staff regarding appropriate screening procedures and processes.

Goal 4: Increase the screening of the most vulnerable children who have high probability of developmental delays and disabilities.

- Provide screening and comprehensive assessment for all children in protective custody and their guardian prior to placement to ensure that there is a match between the needs of the child and the skills of the guardian (parent, relative, or other out-of-home guardian).
- Review and revise training for child welfare, protective services and juvenile justice staff to ensure children in the child welfare and juvenile justice systems (whether being served in-home or in out-of-home care) are screened at recommended intervals as prescribed by the American Academy of Pediatrics/Bright Futures and as indicated by special circumstances.
- Develop tracking and monitoring mechanisms to ensure that children in child welfare and juvenile justice programs and other children receiving Medicaid receive developmental screenings as part of the routine EPSDT on the recommended schedule.
- Identify tools, processes and procedures to support appropriate screening of adolescents.
- Re-establish Developmental Early Intervention screening and services in all hospital Neonatal Units to ensure infants are screened and families are provided follow-up services.

Goal 5: Increase the number of children with special needs and their families who receive consistent early intervention and supports.

- Increase funding and staffing of Early Steps to ensure all children receive follow-up assessment and services as needed.
- Ensure that Part C and Part B service providers are matched to children based on developmental concern (e.g., speech therapist addresses speech problems, physical therapist addresses motor delays).
- Develop resources to assist families in obtaining follow-up services when assessment indicates they are needed.
- Develop and implement policies in early care and education programs that support children with 10-24% delays (who do not qualify for Part B or C).
- Increase funding for the development and implementation of policies that ensure all children in child welfare and juvenile justice programs receive follow-up assessments and interventions as indicated.

Introduction

Scope of Work

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Proposed solution: Using a panel of experts, including professionals trained in comprehensive screening and assessment techniques and professionals representing programs/services throughout the state:

- Collect information on child screenings currently in use.
- Identify facilitators and barriers to sharing screening information across services and agencies.
- Recommend way(s) to make high quality screening and assessment information accessible to parents and all appropriate service providers
- Develop and/or recommend a screening methodology and frequency for children 0-18.

Background

In an effort to support the success of the Florida Children and Youth Cabinet, the Children's Summit Workgroup (a list of workgroup members is in Appendix A) convened a committee of children and youth experts. The members of this committee (also included in Appendix A) reviewed the legislation creating the Cabinet and the Cabinet's strategic plan and identified potential supportive projects. One recommendation of the group was to identify mechanisms to increase coordination of child screening processes and information.

Members agreed to propose this recommendation for several reasons. First, and foremost, child screening is important for optimal development. Child and family research provides a rich understanding of the key transition points in the development and adaptation of children and their parents. Early identification of a missed or delayed developmental stage can be a strong indicator of the need for treatment of, or intervention for, a disability or delay (American Academy of Pediatrics, Committee on Children with Disabilities, 2001). In the United States, 17% of children have a developmental or behavioral disability such as autism, mental retardation and Attention-Deficit/Hyperactivity Disorder. In addition, many children have delays in language or other areas, which also impact school readiness. However, less than 50% of these children are identified as having a problem before starting school, by which time significant delays may have already occurred and opportunities for treatment have been missed (Department of Health and Human Services). Brain research underscores the importance of intervening as early as possible in order for interventions to have the greatest chance for success.

A comprehensive screening process indicates whether there is a need for more intensive assessment; therefore, all infants and children should be screened early, using screening instruments that are adequately sensitive and specific to detect delays, are valid and reliable, and that are standardized on diverse populations. Screenings should be administered by those skilled in the administration and interpretation of reliable and valid screening techniques appropriate for the population. Screenings must involve the family, and results must be given to the family in culturally sensitive, family-centered ways (American Academy of Pediatrics, Committee on Children with Disabilities, 2001).

In addition, members were focused on opportunities to support Cabinet priorities. Identifying mechanisms for coordination of child screening processes and information aligns with the following elements of the Cabinet's strategic plan:

Florida Children and Youth Cabinet Goal 2: Ensure that all children live in permanent, safe and nurturing environments.

2a: Establish mechanisms and strategies to support families in providing for optimal growth and development of their children and youth.

Long-term recommendation: Foster integrated prevention and early intervention services, promote communication between families and service providers, develop funding flexibility, and facilitate data sharing so that Florida's families and children can enter the service provision sector through any number of doors, and any door results in a thorough screening and assessment of family needs, and assistance to access whatever services are needed (The Policy Group for Florida's Families and Children Inc., 2003).

The Children's Summit Workgroup accepted this recommendation and presented a proposal to the Florida Children and Youth Cabinet to convene a panel of experts and develop a set of recommendations for Cabinet consideration. With the Cabinet's approval of the proposal, the Children's Summit Workgroup contracted with The Policy Group for Florida's Families and Children for development and oversight of the project.

The work of The Policy Group for Florida's Families and Children has been comprehensive. The Child Screening Project has included:

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Phase 1: Child Screening Survey

The Policy Group for Florida’s Families and Children commissioned a survey to understand the types and uses of screenings and assessments across Florida. The survey, conducted by Florida State University graduate student, Michelle Craig, was delivered electronically to 251 agencies or programs identified as possibly providing child screenings or assessments. One hundred and sixty-eight surveys were completed and analyzed. The following summary of findings highlights screening and assessment definition and purpose issues, use of tools, staff providing screening, involvement of families, use and follow-up of screening information and barriers to screening. Please note that total number of responses vary as respondents may have provided more than one response for some questions or may have chosen not to answer particular questions.

Screening and Assessment Definitions and Purposes

Though there were a variety of responses to the questions, there were many similarities given when comparing screenings and assessments. Overall there were fewer responses for assessments than screenings. This may be because the assessment questions were at the end of the survey and more participants exited the survey before finishing. In each of the three main sections of the report (developmental surveillance, screening and assessments), participants were asked to give definitions. Table 1 provides an overview of the similarities and differences in definitions and purposes that were given by respondents. The words “screening” and “assessment” often seemed to be used interchangeably. Many participants defined screening as if it were assessment ($n = 23$), and some participants defined assessment as if it were screening ($n = 6$). Also, participants used the terms screening ($n = 26$) and assessment ($n = 23$) often in defining developmental surveillance.

Table 1. Screening and Assessment Definitions and Purposes

	Developmental Surveillance	Screening	Assessment
Definitions			
Monitoring developmental milestones	6	6	14
Looking for developmental delays	13	26	13
Using observation	9	9	7
Brief		22	
Routinely performed		4	
Detailed			25
Continuous			4
Purposes			
Determine overall development		18	14
Identify developmental delays		45	8
Making referrals		15	6
Examining physical development		9	6
Determining program eligibility/placement		4	8
Identifying need for follow-up		26	
Identifying need for interventions			11

Screening and Assessment Instruments

Table 2 includes a list of tools identified most frequently for use in screening and assessment. When asked to identify the tool currently in use in their program, the Ages and Stages Questionnaire (ASQ) was identified most frequently (n =11). The Battelle Developmental Inventory (BDI; n = 11) and the Learning Accomplishment Profile (LAP; n = 11) were identified most frequently as assessments currently in use.

Table 2. Screening and Assessment Tools

Tools	Screening	Assessment
ASQ*	66	8
BDI	12	11

* ASQ or ASQ: SE (Ages and Stages Questionnaire: Social-Emotional)

Administration of Screening and Assessment

Respondents were asked to identify who typically administers screenings and assessments as well as what the minimum qualifications should be for those that administer screenings and assessments. Table 3 summarizes responses. Nurses were identified as the most frequent administrators of screenings and assessments, and specialized training was identified most frequently as the minimum credential for administration of screenings and assessments. Respondents noted that administration of assessment requires more training than administration of screening.

Table 3. Screening and Assessment Administration

	Screening	Assessment
Typical Administrators		
Nurses	22	12
Child care providers/ classroom teachers	19	16
Physicians	11	8
Parents	11	0
Minimum Credentials		
Specialized training	29	9
Baccalaureate degree	21	
Masters degree		10

Family Involvement and Referral Processes

Respondents were asked to identify how families are involved in screening and assessment. Table 4 provides an overview of their responses. Family involvement is similar in the screening and assessment process.

Table 4. Family Involvement

	Screening	Assessment
Family completes survey/answers questions	51	20
Family advised of results/recommendations	20	18
Family present during screening and/or assessment	16	9
Family consent required	15	7

Table 5 includes information on the follow-up process to screening and assessment relative to referrals to gather additional information and referrals for intervention. The process is similar for both screening and assessment, according to the respondents.

Table 5. Screening and Assessment Follow-up

	Most Likely Referral after Screening	Most Likely Referral after Assessment
Referrals for Follow-up		
Early Steps	36	11
Florida Diagnostic and Learning Resources System (FDLRS)	31	12
Non-specified medical provider	14	12
Referrals for Intervention		
Early Steps	42	18
FDLRS	22	13
Non-specified medical provider	16	8

Respondents indicated that results of screenings and assessments are more likely to be shared with other agencies/programs after parent consent (screening, $n = 23$; assessment, $n = 14$) and in follow-up and referral (screening, $n = 24$; assessment, $n = 10$) than within the agency/program after parent consent (screening, $n = 8$; assessment, $n = 9$) and in follow-up and referral (screening, $n = 7$; assessment, $n = 5$). Unfortunately the survey did not provide insight into why communications may be stronger between agencies than within agencies.

Barriers to Screening and Assessment

Those participants who said they did not administer screenings or assessments were asked to rank the barriers. Lack of staff was the most frequent barrier given for both screenings (9 total barriers) and assessments (13 total barriers). The next most frequent responses for barriers to screening were no referral sources in the community ($n = 8$) and lack of adequate reimbursement ($n = 8$). The next most frequent responses for barriers to assessment were lack of time ($n = 10$) and cost ($n = 8$).

In looking at facilitators for sharing screening and assessment results, the most frequent responses included some type of consent/release of information (parent consent, $n = 11$ and unspecified, $n = 8$), interagency agreements/communication ($n = 8$), and technology ($n = 8$). The most frequent responses for barriers to sharing screening and/or assessment results were none/not applicable ($n = 18$), inability to get signed permission to share info/releases ($n = 13$), and lack of resources including cost of travel, time, available staff and limited funds for referrals ($n = 13$). The lack of resources was clearly a major concern for many survey participants because when asked what could make high quality, comprehensive screenings and assessments more accessible to agencies/programs, 20 said additional funds, 11 said additional training and 5 said additional staff. Other frequent responses included technology ($n = 13$) and unknown/not applicable ($n = 10$).

Phase 2: Panel of Expert Review

The panel of experts convened by The Policy Group for Florida's Families and Children began their work by participating in an interview process designed to collect additional information on current practices and issues in Florida specific to child screening. Appendix B contains an overview of the interview findings. This information, along with the survey analysis summarized above and a collection of additional resources and information, served as the starting point for panel deliberations. Member work included agreement on definition of terms, guiding principles and a vision statement.

This report also includes a description of a system approach to comprehensive screening based on best practice evidence and panel deliberations. At each juncture in the system description, information is provided as to the current practices in Florida. The report concludes with an overview of current system strengths and challenges and a set of short-, intermediate- and long-term recommendations.

Definition of Terms

The following definitions were adopted:

***Child Screening** is a brief procedure designed to identify children who should receive more intensive assessment or diagnosis*

***Child Assessment** is a systematic procedure to identify the specific needs of a child for the purpose of intervention.*

Limitations

This project focused primarily on child screening. Members recognize that child screening and assessment go hand-in-hand, and child screening is neither meaningful nor ethical without follow-up assessment and diagnosis when screening raises a red flag. Nonetheless, a detailed analysis of child assessment is not included. Assessment takes many forms, has multiple purposes and has different definitions based on setting. In order to narrow the focus of this effort, respond in a timely manner and develop reasonable recommendations for consideration, workgroup and panel members agreed to limit the primary focus on recommendations regarding child screening and the type of assessments that are required as follow-up to screening.

In addition, the primary focus of review was on screening protocols for young children. Members reviewed and discussed concerns relative to school-age and adolescent children, particularly those children in child welfare and juvenile justice programs, and have included some recommendations addressing these age groups. Nonetheless, the importance of identifying children early in order to intervene and prevent many of the concerns that are found in current populations of older children resulted in a stronger concentration on system development for screening of young children.

It is also noted that some forms of screening are not intended to identify a need for further assessment. For example, screening may be a mechanism to identify eligibility for services for children and families. Although this report does not address this type of screening, the development of child screening protocols should incorporate these types of screening in addition to developmental, health, and environmental screenings.

Guiding Principles

Workgroup and panel members identified the following guiding principles:

- All children in Florida should have access to uniform, high-quality screening protocols that address a broad range of developmental, health and environmental factors, beginning at birth and continuing at regular intervals throughout childhood and adolescence.
- All expectant mothers should have access to uniform, high quality screening protocols to identify protective and risk factors associated with positive birth and child outcomes.
- Families with children should have access to uniform, high quality screening protocols to identify family and community protective and risk factors associated with child outcomes.
- Families must provide consent for child screening and be recognized as essential partners in the child screening process.
- Child screening must be linked to child assessments and intervention services when there are indications that further information or services are needed; likewise, maternal and family screening must be linked to further assessment and services when indicated.
- Screening results should be published in the aggregate by age, population group, and type of suspected problem to advance understanding of the magnitude of issues and potential needs for the optimal development of children.

Devising and Implementing a Comprehensive Child Screening System

Child screening is an essential element of good health and development practices. Families notice and care about their children's development more than anyone else. Because child development is dynamic and complicated, families often need help in understanding what is typical and what is not and how to best support optimal health and development. Having regular opportunities to take a look at their child's development with someone knowledgeable of the normal range of development ensures that families can make the best decisions for their children (McCann & Yarbrough, 2006).

Screening is also very important to long-term development and well-being. Research has demonstrated that early intervention can be very effective in promoting children's language, cognitive, physical, social and emotional development when problems are identified appropriately. There is a system of care in every state to support children identified with disabilities and delays and their families. The Early Intervention (Part C) system, which receives federal funding from the Individuals with Disabilities Education Act (IDEA), provides up to 16 different types of services to all families with children birth to age 3 who have a developmental disability or delay or who are at risk of delay (Florida Department of Health, 2008). Part B of the Act, Education for Children with Disabilities, provides additional supports for children ages 3 through 21 (Florida Department of Education, 2008). Despite the evidence of the importance of screening

for all children, especially between birth and five years of age, it is not standard practice in all service programs for young children, and there are no standard procedures and processes that are consistent across programs and services. Even within specific programs, screening tools and processes may vary from one location in Florida to another.

Screening and assessment should be conducted within a coherent system of services that brings together a range of health, educational and family support services designed to promote optimal development for all children. The evidence is clear that there are multiple determinants of resiliency and risk, and thus, screening, assessment and intervention require comprehensive approaches. Poor child outcomes are consistently linked to poverty, low birth weight, black race, and having a mother over age 35, unmarried, or with a less than high school education (Appendix C includes data from performance-based longitudinal outcome evaluation projects in the areas of pregnancy and delivery, infant and toddler development and efficacy of early intervention programs developed by The Maternal Child Health and Education Research and Data Center at the University of Florida and The Lawton and Rhea Chiles Center for Healthy Mothers and Babies at the University of South Florida). Most importantly, the data demonstrate the interrelationships of the variables and the tremendous hazards that emerge when they occur in combination, underscoring the importance of a child and family screening system that is comprehensive in addressing the full range of developmental, health and environmental factors (Ghazvini & Foster, 2003). A comprehensive system should also include alignment across standards, guidelines, program objectives and curricula, staff training systems and technical assistance supports (National Research Council, 2008).

Child screening is a process that should allow parents and professionals to collaborate to monitor, describe and discuss all domains of a child's development, health issues and environmental hazards. It should be recognized as a key preventive service, similar to immunizations and well-child check-ups, and there should be continuing opportunities for screening during the school-age and adolescent years. Child screening is the *first step* in determining a child's specific abilities and skills, if a child is developing within normal range, if delays are within a normal range, or if delays are outside the normal range. Screening in and of itself does *not* lead to a decision about whether a child *has* a developmental problem (Department of Health and Human Services, 2005; Eggbeer, Littman, & Jones, 1997; McCann & Yarbrough, 2006; National Research Council, 2008).

Developing such a system is not without numerous challenges. Some of these issues are directly related to child development and include:

- Lack of differentiation among very young children making “within normal limits” broad
- Optimal performance is dependent on state of arousal for infants
- Lack of practical or reliable measures of any specific domain in early infancy that gives a precise prediction about the child's performance in that domain several years later
- Lack of or limited expressive language skills
- Difficulty of pinpointing a particular area of concern due to interconnectivity between domains of development in young children
- Incredible rate of change in development in young children
- Influence of values and culture on children's behavior and development
- Subtle nature of many developmental problems in young children requires much experience and knowledge of child development to build acute observation and interpretation skills (Eggbeer, Littman, & Jones, 1997).

A second set of challenges arises from the complexity of putting together the societal conditions required to create a successful comprehensive system. These concerns include:

- Validity and reliability of screening instruments
- Lack of consistency in the range of screening focus areas, the process, and responsibility for conducting child and adolescent screening
- Inconsistencies in referral and follow-up
- Meaningful family involvement in all aspects of the process
- Language barriers
- Professional capabilities of those administering screenings and assessments

These issues are addressed in more detail later in this paper.

What Are the Determinants of Healthy Development that Should Be Screened?

Child screening should focus on identifying the specific skills and abilities that children need for optimal growth and development, the health of the child and the environmental conditions needed to support child outcomes. The National Research Council (2008) identified physical well being and health, social and emotional development, approaches to learning, language development and cognition and general knowledge as the primary domains of child development. The lack of valid and reliable instruments, the difficulties of assessing young children and the lack of standardized processes and procedures limits screening in all of these areas of development.

Many experts in the field argue for an integrated model of child development that takes into account the full range of variables that influence a child's functioning. Such an approach recognizes that the basic functional capacities of relating, interacting, paying attention and symbolic thinking directly impact specific developmental skills. The child's environment plays a powerful role in supporting the emergence of these capacities, underscoring the importance of screening and assessing family, environmental and community supports (Early Head Start National Resource Center, 2006; National Research Council, 2008). These facts underscore the importance of prenatal maternal screening and screening of families and care giving environments as part of the child and adolescent screening process.

Practices in Florida

Current practices include screening in the following areas:

Metabolic Screening. At birth, infants are blood screened for a wide variety of metabolic disorders and diseases (e.g., endocrine disorders, amino acid disorders, Cystic Fibrosis, Biotinidase Deficiency, Hemoglobinopathy, Fatty Acid Disorders). This screening process has been demonstrated to be very effective in improving health and development outcomes (Florida Department of Health, 2008).

Hearing Screening. At birth, infants in Florida receive screening for congenital hearing loss (Florida Department of Health, 2008). A national review of neonatal hearing screening found that the screening is conducted by a variety of personnel using a variety of protocols, resulting in less control and some hearing-impaired infants are missed (National Research Council, 2008).

Vision Screening. Currently vision screening is a recurrent and routine part of the pediatric physical examination, but there is growing evidence that this screening is insufficient in identifying and ameliorating vision problems. One issue is the inconsistency in the vision screening during well-child checks. In addition to younger children and Hispanic children being less likely to be screened, families were not consistently informed when a child failed a vision test, and many children did not receive referrals and follow-up (Wasserman, Croft, & Brotherton, 1992).

Also of concern is that the typical vision screening at physical exam and received in schools focuses on distance vision. Studies have found that many children have other vision problems that require comprehensive screening (including screening for near vision, muscle balance, tracking, fusion, convergence, hyperopia, color vision and visual motor integration). Researchers suggest that undetected vision problems frequently result in children being identified as having learning or reading problems, and unless the vision problems are properly diagnosed and treated, they lead to behavior problems (National Research Council, 2008; Johnson, Nottingham, Stratton & Zaba, 1996).

Developmental screenings. In Florida, developmental screening at birth is not standard practice. Many children receive developmental screenings in a variety of other settings. Developmental screenings frequently include assessments of motor development, language and cognition. Social and emotional development and approaches to learning are addressed in screenings less frequently. There are also concerns among professionals regarding the timeliness of screenings and follow-up assessments. Part C programs in some areas of the Florida reportedly have insufficient staff to meet the demand for screening, assessment and early intervention, creating wait times for services. Additional concerns were noted relative to staff knowledge and skills due to the lack of in-service training opportunities in the field.

Part B programs for school-age and adolescent children provide developmental screenings based upon parent and teacher referral. Comprehensive child screening is also mandated at entry to the child welfare and juvenile justice programs. Processes and procedures for ongoing screening and assessment are less clear.

Where Should Screening Take Place?

There are several settings where screening is appropriate. These include settings where other screenings and assessments take place, such as at service intake for a variety of family supports. Visits with primary care physicians or other medical providers for services such as well-child exams and immunizations frequently provide important screening opportunities. Home visits and natural transitions, such as when children move into new classrooms, child care programs, or schools also provide natural settings for screening (Early Head Start National Resource Center, 2006). Early Steps requires that screening and assessment occur in natural environments, such as homes and care giving settings.

Practices in Florida

Child screening takes place most frequently in medical settings or through home visiting, early care and education and school programs. Community events and fairs also provide screening opportunities across Florida.

Screening in medical settings. Florida Statute 383.14 requires health care providers to offer a prenatal risk screening to every pregnant woman at her first prenatal visit. This screen includes questions to address maternal depression, alcohol and tobacco use, and intendedness of pregnancy. Based on the prenatal risk screening, referrals are made to Florida's Healthy Start Program, delivered through 30 community-based maternal and infant health coalitions, and/or Healthy Families Florida, administered by The Ounce of Prevention Fund.

Pediatricians or family practitioners monitor the majority of children under age 4, and regular developmental assessment is recommended for well-child care, making the pediatric and physician's offices the most likely sites for screening. This fact has implications for the training of medical personnel, data system design, and service system integration and design (National Research Council, 2008). According to Medicaid regulations, medical and developmental screening must be provided to all eligible children under age 21 on a periodic basis according to Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT), and there is growing evidence of the feasibility and effectiveness of such

practices (Schonwald et. al, 2009). Physicians also use the Florida SHOTS™ Registry, a statewide data collection system that houses immunization records and provides a model for tracking child screening data.

The Neonatal Intensive Care Unit (NICU) is an additional medical setting of importance relative to child screening and assessment. Florida Statutes authorize the Developmental Evaluation and Intervention (DEI) Program to assist with identification of infants with high risk for delay in order to provide treatment early when it can be most effective. The DEI Program was a national model until funding was reduced due to budget cuts. The Healthy Start newborn screening (includes screening for abnormal conditions of the infant, mother's age, maternal education level, maternal alcohol and tobacco use and infant birth weight) is offered at each delivery by hospitals and birthing centers. Newborns meeting the threshold for a "positive" screen are referred for Healthy Start program services. According to the Maternal and Child Health and Education Data and Research Center and The Lawton and Rhea Chiles Center for Healthy Mothers and Babies (2008), 80.3% of infants were screened for health and developmental risks, and 11.2% were found "at risk" in 2006. Part C is also expanding the definition of eligibility to include infants born less than 1,200 grams who are at a high probability for later delays and disabilities. Ideally, all NICU infants would receive a developmental evaluation and their families would be connected to Healthy Start and Part C services while in the hospital with follow-up and intervention at home as needed.

There are a number of other challenges associated with screening in the medical setting. More than half (57%) of Florida's children do not have a medical home or a primary health care provider (Stowell, 2009). A recent assessment of the quality of pediatric ambulatory care revealed that children received fewer than half of the recommended procedures and that developmental screening procedures were particularly unlikely to be performed (Early Head Start National Resource Center, 2006; National Research Council, 2008). Other concerns include:

- Health care funding mechanisms that limit the time that pediatricians and physicians spend with children and families
- Policies that reward health care providers for crisis intervention rather than for prevention and health promotion
- Lack of screening for social and emotional capacities
- Lack of screening of family members and environmental issues
- Lack of developmental training for pediatricians and physicians to identify established conditions; to use recommended screening tools, processes, and follow-up activities; and to provide support to families through the process
- Lack of assistance for families with accessing and navigating follow-up services
- Physician liability issues – identification of special needs is perceived as an increased liability for ensuring treatment
- Lack of knowledge about or coordination mechanisms with other potential partners and child-serving agencies
- Health Insurance Portability Accountability Act (HIPAA) requirements that may slow the process of coordination, follow-up, and services
- Under-utilization of EPSDT and the periodic medical and developmental screens required

Screening in home visiting programs. Child screening is an integral part of most home visiting programs. In Florida, the most widely available home visiting programs include Healthy Start, Early Head Start and Healthy Families Florida. Even Start and Home Instruction for Parents of Preschool Youngsters (H.I.P.P.Y.) are available in some areas. Although there are standards and procedures in each home

visiting program regarding child screening, programs serve only a small percentage of the need. There is great variability in screening practices across programs, and coordination of screening information with other entities is often challenging.

Screening in early care and education settings. Children receiving subsidized school readiness services receive a developmental screening and in some communities, early learning coalitions offer child screening to all children in school readiness settings. Concerns regarding these screenings include:

- Variability in the screening process
- Variability in the ages of children and adolescents receiving a screening
- Lack of knowledge among child care providers regarding the purposes and differences between screening, assessment and evaluation
- Lack of screening for social and emotional capacities
- Lack of screening for family member risk and protective factors and environmental hazards
- Lack of training to ensure reliable screening
- Inconsistency in providing assistance for families during referral and follow-up
- Lack of coordination with potential partners

Screening in schools. Children in public school settings and in many private schools receive a series of screenings, including a school readiness screening at kindergarten entry; vision, hearing and health screenings at specified grade-levels; and a variety of screenings for academic skills. In addition, teachers or parents may identify children for development screening and assessment. Screening of adolescents may be particularly infrequent despite some increased risks relative to social-emotional development. Concerns regarding screening in the school setting are very similar to the concerns in other settings. Lack of consistent screening of recommended frequency and breadth may be the biggest obstacles to optimizing child development.

Screening by Part C and Part B. Part C, Early Steps, for children birth to 3, and Part B, for children ages 3 to 21, are the primary coordinators of screening, assessment and service coordination. If an initial child screening determines that more information is needed, physicians, home visitors, early childhood programs and schools are most likely to refer children and families to these federally-mandated programs for further assessment.

Part C, Early Steps also has some responsibilities in neonatal hospital units, but the services available in these settings have been reduced. Although current practices do not include an automatic developmental screening at birth, one follow-up screening is provided at 2 to 4 months of age upon referral or request of the family. Also of concern are the eligibility requirements. Many children at risk do not meet the requirements but nonetheless need services in order to succeed developmentally and academically. Some states have expanded eligibility parameters for Part C to include these children.

Part B includes the Florida Diagnostic and Learning Resources System (FDLRS) that provides diagnostic and instructional support services to district exceptional student education programs and families of students with exceptionalities statewide. FDLRS includes nineteen Associate Centers that serve from one to nine school districts, and these Centers collaborate with districts, agencies, communities and other personnel and educational entities to provide screening for children and education and support for teachers, parents, therapists, school administrators and students with exceptionalities (Florida Department of Education, 2008).

Screening in child welfare and juvenile justice settings. Comprehensive screening is required for children entering state care. As in other settings, there are concerns regarding training of staff conducting

screenings, the comprehensiveness of screening, referral and follow-up practices and continued screening over time. The needs of these populations are tremendous, and screenings need to occur at regular intervals.

When Should Screening Take Place?

Because of the growing evidence of the impact of relationships, care giving and environment on child development, screening and assessment must begin before birth in order to optimize child development and prevent disabilities and delays. Health departments, obstetricians, family practice physicians and other medical and mental health facilities should be engaged in maternal and family screening to detect and provide services relative to depression, relationship disorders and other medical and mental health concerns.

The American Academy of Pediatrics and Bright Futures, a national health promotion and disease prevention initiative of the Maternal and Child Health Bureau, have developed recommendations for preventive pediatric health care (see Appendix D). The recommendations include a prenatal and seven screenings, encompassing physical, developmental, and sensory development, within the first year, five screenings between 12 and 30 months, and yearly screenings thereafter. At a minimum, best practice recommendations include at least three developmental screenings during the first year of a child's life since the most rapid growth is during this year. It is particularly important that screenings include attention to social-emotional development. Two screenings are recommended during the second year of life and annual screenings after age two (Early Head Start National Resource Center, 2006).

In addition to a schedule of routine screenings, certain circumstances should trigger additional screenings. These include:

- Family members have a concern about their child's development
- A child's mother has been diagnosed with post-partum depression or the parents/caregivers have other mental health issues that have an impact on the child
- The family has been homeless
- A child has lost or been separated from parents and/or siblings due to such things as divorce, work or military duty, incarceration, child's removal from the home or death
- A child has been exposed to domestic or community violence, substance abuse and/or child maltreatment (National Research Council, 2008).

These special circumstances highlight the importance of ongoing comprehensive screening for children and adolescents in the child welfare and juvenile justice systems. The focus of service in these systems is typically on safety, and developmental needs may be overlooked. Children and adolescents in these systems have high developmental and behavioral needs, including greater risk for health and development problems, delayed cognitive development, lower academic functioning, depression, poor social skills and other behavior problems. Florida law requires comprehensive screening of children entering foster care, but this is likely inadequate. Developmental scientists report that the needs and development of children change over time and the effects of trauma may not emerge immediately or may emerge in different ways as children and adolescents age. This is true whether the child remains with relatives or is placed in out-of-home care (Ghazvini, 2006). In one study, only 22.7% of the children received the intervention services that were needed (Pediatrics, 2005).

Practices in Florida

Although pediatricians or family practice physicians monitor most children (National Research Council, 2008), well child visits and developmental screenings may not occur as recommended. In addition, there are many children in Florida without health insurance who are likely to receive health care only in emergency situations and miss out on regular and routine screenings. Other concerns are the lack of funding to adequately staff and deliver developmental screenings in neonatal hospital units, inconsistent screening and follow-up among pediatricians and family practice physicians, inconsistent protocols among other screening partners (e.g., home visiting, early care and education, child welfare and juvenile justice programs), infrequent use of social and emotional screening, infrequent screening of adolescents, and lack of maternal and family screening.

What Tools Should Be Used?

The purposes of screening (i.e., to determine which children need further assessment) or assessment (i.e., to identify the specific needs of a child to guide interventions) should direct tool selection, and tools should only be used for their specified purposes. Qualified individuals should evaluate tools based on specified criteria and make selection decisions. Part of selection is planning and preparing for implementation. Screeners and those who use the information should understand the purpose and be able to articulate it to parents and others. The plan should also include a clear process for follow-up steps to ensure information is used appropriately and productively (Early Head Start National Resource Center, 2006; National Research Council, 2008).

Comprehensive developmental screening should be conducted with tools that have been standardized and met scientific standards of accuracy, efficiency, reliability and validity. These standards include:

- Validity – the tool measures what it says it measures
- Reliability – the tool provides consistent results
- Sensitivity – the tool has a high probability of correctly identifying children with delays or special needs
- Specificity – the tool has a high probability of correctly identifying children who do not have delays or special needs
- Standardization and age appropriate – the tool is relevant for the specific ages of children and/or adolescents being screened (Early Head Start National Resource Center, 2006; McCann & Yarbrough, 2006; National Research Council, 2008).

It is also critical that tools are appropriate for the populations being screened. This is accomplished through the development of norms, establishing the normal or average performance on the test and determining how much variation is considered above or below average. This process requires a large representative sample of the population with which it is to be used. It also underscores the importance of the content and process being sensitive to cultural differences and in the primary language spoken or understood by the child and family. Since some developmental milestones differ across cultures, it is important to interpret results in the context of culture and the child's family (Early Head Start National Resource Center, 2006; National Research Council, 2008).

As noted earlier, comprehensive screening is most likely to identify skills and capacities that children and families have as well as those that need further assessment. Developmental screening tools most frequently attend to cognitive, physical and language development, and less attention is given to sensory and social-emotional development. There is strong evidence that mental health issues in childhood, particularly early childhood, have life-long consequences if they are not addressed. With intervention, good outcomes are probable. Early childhood is a time of particular vulnerability because of the strong

connection between children’s psychological health and their relationships. With limited self-awareness and social cognition skills, they also respond to emotional experiences and traumatic events in very different ways than older children and adults, and the broad range of individual differences make it difficult to distinguish typical variations from persistent problems (National Scientific Council on the Developing Child, 2008). These facts highlight the importance of regular social-emotional screening for children and their families.

Practices in Florida

Screening tools commonly used in pediatrician and family practice physician offices are the *Parents’ Evaluation of Development Status (PEDS)*, the *Denver Developmental Checklist* and the *Ages and Stages Questionnaire*. Parents are typically asked to complete the screening during a well child exam. Healthy Start utilizes the prenatal risk screening in coordination with medical practitioners, the newborn screening at birth and the *Tell Us About Yourself Questionnaire* for maternal and family screening (additional screening tools are used in some Healthy Start Coalitions). A variety of tools is used in other settings (see summary of the Child Screening Survey). The *Ages and Stages Questionnaire* appears to be the most frequently used screening tool in Florida with the *Ages and Stages Questionnaire: Social-Emotional* used when a social-emotional screener is included.

One promising new tool developed in Florida is the Communication and Symbolic Behavior Scale by Dr. Amy Wetherby in the Department of Autism and Related Disabilities at Florida State University. This checklist is designed to be completed by a child’s caregiver and assesses seven language predictors.

Who Should Screen?

A variety of professionals and paraprofessionals uses screening tools. For the greatest effectiveness, an individual with a relationship with the child and family is the best one to complete a screening. Screeners must be trained to meet a clearly specified level of expertise in administering screenings, should be monitored systematically and reevaluated occasionally. This includes staff administering parent-report tools, as knowledge and skill is required to assist parents and help them understand the screening. Training is also required for those that analyze, interpret and report screening results (Early Head Start National Resource Center, 2006; McCann & Yarbrough, 2006; National Research Council, 2008).

There are a variety of ways to ensure appropriate staff members are trained. McCann and Yarbrough (2006) recommend options that include:

- **Training all current staff** who work with children and families
- **Training and designating a staff member** (e.g., nurse, developmental specialist) or small team to conduct the screenings, work with parents, and prepare staff to discuss and act on the results
- **Hiring a trained specialist** or consultant to periodically come into the program and work with parents and staff to screen children
- **Investigating what community screenings are already available**
- **Sharing resources** and partnering with other agencies to offer screenings

Developmental Specialists

Emerging as a very promising, albeit limited, practice is the placement of developmental specialists in pediatric practices. Studies have found that parents turn to developmental specialists for assistance with a number of issues, including:

- developmental guidance when a child exhibits delayed or atypical development
- developmental monitoring for children about whom a pediatric clinician or parent felt some concern
- and short-term guidance about aspects of child development such as effective engagement of children, encouraging language development and regulating sleep.

Financing such positions remains a formidable challenge (Eggbeer, Littman, & Jones, 1997).

Part C and Part B developmental specialists are obvious professionals to turn to for screening, assessment and intervention. Part C provides a toll-free resource line, the Central Directory, as a resource to parents and others in the field. In addition, Part C staff members focus on family-centered practices, respecting the pivotal role of the family, and supporting children and families in natural environments. Part B services are integrated into school settings and require family consent, participation and involvement.

Practices in Florida

There are a wide variety of individuals participating in child screening efforts across Florida. These efforts range from staff with little to no training handing over parent-report screening tools to families with no clear follow-up and support process to highly training professionals working together to screen all children in the community. Most screening occurs in medical settings with the assistance of nursing or medical staff.

Even practices in professional settings can vary tremendously. For example, pediatricians may or may not follow American Academy of Pediatrics recommendations for developmental screening, may or may not use a standardized tool, may or may not have a clearly defined process for analysis, and may or may not utilize good practices relative to referral, follow-up and support for families. Part C services for young children and Part B services for school-age and adolescent children also vary across Florida in the screening and assessment instruments and protocols that they utilize.

In home visiting programs, responsibility and training for child screening varies. Some provide excellent protocols. For example, Healthy Families Florida has an extensive protocol for their paraprofessional staff that requires developmental screening at standardized intervals, initial and ongoing training (including knowledge and skill development in child screening), referrals of children for further assessment and services when a delay is suspected, and implementation of activities during home visits to stimulate child development. Training may not be as consistent or extensive in all home visiting programs.

In early care and education programs, there is great variability in who is responsible for screening. Although there is a state child care training program in observation and assessment, it is not required for all staff. In some areas of the state, well-trained staff conduct child developmental screenings at intake for child care subsidy services. In other areas, providers with little or no training have parents complete a screening tool without a system of supports for family follow-up and support. For children who do not receive subsidies, there is not a widespread established system within early care and education settings to provide screenings.

Best Practices in Training to Screen

Screen for Success is an extensive training program developed by Sharon Carnahan at Rollins College targeting early care and education providers. The program helps providers develop a system for child screening using the Ages and Stages Questionnaire. From developing a plan to educating and providing anticipatory guidance to parents to screening and tracking results to making referrals and using findings to inform classroom practices, *Screen for Success* is a comprehensive training program to ensure high quality screening practices.

Hillsborough County offers another best practice on a community-wide scale. After work to map all available child screening resources, leaders in the community developed community-wide screening opportunities. Coordinated by the Early Childhood Council (a network of agencies, professionals, and parents concerned about early intervention) and supported by the Children's Services Council of Hillsborough, this effort provides informal but massive coordination of a network of professionals delivering a full array of developmental screenings (e.g., biological, neuro-motor, social-emotional) once a month in the county. Locations move around the county to insure ease of access for all families and are established and posted one year in advance. Referrals are made, if indicated, for further diagnostic evaluation or early intervention. Other service information is provided to families.

Quality Rating Improvement Systems in early care and education programs offer best practices regarding staff training and standards. Local efforts to implement Quality Rating Improvement Systems (a system of incentives and supports to improve the quality of early care and education programs) include standards related to child screening and assessment for participating early care and education programs.

Docs for Tots is an innovative effort to work with pediatricians and other medical personnel to improve training and practices to support better social and emotional outcomes for children. Improved screening is one goal of the initiative.

A More Comprehensive Vision

In addition to ensuring that Florida's children receive appropriate screening and assessment to identify risks, panel members recognized the importance of creating a broader health vision: Communities throughout Florida provide the supports children and families need to thrive.

Florida will thrive when all children have the supports they need to thrive. Creating optimal environments for children will require a new approach to community development and service planning and delivery – a strengths-based approach. Instead of identifying individual problems and sending children and families to different places for different services, communities and service providers should focus on identifying those community factors that ensure optimal health, development, and well-being and developing mechanisms to ensure all children and their families have or can access those factors.

Currently, we support children and families through a deficit model. Someone must admit to or be identified as having a problem and then be willing to apply for this service, take this test, go to this place, or follow these directions. As noted by the President's Commission on Excellence in Special Education (2002), the current model focuses on waiting for a child to fail rather than early intervention to prevent failure. It is a system that can be daunting, demoralizing and difficult to understand and navigate. Many

are lost along the way, and communities suffer the consequences through decreased productivity and increased back-end service costs. Individual costs are immeasurable (Ghazvini & Foster, 2003).

A strengths-based model, on the other hand, focuses on identifying what works and building human capital. Every child and family has strengths that should be highlighted and built upon. Every community has the potential to include factors that build upon family strengths and provide missing linkages and supports. Families and communities can put into place positive factors that are known to make a difference in children's health, development and well being (Ragg, Coulter, Panacek, & Stone, 1997).

Whole Child Project

The Lawton Chiles Foundation, in partnership with local communities in Florida and Electronic Training Solutions Inc. created the Whole Child Project to assist communities to insure that all children thrive. The project focuses on children ages 0-5 and their families and uses web-based technology:

To assist parents in identifying needs and connecting with providers,

To assist providers in building holistic service delivery networks, and

To assist policy makers, community leaders and advocates to identify critical issues related to the well being of children 0-5 and develop the capacity to address these issues.

The Whole Child Project is not another program, but a philosophy that uses strategic planning, web-based technology, performance measurement and broad-based community engagement to build communities where everyone works together to make sure children thrive. Several communities across Florida are in varying stages of developing Whole Child Initiatives. Risk and resiliency screening is core to the philosophy.

The vision is to create a community strengths-based assessment system. Instead of individual identification of problem areas, communities would assess their ability to support child and family health, development, and well being. Instead of making the focus of child screening and assessment on the identification of problems, a strengths-based screening and assessment would identify child and family strengths and link families to community supports to build greater resiliencies in health and development. A promising tool under development in Florida is the Community Investment Capital Investment Scale. Dr. Peter Gorski at the Children's Board of Hillsborough County is creating the scale to assist communities in screening for social, economic, educational and environmental capital supports for children and families.

Conclusions

There are a number of areas in Florida where families are afforded multiple opportunities to ensure that their children are screened and receive services if needed through exceptional programs and efforts. Coordination efforts across agencies and programs include numerous interagency agreements and memoranda of understanding. In addition, entities such as the Governor’s Task Force on Autism, the Developmental Disabilities Council and the Department of Health Early Childhood Comprehensive Systems Grant provide important leadership and support for child screening coordination efforts. Strong leadership is often behind the collaboration efforts that occur across multiple local service providers to provide comprehensive screening, assessment and intervention protocols and services.

Unfortunately, however, child screening of the full range of developmental, health and environmental factors is not available for most of Florida’s children. Too many children miss out due to lack of health insurance, medical homes, policy and practice barriers to screening in medical settings, or lack of trained and competent screeners. When screening is in place, too often it does not include attention to social-emotional needs, environmental hazards or family functioning. There is little consistency in the tools used by agencies and programs providing child screening, with differences even found in the same program offered in different parts of the state. Due to lack of comprehensiveness and training, many conditions are not identified early when treatment is most beneficial and cost effective. As children age, additional opportunities are missed for screening, assessment and intervention, particularly for children and adolescents in child welfare and juvenile justice programs. Furthermore, staff providing Part C and Part B services are overwhelmed in some areas of Florida resulting in delays in service provision – delays that have major consequences for children’s development and families’ functioning. Although there are many outstanding exceptions, too often families do not have the supports they need to navigate the referral and service provision process.

Recommendations

Goal 1: Create a system of standardized child screening tools, processes, and procedures.

- Identify a set of age-appropriate tools that capture demographic, developmental, health and environmental information important to optimal development and develop a set of criteria and protocol (including commitment to informing and supporting families) for their use across programs and agencies statewide.
- Develop interagency agreements and procedures that ensure all agencies and programs receiving state or federal funding utilize the agreed-upon system of standardized child screening tools, processes, and protocols.
- Develop staff and parent training regarding the system of standardized child screening and incorporate coordinated training in interagency agreements.
- Utilize the Florida Pediatric Society and *Docs for Tots* to identify mechanisms for improved communication and coordination between pediatricians and early intervention, early care and education and other service providers.

Goal 2: Increase the availability of and access to screening that is comprehensive across the range of development capacities, environmental factors and family functioning.

- Expand access to routine maternal mental health screening (through health department clinics, health care providers, birthing centers/hospitals, home-visiting programs, secondary and higher education school clinics).

- Develop awareness and outreach materials for use across state agencies adopting guidelines from the AAP/Bright Futures regarding screening frequency, identifying resources for families and promoting the medical home concept.
- Expand the web-based Florida SHOTS™ Registry Program to include child screening information.
- Develop a plan to promote fuller and better utilization of Early Periodic Screening, Diagnosis and Treatment (EPSDT).
- Review Medicaid policies and practices to provide incentives for providers to conduct child screening, referral and follow-up services.
- Review HMO and AHCA reimbursement policies to remove barriers to child screening by pediatricians and other health care professionals.
- Incorporate requirements regarding child screening and follow-up in a statewide quality rating improvement system for early care and education programs.
- Develop and implement community assessments designed to identify and build social capital (individual, family and community strengths) and optimize child health and well-being.

Goal 3: Increase the effectiveness of screenings by increasing the knowledge and skills of those that administer screenings.

- Utilize the Florida Pediatric Society and Docs for Tots to develop training and practice guidelines regarding child screening in medical settings.
- Assess and address cultural and linguistic appropriateness of screening instruments and protocols.
- Identify mechanisms and funding to support use of developmental specialists in partnership with pediatricians.
- Revise and mandate child care training module on Observation, Screening and Assessment (see a description of *Screen for Success* in this report as a possible model for consideration in the revision process).
- Develop policies and supports to train and utilize skilled developmental specialists to screen in early care and education programs.
- Develop policies and supports to provide continuing education for child welfare and juvenile justice staff regarding appropriate screening procedures and processes.

Goal 4: Increase the screening of the most vulnerable children who have high probability of developmental delays and disabilities.

- Provide screening and comprehensive assessment for all children in protective custody and their guardian prior to placement to ensure that there is a match between the needs of the child and the skills of the guardian (parent, relative, or other out-of-home guardian).
- Review and revise training for child welfare, protective services and juvenile justice staff to ensure children in the child welfare and juvenile justice systems (whether being served in-home or in out-of-home care) are screened at recommended intervals as prescribed by the American Academy of Pediatrics/Bright Futures and as indicated by special circumstances.
- Develop tracking and monitoring mechanisms to ensure that children in child welfare and juvenile justice programs and other children receiving Medicaid receive developmental screenings as part of the routine EPSDT on the recommended schedule.
- Identify tools, processes and procedures to support appropriate screening of adolescents.
- Implement CAPTA by referring all young children with maltreatment to Early Steps for developmental screening and all older children to Part B services.
- Re-establish Developmental Early Intervention screening and services in all hospital Neonatal Units to ensure infants are screened and families are provided follow-up services.

Goal 5: Increase the number of children with special needs and their families who receive consistent early intervention and supports.

- Increase funding and staffing of Early Steps to ensure all children receive follow-up assessment and services as needed.
- Ensure that Part C and Part B service providers are matched to children based on developmental concern (e.g., speech therapist addresses speech problems, physical therapist addresses motor delays).
- Develop resources to assist families in obtaining follow-up services when assessment indicates they are needed.
- Develop and implement policies in early care and education programs that support children with 10-24% delays (who do not qualify for Part B or C).
- Increase funding for the development and implementation of policies that ensure all children in child welfare and juvenile justice programs receive follow-up assessments and interventions as indicated.

References

- Department of Health and Human Services (Sept. 20, 2005). Centers for Disease Control and Prevention. Retrieved March 18, 2008, from <http://www.cdc.gov/ncbddd/child/devtool.htm>
- Early Head Start National Resource Center. (2006). *Developmental screening, assessment, and evaluation: Key elements in individualizing curricula in Early Head Start programs*. Technical Assistance paper No. 4. Washington, DC: Zero to Three.
- Eggbeer, L., Littman, C. L., and Jones, M. (1997) *Zero to Three's developmental specialist in pediatric practice project: An important support for parents and young children*. Washington, DC: Zero to Three.
- Florida Department of Education. (2008). Early intervention services. Retrieved January 18, 2009 at www.fldoe.org.
- Florida Department of Health. (2008). Florida Early Steps Program. Retrieved January 18, 2009 at www.doh.state.fl.us.
- Ghazvini, A. S. (2006). *Chronic neglect: Indicators and strategies for response*. Tallahassee, FL: Human Systems and Outcomes.
- Ghazvini, A. S., & Foster, B. F. (2003). *The Florida vision: A state that promotes the well-being of all of its children* [Available on-line at www.policygroup.org]. Tallahassee, FL: The Policy Group for Florida's Families and Children.
- Johnson, R., Nottingham, D., Stratton, R., & Zaba, J. (1996). The vision screening of academically and behaviorally at-risk pupils. *Journal of Behavioral Optometry*, 7(2), 39.
- Maternal Child Health and Education Research and Data Center and The Lawton and Rhea Chiles Center for Healthy Mothers and Babies. (2008). Florida Medicaid maternal and child health status: Indicators report 2002-2006. Gainesville and Tampa: authors.
- McCann, C. E., & Yarbrough, K. (2006). *Incorporating comprehensive developmental screening in programs and services for young children* [Available on-line at www.ounceofprevention.org]. Chicago, IL: Ounce of Prevention Fund.
- McLean, M., Wolery, M., & Bailey Jr., D. (2004). *Assessing Infants and Preschoolers with Special Needs*. Upper Saddle River, NJ: Pearson Education Inc.
- National Scientific Council on the Developing Child (2008). *Mental health problems in early childhood can impair learning and behavior for life: Working Paper #6*. <http://www.developingchild.net>
- National Research Council. (2008). *Early childhood assessment: Why, what, and how*. Committee on Developmental Outcomes and Assessments for Young Children, C.E. Snow and S. B. Van Hemel, Editors. Board on Children, Youth, and families, Board on testing and Assessment, division of Behavioral and Social Sciences and education. Washington, DC: The national Academies Press.
- Ruggs, D., Coulter, M., Panacek, L., & Stone, W. (1997). *A conceptual framework for service planning for children and families* [Available on-line at www.childrensboard.org]. Tampa, FL: Children's Board of Hillsborough County.

Schonwald, A., Huntington, N., Chan, E., Risko, W. & Bridgemohan, C. (2009). Routine developmental screening implemented in urban primary care settings: More evidence of feasibility and effectiveness. *Pediatrics*, 123(2), 660-668.

Stowell, J. K. (2009). *The state of Florida's child report*. Auburndale, FL: The Policy Group for Florida's Families and Children Inc.

Wasserman, R. C., Croft, C. A., & Brotherton, S. E. (1992). Preschool vision screening in the pediatric practice: A study from the pediatric research in office settings network. *Pediatrics*, 89 (5), pp. 834-838.

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APPENDIX B

Child Screening Panel Interview Summary

October 2008

Members Participating in Interviews: Noelle Bee, Wil Blechman, Jeff Brosco, Nancy Brown, Sharon Carnahan, Fonda Elyer with Sharon Hennesy, Susan Gold, Peter Gorski, Mimi Graham, Jane Murphy, Allison Parrish, and Celeste Putnam

Best Practices in Florida

Members were asked to indicate any best practice models of child screening procedures, tools, and/or processes in Florida. The following is a summary of their responses. Further information regarding several of these examples is included in the Best Practice Model Report.

Tools

Ages and Stages – several members recommended Ages and Stages as a relatively easy to administer and reliable tool for child screening

Ages and Stages/Social Emotional – several members underscored the importance of addressing social emotional issues in the screening process

Communication and Symbolic Behavior Scale – developed by Dr. Amy Wetherby, FSU Department of Autism and Related Disabilities, this tool is recognized as an excellent parent questionnaire to identify infants and toddlers at risk for communication delays. The Checklist is designed for use in pediatricians' offices during routine visits or in early care and education programs for children 6 to 24 months of age. It takes 5 to 10 minutes for a child's caregiver (i.e., a parent or care provider that nurtures the child on a daily basis) to complete. The Checklist measures the following 7 language predictors:

1. Emotion and Use of Eye Gaze,
2. Use of Communication,
3. Use of Gestures,
4. Use of Sounds,
5. Use of Words,
6. Understanding of Words, and
7. Use of Objects

Community Investment Capital Investment Scale – under development by Dr. Peter Gorski, this scale focuses on the responsibilities of communities to make investments that build strong families and children and reduce adverse conditions. The scale will be designed as a screen for communities regarding social, economic, educational, and environmental capital.

Processes

Early Steps - Several members cited Early Steps, administered by Children's Medical Services (CMS) in accordance with IDEA, Part C, as a good, albeit under-funded, child screening program and process

Hillsborough Countywide Child Screening Program – Coordinated by the Early Childhood Council (a network of agencies, professionals, and parents concerned about early intervention) and supported by the Children's Services Council of Hillsborough, this effort provides informal but massive coordination of a network of professionals delivering a full array of developmental screenings (e.g., biological, neuro-motor,

social-emotional) once a month in the county. Locations move around the county to insure ease of access for all families and are established and posted one year in advance. Referrals are made, if indicated, for further diagnostic evaluation or early intervention. Other service information is provided to families.

Hillsborough Healthy Start – Through a grant funded by the Allegany Franciscan Foundation, developmental specialists are paired with private pediatrician offices to provide developmental screening, education of health professionals regarding screening processes and communications with families, and support for referrals to community services.

Healthy Families Florida – provides screening using ASQ and ASQ-SE, refers families for further evaluation as indicated and assists families with the process of evaluation and follow-up service navigation.

Screen for Success – a grant-funded initiative in Orange County to provide training, tools, and resources to personnel in early care and education settings regarding appropriate procedures and processes associated with screening and assessment; a data tracking system for the ASQ as well as a self-assessment system was developed as part of the project

Developmental Screenings in Pediatric Offices – developmental screenings occur in pediatric offices, although there is variability in instruments, processes, and procedures; if concerns are identified, pediatricians are bound by law and ethics to report findings to Early Steps

Quality Rating Improvement Systems – local efforts to implement Quality Rating Improvement Systems (a system of incentives and supports to improve the quality of early care and education programs) include standards related to child screening and assessment for participating early care and education programs

Florida Shots System – a statewide data collection system, housing data on childhood immunizations; model for expansion to include child-screening information

Infant Newborn Hearing and Metabolic Screening – most states, including Florida, routinely offer newborn hearing screening; all states screen newborns for certain metabolic birth defects that can cause physical problems, mental retardation, and, in some cases, death

Docs for Tots – a national advocacy organization formed to encourage doctors to fulfill their important role as active advocates for infants, toddlers, and preschoolers on the national, state, and local level. In Florida, the effort is focused on educating doctors on the mental health needs of children, a review of best practices relative to incorporating broader social emotional supports in the clinical venue, and building a network to impact practice and policy, including practices relative to screening and assessment.

Whole Child Project - The Lawton Chiles Foundation, in partnership with local communities in Florida and Electronic Training Solutions, Inc. created the Whole Child Project to assist communities to insure that all children thrive. The project focuses on children ages 0-5 and their families and uses web-based technology:

To assist parents in identifying needs and connecting with providers,

To assist providers in building holistic service delivery networks, and

To assist policy makers, community leaders and advocates to identify critical issues related to the well-being of children 0-5 and develop the capacity to address these issues.

The Whole Child Project is not another program, but a philosophy that uses strategic planning, web-based technology, performance measurement and broad-based community engagement to build communities where everyone works together to make sure children thrive. Several communities across Florida are in varying stages of developing Whole Child Initiatives. Risk and resiliency screening is core to the philosophy.

Best Practices Nationally

Members were asked to indicate any best practice models of child screening procedures, tools, and/or processes that they were aware of in Florida. The following is a summary of their responses. Additional information regarding many of these examples is included in the Best Practice Model Report.

Tools

Parents' Evaluation of Development Status (PEDS) - Parents are asked to answer ten questions on the *PEDS Response Form*. The questions elicit parents' perspectives on their child for each developmental domain. Across the age range of PEDS, birth to age 8, the same 10 questions are used.

Adverse Childhood Events (ACE) Study Indicators – A longitudinal study correlated nine adverse events in childhood (birth through age 18) that predict adult health conditions.

Processes

Bright Futures, initiated by the Maternal and Child Health Bureau (MCHB) over a decade ago, is a philosophy and approach that is dedicated to the principle that every child deserves to be healthy, and that optimal health involves a trusting relationship between the health professional, the child, the family, and the community. *Bright Futures* is a national health promotion and disease prevention initiative that addresses children's health needs in the context of family and community. In addition to use in pediatric practice, many states implement Bright Futures principles, guidelines and tools to strengthen the connections between state and local programs, pediatric primary care, families, and local communities. The *American Academy of Pediatrics* promotes these practices.

Docs for Tots – a national advocacy organization formed to encourage doctors to fulfill their important role as active advocates for infants, toddlers, and preschoolers on the national, state, and local level. In Florida, the effort is focused on educating doctors on the mental health needs of children, a review of best practices relative to incorporating broader social emotional supports in the clinical venue, and building a network to impact practice and policy, including practices relative to screening and assessment.

Early Childhood System Grants – grants provided through the Maternal and Child Health Bureau, U. S. Department of Health; grants are designed to support States in their efforts to build and integrate early childhood service systems that address the critical components of access to comprehensive health services and medical homes, social-emotional development and mental health of young children, early care and education, and parenting education and support; the focus in Florida includes development of core indicators of child health and a comprehensive coordinated system for improving the health of young children.

Best Practices Internationally

The United Nations Convention on the Rights of Children - The Convention deals with the child-specific needs and rights and requires that states act in the best interests of the child. The rights include guidance on the needs of children that may inform the breadth of screening that should occur. In many jurisdictions, properly implementing the Convention requires an overhaul of child custody and guardianship laws, or, at the very least, a creative approach within the existing laws. The Convention acknowledges that every child has certain basic rights, including the right to life, his or her own name and

identity, to be raised by his or her parents within a family or cultural grouping and have a relationship with both parents, even if they are separated. The Convention obliges states to allow parents to exercise their parental responsibilities. The Convention also acknowledges that children have the right to express their opinions and to have those opinions heard and acted upon when appropriate, to be protected from abuse or exploitation, to have their privacy protected and requires that their lives not be subject to excessive interference. The Convention also obliges signatory states to provide separate legal representation for a child in any judicial dispute concerning their care and asks that the child's viewpoint be heard in such cases. The Convention forbids capital punishment for children. The United States has not signed the Convention.

Facilitators of Collecting Child Screening Information

When questioned regarding facilitators of child screening information, workgroup members identified the following:

- User-friendly tools
- Developmental screening at well-child check-ups
- Primary health care providers/pediatricians
- Service providers
- Well-trained early care and education teachers
- Families

Barriers to Collecting Child Screening Information

Members identified the following barriers to collecting child screening information:

- Family reluctance and resistance to perceived intrusion
- Family lack of follow-through with evaluation and service implementation
- Lack of adequate funding for Early Steps
- Lack of adequate funding for training and other screening supports
- Scarcity of infant mental health service providers
- Lack of family inclusion in the screening process
- Lack of assistance for families with accessing and navigating the screening process and follow-up services
- Lack of medical homes; families that move from one physician to another
- Lack of training for pediatricians in screening tools, processes, follow-up, and supporting families through the process
- Health care funding mechanisms that limit the time that pediatricians spend with families and children
- Physician liability issues; if special need is identified, physicians assume some liability in ensuring treatment
- Lack of consistent and thorough training among agency and service partners, e.g., child care providers often lack sufficient training to provide reliable child screenings
- Lack of knowledge regarding the differences between screening and assessment and the appropriate uses of both
- Language barriers
- Transportation barriers
- HIPPA requirements; most members indicate HIPPA can be adequately addressed but often slows the process of coordinating screenings, follow-up, and services
- Lack of assistance for families and teachers

- Lack of adequately sensitive screening instruments, e.g., 80% of referrals are for late-talkers, and Ages and Stages does not adequately address language concerns
- Lack of coordination with physicians and pediatricians
- Parents that under- or over-estimate children's performance
- Frequent absence of family involvement in public school child screening processes
- Policies that reward health care providers for crisis intervention rather than for prevention and health promotion

Facilitators of Sharing Child Screening Information

Members identified the following facilitators of sharing child screening information:

- Data systems for tracking and follow-up
- Interagency agreements
- Training and education programs
- Clear, appropriate consent forms
- Commitment and direction of state leadership (e.g., Governor, Lt. Governor, agency head)
- Exchange of information between agencies regarding what information is needed and why

Barriers to Sharing Child Screening Information

The following barriers to sharing child screening information were noted:

- Family fears regarding sharing information
- Real and perceived concerns regarding HIPPA; need for a universal consent form
- Lack of shared language between agencies and disciplines
- Lack of a statewide data system for early intervention
- Differences in tools, training, and processes
- Inappropriate use of child screening tools, e.g., Florida Kindergarten Readiness Screen is being used to make high-stakes decisions regarding services to children
- Lack of data collection systems for sharing information
- Lack of adequate funding
- Lack of policy and leadership
- Lack of knowledge and training for pediatricians and early care and education providers regarding the importance of sharing data, follow-up processes, and appropriate utilization of findings
- Workload issues
- Reluctance of providers to share information with families due to real or perceived concerns that the child will be moved
- Process of family identifying the primary service provider often limits coordination of information among full array of service providers
- Agency funding process encourages turf guarding

Other Barriers

The lack of sufficient funding for screening, training, family assistance, follow-up and service provision was cited most frequently as another barrier to child screening service delivery.

Many members were concerned regarding family support and follow-up services, noting that in too many cases families are not adequately prepared for the process of child screening and assessment, informed of the results, or provided necessary services.

It was also noted that once a child is referred for further assessment, the child's early care and education teacher is excluded from the process, receives little or no follow-up information and is rarely included in a plan for service delivery.

The lack of communication and coordination between local early intervention service providers, early care and education professionals, and pediatricians was also a concern. Some members noted that all too often families ask pediatricians about concerns raised by early childhood professionals and are told "let's wait and see", possibly closing an important window of opportunity for effective early intervention.

Turf issues and funding are also barriers to child screening and follow-up. Entities are funding for one service area in many cases and are reluctant to share resources and jeopardize identification of specific service priorities and outcomes.

Policy decisions made in Florida have not supported child screening and assessment, according to members. For example, nine states identify children "at risk" in eligibility categories as identified through Early Steps, and Florida does not. In addition, Florida made major new investments in developmental disabilities during Governor's Bush's term in office, but none of the additional funds were designated for young children. Furthermore, insurance companies are trying to set up waivers so that insurance funds do not have to be spent first, thus reducing the public funds available to support screening and assessment.

Lack of political and moral will was also highlighted as a barrier. Current approaches focus on problems separately, resulting in higher costs, rather than building families that support thriving children. Term limits also impact the political will as new policymakers have a need to see action and change in short time periods.

The current economic crisis also is a barrier to preventive practices. Individuals are more likely to operate from a survival framework rather than one of prevention.

Exchange of Child Screening Information

Members were asked to identify important entities, programs, or services that should be included in exchanges of child screening information. One member indicated that these decisions must be locally specific due to the variability in service providers across the state. Entities that were highlighted as crucial to the exchange of child screening information included:

- Parents
- Head Start
- Early Head Start
- Healthy Start
- Healthy Families Florida
- Pediatricians
- Early Care and Education Providers
- Schools
- Service providers, multi-disciplinary therapists, and content-area Experts
- Children's Services Councils
- Representatives of Children and Youth Cabinet
- Universities and Community College as research, evaluation, and training and education partners
- Children and Youth

Issues of Primary Importance

The issues of primary importance varied among members. They included:

- Screening of mothers for behavioral and mental health issues
- Social-emotional screening for children
- Mental health screening that addresses parent-child relationship concerns
- Multi-disciplinary, culturally competent medical and psychosocial screening in the neonatal unit with appropriate and adequate follow-up; too often substance-exposed infants are not identified or are not provided follow-up services
- Integration of resiliency factors into screening protocols, to highlight strengths for families rather than only deficits
- Psychological and social determinant screening, including resiliency factors for community investment; identifying what every child needs and how it can be provided
- Consideration of the ethics of screening and identifying children with special needs if services are not available
- Screening tools, processes, and services that are culturally competent
- Addressing liability issues for physicians
- Promoting a medical home for all children
- Importance of taking action rather than generating another report that sits on a shelf
- Guiding any decisions about child screening and assessment must be a commitment that information will only be used to benefit the child and family
- Multiple tools for multiple purposes
- Coordination of information, effort, and response
- Screening at multiple points in time
- Multiple informants
- Use of valid and reliable tools
- Any policy or process established must be subject to review and evaluation
- Teachers should be included in the child screening and assessment process
- Children are impacted by a larger ecological system; child screening and assessment should be considered in relation to other system elements

APPENDIX C

Significant Socio-demographic, Behavioral, and Health Factors Associated with Poor or Adverse Pregnancy and Child Outcomes

Rank*	Infant Mortality	Low Birth Weight (LBW)	Birth Defects	Maltreatment	Developmental Disabilities	Lack of Readiness to Start	Kindergarten Special Education	Academic Problems
1	LBW	High risk pregnancy screen	Mom > 35	Drinking	LBW	Poverty	LBW	LBW
2	Birth defects	Not married	Male	Smoking	Birth defects	Male	Birth defects	Hipanic
3	High risk pregnancy screen	Mom > 35	Poverty	LBW	Male	LBW	Male	Black
4	Black	Black		Poverty	No prenatal care	< High school education	Poverty	Poverty
5	Not married	< High school education		< High school education	Complications of labor & delivery	Black	Complications of labor & delivery	Male
6	Smoking	Poverty		Not married	< High school education	Birth defects	Mom > 35	< High school education
7	Drinking	Previous adverse outcome		> 2 children	Mom > 35	Health status	< High school education	Complications of labor & delivery
8	< High school education	Smoking		Previous adverse outcome	Not married		Not married	Mom > 35
9	Poverty	Drinking		High risk pregnancy screen	Poverty			Not married
10	Previous adverse outcome	Female						
11	Male							

Source: *Maternal Child Health and Education Research and Data Center, University of Florida, 2001 and Lawton and Rhea Chiles Center, University of South Florida; published in Ghazvini & Foster, 2003.*

* 1 = strongest correlational relationship

APPENDIX D

Bright Futures Recommended Screening Schedule



Recommendations for Preventive Pediatric Health Care Bright Futures/American Academy of Pediatrics



Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent, parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest deviations from normal.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

The recommendations in this statement do not include an accurate course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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AGE	INFANCY								EARLY CHILDHOOD					MIDDLE CHILDHOOD					ADOLESCENCE										
	PREVICAL*	NEWBORN	2-6 mo	9-12 mo	1-2 yrs	3-4 yrs	5-6 yrs	6-8 yrs	12 mo	18 mo	24 mo	30 mo	3-4 y	4-5 y	6-7 y	8-9 y	10-12 y	13-14 y	15-16 y	17-18 y	19-20 y	21-22 y	23-24 y	25-26 y	27-28 y	29-30 y	31-32 y		
HISTORY	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	
MEASUREMENTS																													
Length/Height and Weight	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	
Head Circumference	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	
Weight for Length	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	
Body Mass Index																													
Blood Pressure†	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
SENSORY SCREENING																													
Vision		*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Hearing		o†	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																													
Developmental Screening‡								o																					
As-User Screening‡																													
Developmental Surveillance‡																													
Psychosocial/Behavioral Assessment																													
Alcohol and Drug Use Assessment																													
PHYSICAL EXAMINATION*																													
PROCEDURES*																													
Newborn Metabolic/Hemoglobin Screening‡		←	o	→																									
Immunization*		o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	
Hemostatic or Hemoglobin†						*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Lead Screening†						*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Tuberculin Test†				*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Dyslipidemia Screening†													*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	
STI Screening†																	*	*	*	*	*	*	*	*	*	*	*	*	
Cervical Dysplasia Screening†																	*	*	*	*	*	*	*	*	*	*	*	*	
ORAL HEALTH†							*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	
ANTICIPATORY GUIDANCE*		o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	

1. A child whose entire visit for the first time at any point in the schedule, or if any items are not accomplished at the suggested age, should be scheduled to be brought up to date at the earliest possible time.

2. A generalist is recommended to provide care up to age 18. For 16-19-year-olds, care for those who request a consultation. The generalist should handle routine pediatric problems, perform initial history and a discussion of benefits of immunizing and planned method of testing per AAP statement "The Family AAP (2005) [URL: <http://www.aap.org/immunization/immunization.htm>].

3. Care should include a history, physical, diet, immunizing, psychosocial, and behavioral and support system.

4. Every infant should have a history, physical, diet, immunizing, psychosocial, and behavioral and support system, to include readiness for feeding and formula. Immunizing infants should receive formal immunizing education, immunization, and behavioral assessment in an "immunizing" team setting and for the first year (18) [URL: <http://www.aap.org/immunization/immunization.htm>].

5. Every infant should have a history, physical, diet, immunizing, psychosocial, and behavioral and support system, to include readiness for feeding and formula. Immunizing infants should receive formal immunizing education, immunization, and behavioral assessment in an "immunizing" team setting and for the first year (18) [URL: <http://www.aap.org/immunization/immunization.htm>].

6. Blood pressure assessment in infants and children with specific risk variables should be performed at visits below age 3 years.

7. If the patient is asymptomatic, assessment with a stethoscope per the AAP statement "The Cardiovascular System, Children, and Young Adults by Professionals" (2005) [URL: <http://www.aap.org/immunization/immunization.htm>].

8. All women should be screened per AAP statement "Sex-Related Physical Abuse and Domestic Violence by Gynecology, Obstetrics and Gynecology" (2005) [URL: <http://www.aap.org/immunization/immunization.htm>].

9. AAP Council on Children With Disabilities, AAP Section on Developmental Behavioral Pediatrics, AAP Bright Futures Healthy Children, AAP Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Identifying Children with emerging early developmental concerns in the medical home: an algorithm for developmental assessment and monitoring. Pediatrics. 2007;119:1401-1410 [URL: <http://www.pediatrics.com/cgi/content/full/119/5/e1401>].

10. Quigley KL, Singer DC, Johnson CC, et al. Identifying children with autism early? Pediatrics. 2007;119:1401-1410 [URL: <http://www.pediatrics.com/cgi/content/full/119/5/e1401>].

11. These may be modified, depending on early pediatric evaluation and individual home.

12. Includes continuous and targeted early screening for children from according to state law. Results should be reviewed at visits and appropriate referrals to various care as needed.

13. Assessment per the Committee on Pediatric Emergencies, published annually by the American Academy of Pediatrics. They are available on a regular basis and available in English and Spanish.

14. See AAP Pediatric Nutrition Guidelines. By Editors (2002) for a discussion of assessment and nutrition screening options. See also Recommendations for general and cardiac risk laboratory in the United States. JAMA. 1998;279:925-930.

15. For children at risk of lead exposure, consult the AAP statement "Lead Exposure in Children: Prevention, Detection, and Management" (2005) [URL: <http://www.aap.org/immunization/immunization.htm>].

16. Pediatric risk assessment or screen as appropriate, based on ordered screening appropriate for patients with diabetes or high cardiovascular risk.

17. Intensively testing per recommendations of the Committee on Infectious Diseases, published in the current volume of Red Book: Report of the Committee on Infectious Diseases. Testing should be done at completion of high-dose therapy.

18. "Risk Report of the National Child Abuse and Neglect Program: NCAN Report Panel on Delivery, Detection, and Treatment of High-Risk Children in Adult Child Treatment Panel III: Final Report" (2002) [URL: <http://www.nacan.org/ncan/ncanreport.htm>].

19. "The Report of the National Child Abuse and Neglect Program: NCAN Report Panel on Delivery, Detection, and Treatment of High-Risk Children in Adult Child Treatment Panel III: Final Report" (2002) [URL: <http://www.nacan.org/ncan/ncanreport.htm>].

20. "The Report of the National Child Abuse and Neglect Program: NCAN Report Panel on Delivery, Detection, and Treatment of High-Risk Children in Adult Child Treatment Panel III: Final Report" (2002) [URL: <http://www.nacan.org/ncan/ncanreport.htm>].

21. If sexually active patients should be screened for sexually transmitted infections (STIs).

22. If sexually active patients should be screened for cervical dysplasia and if a pelvic examination beginning within 1 year of onset of sexual activity or age 21 (whichever occurs first).

23. Refer to state laws, if available. Consider, individual and health risk assessment. If the primary care source is not a child health provider, consider self-testing options.

24. At the time for 1 year and 6 years of age, it is advised to determine whether the patient has a dental home. If the patient does not have a dental home, a referral should be made to one. If the primary care source is not a child health provider, consider self-testing options.

25. Refer to the current guidelines by age as listed in Bright Futures Guidelines, Steps 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

KEY
 o = to be performed
 * = risk assessment to be performed, with appropriate action to follow if positive
 ← o → = range during which a service may be provided, with the spread indicating the preferred age

APPENDIX E

Overview of Interagency Agreements Addressing Services to Children and Youth Between Florida Departments and Agencies

Title	Participating Departments/Agencies	Description	Additional Information
<p>Infants and Toddlers Early Intervention Program</p>	<ul style="list-style-type: none"> • Florida Department of Health, Children's Medical Services, Early Steps • Florida Department of Education, Bureau of Instructional Support and Community Services • Florida Department of Education, Division of Blind Services • Florida Department of Children and Families • Head Start, Early Head Start and related programs • Florida School for the Deaf and Blind 	<p>Define and clarify the responsibilities of each agency in order to ensure the statewide provision of coordinated quality early intervention services, including transition and family-centered services in natural environments for children with disabilities from birth to three years of age and their families</p>	<p>Addresses development of joint initiatives; non-duplication of early intervention services; awareness of full range of services available; sharing of training, technical assistance and assistive technology resources; development of interagency agreements among local agencies; and outlines specific individual agency and joint responsibilities</p> <p>Established to meet requirements of the Individuals with Disabilities Education Act, Part C, Early Intervention Services</p>

Title	Participating Departments/Agencies	Description	Additional Information
Support for Children in Child Welfare	<ul style="list-style-type: none"> • Department of Education • Department of Children & Families • Agency for Workforce Innovation 	Review and ensure coordination of rules, regulations, policies and procedures relative to the education, special education and related services, job training and employment of children in the child welfare system; define and establish communication protocols; promote joint updating of policies and staff training; provide access to pertinent staff and parent training opportunities; coordinate efforts addressing educational stabilization, transportation, data and information-sharing to the extent possible and case planning	Requires agency designees to meet annually, at a minimum, and make recommendations to the Secretary of DCF, the Commissioner of Education and the Director of AWI; addresses appointment of district school board, regional workforce board and DCF district/regional liaisons
Assistive Technology	<ul style="list-style-type: none"> • Department of Health, Infant and Toddler Early Intervention Program • Department of Education, Division of Blind Services • Department of Education, Division of Vocational Rehabilitation • Department of Education, Office of Early Learning • Agency for Workforce Innovation, Office of Early Learning • Department of Education, Bureau of Exceptional Education and Student Services 	Provide a mechanism by which a youth with disabilities, or his or her parent, are informed of assistive technology devices to support transitions and may request that an assistive technology device remain with the youth as she or he moves through the continuum from home to school, to another school district, to postsecondary institutions, to state or community agencies, to employment facilities and to community living facilities	Established based on 1003.575, Florida Statutes.

Title	Participating Departments/Agencies	Description	Additional Information
Infants and Toddlers with Sensory Loss	<ul style="list-style-type: none"> • Department of Health, Children’s Medical Services, Early Steps • Florida School for the Deaf and Blind, Outreach Services, Parent Infant Program 	Facilitate delivery of appropriate and quality early intervention services to children, ages birth to 36 months, with sensory loss (vision and/or hearing) and their families by clarifying roles and responsibilities of each agency	
Students with Disabilities – Support for Transition	<ul style="list-style-type: none"> • Department of Education, Bureau of Exceptional Education and Student Services, Division of Vocational Rehabilitation, Division of Blind Services • Department of Health, Children’s Medical Services • Department of Children and Families, Mental Health • Agency for Persons with Disabilities 	Encourage and facilitate cooperation and collaboration among local leadership and staff in order to provide a smooth and successful transition of students with disabilities to gainful and sustained employment or postsecondary education with access to adult health care and mental health services	Established to address requirements of the Individuals with Disabilities Act; addresses development of joint service plans for students
Child Care Licensing	<ul style="list-style-type: none"> • Department of Children and Families • Department of Health 	Provide for coordination of licensing inspections twice a year at licensed child care centers in 60 Florida counties.	<p>Established to meet requirements of Section 402.305, Florida Statutes</p> <p>The remaining counties have elected to conduct their own licensing inspections, meeting or exceeding state licensing requirements</p>
Title IV-E Claiming	<ul style="list-style-type: none"> • Department of Juvenile Justice • Department of Children and Families 	Create a cooperative collaboration to ensure proper and efficient administration of Title IV-E, Foster Care Programs	Established to meet requirements of the Federal Social Security Act

Title	Participating Departments/Agencies	Description	Additional Information
Jointly Served Youth	<ul style="list-style-type: none"> • Department of Juvenile Justice • Department of Children and Families 	Coordinate the delivery of services to jointly served youth	
Home SafeNet	<ul style="list-style-type: none"> • Department of Juvenile Justice • Department of Children and Families 	Provide for limited interagency access to agency databases	
Title XX Services	<ul style="list-style-type: none"> • Department of Juvenile Justice • Department of Children and Families 	Provide for proper administration and funding of Title XX services (Adolescent Family Life Program) to committed juvenile offenders	Established to meet requirements of Federal Public Health Services Act
Florida Youth Challenge Program	<ul style="list-style-type: none"> • Department of Juvenile Justice • Department of Military Affairs 	Provide for appropriate operation and funding of Florida Youth Challenge Program, an initiative providing training & mentoring to high-risk youth who are high school drop outs and are unemployed or underemployed	
Juvenile Offender Training & Job Placement	<ul style="list-style-type: none"> • Agency for Workforce Innovation • Department of Juvenile Justice 	Initiate and promote cooperation between Workforce Florida, Inc. (WFI), Regional Workforce Boards and DJJ for delivery of services to juvenile offenders and at risk youth, with the common goal of enabling them to reintegrate with their community by entering the workforce through training and job placement.	

Title	Participating Departments/Agencies	Description	Additional Information
Improving Child Care Quality	<ul style="list-style-type: none"> • Agency for Workforce Innovation • Department of Education 	Improve the quality of child care programs through additional statewide assistance and supports	
Self-employment of Youth with Disabilities	<ul style="list-style-type: none"> • Agency for Workforce Innovation • Agency for Persons with Disabilities 	Support self-employment for adults and youth with disabilities	
Data-sharing for Child Support Enforcement	<ul style="list-style-type: none"> • Agency for Workforce Innovation • Department of Revenue, Child Support Enforcement 	Provide disclosure of confidential Unemployment Compensation information on persons who owe a duty of child support and to deduct and withhold child support payments from such person's Unemployment Compensation benefits	
Student Medicaid Medical Services Coordination	<p>Department of Education</p> <p>Agency for Healthcare Administration</p>	Provide for school districts to check students' Medicaid eligibility and obtain Medicaid reimbursement for medical services provided by school districts to students with disabilities	

Title	Participating Departments/Agencies	Description	Additional Information
Students with Disabilities Service Coordination	Department of Education Agency for Persons with Disabilities	Ensure services to persons with disabilities, including developing and enhancing supported employment	Established based on Chapters 393 and 413, Florida Statutes in 2005
One-stop Center Services	Department of Education Agency for Workforce Innovation	Strengthen the one-stop system, including the role of the Division of Vocational Rehabilitation	Established based on Chapter 413, Florida Statutes
Student Transitional Support Services	Department of Education Department of Children and Families	Provide for aftercare services, transitional support services, and the Road to Independence Program (RTI), which assists students who are in high school and those who have enrolled in postsecondary education	Established based on Chapter 409.1451(5)(b), Florida Statutes
Services to Homeless Children and Families	Department of Education Department of Children and Families	Provide services to homeless children and to the families of such children and youth, as needed	Established based on 1003.21(1)(f), Florida Statutes
Abuse Hotline	Department of Education Department of Children and Families	Provides for DOE to contact the Abuse Hotline of complaints involving reports of abuse, neglect, or abandonment at nonpublic schools	

Title	Participating Departments/Agencies	Description	Additional Information
Private School Health Inspections	Department of Education Department of Health	Provide for health inspections required for private schools to participate in the McKay and CTC Scholarship Programs	Established to meet requirements of Section 1002.421(2)(g), Florida Statutes
Coordinated School Health	Department of Education Department of Health	Ensure cooperative interagency planning, development, implementation and the coordination of effective policies, programs and budgets concerning the Coordinated School Health model as defined by the Centers for Disease Control and Prevention (CDC)	Established to meet requirements of section 381.0056 & 1003.453(3)(c), Florida Statutes
Staff Training	Department of Education Department of Juvenile Justice	Provide training for DJJ staff and faculty on effective strategies to prevent HIV/STD and Teen Pregnancy	
Juvenile Justice Education Programs	Department of Education Department of Juvenile Justice	Provide an organizational structure and processes for interagency communication and collaboration essential to the effective and efficient delivery of educational services to youth served in juvenile justice education programs	Established to meet requirements of 1003.51 & 1003.52, Florida Statutes

Title	Participating Departments/Agencies	Description	Additional Information
Independent Living	Department of Education Florida Independent Living Council	Delineate responsibilities regarding state plan for independent living	Established to meet requirements of section 413.395, Florida Statutes
Services for the Deaf and Blind	Department of Education Florida School for the Deaf and Blind	Provide coordination to ensure maximum benefits to eligible consumers	Established to meet requirements of the Individuals with Disabilities Act, the Rehabilitation Act of 1972, & Chapter 413, Florida Statutes
Prekindergarten Services for Children with Disabilities	Department of Education Head Start Programs	Development of programs designed to provide special education and related services to prekindergarten children with disabilities and their families	Established to meet requirements of the Individuals with Disabilities Act
Data-sharing - Foster Care	Department of Education Department of Children and Families Agency for Workforce Innovation	Provide of the aggregation of student data and unit record employment data to evaluate individuals who aged out of foster care programs	
Data-sharing - Kindergarten Screening	Department of Education Agency for Workforce Innovation	Coordinate kindergarten screening results of children participating in school readiness programs by "matching" AWI's school readiness data with the DOE's data on kindergarten screening results	Cooperative initiative, not a formal interagency agreement

Title	Participating Departments/Agencies	Description	Additional Information
Data-sharing – School Performance Impact	Department of Education Department of Health Agency for Workforce Innovation Department of Children and Families	Link agencies’ data sets containing variables (i.e., child and parent demographics, program participation and outcome data) that impact school performance	Cooperative initiative, not a formal interagency agreement
Waivers for Developmental Disabilities	Agency for Persons with Disabilities Agency for Health Care Administration	Delineation of agencies’ responsibilities for administration and operations for Medicaid Consumer Directed Care Research and Demonstration 1115 Waiver, Developmental Disabilities Waiver, Family/Supported Living Waiver, and Intermediate Care Facility Services for the Developmentally Disabled Program	Established in 2005
Articulation Agreement	Agency for Persons with Disabilities Department of Education Department of Children and Families	Agreement to support a smooth and successful transition of students with disabilities from high school to postsecondary education, support services, and/or employment	Established in 2006
Disability Coordination	Agency for Persons with Disabilities Department of Health	Outlines the creation, administration and funding of a Statewide Disability Coordinator	Established in 2007