California Statewide Screening Taskforce

Developmental Screening Landscape Analysis

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Introduction

It is well documented that a child's brain develops faster in the first three years of life than at any other time. During this period of rapid growth, determining if children's development is on track and addressing any developmental concerns helps children to achieve their unique potentials and can prevent long-term challenges. Developmental screenings provide a gauge of how a child is doing in meeting developmental milestones and is an important source of information for parents and others who care for children. Unfortunately, the majority of children do not receive timely developmental screenings at a national level. According to the most recent National Survey of Children's Health 2011/12, only 30.8%[1] of children ages 10 months to 5 years of age received a standardized screening for developmental or behavioral problems. California rates fall below the national average at 28.5%[2], placing it 30th in the country.

In 2016, the California Departments of Public Health and Developmental Services came together to identify opportunities to increase statewide screening and referral rates among health care providers. The work included establishing a statewide taskforce to develop a toolkit focused on primary care along with recommendations for increasing screening rates in primary care settings. One component of this work was to conduct a landscape analysis to create a better understanding of how strategies for developmental screenings fit within existing state and federal programs, the barriers that exist in conducting timely screenings, and the statewide efforts that support increased screenings, referrals, and access to services. The analysis of the screening landscape in California includes:

- Currently available data on developmental screenings in California
- Recommendations and federal and state requirements that support screenings
- Identification of barriers and challenges to children receiving screenings
- Key examples of work underway at program and policy levels

The intent of this analysis is not to present a thorough county-by-county analysis, but rather to focus on information at the state level to create a starting point for improvements in state-wide efforts in developmental and behavioral screening and referral of very young children in California.

The analysis will also be used by the California Screening Taskforce to develop state-level recommendations and action steps for the process.

Landscape Analysis Methodology

This landscape analysis was compiled through Statewide Screening Taskforce member input, key informant interviews with physicians and representatives from state associations, public and private funding organizations and advocacy groups, and a review of reports and online data sources. The initial draft analysis was shared with the Taskforce for additional input and refinement.

The California Statewide Screening Collaborative

In 2003, the California Department of Public Health (CDPH) convened the California Statewide Screening Collaborative (CSSC), with funding from the federal Early Childhood Comprehensive Systems (ECCS) grant. Over the years, the CSSC built upon initial efforts under the ECCS and Assuring Better Child Health and Development (ABCD) Projects with support from multiple state agencies, including CDPH, California Department of Developmental Services (CDDS), and California Department of Education (CDE) through a variety of funding mechanisms described later in this document. The CSSC has brought together state agencies, organizations, and initiatives with the purpose of:

> *Enhancing California's capacity to promote and deliver effective and well-coordinated health, developmental, and early mental health screenings for young children birth to age 5.*

The primary objectives of the CSSC have included:

- Improving coordination among state agencies and programs involved in early identification and referral
- Promoting the use of standardized screening tools, effective screening protocols and increased communication among agencies and services.
- Identifying screening resources, funding and follow-up supports that promote healthy early childhood development, school readiness, positive parent-child relationships and access to services.

Current Focus of the Statewide Screening Collaborative/Taskforce

In November 2016, the CSSC was re-organized under the leadership of the Department of Public

Health and the Department of Developmental services with an emphasis on developmental screenings for children birth through 5 by health care providers and in primary care settings. Health care providers are often seen as a trusted source of information for families and provide a consistent touch point for families in the early years of their children's lives. Health care providers are recognized as one of the optimal administrators of developmental screenings. With this focus, the CSSC shifted to a smaller Statewide Screening Taskforce with a charge of:

1. Developing a statewide, California-specific health care provider guide for developmental and behavioral screenings.
2. Mapping and analyzing screening activities statewide.
3. Developing policy recommendations and action steps.
4. Developing guidance for local health jurisdictions on the health care provider guide.
5. Developing recommendations on outreach to referral sources for IDEA Part C, California's Early Start program.

Developmental Screenings in California

Nationally, there is significant under-detection of developmental delays in early childhood.[3] In California, the potential high number of unidentified delays in young children is coupled with the low rates of developmental screenings reported across the state. The following data points capture the current state of developmental screenings and referrals in California:

- California ranks 30th in the country for its rate of developmental screenings for infants & toddlers.[4]
- Slightly over one in four (28.5%) of the children in California receive timely developmental screenings.[5]
- One in four (28.1 %) of children under the age of 6 in California are at moderate- or high-risk for developmental, behavioral, or social delays.[6]
- One in 68 children are at risk for an autism spectrum disorder.[7]
- 40% of parents with children age 5 and younger report having concerns about their child's physical, behavioral, or social development.[8]
- 76% of children with disabilities ages 0-3 receive early intervention services under IDEA Part C.[9, 10]
- 13% of children under the age of 6 at moderate- or high-risk for developmental, behavioral, or social delays are referred to and receive Part C services.[11, 12]

State and Federal Initiatives with a Developmental Screening Focus

There have been many state and federal initiatives launched in California focused on or including developmental screenings, early identification and linkages of children to services, that are consistent with the priorities of the current Screening Taskforce including (see table in appendix for Summary Table on these initiatives):

- ***Birth to 5: Watch Me Thrive!*** a coordinated federal effort of the Departments of Health and Human Services (HHS) and Education to encourage healthy child development, universal developmental, and behavioral screening for children. In California, an adaptation of the Watch Me Thrive! screening materials was completed for early care and education providers by WestEd Center for Prevention and Early Intervention, and is available for download on the WestEd CPEI website.
- ***Bright Futures***, a national health promotion and prevention initiative led by the American Academy of Pediatrics that is aimed at supporting primary care practices in providing well-child and adolescent care according to Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.
- ***The Assuring Better Child Health and Development (ABCD) Program***, administered by the National Academy for State Health Policy (NASHP) and designed to assist states in improving the delivery of early child development services for low-income children ages 0-3 and their families by strengthening primary health care services and systems that support the healthy development of young children. The program focuses particularly on preventive care of children whose health care is covered by state health care programs, especially Medicaid. California was one of five states selected as part of the ABCD II Initiative launched in 2003 and ending in 2007.[13] ABCD II was funded by the Commonwealth Foundation to assist states in building capacity in Medicaid programs to deliver care supporting healthy mental development in children.

- ***Help Me Grow (HMG)***, a national model for coordination of services that support early identification and services for children at risk of developmental or behavioral challenges. In 2011, *Help Me Grow* National awarded California a small technical assistance grant to spread the model into three counties and to start a Learning Community. The HMG model has spread rapidly within California and is currently being overseen by the First 5 Association. For more details on California counties that are part of Help Me Grow, go to http://first5association.org/policy-areas/early-identification-intervention/

- ***Race to the Top/Early Learning Challenge (RTT/ELC)*** CDE/CDDS won this competitive application in 2012 to establish quality rating improvement systems (QRIS) for early care and education that included specific developmental screening requirements and identified *Help Me Grow* as a preferred approach for early identification and linkages at the county level. CDDS received RTT/ELC partner funds from CDE in 2013 to coordinate/facilitate the Statewide Screening Collaborative.

- ***Linking Actions for Unmet Needs in Children's Health*** *(Project LAUNCH)* is a federal partnership between Substance Abuse and Mental Health Services Administration (SAMHSA), the Administration for Children and Families, the Health Resources and Services Administration, and the Centers for Disease Control and Prevention. LAUNCH is grounded in a public health approach, with the goals of supporting infrastructures needed to improve coordination across child-serving systems and increase access to high-quality prevention and wellness promotion services for very young children and their families. LAUNCH programs are designed to promote wellness, prevent mental, emotional and behavioral disorders, and support early detection and referral to needed resources. CDPH/MCAH was awarded a LAUNCH grant between 2008 and 2013 to pilot five early childhood strategies in MIECHV funded home visiting programs and for families in Alameda County. California was awarded a LAUNCH Expansion Grant for 2015-2019 to support three counties (Fresno, Nevada, and San Francisco) to learn from and build upon successes seen in the original LAUNCH to Alameda County.

- ***First 5 California Special Needs Project*** was a 4-year project, in 10 California counties, focused on screening young children for developmental concerns at school readiness sites and improving service utilization for children with disabilities and other special needs. The following ten counties participated in the SNP: El Dorado, Los Angeles, Mendocino, Merced, Monterey, Orange, Riverside, San Diego, San Francisco, and Sonoma. The county commissions provided matching funds and contracted with local grantees to implement the SNP in a manner consistent with local needs.

- ***The California Developmental Screening Network (CA-DSN)*** is working to develop a statewide system to support and sustain the quality implementation of developmental screening within the California Quality Rating and Improvement System (CA-QRIS). CA-DSN delivers training, regional team planning, and facilitation of a Community of Practice to support implementing and scaling-up developmental screening within the 10 CA-QRIS Regions. The California Developmental Screening Network is coordinated by the WestEd Center for Prevention & Early Intervention (CPEI) and funded by the California Department of Education, Early Education and Support Division between 2016 and 2018.

Current and prior initiatives, at the state and national level, point to recognition of the importance of developmental screenings.

Developmental Screening Best Practice Recommendations & Requirements

Current standards in place are set by the Academy of Pediatrics and specific requirements for the provision of developmental screenings for children embedded in federal and state programs.

American Academy of Pediatrics Recommendations

At the national level, standards of practice have been set by the American Academy of Pediatrics (AAP) on developmental screenings. The AAP's recommendations are captured in the *Bright Futures/AAP Recommendations for Preventative Pediatric Health Care*, a periodicity schedule (see schedule in appendices of this document). Developmental surveillance is recommended at every well-child visit. Developmental screenings using a well-validated tool are recommended at 9, 18 and 30 months of a child's life or whenever a parent concern is raised. In addition, an autism-specific screening is recommended at 18 and 24

months.[14] These recommendations are recognized as best practice and have been incorporated into the Affordable Care Act, as well as some state Medicaid EPSDT periodicity schedules, including that of the California Medi-Cal Program.

Developmental Screening Requirements

There are a number of requirements for screenings built into health insurance and child health and development programs. The following highlights those identified as relevant to the current focus of the Screening Taskforce.

Medi-Cal

In California, more than 57% of children ages 0-5 are enrolled in Medi-Cal.[15] In addition, it is estimated that 36% of the more than one million uninsured children in California would be eligible for Medi-Cal.[16] Early Periodic Screening Diagnostic and Treatment (EPSDT) is a Medi-Cal benefit that provides comprehensive preventative, diagnostic, and treatment services for children under age 21. In 2014, the EPSDT screening requirements were aligned to the Bright Futures/AAP periodicity schedule. The California Child Health and Disability Prevention Program (CHDP) oversees the screening and follow-up components of the federally mandated EPSDT program. In 2013-2014, 1,635,025 children received developmental assessments through CHDP.[17]

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP) serves uninsured children up to age 19 in families with incomes too high to qualify for Medi-Cal. CHIP programs are required to cover well-baby and well-child health care services and to follow the Medi-Cal periodicity schedule, which is aligned to Bright Futures/AAP. States are required to report on developmental screening within the first three years of life under CHIP as part of federal Health Care Quality Measures. In 2015, there were more than 1.9 million children in California enrolled in CHIP and Medi-Cal combined.[18]

Affordable Care Act

Under the Affordable Care Act (ACA), health plans are required to provide preventative care including developmental, behavioral and autism screenings. Developmental screenings for children under 3 and autism screenings for children at 18 and 24 months must be covered without additional cost to families. The federal requirements encompass the Bright Futures/AAP periodicity schedule. Seventy thousand children under the age of 18 were enrolled in Covered California in 2015.[19] Information on rates of screenings in children enrolled in ACA plans are not readily available.

Health Maintenance Organizations (HMOs) & Private Insurance

Under the ACA, most private health plans are required to cover developmental and autism/behavioral screenings, along with two dozen other preventive services, for children at no cost to families. This federal requirement around children's preventive services encompasses the recommendations in Bright Futures/American Academy of Pediatrics (AAP) (4th edition, 2017).[20]

Part C of Individuals with Disabilities Education Act (IDEA)

The Program for Infants and Toddlers with Disabilities (Part C of IDEA) is a federal grant program that assists states in operating a comprehensive statewide program of early intervention services for infants and toddlers with disabilities, birth through age 2, and their families. Congress established the Part C (Early Intervention) program in 1986 in recognition of "an urgent and substantial need" to:

- Enhance the development of infants and toddlers with disabilities;
- Reduce educational costs by minimizing the need for special education through early intervention;
- Minimize the likelihood of institutionalization, and maximize independent living; and,
- Enhance the capacity of families to meet their children's needs.

Eligible infants and toddlers (0-36 months) include those with or at-risk for developmental delay or disability who exhibit a 33% verified delay at the time of referral in at least one developmental area, have an established risk condition, or are identified as at a high risk of having a substantiated developmental disability due to a combination of biomedical risk factors.[21]

The "Child Find" requirement of IDEA obligates Part C to identify, locate, and evaluate all children with disabilities, aged birth to 3, who need early intervention or special education services. Child Find regulations specifically name child care and early education programs as a primary referral source for Part C services. Primary care providers also play an important role in identifying infants younger than 12 months of age who may be eligible for early intervention services. FFY 2014 data indicate that .83 percent of infants, ages birth to 1, were served in California. This figure is 3.2 percent below the national average of 1.15 percent. California reported that a total of 36,895 children with disabilities birth to three years of age received

IDEA Part C services on their most recent State Performance Plan and Annual Performance Report (SPP/APR) to the Office of Special Education Programs (OSEP).[22] This represents about 2.45% of the total number of children, ages birth to three in California.[23] Because OSEP does not require referral counts to be collected or reported, most states, including California, do not track total referrals. This means that it is difficult to understand how many infants under 12 months were referred for Part C services but not enrolled.

Early Start

Early Start is California's program for Part C. The Department of Developmental Services collaborates with state agencies that provide developmental screenings to infants and toddlers and coordinates with regional centers to provide services to eligible families with infants and toddlers between birth and 36 months. Within 45 days of referral to Early Start, an evaluation is conducted to determine eligibility for the program. As of January 2017, 37,968 children under 36 months were participating in the Early Start program.[24]

Title V Maternal Child Health Block Grant

The Title V Maternal and Child Health Block Grant Program is a federal- state partnership designed to improve the health and well-being of women (particularly mothers) and children. Title V is administered in California through a partnership between the Maternal, Child and Adolescent Health (MCAH) Program of the California Department of Public Health (CDPH) and the Systems of Care Division (formerly referred to as Children's Medical Services or CMS) of the California Department of Health Care Services (DHCS).

The Title V Block Grant allocation is earmarked into four categories: 30% of Title V Block Grant funding must go towards preventive and primary care services for children; 30% must support for Children and Youth with Special Health Care Needs (CYSHCN); 30% for support other of MCAH activities; and 10% for administrative activities.[25] Title V-funded programs play an important role in screening and referral coordination for children served by MCAH by conducting screenings and connecting eligible children and their families, including CYSHCN, to the supports and services they need.

Child Abuse Prevention & Treatment Act

The California Department of Social Services receives funding under the federal Child Abuse Prevention and Treatment Act (CAPTA) to support state child protective services and child abuse prevention activities. Specifically related to developmental screenings, the state uses CAPTA funding to improve coordination between child welfare, public and mental health, and developmental disabilities agencies and services to screen children ages 0-5 identified by child protective services and in need of early intervention services. CAPTA stipulates that children under age three with a substantiated child abuse or neglect allegation must receive a developmental screening and be referred to Part C to determine eligibility for services. In 2015, there were 500,976 reports (allegations) of child abuse and neglect in California. Of those, 74,327, or 15%, were substantiated (verified) by the state child welfare system. 28.5% of the cases that were substantiated were for children ages 0-3.[26]

California Home Visiting Program

The California Home Visiting Program, funded through the federal Maternal Infant and Early Childhood Home Visiting (MIECHV) Program is operated through the Department of Public Health. The program serves pregnant and parenting low-income women through 24 sites in 23 counties across California.

The program provides services using one of two evidence- based home visiting models: Healthy Families America and Nurse-Family Partnership Developmental screenings are conducted on all enrolled children. During the federal fiscal year 2014-2015, 2,511 families were served through the MIECHV Program.[27]

California Children's Services: High Risk Infant Follow Up

California Children's Services (CCS) is a state program administered locally for children with certain diseases or health problems. CCS provides diagnostic services and treatment as well as medical case management for CCS-eligible children up to 21 years of age with a CCS-eligible medical condition. The CCS High Risk Infant Follow Up (HRIF) program identifies infants who might develop CCS-eligible conditions after discharge from a CCS-approved tertiary Neonatal Intensive Care Unit (NICU). The program includes three standard visits for infants and children up to three years old, including diagnostic assessments, such as the Bayley Scales of Infant Development (BSID). A financial eligibility determination is not required for HRIF services.[28] According to a 2012 study, a standardized developmental assessment was administered during the first HRIF visit (around 4-8

months of age) following NICU discharge at a rate of 64% (or 3,270 visits).[29]

Head Start/Early Head Start

Head Start Program Performance Standards specify that each child should be screened for a developmental, behavioral, or social delay within 45 days of entry into a Head Start program. Early Head Start programs assess whether children have received regular medical screenings and care, and if not, the program must help connect children and families to those services. Head Start Performance Standards also require that grantees provide linkages for diagnostic testing, examination, and treatment services.

It is recommended that programs refer, or refer with parent permission, eligible children to the local Part C agency for further evaluation and the development of an Individualized Family Service Plan (IFSP) following eligibility determination. Treatment and/or referral must be conducted within 45, 90, or 120 days of entry into a Head Start program, depending on the specific health concern.

In 2014-15, there were 578,617 California children under age five living in poverty.[30] Of those, only 38% of three and four year olds had access to Head Start and only 4% of children under age 3 had access to Early Head Start.[31] The total enrollment in Head Start and Early Head Start was 109,011 in 2014-15.[32] During this same year, 2.5% of children in Head Start/Early Head Start were identified as having a developmental delay, significantly below the federal requirement that 10% of slots be available to children with delays.[33]

Barriers & Challenges to Children Receiving Timely Screenings

Although there are many avenues to support the developmental screening and referral of children in California, including both standard practice recommendations and screening requirements, systemic challenges exist which prevent all children from being screened and connected to the services they need. This is not only an issue in California, but in other states as well.

These challenges exist at many levels, collectively contributing to children not getting timely screenings and follow up, and to a lack of clear data on screening and referrals. The following challenges and barriers to children receiving timely screenings have been identified through national[34], state, and local scans and input processes:

Health Care Provider Practice Level:

- Low attendance at well-child visits
- Insufficient training of pediatric and family practitioners on child development and screening and how to encourage screenings in diverse settings
- Underutilization of valid screening tools and reliance on clinical impressions and informal developmental milestones by providers.[35]
- Lack of sufficient time during visits to complete screenings and discuss results with parents, especially within the context of other health care priorities
- Inadequate rates of reimbursement for Medi-Cal and managed care plans
- Underutilization of EPSDT benefits under Medi-Cal[36]
- Costs associated with purchasing screening tools
- Lack of a comprehensive system to determine if a child has already been screened, to prevent duplication of screenings, and to ensure families are connected to services
- Limited or no information on how and where to refer
- Lack of a feedback loop following referral
- No incentives to screen or penalties for not screening
- Shortage of pediatric and family medicine providers

Policy, Public Health Coordination & Accountability:

- Lack of data to determine if children are receiving screenings per the requirements
- Lack of coordination between state-level screening efforts, leading to silos and duplication of efforts
- Limited number of engaged key stakeholders and supporters who can influence policy on advisory panels[37]
- Lack of meaningful cross-agency partnerships and intentional collaboration
- Challenges in implementing screening recommendations into primary care practices
- Limited number of standardized tools to foster communications across agencies
- Need for improved technology to better link systems and improve coordination across agencies
- Lack of available data that can be leveraged to drive and support policy changes

- HIPAA rules protecting patient health data poses challenges in sharing screening and referral follow-up information, and between primary care and behavioral health providers
- Medi-Cal Managed Care reimbursement structures that reimburse based on enrollment rather than specific services

Family and Community:

- Lack of public awareness of appropriate developmental milestones
- Lack of awareness among parents that their child's pediatrician should be screening their child at regular intervals
- Family difficulties in articulating concerns to providers
- Lack of awareness in parents about the benefits of early intervention services
- Cultural barriers (e.g., perceptions of screening, stigma and fear around certain disabilities, how families access information)
- Access issues such as language differences, literacy issues, or transportation challenges preventing screening and/or follow-up
- 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 and Information Systems & Research

- Absence of Healthcare Effectiveness Data and Information Set (HEDIS) [38] measure for developmental screenings
- Lack of data to adequately track whether a child has been screened according to the recommended periodicity schedule
- Siloed data collection and the inability to link data systems (i.e., inability to properly assess for gaps in system and services or to develop effective programs and policies)
- Limited functionality of electronic health record systems to include evidence-based practice questions and/or embed evidence-based tools
- Limited research on how screening tools work in real life clinical settings that includes diverse populations

In California, many of these challenges and barriers have been identified over multiple years. At the local level, counties have built systems through local pilots and local level partnerships.

Experiences at the local level have helped to contribute to a better understanding of many of the challenges and barriers identified above.

Programs & Policy Efforts Underway In California

There are a significant number of efforts underway, in addition to the recent work by the Statewide Screening Taskforce, that are aimed at addressing systemic challenges, increasing awareness of the importance of screenings, increasing the number of screenings and ensuring that there are local supportive services for children with developmental concerns.

The following is not inclusive of statewide policy and advocacy work, local systems level work or efforts being led by philanthropic organizations. It does include some of the work that is relevant to understanding the screening landscape at a statewide level.

Title V

As part of the Title V Maternal and Child Health (MCH) Block Grant, grantees develop a five-year State Action Plan to address their priority needs. California's Title V 2016 Action Plan identifies developmental screenings as a priority, including an emphasis on developing an infrastructure in local MCAH programs for developmental screening.

The plan also includes the following strategies that are guiding the work on screening and that of the Screening Taskforce:

- Assessing performance by tracking the percent of children, ages 10 months through 71 months, receiving a developmental screening using a parent-completed screening tool
- Collaborating with relevant partners to develop goals, objectives, and activities to improve rates of behavioral, social, and developmental screening and linkages to needed services for all children and youth
- Promoting the use of Birth to 5: Watch Me Thrive or other appropriate materials in local MCAH programs, and supporting local health jurisdictions (LHJs) to develop protocols to ensure that all children in local MCAH home visiting or case management programs are being screened for developmental delays and are linked to their primary care provider or medical home for further assessment and linkages to appropriate services, as needed.

- Providing technical assistance to MCAH LHJs to improve provider, family and community outreach, and develop centralized telephone access and data collection processes.

Health Care Services Developmental Screenings Study

The California Department of Health Care Services and its stakeholders are interested in having a Developmental Screening in the First Three Years of Life measure included in DHCS's Medi-Cal Managed Care (MCMC) External Accountability Set (EAS). This measure is used to calculate the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months before their first, second or third birthday. DHCS has concerns that the rates would be low due to lack of use of the CPT code 96110 by providers, due to a lack of incentive.

DHCS is currently conducting a study to determine "to what extent CPT code 96610 can be used to evaluate managed care provider's rates for developmental screening in the First Three Years of Life measure in California."[39] The study includes questionnaires for stakeholders and managed care providers and an analysis of administrative rates. The intent of this study is to help determine whether providers are using the CPT code 96110 and to identify any barriers to using the code. This study is expected to be finalized in summer 2017.

Help Me Grow

Help Me Grow is a national model designed to provide a comprehensive, statewide, coordinated system for early identification and referral of children at risk for developmental and behavioral problems.[40] *Help Me Grow* is a system that builds collaboration across sectors, including child health care, early care and education, and family support. Through comprehensive physician and community outreach and centralized information and referral centers, families are linked with needed programs and services. Ongoing data collection and analysis helps identify gaps in and barriers to the system.

In California, *Help Me Grow* began in Orange County and has grown to having affiliates in 14 counties, with an additional 15 counties projected to join. This represents 80% of California's population of children 0-5. The First 5 Association serves as the Help Me Grow coordinator in California and is actively working with counties across California to support efforts and local systems development and to advance work at the statewide level.

First 5

At the local level, First 5 county commissions have provided leadership to support early intervention and early identification through screenings and local services for many years. In 2015, First 5 county commissions invested $153 million in health including home visiting, developmental screenings and health access. First 5 California has supported screenings through investments in training and technical assistance, the California Special Needs Project, and through provision of statewide leadership on the issue. The First 5 Association, representing the 58 county commissions, is the statewide coordinator for Help Me Grow, and has been active in advocating systems development and policy changes to ensure that all children receive mandated screenings, that there is cross-system coordination for early intervention, and for improved statewide data collection.

CDE California Developmental Screening Network

The California Department of Education, Early Education and Support Division is funding the California Developmental Screening Network (CA-DSN), coordinated by the WestEd Center for Prevention & Early Intervention (CPEI) from 2016-2018. The CA-DSN is working to develop a statewide system to support and sustain the quality implementation of developmental screening within the California Quality Rating and Improvement System (CA-QRIS). CA-DSN delivers training, regional team planning, and facilitation of a Community of Practice to support implementing and scaling-up developmental screening within the 10 CA-QRIS Regions.

Home Visiting Programs

Home visiting programs in California operate with reliance upon a variety of funding sources, including the federal MIECHV funds, Early Head Start and Head Start funds, Health Department and Social Service funds, First 5 county funds, and multiple foundation program funds. The target of the program typically depends upon funding source but may include: health (physical or behavioral/mental health), child welfare, early education, or early intervention systems. Most programs in the United States are voluntary and are designed to be preventative in nature, although families are often selected for services based on significant risk criteria (e.g., teen parents, families living in extreme poverty, families with histories of child maltreatment) because the costs associated with universal approaches are considered prohibitive.

All home visiting programs include some types of developmental and behavioral health screenings, linkages to community resources and referrals to meet identified needs. Some programs are able to offer intervention services to meet behavioral, health, and developmental needs of both children and their parents. Although linkages and collaborations are essential for effective service delivery, limitations usually exist in the development of seamless systems of care involving all aspects of health and development, creating challenges for referral sources.

Using California Information & Other State Experiences to Enhance Screening Efforts

The information presented in this landscape analysis is a starting point for understanding the status of screenings in California, areas requiring continued work, and avenues for coordination and partnership. There is an opportunity to continue to learn from what is happening at the local and regional levels to build systems that emphasize health care providers as critical partners, and that are addressing data, referral, and financing challenges.

Examining efforts in other states that have led to significant increases in numbers of young children receiving developmental and behavioral screenings in primary care can also be helpful in improving the work in California (see box on next page for example).

Example: North Carolina Assuring Better Child Health and Development (ABCD) Project

California can learn from states such as North Carolina that leads the nation in services to children receiving Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

The ABCD project began in 2000 as a scalable primary care quality improvement initiative in North Carolina focusing on the implementation of a standardized, validated developmental screening tool at certain well-child visits and linkages to referral, follow-up, and community resources for eligible children and their families.

In 2004, after participating in the ABCD-I Project to pilot developmental screening of children receiving EPSDT in pediatric and family practices, North Carolina amended its state Medicaid policies to require screening with a standardized tool at all well-child visits between 6 months and 5 years of age.[41]

Other concurrent activities include the creation of a state advisory board to address barriers and promote policies for strengthening and expanding the program as well as the development and dissemination of parent education materials. Since inception, the North Carolina ABCD program has expanded across multiple counties and health networks. Because of the program, rates of developmental screening for Medicaid-eligible children have improved from 12% in 1999 to 91.4% in 2015.[42]

Next Steps

This landscape analysis will be used as a starting point with the Statewide Screening Taskforce as it develops state level recommendations and action steps. The analysis and Taskforce recommendations will then be shared with representatives from key organizations in the state that have developmental screenings as a focus and priority to determine how, together, they can move the needle on developmental screenings for children in the state.

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AAP Periodicity Table (Front)

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.

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

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017).

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

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	**Prenatal**[2]	**Newborn**[3]	**3-5 d**[4]	**By 1 mo**	**2 mo**	**4 mo**	**6 mo**	**9 mo**	**12 mo**	**15 mo**	**18 mo**	**24 mo**	**30 mo**	**3 y**	**4 y**	**5 y**	**6 y**	**7 y**	**8 y**	**9 y**	**10 y**	**11 y**	**12 y**	**13 y**	**14 y**	**15 y**	**16 y**	**17y**	**18 y**	**19 y**	**20 y**	**21 y**
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																			
Weight for Length		●	●	●	●	●	●	●	●	●	●																				
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																															
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★
Hearing		●[8]	●[9] →	→	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	←	←	●[10] →	←	← ● →		←		● →		
DEVELOPMENTAL/BEHAVIORAL HEALTH																															
Developmental Screening[11]								●			●		●																		
Autism Spectrum Disorder Screening[12]											●	●																			
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[14]																						★	★	★	★	★	★	★	★	★	★
Depression Screening[15]																							●	●	●	●	●	●	●	●	●
Maternal Depression Screening[16]				●	●	●	●																								
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																															
Newborn Blood		●[19]	●[20] →	→																											
Newborn Bilirubin[21]		●																													
Critical Congenital Heart Defect[22]		●																													
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★															
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	←	● →		★	★	★	★	★	←			● →	
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	←	● →		★	★	★
Cervical Dysplasia[31]																															●
ORAL HEALTH[32]							●[33]	●[33]	★		★	★	★	★	★	★	★														
Fluoride Varnish[34]							←	←	●	→	→	→	→	→	→																	
Fluoride Supplementation[35]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★					
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up-to-date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext).
11. See "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
12. Screening should occur per "Identification and Evaluation of Children With Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
13. This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (http://pediatrics.aappublications.org/content/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).
14. A recommended assessment tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.
15. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
16. Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice" (http://pediatrics.aappublications.org/content/126/5/1032).
17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
18. These may be modified, depending on entry point into schedule and individual need.

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ← ● → = range during which a service may be provided

AAP Periodicity Table (Back)

(continued)

19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf) establish the criteria for and coverage of newborn screening procedures and programs.
20. Verify results as soon as possible, and follow up, as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" (http://pediatrics.aappublications.org/content/124/4/1193).
22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at http://redbook.solutions.aap.org/SS/Immunization_Schedules.aspx. Every visit should be an opportunity to update and complete a child's immunizations.
24. See "Diagnosis and Prevention of Iron Deficiency and Iron-Deficiency Anemia in Infants and Young Children (0–3 Years of Age)" (http://pediatrics.aappublications.org/content/126/5/1040.full).
25. For children at risk of lead exposure, see "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
29. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*.
30. Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
31. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
32. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
33. Perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf). See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
34. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.htm). Once teeth are present, fluoride varnish may be applied to all children every 3–6 months in the primary care or dental office. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).
35. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care

(Periodicity Schedule)

This schedule reflects changes approved in February 2017 and published in April 2017.
For updates, visit www.aap.org/periodicityschedule.
For further information, see the *Bright Futures Guidelines*, 4th Edition, *Evidence and Rationale chapter* (https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_Evidence_Rationale.pdf).

CHANGES MADE IN FEBRUARY 2017

HEARING

- Timing and follow-up of the screening recommendations for hearing during the infancy visits have been delineated. Adolescent risk assessment has changed to screening once during each time period.
- Footnote 8 has been updated to read as follows: "Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per 'Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs' (http://pediatrics.aappublications.org/content/120/4/898.full)."
- Footnote 9 has been added to read as follows: "Verify results as soon as possible, and follow up, as appropriate."
- Footnote 10 has been added to read as follows: "Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See 'The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies' (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext)."

PSYCHOSOCIAL/BEHAVIORAL ASSESSMENT

- Footnote 13 has been added to read as follows: "This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See 'Promoting Optimal Development: Screening for Behavioral and Emotional Problems' (http://pediatrics.aappublications.org/content/135/2/384) and 'Poverty and Child Health in the United States' (http://pediatrics.aappublications.org/content/137/4/e20160339)."

TOBACCO, ALCOHOL, OR DRUG USE ASSESSMENT

- The header was updated to be consistent with recommendations.

DEPRESSION SCREENING

- Adolescent depression screening begins routinely at 12 years of age (to be consistent with recommendations of the US Preventive Services Task Force [USPSTF]).

MATERNAL DEPRESSION SCREENING

- Screening for maternal depression at 1-, 2-, 4-, and 6-month visits has been added.
- Footnote 16 was added to read as follows: "Screening should occur per 'Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice' (http://pediatrics.aappublications.org/content/126/5/1032)."

NEWBORN BLOOD

- Timing and follow-up of the newborn blood screening recommendations have been delineated.
- Footnote 19 has been updated to read as follows: "Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf) establish the criteria for and coverage of newborn screening procedures and programs."
- Footnote 20 has been added to read as follows: "Verify results as soon as possible, and follow up, as appropriate."

NEWBORN BILIRUBIN

- Screening for bilirubin concentration at the newborn visit has been added.
- Footnote 21 has been added to read as follows: "Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See 'Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications' (http://pediatrics.aappublications.org/content/124/4/1193)."

DYSLIPIDEMIA

- Screening for dyslipidemia has been updated to occur once between 9 and 11 years of age, and once between 17 and 21 years of age (to be consistent with guidelines of the National Heart, Lung, and Blood Institute).

SEXUALLY TRANSMITTED INFECTIONS

- Footnote 29 has been updated to read as follows: "Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*."

HIV

- A subheading has been added for the HIV universal recommendation to avoid confusion with STIs selective screening recommendation.
- Screening for HIV has been updated to occur once between 15 and 18 years of age (to be consistent with recommendations of the USPSTF).
- Footnote 30 has been added to read as follows: "Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually."

ORAL HEALTH

- Assessing for a dental home has been updated to occur at the 12-month and 18-month through 6-year visits. A subheading has been added for fluoride supplementation, with a recommendation from the 6-month through 12-month and 18-month through 16-year visits.
- Footnote 32 has been updated to read as follows: "Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See 'Maintaining and Improving the Oral Health of Young Children' (http://pediatrics.aappublications.org/content/134/6/1224)."
- Footnote 33 has been updated to read as follows: "Perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf). See 'Maintaining and Improving the Oral Health of Young Children' (http://pediatrics.aappublications.org/content/134/6/1224)."
- Footnote 35 has been added to read as follows: "If primary water source is deficient in fluoride, consider oral fluoride supplementation. See 'Fluoride Use in Caries Prevention in the Primary Care Setting' (http://pediatrics.aappublications.org/content/134/3/626)."

Appendices

State and Federal Initiatives with a Developmental Screening Focus - Page 1

Name	Description	Objectives	Target Population
Birth to 5: Watch Me Thrive!	A coordinated federal effort of the Departments of Health and Human Services (HHS) and Education. Includes materials from a wide array of federal agencies and their non-federal partners. They have published a list of research-based developmental screening tools appropriate for use across a wide range of settings and guides for specific provider types. http://www.acf.hhs.gov/ecd/child-health-development/watch-me-thrive	To encourage healthy child development, universal developmental and behavioral screening for children, and support for the families and providers who care for them.	Primary care providers, early care and education providers, child welfare, home visitors, behavioral health providers, housing and homeless shelter providers; focus is on children birth to five.
Bright Futures	A national health promotion and prevention initiative, led by the American Academy of Pediatrics. http://www.Brightfuturesaap.org	To increase awareness and implementation of the Bright Futures and American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care including recommended timing of developmental and behavioral health screenings.	Families, pediatric health care professionals, community organizations and government agencies' focus is infants, children and adolescents.
The Assuring Better Child Health and Development (ABCD) Program	A program administered by NASHP designed to assist states in improving the delivery of early child development services. The program focuses particularly on preventive care of children whose health care is covered by state health care programs, especially Medicaid. California was one of 20 states selected to participate in this nationally acclaimed project funded by the Commonwealth Foundation to identify specific state-supported strategies for improving the early identification of young children with developmental delays and special needs. http://www.nashp.org/abcd-history/	To strengthen primary health care services and systems that support the healthy development of young children.	State level partners; focus is children ages birth to three and their families.

State and Federal Initiatives with a Developmental Screening Focus - Page 2

Name	Description	Objectives	Target Population
Help Me Grow	A national model that promotes the early detection of delays in children and linkage to appropriate interventions and services within a community. First 5 Association, the coordinating body for Help Me Grow, unites 58 county commissions around a common policy agenda to advance an integrated and effective early childhood system of care. http://www.helpmegrowca.org http://www.first5association.org	More California children will achieve their optimal, healthy development by: 1) promoting periodic developmental screening practices to identify children with delays earlier, 2) coordinating care and linking families to available resources within their community to make treatment more effective, 3) providing ongoing education and outreach among families, providers and communities and 4) regularly reviewing data to identify gaps and opportunities for improvement.	Target Population: Families with children 0-5 years old, health care, early care and education providers, local sponsors, partners and advocates of early childhood issues.
Project LAUNCH (Linking Actions for Unmet Needs in Children's Health)	A federal partnership between Substance Abuse and Mental Health Services Administration, the Administration for Children and Families, the Health Resources and Services Administration, and the Centers for Disease Control and Prevention. CDPH/MCAH holds a SAMHSA grant for Project LAUNCH to promote an integrated approach designed to promote wellness, prevent mental, emotional and behavioral disorders, and support early detection and referral to needed resources. http://www.caprojlaunch.org/	To improve coordination across child-serving systems, build infrastructure, and increase access to high-quality prevention and wellness promotion services for children and their families.	Funding to state agencies; focus is children birth to 8 and their families.
Race the Top Early Learning Challenge (RTT-ELC) Grant	The Race to the Top Early Learning Challenge was a Federal Grant focused on establishing quality rating and improvement systems to increase the level of quality of early care and education programs. The California Department of Education and the Department of Developmental Services were awarded funding in 2012, which supported the development of QRIS in 16 counties. The statewide quality standards established specific developmental screening requirements and identified Help Me Grow as a preferred approach for early identification and linkages at the county level. The Department of Developmental Services received RTT/ELC partner funds from CDE in 2013 to coordinate/facilitate the Statewide Screening Collaborative.	Increase the number of children receiving developmental screenings who are enrolled in early care and education programs.	State and local QRIS operational partners, early education programs and parents of children in QRIS participating programs; focus is children birth to five.

Appendices

State and Federal Initiatives with a Developmental Screening Focus - Page 3

Name	Description	Objectives	Target Population
First 5 California Special Needs Project	A 4-year project (FY 05- FY06-09), in 10 California counties (El Dorado, Los Angeles, Mendocino, Merced, Monterey, Orange, Riverside, San Diego, San Francisco, and Sonoma), focused on universal access to screening for early identification and referrals for physical and developmental issues, including social, emotional, and behavioral issues; improved access to and utilization of services and supports; and inclusion of young children with disabilities and other special needs in appropriate, typical child care and development and other community settings with provision of necessary support to help the child succeed in these environments.	Improve school readiness for children with disabilities and other special needs and their families; promote strategies and practices that improve early identification and intervention for children from diverse backgrounds with disabilities, behavioral/mental health concerns, and other special needs; and strengthen the School Readiness Initiative and other First 5 California programs.	Ten participating First 5 county commissions and their local system partners in health and education; focus on children birth to five.
The California Developmental Screening Network (CA-DSN)	A network which delivers training, regional team planning, and facilitation of a Community of Practice to support implementing and scaling-up of developmental screening within the 10 CA-QRIS (Quality Rating Improvement) Regions. The CA-QRIS is focused on improving the quality of early care and education programs. The California Developmental Screening Network is coordinated by the WestEd Center for Prevention & Early Intervention (CPEI) and funded by the California Department of Education, Early Education and Support Division.	To develop a statewide system to support and sustain the quality implementation of developmental screening within the California Quality Rating and Improvement System (CA-QRIS).	State and local stakeholders and partner agencies in the 10 CA-QRIS regions; focus on children birth to five.
Race the Top Early Learning Challenge (RTT-ELC) Grant	The Race to the Top Early Learning Challenge was a Federal Grant focused on establishing quality rating and improvement systems to increase the level of quality of early care and education programs. The California Department of Education and the Department of Developmental Services were awarded funding in 2012, which supported the development of QRIS in 16 counties. The statewide quality standards established specific developmental screening requirements and identified Help Me Grow as a preferred approach for early identification and linkages at the county level. The Department of Developmental Services received RTT/ELC partner funds from CDE in 2013 to coordinate/facilitate the Statewide Screening Collaborative.	Increase the number of children receiving developmental screenings who are enrolled in early care and education programs.	State and local QRIS operational partners, early education programs and parents of children in QRIS participating programs; focus is children birth to five.

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