Family Home Visiting Child Development Screening & Referrals Toolkit

Summary

Research demonstrates that early identification of developmental and social-emotional issues and the use of appropriate intervention supports and services significantly improve a child's school readiness, academic success, and overall well-being. Investments in early identification and intervention often reduce the high costs and long-term consequences for health, education, child welfare, and juvenile justice systems.[1] However, many children enter school with significant delays and missed opportunities for intervention due to under identification and lack of timely referral to and receipt of necessary services. For example, less than 50% of children with developmental or behavioral disabilities are identified before children start school.[2] Across home visiting programs serving children at high risk for developmental and social-emotional delays, there are gaps between what we know works – to identify and connect families to appropriate services – and actual practice, with large variations in performance across the system. Developing protocols for screening and referrals using quality improvement techniques can help to reduce variations in practice and improve services for families.

The MIECHV Performance Measure Guidance Document (https://www.health.state.mn.us/docs/ communities/fhv/miechvscreenguide.pdf) has been created in addition to this toolkit. The guidance document provides very brief notes on who is included in the measure, when screenings should be completed, what screening tools can be used, and how to track screenings in IHVE. Home visitors can refer to the guidance document for measure specific instructions and should utilize this toolkit to improve aspects of the screening and referral processes in their organization.

Periodicity

The Minnesota Department of Health (MDH) Family Home Visiting Section recommends universal screening for child development and child's social-emotional growth. Universal screens increase screening rates for hard to reach, vulnerable and under-detected populations. Screening reinforces parent and child strengths and supports the home visitor in strategizing planning for visits and interventions.

MDH FHV recommends that all children, at minimum, are screened at the following times:

- 9 months
- 18 months
- 24 months
- As needed based on previous screens indicating a need for monitoring
- As needed based on home visitor judgement

Home visiting model, agency protocol, and the screening tool used are all considerations when determining when to screen. Best practice screening is to screen as early as possible.

Periodicity and standard of practice for the tools included in this toolkit are based on adjusted age. Adjusted ages accounts for premature birth for infants born 3 or more weeks early. The Ages and Stages website provides an Adjusted Age Calculator (https://agesandstages.com/free-resources/asq-calculator/). The ASQ calculator is also available for download as a free app.

Child Development Screening Tools

All MIECHV grantees are required to use Ages and Stages Questionnaire (ASQ) screening tools, which have been validated with many different populations of children and have been widely used in the child development field for several decades. These tools have been translated into many different languages and are available for purchase from Ages and Stages. The ASQ, Third Edition (ASQ-3) is used to screen children for developmental concerns. The ASQ Social-Emotional, second edition (ASQ:SE-2) is used to screen children for behavioral concerns. The ASQ-3 and ASQ-SE:2 can be used independently, but it is best practice to utilize both tools to better identify potential concerns. The Minnesota Department of Health provides regular online training for home visiting staff on ASQ-3 and ASQ:SE-2 (https:/www.health.state .mn.us/ docs/communities/fhv/asqwebinarinfo.pdf).

Ages and Stages Questionnaire, Third Edition (ASQ-3)

The ASQ-3 screens components of child development in five areas: communication, gross motor, fine motor, problem solving, and personal-social. There are six questions within each area with response options of “Yes”, “Sometimes”, and “Not Yet”. The ASQ-3 is designed with parents as the experts on their children’s behavior and parents provide all responses, which takes about 10-15 minutes. The ASQ-3 is designed as a self-report tool and can be completed at home, during a visit, or over the phone. The ASQ can be quickly scored by the home visitor who can then immediately identify if a concern has been identified in any of the five areas and if further evaluation is recommended.

The ASQ-3 includes an overall section in which parents have the opportunity to provide written comments on certain aspects of their child’s development. Reviewing this section requires professional judgement by the home visitor to determine if any information the parent provided potentially identifies a concern or a need for a more detailed conversation.

Ages and Stages Questionnaire Social-Emotional, Second Edition (ASQ:SE-2)

The ASQ:SE-2 screens components of child behavior in seven areas: self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people. The number of questions in each area differs depending on the age interval, but will be about 30 per age interval questionnaire. All questions have the same response options of “Often or

Always", "Sometimes", and "Rarely or Never." The ASQ:SE-2 is designed with parents as the experts on their children's behavior and parents provide all responses, which takes about 10-15 minutes. The ASQ:SE-2 is designed as a self-report tool and can be completed at home, during a visit, or over the phone. The ASQ:SE-2 can be quickly scored by the home visitor who can then immediately identify if a concern has been identified in any of the five areas and if further evaluation is recommended.

The ASQ:SE-2 includes an overall section in which parents have the opportunity to provide written comments on certain aspects of their child's development. Reviewing this section requires professional judgement by the home visitor to determine if any information the parent provided potentially identifies a concern or a need for a more detailed conversation.

The ASQ:SE2 Algorithm (https://www.health.state.mn.us/docs/communities/fhv/asqalgorithmtree.pdf) for home visitors developed by MDH provides guidance to home visitors for timing of screening, response to a positive screen, and referral follow-up best practices. The algorithm is an example of guidance for home visitors but can be modified to be more representative of the protocols and policies of a home visiting agency.

Child Development Screening Process

Developing a Screening Protocol

A written protocol detailing the screening process should be easily accessible to all home visitors and supervisors. Developing a written protocol with staff input can improve buy-in and standardize practice between home visitors while also ensuring that all children are being screened appropriately. The protocol should contain, at minimum, which screening tools will be used, how often children will be screened, and information on how home visitors will track screenings. The timing of screening should be informed by MDH periodicity recommendations. As MDH requires all MIECHV grantees to use ASQ tools, the protocol should include how staff are trained to use these tools. The ASQ is a widely-accepted validated tool for developmental screening and MDH recommends that all home visiting programs use ASQ tools, but other tools are approved for use in Minnesota. MDH provides a list of other allowed screening tools All Instruments at a Glance: Developmental and Social-Emotional Screening Instruments for Young Children in MN (https://www.health.state.mn.us/docs/people/childrenyouth/ctc/devscreen/glance.pdf).

To adhere to periodicity recommendations, home visitors could explore different methods for tracking and reporting when screenings need to be completed. These methods could include using a monthly worksheet or chart or utilizing notes features in electronic health records systems. Public Health agencies can use their Follow along Program software. The ASQ Visit Date Calculator (https://agesandstages.com/free-resources/asq-calculator/) can be used to determine when specific age interval visits should occur and can be helpful to plan screenings.

Supporting the Home Visitor

Staff discomfort with using screening tools could be related to desire for more training or support around how to introduce screening tools to families. Incorporating discussions of screening practices into **reflective supervision** can support continued learning with screening tools, maintenance of screening rates, and resolving barriers to screening completion. The Alliance for the Advancement of Infant Mental Health has compiled Best Practice Guidelines for Reflective Supervision (https://mi-aimh.org/wp-content/uploads/2019/01/Best-Practice-Guidelines-for-Reflective-Supervision-and-Consultation.pdf).

The Minnesota Department of Health provides regular online training for home visiting staff on the ASQ-3 and ASQ:SE-2 (https:/www.health.state .mn.us/ docs/communities/fhv/ asqwebinarinfo.pdf). These trainings cover **guidance and tips** on of how to discuss screening tools with families to help home visitors become more comfortable with introducing and explaining the value in using screening tools. The trainings also cover sharing results of screenings with caregivers and Ages and Stages has provided a tip sheet for home visitors Sharing Screening Results with Families (https://agesandstages.com/wp-content/uploads/2015/03/Sharing-Results-with-families1.pdf).

Brookes Publishing Ages and Stages has developed How to introduce the questionnaires in ways that ease parents' concerns (https://agesandstages.com/wp-content/uploads/2017/03/How-to-introduce-the-questionnaires-in-ways-that-ease-parents-concerns.pdf) and What is ASQ-SE:2 (https://agesandstages.com/wp-content/uploads/2015/10/ASQSE_What-is.pdf).

Child Development Referrals

This toolkit provides information on two foundational components of building a referral network:

- Identifying resources and building relationships with organizations in the community.
- Developing a process and protocol to ensure all children and families receive referrals if they screen positive.

Identifying Resources & Building Relationships

To streamline the referral process and improve referral follow-up, home visiting organizations should have collected information about resources in their community prior to screening.

A home visiting organization could identify child development assessment and resources by completing a community inventory. An inventory of community resources can be most helpful to home visitors and caregivers when it contains up-to-date information on address, hours, services, and eligibility. If an inventory is developed, a process for regularly updating the inventory should be developed as well to ensure that clients are receiving accurate information. The inventory could be used to create an accessible list of resources for families. Accessible

could mean placing the inventory online, making a visual display in home visiting offices, or creating a brochure with the most commonly used resources. Collaborating with parents and seeking their feedback on how best to display resource information could improve accessibility and result in creating a resource list that is most responsive to the needs of home visiting families.

Asking home visitors and caregivers about resources that are commonly used can help home visiting organizations identify potential referral partners. A referral partner could be an organization that frequently partners with home visiting services or serves a lot of home visiting clients. Placing materials like a brochure or flyer from a referral partner in home visiting offices could provide clients with another way of accessing information on resources outside of screening and referrals.

Most home visiting organizations are likely familiar with community organizations that provide support around child development including:

- Minnesota Help Me Grow (http://helpmegrowmn.org/HMG/index.htm)
- Early Childhood Family Education (https://education.mn.gov/MDE/fam/elsprog/ECFE/)
- Early Head Start (https://education.mn.gov/MDE/fam/elsprog/start/)

Minnesota Help Me Grow has a wealth of information on child growth and development and is also where home visitors or parents can complete online referrals to request an early childhood special education assessment, which is then sent to the family's school district to arrange for an evaluation with the family. ECFE and some Early Head Start programs provide services by school district as well.

Identifying private referral sources such as private-practice child mental health practitioners can be done through a community inventory and discussions with home visitors and parents.

A home visiting organization could also identify community organizations that can provide continued support to families, such as cultural, faith-based and other community-based parenting groups. Some state and national resources for children with developmental concerns or special health needs include:

- Family Voices of Minnesota (http://familyvoicesofminnesota.org/) - Advocacy group and connection to other families of children and youth with special health needs
- PACER Center (https://www.pacer.org/) - Provides assistance to individual families, hosts workshops, and advocates for policy that protects the rights of children and youth with special health needs
- Minnesota Hands and Voices (https://www.mnhandsandvoices.org/) - For families of children that are deaf or hard of hearing
- Healthy Children (https://healthychildren.org/English/Pages/default.aspx) from The American Academy of Pediatrics - Resources on healthy development for different ages of children

- Zero to Three (https://www.zerotothree.org/) - Resources focused on early development and well-being
- CDC Milestones in Action (https://www.cdc.gov/ncbddd/actearly/milestones/milestones-in-action.html) - Photos and videos showing developmental milestones by age so parents can track
- Infant Mental Health Specialists (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5448D-ENG) are located across Minnesota. Agencies can be contacted directly for referrals
- Other condition-specific groups and organizations

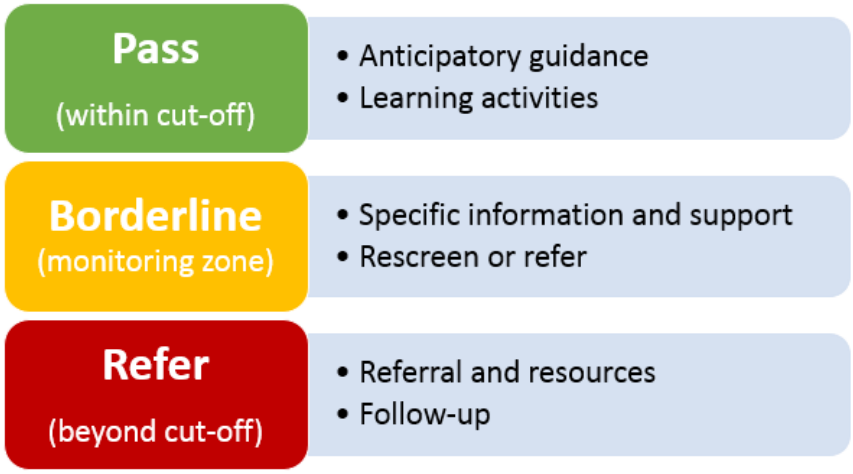
Developing a Referral Process and Protocol

Rapid referral, defined as referral to resources appropriate for the level of support indicated by the screening result, is the goal of screening. Connecting a caregiver and child to resources as soon as possible can lead to improved outcomes. As a best practice, referrals should be made as soon as possible.

Home visitors are most likely already very familiar with the organizations in their communities that they make referrals for, but examining the referral process using a Swim Lane Map (https://www.health.state.mn.us/communities/practice/resources/phqitoolbox/swimlanemap.html), also called a swim lane map, may help to identify barriers and opportunities for improvement to streamline the referral process.

The referral process begins when a child is screened using one of the validated developmental screening tools. A written referral protocol should include guidance for home visitors based on each type of screening result (see Figure 1). The referral process and protocol should include next steps for children who don't screen positive for a potential developmental concern as well as for those with an identified concern. If a child does not screen positive, the family could still benefit or be in need of services that could support a child's healthy development. Home visiting organizations should detail in a referral protocol how children and families without an identified concern can still receive follow-up in the form on continued screening or referral to appropriate services. For example, a child does not have an ASQ-3 screening that indicates a concern but the family has shared that they feel the child could benefit from more social interactions with other children. The home visitor should connect the family with ECFE resources in their community record this referral, regardless of the screening result. Although this referral will not be counted towards MIECHV performance measure data, it is best practice to provide referrals when clinical judgement indicates the family could benefit from additional services or when a referral is requested. Figure 1 provides an example of next steps a home visitor could take based on screening result.

Figure 1. Follow-up guidance for developmental screening.



MDH has created an example of a written referral protocol for using the ASQ:SE-2 SAMPLE ASQ-SE2 (Social Emotional) Referral Guidance (https://www.health.state.mn.us/docs/communities/fhv/asqrefguide.pdf). This referral guidance document should serve as a guide for home visiting agencies to develop their own referral protocols that include information on both the ASQ-3 and ASQ:SE-2.

A referral protocol should detail how quickly home visitors are expected to make a referral to services if a concern has been identified. A best practice to implement could be that home visitors make referrals within 24 hours of identifying a concern.

It is recommended that home visitors provide a dual referral when developmental concerns are identified and a triple referral when social-emotional concerns are identified. A dual referral includes both a medical and educational evaluation (see Figure 2). A triple referral includes a medical evaluation, educational evaluation, and mental health evaluation. A written referral protocol should detail when how home visitors will utilize this best practice and communicate information about a dual referral to families.

Figure 2. Dual referral for developmental concerns

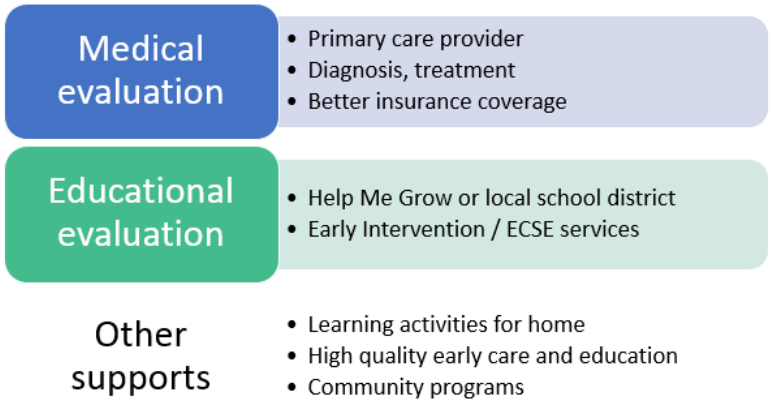
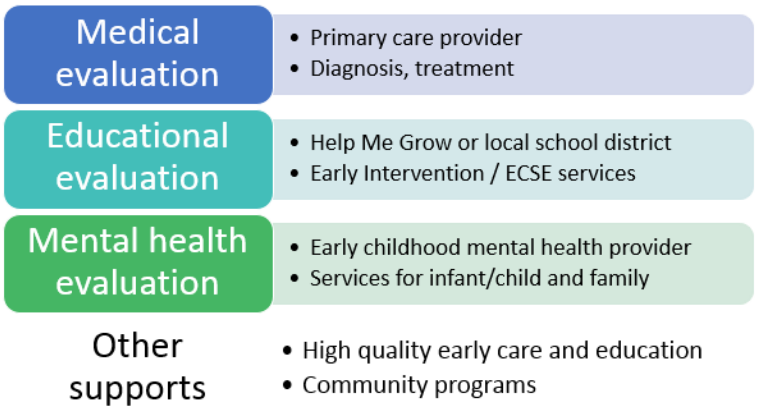


Figure 3. Triple referral for social emotional concerns



Home visiting organizations should determine if the referral process differs if the screening is done in the home or in a public place, such as a WIC office. If a screening is done in a public place, how can home visitors ensure that the family and child's comfort and private health information are protected if a referral needs to be made?

Home visiting organizations should also determine if the referral process will be different if the scoring is done immediately or at a later time. For example, a parent could complete the ASQ:SE-2 during a visit but the home visitor might not complete the scoring until they return to their office at the end of the day. If the child screens positive for a concern, how will the home visitor inform the child's caregiver of the screening result? If the scoring is done outside of a visit, how can home visitors ensure that families are receiving rapid referrals?

It is a recommended best practice to score screening tools and provide referrals based on screening results immediately. A referral protocol should include information on how home

visitors should respond to screening results if the scoring cannot be immediately completed and shared with the caregiver.

Completed developmental and social-emotional referrals made by home visitors working for agencies that receive MIECHV funds must include at least one of the following:

1. Received individualized developmental support from a home visitor;
2. Were referred to early intervention services and received an evaluation within 45 days; OR
3. Were referred to other community services and received services within 30 days

More detailed information on each of these components of a referral can be found in the MIECHV Performance Measures-Target Timeframes for Screening and Referral document (https://www.health.state.mn.us/docs/communities/fhv/miechvscreenguide.pdf). A referral protocol should detail how home visitors will ensure that referrals contain at least one of these components and how they will track when families receive services.

Child Development Follow-Up

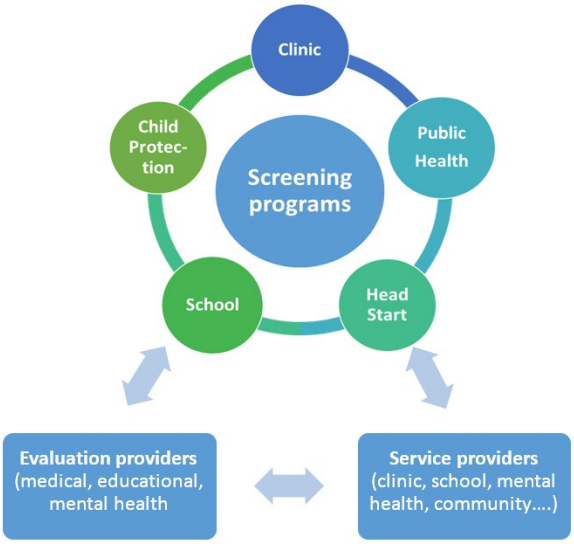
Once a concern has been identified and a referral has been made, referral follow-up begins. As noted above, the MIECHV measure for developmental referrals includes recording when a referral is made and when families receive services. Following up on a referral involves many different people including the home visitor, caregiver(s), and other service providers. Figure 4 provides an example of the multiple organizations involved in developmental screening, referral, and assessment. A written protocol should detail expectations for referral follow-up including how often home visitors will follow-up with families, if home visitors will communicate with referral sources directly, how to manage releases of information, and how follow-up information will be recorded. The protocol could contain information specific to each of the organizations listed in Figure 4 and details on how referral follow-up processes will differ between dual and triple referrals.

It is best practice to incorporate family-centered decision-making into follow-up expectations. Family-centered decision-making involves working closely with a family to determine what their highest priority is, what types of resources they prefer to receive, preferred communication strategies, and how they would like to be supported during the referral process.

For many families, following-up on a referral could be stressful or confusing. A home visitor can support referral follow-up by helping the child's caregiver make a personal plan for acting on the referral. The home visitor and caregiver could agree on a plan for the home visitor to follow up with a phone call or visit in a few hours or days to provide support and encourage follow-through. If a caregiver has not acted on a referral, the home visitor could use motivational interviewing to identify barriers to acting on the referral. Barriers could include lack of transportation, limited availability of appointments, or confusion about next steps. Home visiting organizations could complete a Fishbone Diagram (https://www.health.state.mn.us/

communities/practice/resources/phqitoolbox/fishbone.html) to identify barriers to referral completion or timely follow-up. When working with families, a home visitor could also use "teach back" strategies to ensure that caregivers understand what the next step is in the referral process.

Figure 4. A visual diagram of organizations typically involved in developmental screening processes



Home visitors can utilize relationships with referral partners to support improved follow-up. Information sharing, with permission from the child's caregiver, between a home visitor and service provider can reduce barriers by allowing home visitors to check on a referral status, support coordinating transportation, and provide medical information. For example, a home visitor with permission from the caregiver and a signed release of information could connect with Early Head Start staff to share information on the best ways to contact the caregiver to make scheduling a first appointment a bit easier or to provide screening results prior to the child's assessment.

Developing and utilizing a referral tracking system can improve referral follow-up by identifying internal and external barriers to referral completion. A referral tracking system could have many different forms, but many home visiting organizations might find it convenient to use electronic record systems to support home visitors managing referrals with different statuses. All home visitors will be required to use IHVE to record and report referral data in addition to any internal referral tracking and documenting. A referral tracking system should at minimum include the date a referral is made, what the referral is for, the status of the referral, and a plan for following up with the caregiver and/or the service provider receiving the referral. A referral status could include:

- Not yet in process-family has not acted on referral
- In process-family has contacted service provider and is awaiting action
- Scheduled-family has an appointment scheduled with service provider
- Complete-family received at least one service or appointment from service provider
- Declined- family is not pursuing services
- Unavailable-referral providers was contacted and cannot provide services to family
- Ineligible-referral provider was contacted and family is not eligible for services

Documenting and Reporting Data

All home visitors should follow guidance provided in the MDH IHVE Data Collection Manual (https://www.health.state.mn.us/docs/communities/fhv/ihvedatacollmanual.pdf) when documenting and reporting data. The instructions for the screening form can be found on page 53. The instructions for the referral form can be found on page 61.

All screenings and referrals should be documented in IHVE as soon as possible after they occur. Documenting and reporting when a referral progresses through different statuses, such as when a family schedules an appointment or receives services, provides information on whether families are receiving referral services quickly, or if there are barriers that prevent families from acting on a referral. Regardless of the amount of time between when the referral is provided and when the referral status changes, it is important to report this information to document how home visitors support connecting families to resources.

Please note that IHVE data collection forms vary between electronic record systems. For technical assistance, contact the support email address listed below for the system your organization is using.

- Nightingale Notes: support@champsoftware.com
- PH-Doc: supportdesk.wpark@avenuinsights.com
- IHVE REDCap forms: Health.FHVData@state.mn.us

Resources

- MDH Home Visiting Program and Practice Child and Teen Checkups (https://www.health.state.mn.us/docs/people/childrenyouth/ctc/devscreening.pdf)
- Minnesota Interagency Developmental Screening Task Force (https://www.health.state.mn.us/people/childrenyouth/ctc/devscreen/index.html)
- Follow Along Program (https://www.health.state.mn.us/people/childrenyouth/fap/index.html)
- Help Me Grow (http://helpmegrowmn.org/HMG/index.htm)

- MinnesotaHelp (https://www.minnesotahelp.info/public/)
- CDC Developmental Monitoring and Screening (https://www.cdc.gov/ncbddd/childdevelopment/screening.html)
- CDC Learn the Signs, Act Early (https://www.cdc.gov/ncbddd/actearly/index.html)
- Zero to Three (https://www.zerotothree.org/)
- ASQ Training Portal (https://agesandstages.com/resource/training-portal/)
- Just in Time Parenting (https://jitp.info/)
- Wilder Research Home Visiting Engagement and Retention (https://www.wilder.org/wilder-research/research-library/home-visiting-engagement-and-retention)

References

1. U.S. Department of Health and Human Services. (2017). Birth to 5, Watch Me Thrive. (https://www.acf.hhs.gov/ecd/child-health-development/watch-me-thrive)
2. National Academy for State Health Policy. (2012). Making the Case. (https://nashp.org/making-the-case/).

Contact

If you have questions regarding this toolkit or continuous quality improvement efforts within the MDH Family Home Visiting Section, please email health.fhvcqi@state.mn.us.

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