Orange County Developmental Pilot Project: Final Evaluation Report
Executive Summary

Developmental and behavioral disabilities, delays and risks are more prevalent in early childhood than many people realize.[1] According to the Centers for Disease Control and Prevention (CDC), 17% of children in the United States "have a developmental or behavioral disability such as autism, mental retardation, and Attention-Deficit / Hyperactivity Disorder."[2] Additionally, many other children have delays in language or other areas that can detrimentally impact their readiness for school. Despite the prevalence of developmental delays and disabilities in early childhood, the CDC reports that less than 50% of children experiencing delays are identified as having a problem before starting school.[3] Failing to identify delays early results in missed opportunities for effective treatment.

This report focuses on the Orange County Developmental Screening Pilot Project and the four agencies that spearheaded efforts to integrate developmental screenings into well child visits through their participation as pilot sites: The American Academy of Pediatrics (AAP), CalOptima, Help Me Grow Orange County (HMG-OC), and Orange County Health Care Agency's Family Health Department (HCA-FHD). Challenges and lessons learned are documented as well as issues to explore if the Commission wants to expand the implementation of developmental screening efforts in Orange County.

Findings

- Ninety-four percent (94%) of the AAP screenings indicated no concerns and no risk factors; 80% of the HMG-OC screenings had no concerns or risk factors; and 69% of screenings at the HCA-FHD site indicated no concerns or risk factors.
- There were 425 screenings with at least one concern noted (13% of the screenings completed). Throughout the period of the pilot, language or communication was consistently the most common concern identified. The next most common concern was social-emotional/ behavioral.
- There were 325 screenings that led to a referral, with an average of 1.7 referrals for each child referred. The two most common referral agencies were the Regional Center (typically for children under three years old) and school districts (typically for children three and older).
- In one to two percent of the screenings conducted, a referral was provided when the screening tool indicated that there was no concern. One reason for this could

[1] See American Academy of Pediatrics, Committee on Children with Disabilities, Role of the Pediatric Clinician in Family-Centered Early Intervention Services. *Pediatrics*. 2007; 107: 1155-1157; Margaret Dunkle, *High Quality Developmental Screening* (reprinted from dpeds.org, Sept. 2009) available at www.dbpeds.org/screening/; Laura Sices, *Developmental Screening in Primary Care: The Effectiveness of Current Practice and Recommendations For Improvement* (The Commonwealth Fund, Dec. 2007) available at www.commonwealthfund.org/Search.aspx?search=developmental+screening.

[2] Centers for Disease Control and Prevention, "Child Development: Developmental Screening;" available at www.cdc.gov/ncbddd/child/devtool.htm.

[3] See www.cdc.gov/ncbddd/child/devtool.htm.

be that the parent did not have a concern but the physician did and decided to refer or the parent had a concern not reflected on the screening tool, such as a qualitative difference in a skill or behavioral concern.

Percent of Screenings with *Referrals*, by Site and Type of Concern

	AAP	HMG-OC	HCA-FHD
No concerns. No risk factors	1%	2%	1%
No concerns. Risk factors present (Questionable)	75%	33%	21%
Concerns, Recommend assessment	80%	59%	91%

Lessons Learned

Identify "Champions" at each site. There is agreement among pilot sites that the project was most successful in those practice sites that had someone to act as a champion. A two-tiered process of identifying champions is recommended. The first tier, identifying a physician, is important for getting an office to participate. The next tier, identifying a day-to-day champion at each site, usually occurs once the project is implemented and a natural champion emerges.

Educate physicians and office staff about child development. Such education includes information about the importance of screening children using a validated tool, early childhood development and milestones, and early intervention referrals. Education about developmental milestones can assist physicians and office staff with interpreting the developmental screenings whereby reducing the chance for under- or over-referrals.

There is no "right" model for scoring screenings. Pilot sites had the option of scoring the screenings themselves or training practice sites to score the screenings in house. In general, the practice site/medical home model for scoring is useful if child needs an authorization for a medical referral. Conversely, having an outside agency (e.g., HMG-OC) score the screen is helpful if there is a need for a community-based referral.

It is feasible to implement developmental screenings without the use of monetary incentives. Providing monetary funds to physicians for completing the developmental screenings did not seem to be a factor in practice sites successfully conducing screenings. In general, the monetary incentive was not enough to get some provider offices to actively participate in the pilot. Incentives such as referral resources, technical assistance, and free access to screening tools are valued as an incentive for offices to participate. In addition, it is important to develop the infrastructure and office flow necessary to implement screenings when feasible.

Recommendations

The process of implementing the Developmental Screening Pilot provided an opportunity to identify the steps necessary for implementing developmental screenings

in practices. It has also provided an opportunity to refine the process should the Commission wish to move forward with expanding implementation of developmental screening efforts in Orange County. The following are recommendations for issues to explore if the Commission considers moving forward with other screening efforts:

Explore ways to follow up on referrals. One piece of the data collection effort that is missing is the link between a referral and the outcome. Once a child receives a referral, it is difficult to track whether the family followed up on the referral, if the child was found eligible for services, and the outcome of the child receiving services. The use of a data management system (e.g., CMIS, CHADIS) would be helpful for capturing information about screenings and referrals. In addition, having a Memorandum of Understanding (MOU) between agencies could assist with the sharing of information.

Identify the service gaps. In general, practice sites know to use the Regional Center as a referral. Unfortunately, they are often unsure about non-Regional Center resources. Along with provider education about available resources, it is important to promote the use of Help Me Grow. HMG-OC is working to build increased visibility in the county and is actively working with the Regional Center to strengthen their relationship.

Coordinate developmental screening efforts. As more agencies and practices begin to conduct developmental screenings (e.g., Early Head, Head Start, home visiting programs) it will become more important for screening efforts to be coordinated. This includes increased communication between a child's Early Care and Education program and his/her medical home. One way to ensure this is the use of electronic medical records or having a shared database. Such efforts are already occurring in the nation. A first step to take in Orange County is to make sure that families read and sign a consent form that allows their information to be shared with other programs and agencies. The use of MOUs between agencies can also assist with this effort and ensure that once a child is referred s/he does not receive an unnecessary rescreen.