1st Five Site Coordinator Guidance

Section 1. Surveillance and Screening

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IOWA | Health and Human Services

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Welcome Note

Guidance for 1st Five Site Coordinators

The 1st Five Healthy Mental Development Initiative (HMDI) builds partnerships between primary care practices and public service providers to support and enhance models of service delivery that promote high-quality, well-child care in primary care clinics. 1st Five promotes the use of developmental surveillance and standardized developmental screening tools that support healthy mental development for young children during the first five years. By using surveillance and screening for all children, providers are able to identify children at risk for developmental concerns that, if left untreated, would play out later in life.

The basics of 1st Five include:

- Targeting the population of children birth to age five (up to a child's fifth birthday).
- Increasing the use of surveillance and standardized developmental screening by partnering with (engaging) primary care providers.
- Providing a one-step referral resource for primary care providers.
- Connecting referred children (and their parents/guardians) to existing services in their local communities.
- Keeping primary care providers informed about children's progress.
- Supporting healthy social, emotional and cognitive development.

1st Five Site Coordinator guidance is intended to support the successful implementation of the 1st Five initiative by providing information to 1st Five Site Coordinators and those in support of 1st Five programming to understand the following concepts essential to successful implementation:

- Surveillance and developmental screening concepts in primary health care,
- the 1st Five Levels of Engagement Framework, and
- 1st Five Medicaid matchable EPSDT infrastructure.

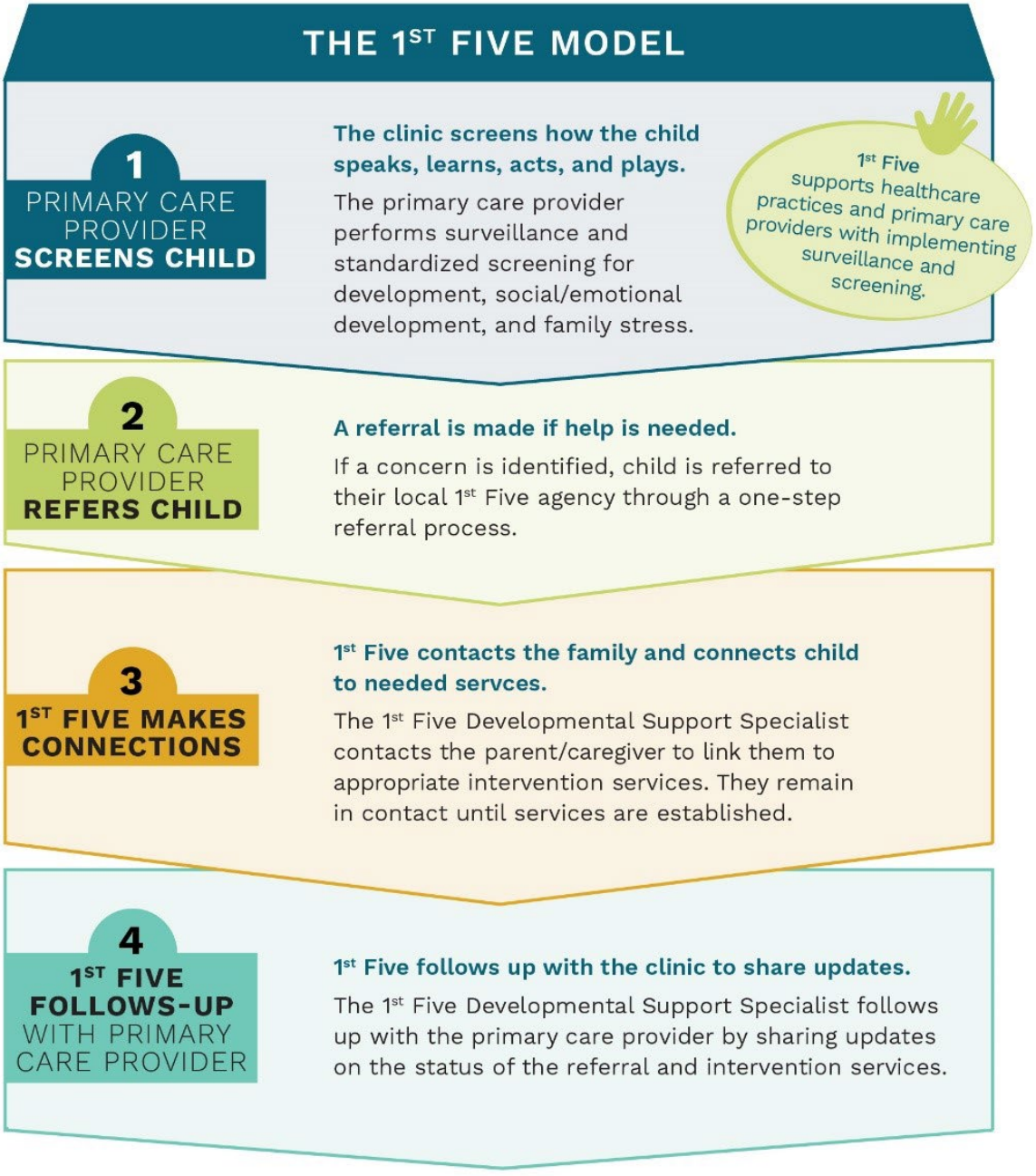
"The 1st Five program is a free and voluntary resource designed to support primary care providers in caring for children from birth to age five. We partner with providers to implement developmental screening to identify developmental delays as young as possible. Our intentional partnerships ensure that we stay updated on available community resources, allowing us to efficiently connect families to early intervention services while also following up on referrals and reporting back to providers, ultimately freeing up time for providers to focus on patient care."

Source: 1st Five Elevator Pitch, 2025: https://hhs.iowa.gov/media/14843/download?inline

Section 1. Surveillance and Screening

This section of the Site Coordinator guidance includes helpful information of core 1st Five concepts that are the foundation of 1st Five Site Coordinator work and activities. The importance of these concepts is illustrated in the first step of the 1st Five four-part Model of Implementation (highlighted below in step 1 of the four-part Model).

Figure 1. 1st Five four-part Model of Implementation



This section begins with an overview of Iowa's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program, considerations for planning engagement with EPSDT providers, and why it's important to understand Iowa's EPSDT program and its connection to 1st Five program goals.

The Iowa EPSDT program provides screening guidance used by 1st Five to assist with promotion of standardized developmental surveillance and screening tools in children's physical exams, also called well-visits and well-child exams. Considerations for how to move forward with this knowledge are included in the "Putting it All Together" and "Action Steps for Success" sections following each topic in this section of guidance.

Takeaways from this section of the Site Coordinator Guidance include:

- 1st Five core concepts of surveillance and developmental screening and how to successfully apply this information to Site Coordinator work supportive of program implementation success,
- 1st Five supported surveillance and screening tools, and considerations for how to successfully apply this knowledge when planning and developing training and education plans for primary care partners,
- insight into essential planning and preparation steps for successful implementation of surveillance and screening tools in primary care settings, and
- the Importance of using intentional and planned approaches and strategies to assure application of surveillance and screening as part of 1st Five engagement with primary care practices and partners.

Iowa Periodicity Schedule and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Care for Kids

Introduction to Iowa's Medicaid Program for Children and Teens

Information in this section is from the "Landing" "EPSDT Overview" pages at https://www.iowaepsdt.org/ ***(Reference #1)***

Iowa EPSDT Care for Kids is the state's federally mandated Medicaid program for children and adolescents. The EPSDT program was first created by Congress in 1967.

The role of EPSDT is to promote the physical, mental, social, emotional and behavioral health of children from birth to age 21. The EPSDT program emphasizes the use of a regular schedule of recommended well-child health visits and screenings to provide preventive health care and to identify medical, developmental and social-emotional concerns ***(Reference #2)***. The EPSDT program requires that Medicaid pay for any medically necessary diagnostic and treatment services for problems detected as part of a well-child screening exam.

In addition to billing for the well-visit, Medicaid allows primary care providers to bill for developmental screenings like the ASQ, ASQ:SE, and the M-CHAT-R/F, with some exceptions, as a way to incentivize the screening process during the well-visit. Many private insurers also provide preventative benefits for code 96110 for developmental screening at 9, 18, and 30 months, and autism screening at 18 and 24 months in addition to the recommended preventative medicine services (i.e. well child visits) ***(Reference #3)***. Screenings take time and follow up is necessary to assure appropriate referral and connection follow through. Generally, primary care providers that screen are then being reimbursed for the time it takes to complete the screening, and the follow up that's important to successful identification of early intervention needs and the early intervention follow up embedded in this process.

EPSDT - The Acronym

E is for Early - Children should receive quality health care beginning at birth and continuing throughout childhood and adolescence, including the identification, diagnosis and treatment of medical conditions as early as possible.

P is for Periodic - Children should receive well child visits at regular intervals throughout childhood and adolescence, according to the Iowa EPSDT Periodicity Schedule. Health care may be provided between regularly scheduled visits.

S is for Screening - Children should be screened for health and developmental and behavioral concerns. Services should include health history, developmental and

behavioral assessment, physical exam, immunizations, lab tests, nutrition/obesity prevention, oral health exam, health education (anticipatory guidance), and vision and hearing screenings.

D is for Diagnostic - Children should receive further evaluation of health, developmental or social-emotional problems identified during well-child visits that may require treatment.

T is for Treatment - Children should receive treatment for health, developmental or social-emotional problems identified during well-child visits.

Additional Resources are available on Iowa EPSDT at Medicaid.gov by searching "Iowa EPSDT" here: https://www.medicaid.gov/ ***(Reference #4)***

Putting it All Together

- 1st Five provides support to primary care providers that see children birth to age five for well-child exams to assist them with implementing developmental surveillance and screening as a component of the well-child process.
- Per the Iowa EPSDT recommendations, primary care providers that see children should be completing developmental screenings at 9, 18, and 30* month well-visits, and completing surveillance at every well-visit regardless of a child's age.
    - While 1st Five receives referrals for children birth to age five regardless of insurance type, the 1st Five Initiative uses these recommendations provided by the Iowa Medicaid EPSDT Program and based off of the American Academy of Pediatrics (AAP) Bright Futures, to promote when developmental surveillance and screening processes should be completed by a primary care provider.

Site Coordinator Action Steps for Success-Using Iowa EPSDT Guidelines

- Site Coordinators must become knowledgeable of Iowa's EPSDT Medicaid Program, and the recommendations included in the Iowa EPSDT Periodicity Schedule.
- These guidelines will be useful when interacting with primary care providers regarding when to provide developmental surveillance and screening.
- Site Coordinators will want to include this guidance in early discussions with primary care provider partners so that engaged partners are aware of which recommendations 1st Five supports, and why.
- Consider providing the Iowa EPSDT Periodicity Schedule to engaged primary care providers and practices as a reminder for when to complete surveillance and conduct standardized developmental screening for all children ages birth to age five. The Iowa EPSDT Periodicity Schedule can be found here: ***(Reference #5)*** https://www.iowaepsdt.org/iowa-epsdt/periodicity-schedule/

The American Academy of Pediatrics recognizes that some health care providers do not routinely do the 30-month well child visit. In these cases, they recommend moving the general developmental screening recommended at 30 months to be pushed to the earlier 24-month visit.

The Iowa EPSDT specifically identifies the Ages and Stages Questionnaire (ASQ) as the recommended developmental screening tool to complete screening recommendations at 9, 18, and 30* month well-visits included in the Periodicity Schedule. **This information is shared with engaged providers to illustrate 1st Five's alignment with these recommendations.**

While primary care providers may choose to use different surveillance and/or screening tools, 1st Five does not provide training on tools outside of the ASQ, ASQ:SE, and/or the M-CHAT-R/F. Descriptions of these 1st Five supported surveillance and screening tools are included later in this section.

What is: Developmental Monitoring/Surveillance

Developmental monitoring observes how a child grows and changes over time and whether a child meets the typical developmental milestones in playing, learning, speaking, behaving, and moving.

Surveillance is the process of recognizing children who may be at risk for developmental delays at every well-child visit.

The Surveillance process includes 6 identifiable steps ***(Reference #6)***:

- Review of developmental history,
- Asking about parental concerns,
- Assessment of the child's risk factors including prematurity and medical conditions,
- Observation of the child (visual assessment),
- Documentation of Surveillance findings,
- Obtaining and sharing results with other professionals (i.e. early childhood educators, WIC, 1st Five)

When a child attends a well visit, the primary care provider or nurse will perform developmental monitoring also called developmental surveillance. The primary care provider or nurse might ask questions about a child's development, will talk with the parent/guardian, and/or play with the child to see if he or she is meeting typical developmental milestones. A missed milestone could be a sign of a problem, so the clinician will determine whether additional assessments and tools, such as standardized developmental screening, are appropriate next steps.

Examples of recommended tools used in primary healthcare to complete surveillance as a part of the well-visit process include checklists embedded within well child templates; examples include the Iowa Child Health Development Record (CHDR) and the American Academy of Pediatrics (AAP)'s Bright Futures well child template.

1st Five & the Child Health Development Record (CHDR) Surveillance Tool

The 1st Five initiative began as the Assuring Better Child Health and Development (ABCDII) pilot project in 2004. Iowa was included in the second cohort of states in this pilot project, which focused on improving the utilization of surveillance in primary healthcare. During this time, the Iowa EPSDT Care for Kids program developed the Child Health Development Record (CHDR) forms to guide and document children's health maintenance visits from birth up to age 18 years old. The CHDR forms have helped to identify risk factors, the need for screening follow-up, and potential red flags for referral to 1st Five for developmental support. The CHDR forms to ensure that all components of an EPSDT well-child exam are met.

These components include:

- documenting family history,
- social history,
- general health,
- development,
- medical history and include anticipatory guidance for each age interval.
- Physical examination notes and a plan of care are also included on CHDR forms, which can assist with streamlining the well-child visit to complete all areas of assessment.

CHDR Forms have been revised and updated

CHDR forms are free to access and download. More information about the Iowa Child Health Development Record, including CHDR age-appropriate forms for children ages birth to 21 years old can be found here: https://www.iowaepsdt.org/other-resources/iowa-child-health-development-record/ ***(Reference #7)***

Additionally, CHDR forms have been updated as recently as 2023 with fillable versions of revised forms NOW available for download and implementation! ***(Reference #7)***

1st Five & the AAP Bright Futures Surveillance Tool

Bright Futures is a national health promotion and prevention initiative, led by the American Academy of Pediatrics and supported, in part, by the US Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).

The Bright Futures Guidelines provide theory-based and evidence-driven guidance for all preventive care screenings and well-child visits.

Bright Futures has created a surveillance tool recommended by the AAP for well-child visits; these surveillance questions are only one part of a larger system of well child care that also includes other recommended best practices including recommended well child templates and age-based developmentally appropriate anticipatory guidance. Unlike the CHDR forms, Bright Futures, a surveillance system, must be purchased from the AAP, which also includes anticipatory guidance for each well-visit.

1st Five Site Coordinators may support practices with this process by directing them to the AAP website for access to this system.

More information about the Bright Futures Surveillance Tool can be found here: ***(Reference #8)*** https://brightfutures.aap.org/Pages/default.aspx

Putting it All Together

Based on the successful ABCDII pilot and successful replication across much of Iowa, increase in surveillance utilization in primary health care has been achieved. The 1st Five Initiative now has an added focus on improving rates of developmental screening in primary care.

Why is this focus on developmental screening important?

This 1st Five focus on developmental screening supports best practice in well-child care provided by primary care providers as promoted by the Iowa's EPSDT Program, and the AAP. Additionally, this focus on developmental screening is in alignment with National Performance Measure 6 (NPM 6) on the National Survey of Children's Health "percent of children ages 9 through 35 months who received a developmental screening using a parent-completed screening tool in the past year". Data from NSCH as recent as 2021 (see Figure .2 for data trends) demonstrates the continued need for Iowa to focus on universal developmental screening for children birth to age 5: https://www.childhealthdata.org/browse/survey/results?q=9597&r=1 ***(Reference #9)***

Figure 2. NSCH Data – NPM 6

National Performance Measure 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

		Parent completed developmental screening	Parent did not complete developmental screening	Total %
Nationwide	%	**34.8**	**65.2**	**100.0**
	C.I.	32.9 - 36.7	63.3 - 67.1	
	Sample Count	4,672	6,828	
	Pop. Est.	2,900,316	5,443,819	
Iowa	%	**35.0**	**65.0**	**100.0**
	C.I.	26.7 - 44.3	55.7 - 73.3	
	Sample Count	92	118	
	Pop. Est.	31,234	58,042	

C.I. = 95% Confidence Interval.
Percentages and population estimates (Pop.Est.) are weighted to represent child population in US.

As we can see, achieving the goal of improving rates of developmental screening can be difficult for many reasons.

One of the biggest challenges in reaching universal screening goals is correcting most providers' assumption that developmental surveillance is the same as developmental screening.

Why the confusion and what to know!

Developmental surveillance has been an intrinsic part of most well child visits for a long time; developmental screening recommendations have only been pushed as part of a new standard of care since 2006. Hopefully these tips below will help crystalize the differences between the two processes for 1st Five Site Coordinators and the providers that you serve.

1. Primary care practices typically use some sort of surveillance as a part of the well-visit process. This is sometimes referred to as developmental monitoring, a developmental checklist, or developmental milestone questions. Shared terminology across primary care providers and practices does not always clearly identify what type of surveillance tool is being used. This makes it difficult to assess what improvements are needed in the well-visit process.

2. There is often confusion about whether a practice is actually doing screening or if what they believe is developmental screening is actually developmental surveillance. Primary care providers may understand their surveillance process as a screening because developmental milestone questions are also part of the surveillance process.

3. **Surveillance and screening are two different processes** and are both equally important in the beginning steps toward identification of developmental delay in the birth to age five population.

   Surveillance protocols include:

   - developmental milestone questions,
   - assessment of parental concerns,
   - integration of provider's knowledge of patient's own risk for developmental delay based on their medical history (ex: prematurity, mild hearing loss),
   - social need questions, and often
   - mental health indicators

   In contrast, **developmental screening** assesses children at-risk of developmental delay using standardized developmental milestones as benchmarks for determining if additional evaluation is needed.

   Practitioners may not fully be aware of the need for both surveillance and screening in the well-visit process because they are similar and historically providers have used these terms interchangeably.

4. Primary care providers may have surveillance processes that include components of multiple types of surveillance tools. Often, surveillance questions are embedded within the well child template, included amongst additional questions asked of the family during the well child visit. Examples include questions about a child's feeding, elimination and sleep.

5. Site Coordinators should start by asking practices what surveillance tools the providers use during well-child visits. If the practice is unsure, Site coordinators should ask if they ask a set of developmental milestones or checklist of developmental skills that they review with parents and expect a child to have mastered at each well child visit. This is their developmental surveillance checklist. If it is embedded within an electronic medical record, it is likely that the providers might not know the source of these questions. Providers may use a combination of surveillance tools to meet the specific needs of their patient population.

6. Site Coordinators may consider requesting to see what the well child templates/forms look like to help determine what surveillance is actually being used in the clinic.

Site Coordinator Action Steps for Success - Using Surveillance in Primary Healthcare

- Site Coordinators understand and can explain what surveillance is, the difference between surveillance and screening, and how to assist practitioners with implementing surveillance and screening in well-child visits.
    - Surveillance is the systematic process of identifying and collecting developmental milestone information (often including social needs information) during each well-visit. Surveillance indicates the need for follow up with a standardized developmental screening tool, when appropriate.
    - Screening follows recommended AAP and Iowa EPSDT screening intervals to assess which children may benefit from connection to early intervention evaluation or medical specialist evaluation and/or are identified as at-risk on the screening tool.
- Site Coordinators are familiar with Iowa CHDR Forms, how to access Bright Futures, and the EPSDT Periodicity Schedule in order to effectively support primary care practices with understanding the differences between surveillance and screening concepts, which allow for implementation of screening alongside the surveillance process.
- Site Coordinators are aware of what surveillance tool an engaged practice is using. This assists the Site Coordinator with understanding what technical assistance may be needed in terms of implementing surveillance or working to incorporate a different surveillance tool if needed or requested (Bright Futures) for an engaged practice.
- Site Coordinators inquire about provider understanding of what surveillance is, and how it compliments developmental screening as an important component of every well-child visit. Investigation of this understanding will highlight the need for surveillance and screening education, if they exist.
- Site Coordinators provide education and training on surveillance tools to practices and providers when gaps exist relative to:
    - understanding what surveillance is,
    - how it is different from screening, and
    - why surveillance and screening are both needed to support improved identification of children at-risk of developmental delay.
- Practices may or may not be using one surveillance system or type of surveillance to conduct surveillance in well-child visits. For practices that are using a “hybrid” of surveillance and developmental milestones questions and or processes, the 1st Five Site Coordinator should continue to support the practice by:
    a. continuing to support sustained surveillance processes in the well-visit process and

b. providing information on updated surveillance forms offered by the Iowa EPSDT and the AAP Bright Futures system.

1st Five Site Coordinators are a centralized resource for primary care providers to access best practices and information relative to surveillance and screening platforms and tools.

Don't Forget

1st Five Site Coordinators are responsible for the following in terms of the education and training they provide engaged primary care providers on surveillance tools, such as the CHDR and Bright Futures:

- Site Coordinators provide information to primary care providers about the concept of surveillance, explaining surveillance as a recommended component of every well-child visit per the Iowa American Academy of Pediatrics, and the Iowa EPSDT program.
- Site Coordinators provide examples of surveillance tools (CHDR and Bright Futures) and provide connections to resources for primary care practices and providers that are interested in implementation.
- Site Coordinators provide education on the differences between surveillance and screening conceptually and how these two processes function together to identify children at-risk of a developmental delay.

What is Developmental Screening

This section includes content from the following sources:

- https://www.cdc.gov/ncbddd/actearly/screening.html ***(Reference #6)***
- https://pediatrics.aappublications.org/content/145/1/e20193449 ***(Reference #10)***

Developmental screening takes a closer look at how a child is developing skills compared with peers. 1st Five supported standardized developmental screening tools used for developmental and behavioral screening are parent-completed formal questionnaires based on research that ask questions about a child's development, including language, movement, thinking, behavior, and emotions. Developmental screening can be done by a primary care provider or nurse, but also by other professionals in healthcare, community, or school settings.

Developmental screening is:

- more in-depth than developmental surveillance (monitoring) and
- normally done less often than developmental surveillance (monitoring).

A child should be screened if a parent/caregiver or primary care provider has a concern. **However, developmental screening is a regular part of specific well-child visits for all children, even if there is not a known concern**.

Because development is dynamic in nature and surveillance has limits, periodic screening with a validated instrument should occur so that a developmental concern not detected by surveillance or an earlier screening can be detected by subsequent screening.

The American Academy of Pediatrics recommends developmental screening for all children during regular well-child visits at these ages:

- 9 months
- 18 months
- 30 months*

*The American Academy of Pediatrics recognizes that some health care providers do not routinely do the 30 month well child visit. In these cases, they recommend moving the general developmental screening recommended at 30 months to be pushed to the earlier 24-month visit.

Universal Screening in Primary Healthcare

AAP driven screening policy recommends surveillance at every well child examination and developmental screening at periodic intervals from 9 months to 30 months of age. These recommendations support primary care provider understanding of how to use screening to better identify children at risk of a developmental delay. ***(Reference #11)***

That said, screening recommendations support an approach to screening in primary health care where providers drive at implementing developmental screening universally, which means screening across the entire pediatric population regardless of socioeconomic status, parent education, parent occupation, race, gender, ethnicity, or primary language.

The 1st Five Healthy Mental Development Initiative promotes AAP screening recommendations, which assures that children are screened universally in primary health care.

The concept of universal screening in primary care includes implementation of development screening to identify children at-risk of a delay anytime there is a provider or parent concern, even if that concern does not fall within the recommended screening

window (at 9, 18 and 30 months of age). Practices may have preferences for adding on screening intervals to the 9, 18, and 30 month AAP recommendations.

Reaching universal screening goals in primary care begins with understanding what developmental screening standards are, how to achieve current AAP recommendations, and how to allow for workflows that identify at-risk children as they are encountered during the well-child exam process. Universal screening begins with following screening standards of care identified by the AAP and using developmental screening tools as needed to better identify children at risk of delay.

Screening vs Diagnosis

It is important to note that standardized developmental screening tools are used to identify children at risk of developmental delays. The screening process itself is **not intended to diagnose a child with a developmental dela**y, but rather, screening helps to identify children that may not be picked up through routine developmental surveillance during the well-child visit. Based on the score of a completed developmental screening, a provider might refer the child for an additional evaluation through early intervention services to further evaluate if the child has a developmental delay. This follow-up may also include a medical evaluation that might lead to a diagnosis of developmental delay by healthcare professionals. Please refer to ***Reference #12***, Figure 3. for a visual algorithm of the preventive well-child visit process, and where developmental surveillance and screening exist is a typical practice workflow.

1st Five & The Ages and Stages Questionnaire (ASQ) Developmental Screening

1st Five promotes the use of standardized developmental surveillance and screening tools in primary care. The Ages and Stages Questionnaire (ASQ) is a validated, standardized, and reliable developmental screening tool recognized by the American Academy of Pediatrics for use in well-child visits to detect developmental delays. The ASQ is also currently the only recognized developmental screening tool by name and is promoted by the Iowa EPSDT for use in well-child visits. The ASQ screening tool is a series of parent completed questionnaires to screen for developmental performance in the five developmental domains:

- Communication
- Fine Motor skills
- Gross Motor skills
- Problem Solving skills
- Personal - Social skills

There is an additional open-ended section on the ASQ where parents and caregivers can report any additional concerns relative to the growth and development of their child.

1st Five supports implementation of the ASQ, and the ASQ:SE as important components of well-child visits to identify children that present as at-risk of developmental and social-emotional delays. For this reason, 1st Five Site Coordinators are required to attend formal training on these tools provided by the ASQ publisher, Brookes Publishing. The Brookes Publishing Training of Trainers Institute positions the Site Coordinators to be a primary resource for primary care provider training, and primary care provider education on screening implementation.

Putting it All Together

Despite recommendations put forth by the American Academy of Pediatrics, only 63% of pediatricians are screening all children at recommended time frames. Additionally, there are disparities present when looking at rates of developmental delay relative to demography, which accelerate the need for this improvement. For example: for children living in urban areas the prevalence of developmental delay is 17.4% of the population. When looking at children in rural areas, the prevalence of developmental delay is slightly higher at 19.8% ***(Reference #13)***. The 1st Five Initiative is responsive to this need for improving rates of developmental screening by working with primary care providers and community partners to improve rates of identification of developmental delay and improve access to community providers and resources important to early intervention efforts for children birth to age five.

The 1st Five Site Coordinator is trained on the ASQ in order to improve rates of developmental screening performed in primary healthcare by primary care providers that see children birth to age five.

Site Coordinator Action Steps for Success: The ASQ - What the Site Coordinator Needs to Know to Get Started

The ASQ is a screening tool that includes screenings for children ages 1 to 66 months. Each screening is specific to determining whether a child is meeting developmental milestones typical for their peer group. Scoring outcomes assist primary care providers with determining which children are in need of further evaluation and referral to 1st Five for connection to early intervention supports.

1. The ASQ is not a diagnostic tool. The ASQ is a parent/caregiver-completed assessment to identify children at-risk of a developmental delay that might need additional evaluation to assess delays and the need for early intervention.
2. A primary care provider can make a referral to 1st Five even when outcomes on an ASQ do not identify areas of concern. Results on the open-ended section of the ASQ may identify concerns not reflected in scoring outcomes.
3. Scoring cutoffs are measured by two standard deviations below the typical milestones recorded for a particular peer group. Children identified as at-risk include those with completed screenings with scores below the cut-off in the black area, which indicates a potential misalignment in meeting developmental milestones

according to their peer group, and two or more scores in the gray area (or monitor zone). To more easily identify scoring outcomes and appropriate responses to when to make a referral for early intervention to 1st Five, Site Coordinators may share the following pathways with their primary care providers for when to refer using ASQ scoring outcomes to guide referral action to 1st Five:

   a. If the ASQ scoring sheet reflects scores in the white area, the child scores as meeting developmental milestones typical for their peer group. No further action for domains in this group is necessary at this time.
   b. If the ASQ scoring sheet reflects scores in the gray area, the child scores close to the cutoff score for developmental follow-up. The gray area is considered the monitor zone, and providers may exercise professional judgment as to a referral to 1st Five. Two-or-more scores in the gray area are indication of the need for referral to 1st Five.
   c. If the ASQ scoring sheet reflects scores in the black area for any domain, the child scores below the cutoff score and should be referred to 1st Five to begin developmental support.

4. ASQ screenings are a billable service for a primary care practice, with some exceptions. Site Coordinators that support Rural Health Clinics (RHCs) should be aware of the billing and payment structure unique to these types of practices.

It is possible that a child may fall within different areas (white, gray, black) for each of the domains.

Site Coordination Action Steps for Success; The ASQ - Considerations for Training your Primary Care Providers

Site Coordinators must complete the required ASQ Training of Trainers provided by Brookes Publishing in order to be fully prepared to support developmental screening implementation in primary care.

More information about ongoing ASQ training, helpful webinars on the ASQ, and information about ASQ screening kits can be found here: https://brookespublishing.com/product/asq-3/ ***(Reference #14)***

When practice engagement is successfully performed by a 1st Five Site Coordinator, a primary care practice will achieve developmental screening implementation. Successful screening implementation will include the development of a pathway to a consistent, standardized approach to screening implementation and what to do when a concern is identified on a completed developmental screening for all children in the practice.

Successful implementation of the ASQ includes approaches to screening and referral implementation that include practice culture as informed by the type of practice (rural or urban practice settings).

The ABCD II Pilot was implemented in both a rural and urban clinic. This was intentional to identify the different needs and expectations of clinics in both environments. A Site

Coordinator will support workflow development that meets the needs of the practice and considers practice culture, and practice needs when proposing screening implementation pathways.

The following scenarios are helpful for thinking through workflow considerations for a rural practice and an urban practice.

Note: Site Coordinators may not be able to easily categorize engaged practices into clearly rural or clearly urban healthcare settings. These scenarios are to assist with understanding common differences in urban and rural perspectives when approaching surveillance and screening concepts. The Site Coordinator works with a practice to determine a best-fit approach to support for each practice.

Whether a practice is rural or urban has implications for healthcare staffing and access to resources to support patient care

Practices situated in more rural demography must consider the need to treat patients of all ages, especially due to access and availability of other specialties available, or not available in that area. For this reason, Site Coordinators may become familiar with the connection between rural practices and the family medicine providers that support these rural populations. The opposite may be true for urban areas that have access to larger professional pools. There is a shortage of primary health care physicians everywhere, but this is more acute in rural areas. ***(Reference #15)***

Site Coordinators should consider the following information supportive of positive relationship building within rural practice settings:

Table 1. Rural PCP Support and Considerations

Rural PCP Healthcare Setting Considerations	1st Five Expectations for Support
• **Staff capacity**	• Development of a screening and referral process that meets the staffing capacity of the practice.
	• May include a desire to mail ASQ's ahead of the well-child visit to soften changes made to the patient experience.
	• May include development of a script to support the PCP with how to talk about the need for referral relative to any identified concerns.
• **Likelihood of Family Medicine Focus – serving all patients birth to old age**	• Training and education frequency is accelerated due to the likelihood of fewer pediatric patients overall resulting in less frequent use of screening tools and the referral process.
	• Development of a calendar of connections to ensure frequent contact and training for the practice.

• **Access to resources may impact readiness to identify needs when/if resources are unknown**	• Trust building is a focus through demonstrating investment in the local community through coalition attendance and visibility within the local community being served by 1st Five.
	• Sharing community resource guides with the practice to demonstrate awareness of locally available supports for children that may be referred.

A Site Coordinator will work with the practice to implement developmental screenings in such a way that recognizes what the practice wants, while also offering insight into how developmental screening may be completed in a variety of scenarios with different work plan options.

1st Five & The Ages and Stages Questionnaire Social-Emotional (ASQ:SE) Screening

The Ages and Stages Social Emotional (ASQ:SE) Questionnaire is a series of 9 parent completed questionnaires to screen for child performance in the areas of social and emotional development for children ages 1 month to 72 months old.

Like the ASQ, the social emotional screening is self-completed by a parent or caregiver and assesses the need for additional evaluation and follow up relative to a child's social, and emotional growth. The ASQ:SE is also not a diagnostic tool but rather assists the provider and parent or caregiver in identifying the need for further support to promote healthy social-emotional development of children ages birth to age five. Unlike the ASQ, which includes assessment of various domains of development (gross motor, fine motor, etc.) the social emotional screening is scored using a single cutoff score based on responses typical for social-emotional competency appropriate to the screening age. If a child scores above the screening cutoff (in the dark area) that child has been identified as needing additional support and referral to 1st Five. ASQ:SE scores falling within the monitor zone (gray area) should be considered for referral to 1st Five and subsequent ASQ:SE screening at the next well-child examination. Children with scores in the white area are identified as meeting social-emotional competencies typical for their peer group and no intervention is needed at this time. This screening tool includes questions sensitive to autism spectrum disorder (ASD) concerns but does not replace

the EPSDT and AAP recommendations for a separate autism specific screening at 18 and 24 months (Modified Checklist for Autism in Toddlers or M-CHAT-R/F).

Recommendations for implementation of the ASQ:SE are determined collaboratively with the primary care practice. Unlike the ASQ, which adheres to AAP and Iowa EPSDT periodicity guidelines for when to screen, **there are no set guidelines for ASQ:SE screening intervals**. This can make advocacy for implementation of the ASQ:SE difficult. However, the following parameters will assist a 1st Five Site Coordinator in determining appropriate implementation strategies for ASQ:SE screenings with their primary care partners:

- Site Coordinators should encourage primary care providers to develop social-emotional screening protocols that are supportive of understanding child development as a whole. Consider staggering ASQ:SE screenings at intervals where providers typically begin to see social-emotional delays or behaviors that might benefit from further evaluation after a completed screening.
- Children that present at a well-visit with parent/caregiver concerns related to social-emotional and/or behavioral development will receive an ASQ:SE to further identify delays in this area of development.
- Primary Care Practices that are currently implementing a developmental screening, like the ASQ, are excellent candidates for implementation of the social emotional screening. In these practices the current workflow already supports screening to be done. Adding a screening to this workflow is not labor intensive, and practices can determine at what frequency these screenings might be helpful following developmental screening.
- Site Coordinators should consider how the personal-social domain on the ASQ can support a practice in identifying areas where the ASQ:SE is an appropriate follow up step. The Site Coordinator will work with the practice to promote this follow up as a way to understand the child's development as a whole, referring when concerns are identified during the screening process.

1st Five supports implementation of the ASQ, and the ASQ:SE as important components of well-child visits to identify children that present as at-risk of developmental and social-emotional delays. For this reason, 1st Five Site Coordinators are required to attend formal training on these tools provided by the ASQ publisher, Brookes Publishing. The Brookes Publishing Training of Trainers Institute positions the Site Coordinators to be a primary resource for primary care provider training, and primary care provider education on screening implementation.

More information about on-going ASQ:SE training, and helpful webinars on the ASQ:SE can be found here: https://brookespublishing.com/product/ASQ:SE-2/ ***(Reference #16)***

*The American Academy of Pediatrics recognizes that some health care providers do not routinely do the 30 month well child visit. In these cases, they recommend moving

the general developmental screening recommended at 30 months to be pushed to the earlier 24-month visit.

Putting it All Together

Practice culture accounts for perceptions of how and why a specific approach to screening implementation might be explored first. The Site Coordinator will work with the practice to encourage development of a sustainable approach to screening implementation with technical assistance provided to the practice over time to assure this happens. This may include meeting with the office point-of-contact, or directly with primary care providers, nurses, or additional healthcare support staff. Practices have the ability to determine what workflow is sustainable for them, their patients, and their providers. 1st Five supports developmental screening implementation during the planning stage, development phase, and implementation process.

If a practice is reluctant to begin screening, the Site Coordinator will want to use a coaching approach to engagement, which supports practice understanding of why screening is important, why screening is an appropriate component of the well-child visit, and how to work towards meeting screening goals.

If after a time, a practice conveys no interest in or commitment to moving towards meeting screening goals, the Site Coordinator should employ support from their 1st Five HHS Consultant. Considerations for whether these types of partnerships assist 1st Five contractors with meeting program goals, and maintaining model alignment will be explored.

For an example of a common developmental screening implementation scenario within a primary care practice, please see: **Attachment A in the MCAH Portal.**

Helpful Tips for Screening Implementation in Primary Care Practices

1. Provide ASQ kits. 1st Five sites may provide an ASQ/ASQ:SE screening toolkit to practices working on screening implementation with 1st Five. Providing kits is an approved use of the screening tool.
2. Present ASQ kits to an engaged 1st Five practice. Presentation of ASQ kits occurs alongside training on the screening tool itself. Site Coordinators provide training on the ASQ tool including:

a. why developmental screening is an important component of the well-visit process in primary care,
b. a review of the screening assessments,
c. how to complete the assessment,
d. how to score the assessment,
e. how to read screening outcomes, and
f. when to refer to 1st Five for early intervention follow-up.

Delivery of a kit without also providing training has not proven effective for engaging practices to support screening implementation. The ABCDII pilot did not include delayed follow up with practices where surveillance information was not a part of the review of the actual surveillance tool.

As a learned best practice, 1st Five engagement carries over this approach with practices to include education and training alongside review of the screening tool, not at delayed points in time if possible.

3. Educate and train about 1st Five referral protocols when a concern is identified on the ASQ by the primary care provider. This includes expectations relative to receipt of referrals for children birth to age five that have received a completed developmental screening that would benefit from connection to early intervention supports.
4. Consider the use of the 1st Five Peer Consultation resource as a component of each step of the screening implementation process. Local subcontracted, and the state available peer-to-peer resource is unique to the 1st Five Initiative and was an important component of the ABCDII pilot project. Medical providers and healthcare professionals seek information and consultation from peers throughout their professional training and practice. This familiar structure of peer consultation is modeled for primary care providers in how 1st Five offers peer consultation to engaged 1st Five partners.
    a. Considerations for implementation of the peer consultation resource includes:
        i. initial meetings with a practice,
        ii. training on screening tools (ASQ, ASQ:SE, and the M-CHAT-R/F) and
        iii. as a part of follow up with the practice after screening training has been completed.

Your local 1st Five Peer Consultation Champion, or 1st Five state available Medical Consultant can assist with primary care provider questions about workflow, screening implementation, articulating the benefits of screening in primary care, referral to 1st Five and translation of the importance of primary healthcare partnership with public health initiatives like 1st Five.

Consider use of a peer consultant in these situations:

1. When meeting with a practice to address questions and concerns about screening implementation, time commitment to the screening process, how to add screening protocol to an already busy clinic workflow, and very important healthcare professional peer support for meeting best practice standards in clinic workflow that include developmental screening for patients' birth to age five.
2. When conducting screening training with providers to support enhanced understanding of the screening tool, screening process, and referral benefits to 1st Five.
3. When following up with providers after screening training has been completed. A local 1st Five Peer Consultation Champion, or a 1st Five Medical Consultant, can assist with responding to implementation stalls and support providers with solutions to overcoming barriers to screening and referral to 1st Five.

5. Plan for education and training on the developmental screening tool proposed for implementation. General recommendations for on-going ASQ training begins with what the practice identifies is needed. This on-going training may include annual refresher training on the ASQ and 1st Five Basics, and as needed support.
   a. Screening education and training may occur more frequently for a practice:
      i. that sees higher rates of staff turnover as this may create opportunity for gaps to exist in carryover of training relative to screening and referral protocols.
      ii. That sees fewer numbers of children birth to age five, which may include rural primary healthcare settings. Developmental screening conducted less often typically creates gaps in missing information for how to complete the screening, how to score, and when to refer when these processes are used less frequently.
      iii. That sees a high volume of children birth to age five. Large pediatric or family medicine practices will need continued monitoring and maintenance of screening protocols to assure barriers to screening, scoring, and referral are identified as soon as challenges occur.
   b. Screening education may be needed less frequently for practices that are currently implementing developmental screening and have consistently for an extended period. These partnerships will require regular engagement throughout the year but may not need more than the recommended annual ASQ training.
6. Establish a timeline towards reaching the screening “Go-Live” screening and referral implementation date for the engaged provider/practice. Creating a timeline of action steps towards completion of developmental screening implementation holds the practice, the providers, and 1st Five accountable for this progress and eventual success in becoming a fully implementing practice.

Timelines towards full screening implementation vary due to practice priorities, and staffing considerations. However, it is appropriate to work towards general targets for screening implementation despite typical on-going health care tasks.

7. Follow up throughout the ASQ training and implementation process. It will be difficult to secure follow-up meetings and interaction with providers and engaged practices. However, intentional follow up is key to moving forward with progress towards full screening implementation. Follow-up formats may include phone calls, mailings, in-person meetings, and virtual coordination of connections with engaged primary care partners.
8. Focus on implementation of developmental screening tools in primary care, and when full implementation has been reached, this focus shifts to maintenance of screening processes and protocols and sustainability of screening tools in the practice. 1st Five support as a quality improvement measure relative to practice protocols is further discussed in the guidance section on infrastructure.
9. Consider developing a brief-but-concise description of the ASQ Screening tool, which can be shared during initial intake conversations with engaged practices and primary care providers. This brief 1–3-minute description (elevator pitch) of the ASQ will answer the following questions your provider partners will have about this tool and 1st Five:
    - What is the ASQ?
    - Why should the provider/practice implement this tool?
        - benefits and value
    - What is the connection between the ASQ screening and the 1st Five initiative?

<u>ASQ ELEVATOR PITCH:</u> The ASQ is a valid and highly reliable parent-completed questionnaire that identifies children at-risk of developmental delay. With primary care providers seeing the majority of children before their first birthday, you are in the best position to root out delays as early as possible. 1st Five partners with primary care providers to offer access to the screening tool, training on how to use and score the tool, and ongoing support to make sure screenings are a sustainable part of your workflow for your pediatric patients. We also offer a one-stop referral resource when screenings indicate a need for referral to early intervention. That resource also supports the family to assure connection to developmental interventions and social supports are possible.

1st Five & The Modified Checklist for Autism in Toddlers Revised with Follow-Up (M-CHAT R/F)

This section includes content from the following sources:

- https://www.mchatscreen.com/ ***(Reference #17)***

Children with Autism Spectrum Disorder (ASD) develop at different rates in different areas. They may experience delays in communication, social and learning skills, and physical ability compared to their peer group. ***(Reference #18)***

Some possible "Red Flags" associated with autism spectrum disorder include: ***(Reference #18)***

- Not respond to their name by 12 months of age
- Not point at objects to show interest (point at an airplane flying over) by 14 months
- Not play "pretend" games (pretend to "feed" a doll) by 18 months
- Avoid eye contact and want to be alone
- Have trouble understanding other people's feelings or talking about their own feelings
- Have delayed speech and language skills
- Repeat words or phrases over and over (echolalia)
- Give unrelated answers to questions
- Get upset by minor changes
- Have obsessive interests
- Flap their hands, rock their body, or spin in circles
- Have unusual reactions to the way things sound, smell, taste, look, or feel

Social skills are also impacted by autism spectrum disorder and might include: ***(Reference #18)***

- Does not respond to name by 12 months of age
- Avoids eye-contact
- Prefers to play alone
- Does not share interests with others
- Only interacts to achieve a desired goal
- Has flat or inappropriate facial expressions
- Does not understand personal space boundaries
- Avoids or resists physical contact
- Is not comforted by others during distress

- Has trouble understanding other people's feelings or talking about own feelings

According to the CDC, research has found that ASD can sometimes be detected at 18 months of age or even younger. By age 2, a diagnosis by an experienced professional can be considered very reliable. However, many children do not receive a final diagnosis until they are much older. This delay means that children with an ASD might not get the help they need. The earlier an ASD is diagnosed; the sooner treatment services can begin. ***(Reference #19)***

The M-CHAT-R/F is a screening recommended by the AAP and included in the Iowa EPSDT Periodicity Schedule for children at 18 and 24 months of age to identify children at risk of an autism spectrum disorder or ASD. Additional screening may be appropriate for children of siblings that have been diagnosed with ASD or have symptoms consistent with Autism. ***(Reference #19)***

Site Coordinator Action Steps for Success: The M-CHAT-R/F - What the Site Coordinator needs to know to get started when training primary care providers on how to use, and understand the M-CHAT-R/F

- The M-CHAT-R/F is not a diagnostic tool. Instead, the M-CHAT-R/F assists primary care providers and parents/caregivers identify children at risk for autism spectrum disorder any earlier age than most are identified; this allows for earlier identification of delays and earlier implementation of interventions to minimize delays.
- The M-CHAT-R/F is recommended for all children at the 18 and 24 month well child visits.
- The M-CHAT-R/F screening is completed by responding to a series of yes and no questions relative to the development of the child. There are 3 possible outcomes of the screen:
    1. High risk: 8 or more failed questions, which should prompt the provider to refer immediately to both 1st Five for early intervention and a child developmental specialist for medical evaluation.
    2. Low risk: A score of 2 or less indicates a low risk of autism with no follow up needed.
    3. Moderate Risk: A score of 3-7 means follow up screening is recommended. Follow-Up occurs only relative to the questions that are failed. Follow up screening on failed items must occur at a time different than the original screening event. This can be done at a follow up office visit or via the phone with the provider or their designate; ideally the follow-up should occur without excessive delay but should allow sufficient time for the family to observe the child more intentionally.
- Considerations for how to coach primary care providers to discuss M-CHAT-R/F outcomes will include sensitivity to using words like "normal" or "abnormal". Sensitivity to how a provider frames this tool to patients may have an overall

impact on how a client chooses to follow through with a 1st Five referral. For parents/caregivers that are not necessarily ready for support, these terms may be an added barrier for promoting connection to resources. Site Coordinators provide supportive coaching to their primary care providers, so they consider all aspects of what success includes for a 1st Five client.

Sample scripts for a supportive and sensitive approach to discussing screening outcomes on a completed M-CHAT-R/F are included below and should be considered when coaching engaged primary care providers relative to this screening tool:

Table 2. MCHAT R/F Scripts and Intentions

Risk Level	Script	Positive Intention
Moderate	"Your child may need some support in one or more areas of development. This could mean that (child name) might benefit from some developmental support while we work on a referral for an additional evaluation to get a better sense of what's needed to support meeting developmental milestones."	• Sensitive to identification of potential delays • Appropriate use of the tool as a risk identifier, not a diagnostic tool
High	"Our office will be making a referral to the Centers for Disability and Development so that (child name) can be further evaluated for autism risk. Additionally, we will make a referral to 1st Five to make connections to (speech, etc.) while the referral to the CDD is in progress. This assures us that we don't "watch and wait" for improvement."	• Includes supportive direction for next steps and • A plan for interim support so the child receives some services during any wait times for formal evaluation and diagnosis
Low	"Your child seems to be on track developmentally. At this time there is no further need for follow up. We should plan to continue to monitor developmental progress and follow upcoming screening recommendations for (name of the child)."	• Includes supportive direction for next steps and • The expectation for ongoing screening as recommended by the AAP and Iowa EPSDT

M-CHAT-R/F Specific Resources for Site Coordinators

In collaboration with Child Health Specialty Clinics, 1st Five now has an MCHAT R/F Screening Training, which 1st Five Site Coordinators may implement across their primary care practice networks to onboard, and train engaged providers on completion of the MCHAT R/F screening tool. The MCHAT R/F training tool can be found on the

MCAH Project Management Portal within the 1st Five tab here: https://hhs.iowa.gov/portal-mcah-project-management/1st-five (***Reference #20***)

1st Five Site Coordinators may connect with their 1st Five Consultant, and/or the peer consultation resource for additional support during implementation of this training tool.

Additional information about autism spectrum disorder/ASD can be found here: https://www.cdc.gov/ncbddd/autism/index.html **(*Reference #21*)**

The M-CHAT-R/F is free to download and implement in primary care. The M-CHAT-R/F screening can be found here for download:

- https://www.mchatscreen.com/mchat-rf/ (***Reference #17***)

Learn how to score the M-CHAT-R/F here:

- https://mchatscreen.com/mchat-rf/scoring/ (***Reference #22***)

For translations of the M-CHAT-R/F:

- https://mchatscreen.com/recommended-resources/ (***Reference #23***)

Surveillance and Screening - Knowing the Difference

1st Five Site Coordinators need to be aware of the difficulty that can exist around how to describe surveillance and screening as separate, and unique components of a well-child visit. The following distinctions need to be made when describing surveillance and screening tools to 1st Five partners and our primary care provider network.

Table 3. Surveillance and Screening Comparison (see **Attachment B in the MCAH Portal**)

Surveillance	Screening
Flexible, and ongoing routine collection of information at every well visit	Performed at intervals during specific ages of a well visit
The process of *recognizing* children who may be at risk for developmental delays. Next steps when recognized using surveillance is to use a screen to identify & refine the risk	The use of standardized tools to *identify and refine* the risk recognized during the surveillance process.
When physicians ask questions about development as a part of the general informal developmental survey or history.	Developmental screening asks a parent or caregiver to provide his/her observations of a

Surveillance includes: • Asking about developmental concerns • Taking a developmental history • Observing the child • Identifying strengths & risks • Documenting results • Communicating with other providers	child's skills, which are then recorded on a standardized and validated screening instrument.
Surveillance questions are a component of every well-child visit. This may look like a completed checklist on a patient intake form or be in electronic format i.e embedded into the practice's electronic health record (EHR), or electronic medical record (EMR). For more information on Electronic Health Records and Electronic Medical Records go to: • https://www.healthit.gov/faq/what-electronic-health-record-ehr • https://www.cms.gov/Medicare/E-Health/EHealthRecords	Developmental screening is recommended by the AAP, and supported by the Iowa EPSDT periodicity schedule at 9, 18, and 30* month well-child visit exams using a standardized screening tool. A developmental screening may be electronically embedded into a health system or be available in paper form for completion by the parent or caregiver. *If a provider does not do 30-month well child visit as part of their routine care, it is ok to move the recommended 30-month developmental screening to the 24 month visit to be done together with the ASD screen.
The surveillance process may include questions pertaining to social and environmental risk factors that have the potential to impact development	Developmental screening questionnaires may include questions pertaining to social determinants of health and/or environmental risk factors; however, they will always include questions about the development of the child.
The Iowa Child Health Development Record (CHDR) and the AAP Bright Futures are both examples of commonly used Surveillance tools.	The Ages and Stages Questionnaire (ASQ), The Ages and Stages Social-Emotional Questionnaire (ASQ:SE), and the Modified Checklist for Autism in Toddlers (M-CHAT) are all examples of commonly used standardized developmental screening tools.
Surveillance is not a billable service as it should be a standard part of all well visits.	Standardized developmental screenings are a billable service* using the 96110 CPT code. When two standardized screenings are performed on a patient a practice will report the 96110 CPT code with 2 units (or on separate line items) and use the 59 Modifier to indicate that the services are distinct. Rural Health Clinics and Federally Qualified Health Centers (FQHCs)** bill per encounter rate for services and therefore do not bill for screenings separately.

*Additional information on billing codes for developmental screenings may be found here:

- https://www.aap.org/en/practice-management/practice-financing/coding-and-valuation/coding-fact-sheets/ (***Reference #24***)

**Additional information about Federally Qualified Health Centers may be found here:

- https://www.healthcare.gov/glossary/ (***Reference #25***)

State-level information for FQHC's can be found here:

- https://data.hrsa.gov/data/reports/datagrid?gridName=FQHCs (***Reference #26***)

Putting it All Together

Many primary care practices are using some sort of surveillance during the well visit process. However, there is likely to be some difficulty discovering what surveillance tool is actually being used by a practice. This is often connected with the difficulty that exists around articulating the differences between surveillance and screening tools. Primary care providers use surveillance as the process of recognizing children who may be at risk for developmental delays, and standardized developmental screening tools are used to identify and refine that recognized risk. The American Academy of Pediatrics recommends a combination of surveillance and screening to improve detection of children at-risk of a developmental delay that may need early intervention support.

Site Coordinators may find it helpful to review the following AAP Video on how surveillance and screening are to be used together in the well visit to promote early identification of children with delays.

To find it, search YouTube for:

- "American Academy of Pediatrics" and look for "Developmental Surveillance: What, Why and How". ***(Reference #27)***

This video may also be used as a supplemental training tool for primary care providers on their journey to implementing surveillance and screening in primary care.

Oftentimes a practice may believe they are performing screening when in fact they are using surveillance. The Site Coordinator will need to have conversations early on in a 1st Five partnership with a practice about Surveillance and Screening, how they are different, and how they are both equally important to the process of early identification of developmental delays and early intervention follow up. It is important that primary care providers understand that surveillance and screening work in harmony to maximize the potential for early intervention in order to promote healthy child development.

How to Know What Surveillance & Screening is Being Used in a Practice?

It might be difficult to determine what surveillance and screening tools a practice may currently be using. Site Coordinators will begin by asking questions early in the partnership to determine what protocols and processes are currently included as a part of the practice workflow. Site Coordinators inquire about the following during initial meetings with the practice champion, which might include an office manager, lead nurse, or administrative person. Keep in mind that these points of contact may not officially know the protocols for these processes because of their lack of proximity to workflow happenings. Please refer to the following guidance when interacting with your clinic points of contact. These questions will be helpful to Site Coordinators working on understanding what surveillance and screening education and training may be needed in the primary care practice setting (see below and **Attachment C in the MCAH Portal**):

Table 3. Helpful questions for determining what surveillance and screening tools a practice is using

Discussion Questions to get to know the needs of your engaged practice	By learning more about the needs of the practice, a Site Coordinator will be prepared to help with (or do) the following:
Can you describe the components of a typical well-visit?	*Learn about areas where the practice is strong, and areas where the practice may need assistance.*
Are there typical developmental questions providers ask at every well-child visit? What Surveillance tool is being used?	*Learn more about whether or not surveillance is a part of the well-visit process and how often surveillance is completed.*
Do these include questions about developmental milestones and/or social and environmental factors?	*Learn more about what areas of concern the practice is focused on addressing in their birth to age five patient population and their families. This helps with knowing what resources 1st Five might assist with providing connections to.*
Are there developmental screenings performed at any of the well-visits? Examples would be the ASQ, ASQ:SE, M-CHAT-R/F. If so, how often are these given?	*Learn more about whether screening is a component of the well-visit process, and how often, and when screening is completed.*
For family medicine practices - Is there one main provider that serves the birth to age five population seen at the	*Learn more about which providers might be a potential provider champion to advocate for developmental screening in well-visits. Site Coordinators may consider training these providers first.*

practice? Or do a number of providers see children?	
When a developmental concern is identified during a well-visit how are referrals handled?	*Learn about how the practice identifies and manages developmental referrals for children birth to age five. This also provides insight into internal partners that might be helpful to the Site Coordinator i.e internal referral coordinators, community health workers, social workers, internal care coordinators, that may help determine a referral process and plan for when to refer to 1st Five versus using internal supports.*
Are there regularly scheduled practice meetings with providers and nurses where information is shared?	*Learn more about potential opportunities for training spaces and times for both the providers and support staff in a practice.*
What's the best way to connect with your practice point-of-contact, and the provider champion?	*Learn helpful contact information for your practice point of contract and provider champion (emails and direct phone numbers, times of day or days of the week when they can respond, etc.).*

How to Unpack the ASQ for Primary Care Providers - A 2-Step Approach

Site Coordinators must complete the required ASQ Training of Trainers provided by Brookes Publishing in order to be fully prepared to support developmental screening implementation in primary care. Once this training is completed, the Site Coordinator is ready to begin training their provider network on these screening tools.

1st Five is unique in that the population we train on implementation of and use of these tools are primary care providers and the healthcare professionals that see children for well-visits. Although the ASQ Train-the-Trainers program is extremely helpful in understanding the screening tools, their training is generic to a variety of audiences. The unique audience we work with necessitates a deeper understanding of how to promote these screening tools as a part of primary health care. This is an entirely different focus from how a home visiting program for example, would approach training and education on these screening tools.

The following step-by-step approach to unpacking the ASQ for Primary Care Providers includes a 2-step training approach, which targets information to specific populations in the primary care setting thereby making the training approach more effective and streamlined for our referring providers and other primary care practice staff.

ASQ Training - Part A

For a visual map of how to complete an ASQ Training-Part A and B, see **Attachment D in the MCAH Portal,** titled "Typical Screening Training Process-ASQ Training Process-Part A and B".

Step 1 - Introductory Meeting with a Practice - Point of Contact

Introduction of the ASQ (or ASQ:SE, or MCHAT) into a primary care practice setting requires foundational knowledge of the practice in terms of what surveillance and screening processes are currently in place. Information must be collected as to how the practice currently identifies children at-risk of a developmental delay and how follow up happens (i.e. how are referrals made for early intervention) relative to identified developmental delays. An introductory meeting with the office point of contact (POC) creates the optimal opportunity for the Site Coordinator to learn more about the practice and identify next steps for successful screening implementation for the practice.

Minimum Time Expectation to Accomplish this Step = 10 to 15 minutes (or more if permitted).

The Site Coordinator will anticipate providing high level information to this POC in case time is cut short.

Step 2 - Meeting with Primary Care Providers

The Site Coordinator provides an introduction to the 1st Five Initiative, developmental screening, and the process for screening implementation at this initial meeting. The goal here is to explain the "what" and the "why". What is developmental screening, what are we asking from the practice and the providers, and why. Why is it important that developmental screening be situated in primary care at the well-visit, why is this a priority for the practice? It is important that prior to the close of the meeting that the Site Coordinator communicates the plan for training the practice on the ASQ (or ASQ:SE, MCHAT R/F), beginning with the support staff, nurses, float nurses, patient service representatives, front clinic staff, health coaches, and care coordinators. Teams in a practice have different roles in terms of screening implementation. By coordinating training specific to each team, the Site Coordinator is able to tailor roles and responsibilities of the screening process directly to that team.

This 2-step training approach maximizes time with the practice, and allows for targeted implementation in steps, thereby making the process manageable.

Minimum Time Expectation to Accomplish this Step = 10 to 15 minutes (or more if permitted).

This type of meeting with primary care providers might be alongside other agenda items during a monthly, or meeting held by the practice at a regular interval (often monthly or quarterly). The Site Coordinator requests a minimum of 10 -15 minutes to accomplish

this step, but should be prepared to condense content, if needed, due to time constraints.

Step 3 - ASQ Training - Part A (Nurses, Float Nurses, Patient Service Representatives, Health Coaches, Care Coordinators)

Training components of this part of the ASQ training includes the following training objectives:

- About the ASQ
- Scoring Considerations
- Workflow Mapping
- Next Steps

Typically, although not always, nurses and front-line staff in a practice setting are responsible for the day-to-day operations of the clinic with oversight of operations managed by the clinic/office manager. This includes organization of how daily work tasks are completed and managed in a busy clinic setting. For this reason, nurses, and front-line staff receive more detailed information and discussion relative to how screening implementation will be conducted for the practice. The Site Coordinator offers a sketched-out plan to the practice for how screening may be conducted. For an example of a typical workflow scenario that supports developmental screening in primary care please refer to **Attachment A in the MCAH Portal**. When a plan is confirmed for how developmental screening will occur, and who will administer the screen and confirm its completion, this training will also provide information for how to overcome typical challenges a practice might encounter relative to these steps. For example, how to score an ASQ, how to score an ASQ when an item is not completed, and how to determine which ASQ to administer based on a child's age if not a 9, 18, or 30 month* well-child visit. Considerations focused on screening implementation including workflow, screening completion, and scoring are a specific focus of the ASQ Training - Part A. This training will also include expectations for how to complete the 1st Five referral form when and if a concern is identified on the ASQ. Determination for when to make a referral is housed in the ASQ Training - Part B, for providers.

*The American Academy of Pediatrics recognizes that some health care providers do not routinely do the 30 month well child visit. In these cases, they recommend moving the general developmental screening recommended at 30 months to be pushed to the earlier 24-month visit.

ASQ Training - Part B

Step 4 - ASQ Training - Part B (Primary Care Providers)

Training components of this part of the ASQ training include the following training objectives:

- About the ASQ
- Screening Implementation Plan
- Scoring Considerations
- When to Refer
- Next Steps

Primary healthcare providers serve as the first point of entry into the healthcare system for a patient. Interaction with primary care providers includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis, and treatment of acute and chronic illnesses in a variety of healthcare settings (Reference #28). Health maintenance activities include surveillance and screening. The primary care provider is focused on assessing the right tool for identifying challenges to healthy development and knowing when to utilize consultation and referral to address any health concerns. That said, it makes sense that our focus in the ASQ Training - Part B with providers includes intentional discussion on how to read a scored ASQ, what the scoring cutoffs mean, when to determine a referral is necessary to 1st Five for connection to further evaluation, and what to expect as a result of referral to 1st Five. In addition to review of the referral process, the Site Coordinator is able to describe how to prompt a successful referral to 1st Five. This will include an explanation of how the primary care provider will explain 1st Five services to the parent/caregiver, and what the parent/caregiver can expect in terms of the referral process. A sample script for Site Coordinator use is included in the table below:

Table 5. Helpful Provider Scripts during the Process to 1st Five

Provider Sample Script	Purpose of the Script
1st Five is a program that partners with our clinic to support children birth to age five with connections to developmental and early intervention supports. My recommendation is to make a referral to 1st Five and request resources for (speech, fine motor, gross motor, community resources, etc.) for your child. 1st Five will work with you to get you connected and make sure you're supported during that process. How does that sound to you? Do you have any questions about the referral we're making to 1st Five for (child's name)? **Great! Let's complete this referral paperwork and get that referral to 1st Five.**	To provide the parent/caregiver with information about what the 1st Five program is, and the purpose of connecting the client to 1st Five services. This promotes parent/caregiver follow through with being responsive to the referral. By taking time to discuss 1st Five, and why the referral is important, the clinician illustrates to the parent/caregiver the importance of connecting to 1st Five after the well-visit. 1st Five is a part of the standard of care the clinician is providing to their patient. We are partners in their care, health, and success.

We'll need you to sign this release of information for us so that 1st Five can reach out to you and begin coordinating those referrals for (child's name). 1st Five will not make any referrals on your behalf without your approval. That's why it is important that you answer their phone call when they reach out to you to determine what works best for your child and family.	Secures the parent/caregiver signature for the Release of Information that is needed so that 1st Five can begin working with the client.
1st Five will call you within 48 hours to discuss the referral and talk through those options that address the concerns we talked about today for (child's name). Make sure the front desk has your correct phone number so we can be sure 1st Five can reach you. If you receive a phone call from a number you don't recognize, be sure to call that number back, check your voicemail and connect with 1st Five. They'll work on connecting with you to get those referrals in place for (child's name).	Promote parent/caregiver responsiveness to the phone call they will receive from 1st Five after the referral is made. This promotes parent/caregiver follow through with being responsive to the referral and prevents loss-to-follow up by alerting the parent/caregiver that 1st Five will be attempting to contact them via phone at the most up-to-date current contact number provided to the practice and included on the referral form.
It looks like the autism-specific screen is positive based on the results today and what we have discussed; I will refer your child for additional evaluation to know more. My colleague at 1st Five will contact you within the next week to connect you to a free in-home developmental evaluation with Early ACCESS, as well as any other resources that could be helpful to support your child's development. My office will send a referral to the developmental pediatrician and they should also call you to set up an appointment; even though this appointment might not be for 6-9 months, if Early ACCESS notes any concerns with your child's development, they can start services right away and 1st Five will keep me updated on the specific needs they find.	Empower PCP's with examples of phrases to allow for smooth referrals when supporting children identified as at risk of developmental delay.

1st Five Site Coordinator success in meeting screening implementation goals hinges upon:

- intentional follow up after practice training and education, including confirming screening launch dates and times, referral understanding,
- assessment of workflow challenges for targeted support, and
- follow up essential to assuring 1st Five partnership sustainability, and screening sustainability.

Consider the following approach to framing follow up with practices and providers as the final step in the implementation process.

Table 6. Considerations for Follow-Up

Step	Action Step	Examples of How to Consider Follow Up Action Steps
Follow Up Step - 1	Prime the practice & providers for expecting that follow up will occur at every stage of the implementation process as a part of 1st Five partnership.	All meetings should include a preparatory conversation of what follow up will look like at each step of the implementation process. This assures accountability for both 1st Five, and the practice in terms of moving towards screening implementation. Build in follow up to each touchpoint with the practice during engagement.
Follow Up Step - 2	Consider a *1-week* follow up to screening launch date.	Schedule a follow up phone call/in-person/virtual meeting with the *practice point of contact* one week after screening launch has occurred. Follow up will include general follow up assessing initial challenges the practice is experiencing with implementation: ● Question: How is the screening process going so far? ● Question: Are there initial challenges with completing the screenings? ● Question: Are there initial challenges with scoring the completed screenings? ● Question: Are there initial challenges with making a referral to 1st Five or determining when to make a referral to 1st Five?
Follow Up Step - 3	Complete a *1-month* follow up to the screening launch date	Schedule a virtual/in-person meeting with *providers & nurses* one month after screening launch has occurred. Follow up will include more detailed investigation of the implementation process. ● Question: Is the practice finding that the screening process is working for clinic staff and patients? Is there any part of the workflow process that needs adjusting? ● Question: Are patients completing the screening with ease? ● Question: Is scoring relatively easy? What about adjusted scores for missing items or prematurity? Be prepared to clarify these steps for the practice if needed. ● Question: How is the referral process going? Is the provider able to secure the signature for the Release of Information on the 1st Five referral form? How is the provider/practice explaining 1st Five referral to the client being referred? Ask for examples of this conversation and offer support to encourage referral follow through. Suggestions for provider scripts can be found in Table 3. in section F and **Attachment E in the MCAH Portal**. ● Question: Is referral follow up from 1st Five meeting practice expectations? ● Question: Is the practice making appropriate referrals to 1st Five? If not, discuss how the practice is routing children that screen as at-risk of delay. ● Are there additional questions/concerns/challenges reported by the practice during this first full month of implementation?

Follow Up Step - 4	Consider *6-month* follow up to screening implementation	6-month check-ins include the following: ● Question: How is screening implementation going? Are there any reportable challenges in the workflow process, or the referral process? ● Question: Are there incoming or anticipated new staff that may need to be trained on the screening and referral process? ● Provide a review of the referrals received from the practice since screening implementation. Note any referrals that are not appropriate (over five years old) or trends in referrals that should have included a completed screening - 9, 18, 30* month children that have been referred. Clarify appropriate referrals, and the importance of screening as the basis for referral to 1st Five. ● Discuss patterns of referral that may indicate a need for additional education on the referral process or the purpose and goal of 1st Five. Are referrals missing the Release of Information signature on the 1st Five Referral Form? If so, provide clarification that this is important in order to begin working with a client. Is the practice attempting to call-in referrals instead of faxing a 1st Five Referral Form? If so, provide clarification that the practice must complete a 1st Five Referral Form and fax this to the Site Coordinator to begin services for the client. ● Discuss patterns of patients lost to follow up, if there are persistent challenges in connecting with a client that is referred from the practice. Provide support for standardized scripts that providers should use when making a referral to 1st Five. See section F and **Attachment E in the MCAH Portal** for sample scripts that may prevent loss to follow up.
Follow Up Step - 5	Ongoing follow up as needed.	Annual follow up should occur to assess the following: ● Is screening happening at the AAP recommended intervals of 9, 18, and 30* months? If not, seek to understand challenges and begin developing workarounds for improving alignment with this well-care best practice. ● Are referrals to 1st Five indicating completed developmental screenings on the 1st Five referral form for children seen when developmental screening is recommended? If not, provide clarification of the importance of screening as a prompt for referral to 1st Five and stress the purpose and goal of the 1st Five initiative to improve rates of developmental screening in primary health care at recommended screening intervals. If screenings are happening, then discuss how to complete the 1st Five Referral Form to include indication of a completed developmental screening (if completion of the referral form is inaccurate or incomplete). ● Is the practice completing the Release of Information on the 1st Five Referral Form when a referral is made? If no, clarify the importance of having the parent/guardian sign the ROI so a referral can be followed up on and the developmental support can begin for the client. ● Are clients being connected to services during the developmental support process? If there are persistent challenges to contacting referred clients, the Site Coordinator will want to provide strategies to the practice to encourage patient responsiveness to 1st Five contact. For example: The practice

		(nurses typically) may confirm the best time of day and contact number for 1st Five to contact the client. This should be included on the 1st Five Referral Form when the referral is being made, and the Release of Information is being signed. ● All of the above points may be included as a component of the "Letter of Support" activity recommended annually with primary care partners. The "Letter of Support" activity is further explained in the Infrastructure section of Site Coordinator guidance.

**The American Academy of Pediatrics recognizes that some health care providers do not routinely do the 30 month well child visit. In these cases, they recommend moving the general developmental screening recommended at 30 months to be pushed to the earlier 24-month visit.*

Putting it All Together

All healthcare staff are essential to create a sustainable plan of implementation for developmental screening in a primary care setting. By following the recommendations for streamlining and structuring training based on role and responsibilities in that specific process, implementation can be viewed as manageable and sustainable for the practice.

Practices may not require separate training components, as we have previously discussed, if the practice is very small and/or the practice uses staff that perform multiple roles/functions. In these instances, the Site Coordinator should clearly name/identify the specific roles and responsibilities of the nurses and support staff, and the clinicians that read the screening scores and determine if a referral is appropriate. This may be accomplished by highlighting various content in the presentation as nurse-focused or provider-focused. Again, this is most easily accomplished through separate training experiences with 1st Five on screening tools, however it is possible to achieve this understanding by being intentional, focused, and organized during an all-practice training session for smaller groups.

For a step-by-step approach to screening training implementation illustrating this 2-part approach, please refer to **Attachment D in the MCAH Portal**.

How to Approach Training on the MCHAT (R/F)

Site Coordinators may find the following steps and accompanying toolkit helpful when conducting training with primary care providers on how to implement the MCHAT screening tool into their 18- and 24-month well-visit appointments.

Site Coordinators may consider training on the MCHAT to include both providers, nursing and support staff in one universal training. This approach is slightly different from the 2-step approach discussed when providing training on the ASQ developmental screening tool for the following reasons: the MCHAT R/F includes a screen and a follow

up screen to questions failed on the MCHAT. If the screen's score is 3-7, the child will require specific follow-up questions on another day in the near future. As trained staff can assist the provider with completing the follow-up questions with the family, it makes practical sense that everyone is trained together to facilitate this team-based approach to positive screens.

If there are any questions about how to facilitate MCHAT screening or administering the follow-up questions, a Site Coordinator may want to consider the peer consultation resource to assist with answering the provider's questions.

Table 5. MCHAT Training Steps to Consider

Training Step	1st Five Training Focus & Information
Follow Up Step - 1	Education is provided about the M-CHAT-R/F Tool: The M-CHAT-R/F is given at 18- and 24-month well-child exams and is a valid screening tool for children ages 16 - 30 months old. The screening takes 2 minutes to score. The M-CHAT-R/F is not a diagnostic tool but rather identifies children at risk of ASD or other developmental delay. According to a study validating the M-CHAT-R/F https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3876182/ those children that initially scored 3 or more points on the MCHAT-R, and 2 or more points on follow up screen had a 47.5% risk of being diagnosed with autism spectrum disorder. While not all children referred for further evaluation after an MCHAT screen will be diagnosed with Autism, 94.6% of children were identified with a developmental delay or concern that warranted intervention (ex: speech delay, gross motor delay).
Follow Up Step - 2	Review of the M-CHAT-R/F Tool is provided along with training on how the parent/caregiver should complete the screening: ● Review the M-CHAT-R/F screening form with the providers. ● Parents/caregivers will answer Yes or No to 20 questions. ● For all items but 2, 5, and 12 a No response indicates an ASD risk. ● For items 2,5, and 12 a Yes response indicates an ASD risk. ● Use the MCHAT-R Algorithm to determine the level risk based on failed items. ○ 0 - 2 is Low Risk - If the child is younger than 24 months, screen again at 24 month well visit. No additional referral is needed if no additional concerns are noted (ex: no hearing concerns noted on question #2). ○ 3 - 7 is Medium Risk - Administer the Follow-Up questions for the failed questions only. If the child fails 2 or more items on the MCHAT-R Follow-up, the child screens positive. Referral is needed for additional evaluation. ○ 8 - 20 is High Risk - Refer child to early intervention and for additional medical evaluation.

Follow Up Step - 3	<u>Workflow discussion:</u> Discuss who is going to be responsible for identifying upcoming well-visits for the M-CHAT-R/F screening at 18 and 24 months. If a screen is failed indicating Medium risk, how and when are re-screens going to be completed? This typically happens during a follow up office appointment or over the phone after the in-person visit has been completed. The Site Coordinator will work with the primary care practice to determine workflow steps for practice staff to complete this follow up.
Follow Up Step - 4	<u>Referral discussion:</u> ● Discuss how providers may make a referral to 1st Five for intervention. ● Review the 1st Five Referral Form and the Release of Information that is needed for 1st Five to contact the client. ● Discuss with the practice their role in referring for an autism evaluation (1st Five cannot do this autonomously without the provider ordering an evaluation and initiating that process). 1st Five can connect the client to interim supports while an evaluation is being processed. ● Discuss how the provider will explain the 1st Five referral to the parent/caregiver and promote follow through with 1st Five when that contact is attempted.
Step 5	<u>Follow Up:</u> Discuss implementation progress of the MCHAT-R and identify any areas of the workflow that require additional support. Schedule this for 1 month after the launch date of the M-CHAT-R/F.

The 1st Five MCHAT Training Toolkit can found on the MCAH Project Management Portal here: https://hhs.iowa.gov/portal-mcah-project-management/1st-five

Continue for references.

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