Introduction
Screening for healthy development can help identify potential delay areas for further evaluation and diagnosis, and reduce the likelihood of developing other delays. As states look to improve developmental screening and early identification, collaborations across early childhood programs and implementation of data-driven, evidence-based strategies are critical to having functional and efficient statewide screening systems.

In summer 2014, the Association of Maternal and Child Health Programs’ (AMCHP) State Public Health Resource Center (SPHARC) conducted an environmental scan of the wide range of developmental screening activities occurring within all U.S. states and jurisdictions. Since then, the data has been further analyzed and shared with stakeholder groups to gather more feedback and inform the development of resources to assist states, particularly Title V programs, in building and improving developmental screening and early identification systems.

Currently, Title V programs are working on five-year needs assessments in preparation for submitting their FY2016 MCH Block Grant applications in July 2015. As part of the process, grantees will develop interim five-year action plans around selected priorities and national outcome and performance measures. This includes setting objectives and strategies related to those priority areas and measures. In the second year (FY2017) application to be submitted in July 2016, grantees will include evidence-based/informed strategy measures (ESMs), which track and measure a state Title V programs’ strategies, activities and impact on a national performance measure.

This document highlights strategies, measures and resources to help Title V and other state programs develop action plans to implement and improve screening and early identification systems. This document is part of a set of SPHARC resources on state systems for developmental and autism screening. These resources are a first step based on a scan of current programs and activities. They will continue to be updated and aligned with other AMCHP and partner efforts. Additionally, it is important to recognize that screening is just the one step in efforts to assure effective system-wide programs for screening, referral, care coordination and access to evidence-based services to meet the needs of children, families and communities.

MCH Title V Transformation & the Developmental Screening National Performance Measure
As part of the recent transformation of the Title V MCH Services Block Grant, a new performance measurement system and set of National Performance Measures (NPMs) were developed in partnership with states, families and other stakeholders. Grantees will develop annual performance objectives for eight of 15 NPMs to work toward over the next five years. One of the performance measures (NPM#6) is focused on rates of developmental screening and tied to the national outcome measure (NOM) on school readiness (#13) and children in excellent or very good health (#19). An overview of the NPM is provided in the table below:

<table>
<thead>
<tr>
<th>NPM #</th>
<th>Short Title</th>
<th>Description</th>
<th>Details</th>
<th>Changes in the Revised National Survey of Children’s Health</th>
<th>Related NOM</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Developmental Screening</td>
<td>Percent of children, ages 10 through 71 months, receiving a screening</td>
<td>Screening must include questions regarding</td>
<td>Data will now be collected for children</td>
<td>13. % children meeting the criteria</td>
</tr>
</tbody>
</table>

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2 http://www.mchb.hrsa.gov/programs/titlegrants/blockgrantguidance.pdf
3 http://www.mchb.hrsa.gov/blockgrant/index.html
5 Adapted from: http://www.amchp.org/AboutAMCHP/Newsletters/Pulse/MarApr2015/Pages/DataandTrends.aspx
### Changes in the Revised National Survey of Children's Health

- **Developmental screening using a parent-completed screening tool**
  - Child's language and social development aged 9–71 months to be consistent with AAP guidelines.
  - Related NOM developed for school readiness 19. % children in excellent or very good health.

### Addressing Barriers to Recommended Rates of Screenings

When selecting strategies and action steps, states may want to consider the barriers or drivers of low screening rates in their states. This information can be paired with state needs assessments to identify areas where a program can have the most impact or address a pressing need. Common reported challenges that contribute to low developmental screening rates can be categorized as those related to:

- **Provider/Practice Level**
- **Policy & Public Health Coordination**
- **Family and Community Supports & Resources**
- **Data and Information Systems**

The figure below further illustrates the types of barriers and contributors to low screening rates:
Figure 1: Common Challenges that Contribute to Low State Developmental Screening Rates

Provider/ Practice Level:
- Lack of time during visits
- Inadequate reimbursement / Costs associated with purchasing screening tools
- Lack of knowledge about billing codes
- Lack of knowledge about valid screening tools (what/when to use and how to interpret)
- Lack of training on how to encourage screening in diverse cultures
- Low attendance rate at AAP recommended well-child screening visits
- No comprehensive system to determine if a child has been screened to ensure no duplication, or to ensure families are being connected to services

Policy & Public Health Coordination:
- Lack of coordination between state level screening efforts (leads to silos, duplication)
- Lack of key stakeholders and supporters that can influence policy on advisory panels
- Lack of available data that can drive and support policy changes.
- Lack of meaningful cross agency partnerships and intentional collaboration
- Lack of standardized tools to foster communication

Family & Community:
- Lack of public awareness of appropriate developmental milestones
- Families often do not know how to articulate concerns to providers
- Cultural barriers, e.g. perceptions of when screening is needed, where families get information, etc.
- Stigma and fear around certain disabilities
- Lack of services (or perceived lack of services) in communities
- Long wait times and lack of supports to help families navigate referrals and other services

Data & Information Systems:
- No data system to track if a child has been screened or not
- Siloed data collection and inability to link data systems (Unable to properly assess for gaps in systems and services or to develop effective program and policies)
- Lack of data/research on how screening tools work in real-life clinic settings and ease of use
- Need for more research that includes diverse populations

Low state rates of screening at recommended times
Improving Developmental Screenings: Example Strategies and Measures

This section includes examples of strategies that states have used to increase developmental screening and improve screening and early identification systems and services (see Table 2). It also includes examples of how states can measure success and assess that their efforts are having an impact on screening rates. The strategies and measures are grouped in order to address the common challenges noted in Figure 1 above. These examples are not specific to any one state and not intended to be directives on which strategies and measures a state should adopt. Rather, they are samples based on the common types of strategies states are currently working towards, and ways that states are measuring their progress. Additionally, the tables list examples of data sources or other relevant programs/resources that states may find helpful in aligning strategies and reporting measures. An overview of programs and initiatives that have screening related objectives and/or measures is included in Appendix 1. More information about these programs can be found in the *National Landscape* document.

<table>
<thead>
<tr>
<th>Strengthening the Evidence for Maternal and Child Health Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Johns Hopkins University has been awarded the “Strengthen Evidence Base for Maternal and Child Health Programs” cooperative agreement to provide support and resources to assist State Title V Maternal and Child Health (MCH) programs in developing evidence-based or evidence-informed State Action Plans, as well as in response to the National Outcome Measures, National Performance Measures, State Performance Measures, and state-initiated Structural/Process Measures. This will facilitate the transformation of the MCH Title V Block Grant program.</td>
</tr>
<tr>
<td>Activities funded under this cooperative agreement include:</td>
</tr>
<tr>
<td>- Develop criteria for evidence-based and evidence-informed strategy measures</td>
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<tr>
<td>- Provide a critical review of the evidence of effectiveness of possible strategies to address National Outcome Measures, National Performance Measures, State Performance Measures, and state-initiated Structural/Process Measures via the Team of Experts</td>
</tr>
<tr>
<td>- Provide ongoing consultation to state Title V MCH programs via the Team of Experts, to support the State’s development of evidence-based or evidence-informed State Action Plan</td>
</tr>
<tr>
<td>- Develop web-based supports and resources for State Title V (MCH) programs and an online community of practice.</td>
</tr>
<tr>
<td>- Maintain and enhance a MCH digital library to facilitate access to historical and current MCH documents</td>
</tr>
<tr>
<td>AMCHP will work closely with Johns Hopkins and other partners to align efforts to provide comprehensive technical assistance and resources to states and jurisdictions.</td>
</tr>
<tr>
<td>For more information: contact Cynthia Minkovitz at <a href="mailto:cmink@jhu.edu">cmink@jhu.edu</a>.</td>
</tr>
</tbody>
</table>
### Table 2: Example Strategies and Measures to Improve Developmental & Autism Screening

<table>
<thead>
<tr>
<th>Challenge/Need Area</th>
<th>Sample Strategies</th>
<th>Sample Measures</th>
<th>Example Data Sources/ Resources</th>
</tr>
</thead>
</table>
| **Provider / Practice Level** | a) Implement a quality improvement learning collaborative to help provider practices improve their screening rates and processes according to the Bright Futures Guidelines. | a) #/\% of annual well child visits at 9, 18 and 24 months where a validated developmental screening tool is administered, scored and documented in participating practices  
  • #/\% of practices that adopt/achieve recommended screening protocols | Example Data Sources  
  a) Quality improvement run charts / monthly reports  
  b) - d) Training participant records; pre-post test data  
  e) Medicaid claims data; CHIPRA Child Core set measure  
  f) Participant records; CME/CEU records  
  g) Dissemination tracking  
  h) - i) Participant/ attendance records; Other Relevant Programs/Resources  
  - Head Start/Early Head Start  
  - EPSDT  
  - Child Find Program  
  - HRSA State Autism Implementation Grants  
  - Project LAUNCH  
  - Bright Futures  
  - NIPN Improvement Partnerships  
  - Promoting Healthy Development Survey  
  - MIECHV CoIN |
|                     | b) Provide intensive technical assistance to help practices establish a screening process, a data entry process, and a referral process for secondary screening and full diagnostic evaluations, and to improve ability to address family needs. | b) # of primary care practices have received training and support for conducting developmental screening according to the AAP Bright Futures Guidelines |  
  |                     | c) Provide trainings on use of screening tools | c) # of providers that receive trainings on validated screening tools  
  • Increase in knowledge measured by pre- and post-tests |  
  |                     | d) Use a Train the Trainer model to train providers on cultural considerations when screening children for developmental delays. | d) # of providers that receive training in cultural competence/considerations |  
  |                     | e) Educate providers’ practice staff on when and how to bill appropriately for developmental screening | e) % of visits where administration of a screening tool for children < 30 months of age was used and is appropriately coded and/or billed.  
  • # and % of 9, 18, 24 and 30 month olds with 96110 CPT code in Medicaid Claims data |  
  |                     | f) Develop mechanism to provide CMEs/CEUs for trainings and professional development webinars | f) # participants and # of CMEs/CEU credits delivered through trainings and webinars |  
  |                     | g) Partner with other entities (AAP, Medicaid/EPSDT, MCOs, etc.) to develop and disseminate resources for clinical pediatric providers and early childhood professionals to improve screening rates and coordination of referrals and linkage to services within the state | g) # resources developed  
  • # resources disseminated and # of clinical providers and early childhood professionals receiving resources |  
<p>|                     | h) Leverage physician Maintenance of Certification Part 4 requirements to incentivize participation in performance improvement efforts related to increased/improved screening | h) # of providers participating in screening performance improvement activities |<br />
|                     | i) Identify and partner with physician champions to provide education and support to practices around care and screening for families and children | i) # of participants reached through “champion” education and support efforts |<br />
|                     | | |</p>
<table>
<thead>
<tr>
<th>Challenge/Need Area</th>
<th>Sample Strategies</th>
<th>Sample Measures</th>
<th>Example Data Sources/ Resources</th>
</tr>
</thead>
</table>
| Policy and Public Health Coordination     | a) Strengthen partnerships between Title V and entities who administer or lead programs that coordinate, finance and/or developmental screening (EPSDT; state chapter AAP/FP, HS/EHS, etc.) at the state, local and community level.  
  b) Engage in cross system planning and coordination of activities.  
  c) Establish common language and/or standardized for screening and referral that cross systems.  
  d) Develop and deliver a common training curriculum on screening and coordination of referrals  
  e) Partner with Medicaid to leverage payment policies to incentivize developmental screening and referral, e.g.:  
    • Structure per member per month fees such as PCCM, PCMH, and health home payments under section 2703 of the Affordable Care Act to incentivize care coordination between PCPs and other systems.  
    • Target Medicaid targeted case management payments when coordination between PCPs and other systems is needed.  
    • Pay MCOs an incentive for increasing screening rates with validated screening tools  
    • Require PCPs to conduct a developmental screen to receive EPSDT payments  
  f) Support a state-wide developmental screening coordinator                                                                                           | a) # and type of partnerships to promote early childhood screening  
  • # of specific collaborations between partners  
  b) # of cross-agency meetings  
  • % of cross-system partnership members present at meetings  
  c) # and type of standardized forms/common language adopted by agencies  
  • # and type of screening and early childhood referrals using standardized forms  
  d) Yes/No on whether curriculum was developed  
  • # of cross-systems partners receiving the training  
  • % increase on improvements in screening/referrals across systems partners  
  e) #/% children enrolled in Medicaid that receive routine age-specific developmental screenings  
  • % increase in MCO screening rates with validated screening tools  
  f) # and type of training and outreach strategies developed and implemented  
  • # and type of collaborative partnerships formed  
  • # and type of standard reporting and referrals used by partner groups                                                                 | Example Data Sources                                                                                       |                                                                                                               |
|                                           |                                                                                                                                                                                                                | **Example Data Sources**                                                                 | **Example Data Sources**                                                                                       |
|                                           |                                                                                                                                                                                                                | a) Partnership tracking; collaboration measurement tools                                                                 | a) Partnership tracking; collaboration measurement tools                                                                 |
|                                           |                                                                                                                                                                                                                | b) Meeting documents (agendas, notes, sign-in sheets, evaluations)                                                                 | b) Meeting documents (agendas, notes, sign-in sheets, evaluations)                                                                 |
|                                           |                                                                                                                                                                                                                | c) Agency administrative records                                                                                                                                | c) Agency administrative records                                                                                                                                |
|                                           |                                                                                                                                                                                                                | d) Agency administrative records; Training participant records; pre-post test data; aggregated EMRs/EHRs; state Health Information Exchange | d) Agency administrative records; Training participant records; pre-post test data; aggregated EMRs/EHRs; state Health Information Exchange |
|                                           |                                                                                                                                                                                                                | e) Medicaid claims data; payor claims database                                                                                                                  | e) Medicaid claims data; payor claims database                                                                                                                  |
|                                           |                                                                                                                                                                                                                | f) Agency administrative records; Partnership tracking; collaboration measurement tools                                                                     | f) Agency administrative records; Partnership tracking; collaboration measurement tools                                                                     |

**Other Relevant Programs/Resources**  
- Promoting Healthy Development Survey  
- CAHPS  
- HRSA State Autism Implementation Grants  
- Healthy Start  
- Birth to Five: Watch Me Thrive!  
- CHIPRA/Child Core Set Measures  
- EPSDT  
- Race to the Top: ELC

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<table>
<thead>
<tr>
<th>Challenge/Need Area</th>
<th>Sample Strategies</th>
<th>Sample Measures</th>
<th>Example Data Sources/ Resources</th>
</tr>
</thead>
</table>
| Family and Community Supports | a) Conduct an education and awareness campaign for families and communities on the importance of developmental screening  
  b) Engage family and community leaders in the development and implementation of activities to increase screening rates  
  c) Partner with the Family to Family (F2F) to provide resources for families about signs and symptoms of ASD/DD, developmental milestones, and services that exist in their community.  
  d) Empower families to be an equal and essential part of the healthcare team by promoting and supporting family engagement in quality improvement healthcare activities for children with ASD.  
  e) Support Parent Partners in programs to help practices improve screening and quality of service delivery  
  f) Train child-care providers on recognizing problems early and how to talk with parents to promote developmental screening | a) # families that receive campaign resources  
  o # of hits or downloads to campaign website/materials  
  b) % increase in knowledge of the system and parent perception that the system has improved  
  c) # of families who receive information, support, and systems navigation from the F2F specific to ASDs or early and continuous screening  
  o Increase in family/community awareness of importance of screening and resources available  
  d) % family satisfaction with services  
  o # families that report partnering in decision-making at all levels  
  o # of technical assistance and professional development opportunities offered to families on evidence-based screening, diagnostic and treatment referral strategies for ASD | a) Education and awareness campaign program data; website analytics  
  b) Training participant records; pre-post test data  
  c) state F2F program data  
  d) Family satisfaction surveys  
  e) Parent Partner surveys/evaluations  
  f) Training participant records; pre-post test data  
  | Example Data Sources:  
  a) Education and awareness campaign program data; website analytics  
  b) Training participant records; pre-post test data  
  c) state F2F program data  
  d) Family satisfaction surveys  
  e) Parent Partner surveys/evaluations  
  f) Training participant records; pre-post test data  
  | Other Relevant Programs/Resources:  
  - Learn the Signs. Act Early. materials are publicly available to states  
  - HRSA Family to Family HIC  
  - Family Voices resources/tools on family engagement  
  - HRSA State Autism |
### Research, Data & Information Systems

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Negotiate interagency data sharing agreements with agency and provider responsibilities delineated and with data-sharing and privacy protocols.</td>
</tr>
<tr>
<td>b)</td>
<td>Create and administer an autism registry</td>
</tr>
<tr>
<td>c)</td>
<td>Develop an inventory of existing data systems and their elements to identify opportunities for linkage and integration</td>
</tr>
<tr>
<td>d)</td>
<td>Promote the integration of developmental screening and referral results into EMRs through provider outreach, education and software stipends.</td>
</tr>
<tr>
<td>e)</td>
<td>Integrate developmental screening modules into an existing state data system</td>
</tr>
<tr>
<td>f)</td>
<td>Develop a web portal for state data sharing systems</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>% increase in knowledge gains of child care provider obligations and resources measured by pre- and post-tests</td>
</tr>
<tr>
<td>b)</td>
<td>% increase in knowledge among trained child-care providers on recognizing problems early and how to talk with parents to promote developmental screening</td>
</tr>
</tbody>
</table>

### Example Data Sources

<table>
<thead>
<tr>
<th>Source</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Agency administrative records</td>
</tr>
<tr>
<td>b)</td>
<td>Agency administrative records</td>
</tr>
<tr>
<td>c)</td>
<td>Data systems inventory</td>
</tr>
<tr>
<td>d)</td>
<td>Administrative records</td>
</tr>
<tr>
<td>e)</td>
<td>Agency administrative records</td>
</tr>
<tr>
<td>f)</td>
<td>Website analytics</td>
</tr>
<tr>
<td>g)</td>
<td>Data systems inventory/ Medicaid claims data</td>
</tr>
</tbody>
</table>

### Other Relevant Programs/Resources

- ADDM
- EPSDT
- Child Find Program
- Race to the Top: ELC
- ECCS
Other Resources on State Strategies and Measures
Below are some other resources that include examples of state strategies and/or measures around developmental and autism screening.

Additional AMCHP/SPHARC Developmental Screening Resources:
- Environmental Scan: State Strategies and Initiatives to Improve Developmental and Autism Screening, and Early Identification Systems (includes broad themes and specific examples from states)
- Case Example: Putting It All Together (Action planning for addressing developmental screening rates)
- SPHARC Peer-to-Peer Exchanges on Screening
  - Early and Periodic Screening, Diagnosis and Treatment - Putting the "S" in EPSDT (Hosted by Alaska)
  - Screening and Beyond (hosted by Maryland)
- Innovation Station: AMCHP’s online database of emerging, promising and best practices in MCH

National Academy for State Health Policy: Assuring Better Child Development (ABCD) Program
- ABCD Resource Center: http://www.nashp.org/abcd-welcome
- ABCD Publications:
  - Measuring and Improving Care Coordination: Lessons from ABCD III
  - State Strategies for Care Coordination, Case Management, and Linkages for Young Children: A Scan of State Medicaid, Title V, And Part C Agencies

Zero to Three

More information on many of the programs that address developmental screening, can be found in "National Landscape: Developmental and Autism Screening Programs and Initiatives."
## Select Federal Programs/Initiatives

<table>
<thead>
<tr>
<th>Agency/Org</th>
<th>Program Name</th>
<th>Objective/Measure</th>
</tr>
</thead>
</table>
| **ACF**    | Head Start/Early Head Start | - # all newly enrolled children who completed required screenings within 45 days for developmental, sensory, and behavioral concerns  
  - Of these, # identified as needing follow-up assessment or formal evaluation to determine if the child has a disability  
  - The instrument(s) used by the program for developmental screening |
| **Federal** | Birth to Five: Watch Me Thrive! | - Objectives: 1) Celebrate milestones; 2) Promote universal screening; 2) identify possible delays and concerns early; 4) Enhance developmental supports  
  - Developed a Compendium of Screening Measures for Young Children |
| **CDC**    | ADDM (Autism & Developmental Disabilities Monitoring Network) | Measures the prevalence of ASD in 8-year old children. Data tracked also includes: characteristics/demographics of children identified with ASD; Children more likely to be identified with ASD; intellectual ability of children identified with ASD; when children were first evaluated for developmental concerns; number of children diagnosed and when diagnosed with ASD; # of children that had an eligibility for ASD special education services at school; etc |
| **CDC**    | Learn the Signs. Act Early. | Ambassador and state systems grantees report at least annual on measures developed to measure progress towards their goals, including to improve screening/early identification and referral to services. |
| **CMS**    | CHIPRA/Child Core Set Measures | DEV-CH: The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday (Data source: Claims Data or Medical Chart Review Data / NQF #1448) |
| **CMS**    | EPSDT | (Annual performance report form CMS-416)  
  - Number of children provided child health screening services  
  - Number of children referred for corrective treatment |
| **Dept. of Ed.** | Child Find Program | - Part B Indicator 11: % children who were evaluated within 60 days of receiving parental consent for initial evaluation or, if the state establishes a timeframe within which the evaluation must be conducted, within that timeframe.  
  - Part C Indicator 1: % infants and toddlers with IFSPs who receive the early intervention services on their IFSPs in a timely manner.  
  - Part C Indicator 5: % infants and toddlers birth to one with an Individualized Family Service Plan (IFSPs) compared to national data.  
  - Part C Indicator 7: % eligible infants and toddlers with IFSPs for whom an evaluation and assessment and an initial IFSP meeting were conducted within Part C’s 45-day timeline |
| **Dept. of Ed.** (OSEP) | Race to the Top: ELC | Progress in this area is reported in six areas: standards, screening and referral, promoting child development, training educators, healthy children, and leveraging resources. Screening and referral performance measures are:  
  - Number of Children with High Needs screened  
  - Number of Children with High Needs referred for services who received follow-up/treatment |
<table>
<thead>
<tr>
<th>Agency/Org</th>
<th>Program Name</th>
<th>Objective/Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRSA</td>
<td>Title V MCH Block Grant</td>
<td>NPM6: Percent of children, ages 9–71 months, receiving a developmental screening using a parent-completed screening tool</td>
</tr>
<tr>
<td>HRSA</td>
<td>State Autism Implementation Grants</td>
<td>Objective: 1) developing a system of service that includes screening children early for possible ASD/DD. (Grantees provide progress reports and evaluation data annually.)</td>
</tr>
<tr>
<td>HRSA</td>
<td>D70 - CYSHCN Systems Integration</td>
<td>Aims and measures are currently under development and will vary by grantee. Some may focus on measures related to better integrating/linking screening and referral.</td>
</tr>
</tbody>
</table>
| HRSA      | ECCS | Strategy focus area 2) Coordinate the expansion of developmental screening activities in early care and education settings  
 • Report on statewide data related to the six MIECHV Benchmarks - See MIECHV entry below |
| HRSA      | Family to Family HIC | Annual data reports includes F2Fs self-reports of their impact in specific policy areas in their communities, including promoting continuous screening |
| HRSA      | Healthy Start | (Infants 0-23 mo) Participants that Receive Risk Prevention Counseling and/or Risk Reduction Counseling for Developmental Delays |
| HRSA      | MIECHV | Benchmark 3: % of children who received developmental screening and did not need follow up or referral.  
Suggested Data Sources: State surveys; State records; Head Start, EPSDT; Potential Data Sources: National Survey of Children's Health, HRSA/MCHB and CDC/NCHS  
Benchmark 6: Measured coordination with documented referrals between child care programs, medical homes and early intervention service providers.  
Suggested Data Sources: Program documents, referral records and/or documentation of a statewide central intake system |
| HRSA      | MIECHV CoIIN | Aim: Increase by 25% from baseline the percent of children with developmental or behavioral concerns receiving intervention in a timely manner.  
Screening related process measures:  
• Increase to 95% the percent of visits during which parents are asked if they have any concerns regarding their child’s development, behavior, or learning.  
• Increase to 75% the percent of children screened with an appropriate instrument at appropriate intervals.  
• 75% of all children with a parental concern and/or positive screening, and where a home visitor judges need, will be referred to community resource(s) for assessment or intervention services, including EI services. |
| HRSA      | Training Programs: LEND & DBP | • # trainees who completed coursework covering one of more of the following topics: early signs of ASD/DD; screening, diagnosis, and/or evidence-based interventions for ASD/DD.  
• # trainees who participated in clinical activities or field work that included one or more of the following topics: early signs of ASD/DD; screening; diagnosis; and/or evidence-based interventions for ASD/DD.  
• Total # of CE events that addressed one or more the following topics: valid, reliable screening tools; valid diagnostic tools,
## Appendix 1: Select Federal and National Program Screening Objectives & Measures Overview

### Select Federal Programs/Initiatives

<table>
<thead>
<tr>
<th>Agency/Org</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>and/or evidence-based interventions for ASD/DD.</td>
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<tr>
<td></td>
<td></td>
<td>• # training events (excluding CE) offered through the LEND/DBP program relating to one or more the following topics: valid, reliable screening tools; valid diagnostic tools, and/or evidence-based interventions for ASD/DD.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• # faculty and trainees who participated in the conduct of ASD/DD related research (for example, screening or diagnostic tools).</td>
</tr>
<tr>
<td>SAMHSA</td>
<td>Project LAUNCH</td>
<td>Related Objective: Increase access to screening, assessment, and referral to appropriate services for young children and their families</td>
</tr>
</tbody>
</table>

### Select National Programs/Initiatives

<table>
<thead>
<tr>
<th>Agency/Org</th>
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</tr>
</thead>
<tbody>
<tr>
<td>AAP</td>
<td>Bright Futures</td>
<td>Bright Futures provides a set of materials and measures to track and document preventive care activities and services. Related measures include:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Perform developmental screening and follow-up</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Perform autism-specific screening and follow-up</td>
</tr>
<tr>
<td>AMCHP</td>
<td>National CYSHCN Systems Standards</td>
<td>• SA5: All children receive periodic, developmentally appropriate, and recommended comprehensive screenings, in accordance with Bright Futures.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• SA6: Screening efforts, results and referrals for further assessment are documented, relayed to the child's medical home and family, and coordinated among all screening entities.</td>
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<td>• RF1: Following a screening and assessment, the CYSHCN and their family are referred to needed services, and follow-up is provided to ensure such referrals are completed.</td>
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<td>• RF2: Regardless of the entity conducting a screening and referral, protocols and documentation methods are in place for the primary care provider, medical home, etc. to follow-up with the child and family.</td>
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<tr>
<td>AUCD</td>
<td>Six by Fifteen Campaign</td>
<td>Early childhood goals include:</td>
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<td>• At least six states increase by 15% the proportion of children ages 0-3 who receive recommended developmental screening.</td>
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<td>• At least six states commit to improving cross-system information exchange that supports access to services for children identified by screening.</td>
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<tr>
<td>HMG Nat'l Ctr</td>
<td>Help Me Grow</td>
<td>Developmental screenings conducted within the HMG system:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Total Number of Children Who Participated in Developmental Screening Programs Per Year</td>
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<td></td>
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<td>• Total Number of Developmental Screenings with Low Scores</td>
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<td></td>
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<td>• Total Number of Children Referred for Services Based on Developmental Screening Results</td>
</tr>
<tr>
<td>NIPN</td>
<td>Improvement Partnerships</td>
<td>Each project has defined measures and targeted over-arching goals, involves PDSA cycles, and longitudinal data collection.</td>
</tr>
</tbody>
</table>
## Appendix 1: Select Federal and National Program Screening Objectives & Measures Overview

<table>
<thead>
<tr>
<th>Agency/Org</th>
<th>Program Name</th>
<th>Objective/Measure</th>
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</thead>
</table>
| AHRQ       | CAHPS Clinician & Group Survey| Related Items from Provider’s Attention to Your Child’s Growth and Development:  
- Respondent and provider talked about child’s learning ability  
- Respondent and provider talked about age-appropriate behaviors |
| HP2020     | Healthy People 2020           | MICH-29: Increase the proportion of young children with autism spectrum disorder (ASD) and other developmental delays who are screened, evaluated, and enrolled in special services in a timely manner  
- MICH 29.1: Increase the proportion of children (aged 10-35 months) who have been screened for an ASD/DD  
- MICH 29.2: Increase the proportion of children with ASD having a first evaluation by 36 months of age  
- MICH 29.3: Increase the proportion of children with ASD enrolled in special services by 48 months of age  
- MICH 29.4: (Developmental) Increase the proportion of children with a developmental delay with a first evaluation by 36 months  
- MICH 29.5: (Developmental) Increase the proportion of children with a developmental delay enrolled in special services by 48 months |
| CAHMI      | Promoting Healthy Development Survey | Developmental surveillance – assesses whether the provider asked about and addressed parents’ concerns about their child’s learning, development and/or behavior.  
- Developmental screening – determines whether standardized screening tools for developmental and behavioral delays were used.  
- Follow up for children at risk – measures whether children at risk were referred and/or received follow-up services. |
| HRSA       | National Survey of Children’s Health | Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool *(the screening must include questions regarding child's language and social development)* |
| National Quality Forum | NQF Endorsed Measures | #1385: Developmental screening using a parent completed screening tool *(Parent report, Children 0-5)*  
The items are age-specific and anchored to parent-completed tools. The age-specific items assess whether children 10-71 months are screened.  
#1448:: Developmental Screening in the First Three Years of Life  
Includes 3 age-specific indicators assessing if a child is screened for risk of developmental, behavioral or social delays using a standardized screening tool at 12, 24 and 36 months of age. |