Child Health & Developmental Screening

MINNESOTA

QUALITY INDICATORS

A Comprehensive Framework
to Build and Evaluate
Community-Based
Screening Systems

Minnesota Department of Education

MINNESOTA MDH DEPARTMENT OF HEALTH

Minnesota Department of Human Services

Acknowledgments

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The commitment to this project demonstrates the desire not only to improve health and developmental screenings for children, but also to participate in building a model of community-wide collaboration, and to enhance coalition-building across screening systems for the good of all children. We are grateful for any past and future feedback on this document and hope it becomes a useful tool for program planning, evaluation, self-assessment, and continuous program improvement for community-based health and developmental screening efforts for children, adolescents, and their families.

The

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Introduction

The Minnesota Quality Indicators for Child Health and Developmental Screening: A Comprehensive Framework to Build and Evaluate Community-Based Screening Systems (Quality Indicators Framework) is a guide to assist schools, service providers, organizations, and communities in the planning and self-evaluation of children's screening programs for the purposes of program improvement and enhanced coordination across screening systems. The document provides a framework to improve the content, quality, consistency, and credibility of community child health and developmental screening programs throughout Minnesota. Through the *Quality Indicators Framework*, a common set of standards will be in place to plan and analyze community-based screening efforts. This document is a guide for a community-wide planning process and can enhance coalition building across screening systems. It is through shared efforts of responsibility among all key stakeholders that developmental and health outcomes for Minnesota's children are improved.

The *Quality Indicators Framework* is designed for child health and developmental screening programs, such as Early Childhood Screening, Child & Teen Checkups/EPSDT, and Head Start. Specific outcomes, indicators, criteria for measurement, strategies for improvement, and potential data sources are suggested for service providers, organizations, and community members to improve screening for health and developmental concerns that impact children's well-being and future development and learning. *Quality Indicators Framework* is vital to anyone who is concerned about supporting children's development, health, growth, or learning. It can be adapted for use in other screening programs for young children or expanded to include adolescents.

Goals of the Quality Indicators Framework

Currently, community-based quality indicators or measures across child health and developmental screening programs in Minnesota do not exist. The use of the Quality Indicators Framework will help fill this gap, demonstrate state support for community collaboration, identify the need for appropriate evaluation of both program outcomes and partnerships, and provide a framework for ongoing community self-assessment of screening efforts. It will promote improved community collaboration and accountability within programs and

partnerships. Ultimately, the health, development and learning of all children in Minnesota will be improved through the early identification and subsequent interventions based on identified need.

The document supports three goals for children's health and development:

1. All eligible children participate in community-based health and developmental screening within recommended timeframes.
2. All eligible children receive age-appropriate and complete health and developmental screening to identify potential health and developmental concerns in a family-friendly, culturally and linguistically responsive way.
3. Children and their families who are referred through health and developmental screening receive appropriate and timely assessment, evaluation, and/or services to meet their identified need(s).

It is expected that the *Quality Indicators Framework* will have the following outcomes for Minnesota's screening systems:

1. Implementation of cross-system quality indicators that assist community-based screening programs in the evaluation of the screening processes and subsequent results for children and their families.
2. Improvement of the collaborative process through the use of the *Quality Indicators Framework* that promotes discussion, evaluation of current practice, and planning for future improvement in screening efforts.
3. Reduction in the duplication of screening services for children through cooperation, coordination, and integration of services between education, health, social services, Head Start, and other community partners.
4. Enhanced outreach, referral, and follow-up services to eligible and/or special populations.
5. Assurances that local screening programs are in compliance with state and federal laws, rules, regulations, and program standards.
6. Validation of those practices that meet quality indicator measurements for screening in early childhood and with other populations for whom health and/or developmental screening is intended.

Background About Minnesota's Screening Programs

Currently, the State of Minnesota has three programs that include health and developmental screening requirements for children. Although these programs have been created for different purposes and are funded in different ways, many of the elements are similar and subsequently provide the opportunity to improve child outcomes through significant and meaningful program coordination. These programs include:

Child and Teen Checkups Program (C&TC)/EPSDT – C&TC is the name for Minnesota's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. EPSDT is a federal program that provides for the coverage of comprehensive and periodic evaluation of the health, developmental, and nutritional status, in addition to vision, hearing, and dental screening services to all Medicaid enrolled children from birth to 21 years of age. The program's primary goal is to prevent disease and detect treatable conditions early to avoid further serious health problems and more costly health care. Program providers include primary care providers and public health nurses who have been specially trained.

Early Childhood Screening – Early Childhood Health and Developmental Screening was created to assist parents and communities to improve the educational readiness and health of all young children through the early detection of children's health, development, and other factors that may interfere with a child's learning and growth. Participation in screening is required for children prior to public school enrollment. Minnesota school districts are required to offer Early Childhood Screening to young children before kindergarten entrance, targeting children 3 1/2 to 4 years of age.

Head Start – The purpose of Head Start is to promote school readiness by enhancing the social and cognitive development of children through the provision for health, education, nutritional, social and other services to low-income children and their families based upon identified needs through an assessment. Within 90 days of enrollment in the Head Start Program, all children are required to have an up-to-date, age appropriate preventive health care check-up. The screening must incorporate the requirements of the schedule used by the state's EPSDT program. In addition, within 45 days of enrollment, agencies must perform or obtain linguistically and age-appropriate screening procedures to identify concerns regarding a child's development, sensory (visual and auditory), behavior, motor, language, social, cognitive, perceptual, and emotional skills.

Process of the *Quality Indicators Framework* Development

Since 1995, the Minnesota Departments of Education, Health, and Human Services and the Minnesota State Head Start Collaboration Office have coordinated staff development, policies, and program information for the Early Childhood Screening Program, Child and Teen Checkups/EPSDT, and screening that occurs in Head Start. The goal was to reduce duplicative screenings for young children and to eliminate gaps in the identification of children who needed further evaluation or assessment of development or health concerns.

Through the process of working across three state agencies and with community partners, it became increasingly evident that a common set of standards for best practice in outreach, screening, and referral and follow-up needed to be articulated. It was essential that the standards be developed within a framework that supported community partnerships, while at the same time providing a comprehensive approach for evaluation of the effectiveness of the screening process through different perspectives.

The Interagency Screening Workshops offered by the state agency partners across Minnesota in 2001 and 2002 provided significant input to the foundation for the *Quality Indicators Framework*. The Workshops included participants who represented the school-based Early Childhood Screening Program, Early Childhood Special Education, Part C/Early Childhood Intervention, Interagency Early Intervention Committees, Early Childhood Family Education, School Readiness Programs, Head Start, public health agencies, Child and Teen Checkups/EPSDT providers, and members of the Reservations.

In fall 2002, the state agency partners convened several regional groups consisting of 40 community experts from education, health, and Head Start to identify measures of best practice in the three components of the screening process (outreach, screening, and referral and follow-up) and across three levels of impact (service delivery, organizational, and community).

Parent input was solicited through a focus group convened in a rural region of Minnesota in which participants reflected diverse points of view and experiences. In addition, data from ten Early Childhood Screening Program Community Review Groups were included in the *Quality Indicators Framework* and the Child Health and Developmental Screening Family Survey. The parent and community groups were representative of families who spoke Arabic, Cambodian (Khmer), English, Hmong, Laotian, Oromo, Russian, Somali, Spanish, Serbo-Croation, and Vietnamese as their primary language.

Organization of the Document

The measures in the *Quality Indicators Framework* identify specific observable criteria that reflect characteristics of effective screening programs. All of the indicator measures included meet Minnesota statutes, rules, and regulations and federal regulations applicable to screening programs including the Federal Head Start Performance Standards. The indicators listed portray the ideal screening system for communities to plan and work towards supporting children's health and development. The *Quality Indicators Framework* is designed to be comprehensive, yet flexible, allowing communities to determine areas for improvement in services for children. Education, health, and community partners may start by focusing on only one or two outcome areas, components, or levels of impact.

The *Quality Indicators Framework* is broken down into several different manageable sections that are organized according to the three required screening components:

1. Outreach
2. Screening
3. Referral and Follow-up

Within each of these three component areas, three different levels of impact are detailed:

1. Service Delivery
2. Organization
3. Community

The three components and three levels of impact are developed into a matrix. The first matrix in Part II overviews the nine outcomes of the *Quality Indicators Framework* document. For each outcome in the matrix, specific indicators or measures are identified. Following each outcome and indicator, brief criteria for determining if the indicator has been met is presented. Suggested strategies for improvement in an outcome area are also provided for each indicator. Possible data sources are identified as evidence sources that provide information or documentation about the indicator being measured.

Part II of the *Quality Indicators Framework* includes a "Quality Indicator Framework Checklist" for each of the outcomes. The checklist is formatted in a way to help service providers, organizations, and community members consider the screening process and the application of each outcome and indicator in their work in how to improve children's health and development. Space is provided to rate each indicator and identify priorities for each outcome. Additional space is included in the checklist to develop a brief action plan to improve the screening process for children and their families. When used over time, the *Quality Indicators Framework* and checklist becomes a documentation of the partners' efforts to build and evaluate community-based child health and developmental screening systems.

Conclusion

The Quality Indicators Framework is a new approach to supporting child and family development and health through partnerships and the use of a common set of standards for practice. It is designed to encourage effectiveness, understanding, and meaningful work between education, health, and community programs that serve children and their families so that collectively Minnesota's youngest citizens have the brightest future possible.

Matrix of Outcomes

	OUTREACH	SCREENING	REFERRAL & FOLLOW-UP
SERVICE DELIVERY LEVEL	All eligible children participate in community-based health and developmental screening within recommended timeframes	All eligible children receive age-appropriate and complete health and developmental screening to identify potential health and developmental concerns in a family-friendly, culturally, and linguistically responsive way.	Children and their families who are referred through health and developmental screening receive appropriate and timely assessment, evaluation, and/or services to meet their identified potential need(s)
ORGANIZATION LEVEL	The organization has an effective process and sufficient resources to work with other screening-related providers to ensure all eligible children participate in health and developmental screenings.	The organization participates in community-based health and developmental screening efforts to effectively identify children who need further assessment, evaluation, and referral for services.	The organization has an effective process and sufficient resources to work with other screening-related providers to ensure effective, family-friendly, culturally, and linguistically responsive assessment, evaluation, and/or referral and follow-up services for children and their families.
COMMUNITY LEVEL	The community works together to ensure that all children participate in health and developmental screening within the recommended timeframes.	All children in need of assessment, evaluation, diagnosis, and/or treatment are identified through a comprehensive, non-duplicative community-wide health and developmental screening process.	The community has an effective follow-up and referral process in place to ensure appropriate and timely services will be provided to any child whose screening indicates a need for further evaluation, assessment, and/or treatment.

Outreach Component

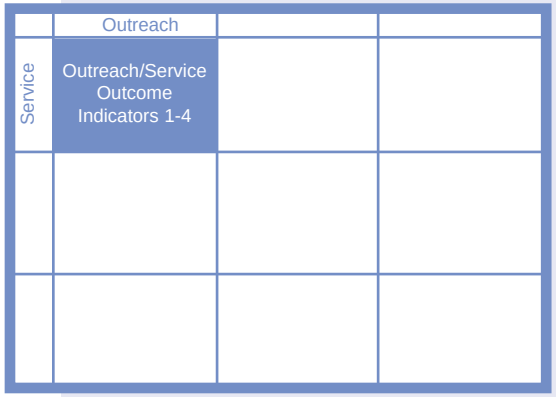
	Service Delivery Level	Organization Level	Community Level
OUTCOMES	All eligible children participate in community-based health and developmental screening within recommended timeframes.	The organization has an effective process and sufficient resources to work with other screening-related providers to ensure all eligible children participate in health and developmental screenings.	The community works together to ensure that all children participate in health and developmental screening within the recommended timeframes.
QUALITY INDICATORS	1. Families of eligible children are effectively informed of age-appropriate health and developmental screening services.	1. The organization implements a comprehensive outreach plan that includes evaluation.	1. The community develops and operationalizes a comprehensive plan for outreach to all eligible families. (This plan is part of a comprehensive community-based screening plan that includes screening and referral and follow-up components)
	2. Families are offered assistance with county or community transportation as needed and available.	2. The organization promotes health and developmental screenings.	2. The community uses common/consistent messages regarding health and developmental screening programs.
	3. Families are offered assistance with interpretive services, as needed.	3. The organization recruits, hires, and retains appropriate and adequate staff FTEs to meet outreach objectives.	3. The community conducts outreach activities and uses public awareness materials that are sensitive to culture, language, literacy, and family needs.
	4. Families have choices in health and developmental screening providers and hours of service.	4. The organization ensures staff development on effective outreach strategies to families.	4.The community evaluates outreach to eligible children and their families annually.
		5. The organization evaluates outreach to eligible children and their families annually.	

Outreach, Service Delivery

Outcome: All eligible children participate in community-based health and developmental screening within recommended timeframes.

1 INDICATOR:

Families of eligible children are effectively informed of age appropriate health and developmental screening services.



Criteria for Full Implementation of Indicator

Health and developmental screeners or outreach staff have current knowledge about the service population including culture, ethnicity, literacy and language needs, and other identified family needs.

Health and developmental screeners or outreach staff consistently inform families about screening services using program brochures, newsletters, and other media which are reflective of:

- culture / ethnicity
- language and literacy needs
- income levels
- family needs
- other characteristics of eligible families within the community

Health and developmental screeners or outreach staff use a wide variety of approaches to reach eligible population including hard-to-reach children and families. These approaches are responsive to cultural preferences in order to inform families about screening services. These methods include personal contacts such as telephone calls, home visits, contacts vis-a-vis other service providers, and other face-to-face contacts as appropriate.

Suggested Strategies for Implementation and Possible Data Sources

Review community data periodically to determine needs of the eligible population (e.g. census).

Use multiple appropriate data sources to identify all eligible children (e.g. through census data by age and demographics, program data updates/reports, CATCH system, IEIC Central Directory, Follow Along Program).

Identify effective methods for culturally responsible communication to service population.

Provide appropriate outreach materials based upon the target audience.

Provide means to communicate effectively with eligible children and their families who are blind, deaf/hard of hearing, or cannot read or understand the English language.

Use clear, non-technical language no higher than a 7th grade reading level in all written communication to families of eligible children.

Maintain an updated list of translators and interpreters who are able to assist in alternative forms of communication.

Maintain updated list of community screening providers.

Data Sources

Survey

Tracking data (for example):

- Health Care Financing Administration (HCFA-416), Centers for Medicare and Medicaid Services (CMS)
- CATCH 3 reports – Child and Teen Checkups/EPSDT
- Data Tracking Program - *PROVIDE*
- Early Childhood Screening Annual Report
- IR – Head Start Program Information Report
- Follow Along Program Data
- Interagency Early Intervention Committee (IEIC)Central Directory Tracking Data
- County birth records
- WIC

Screening provider lists

Community data

Census data

Print materials

Program guidelines, requirements, and timelines

Outreach, Service Delivery

Outcome: All eligible children participate in community-based health and developmental screening within recommended timeframes.

2

INDICATOR:
Families are offered assistance with county or community transportation as needed and available.

	Outreach		
Service	Outreach/Service Outcome Indicators 1-4		

Criteria for Full Implementation of Indicator

Health and developmental screeners or outreach staff:

- are knowledgeable about available transportation services
- inform families of available transportation services for those families needing it
- assist families to access transportation services, as appropriate
- follow program guidelines, requirements, and timelines for assistance with transportation

Suggested Strategies for Implementation and Possible Data Sources

Maintain an updated list of transportation providers.

Include offers of assistance with transportation in all outreach contacts with eligible children and their families as appropriate.

Develop a means to identify families who need transportation assistance.

Identify resources to pay for needed transportation services.

Identify procedures for obtaining transportation services.

Data Sources

Organization program protocol

Family and individual participant surveys

Transportation lists

Annual report data on use of transportation services

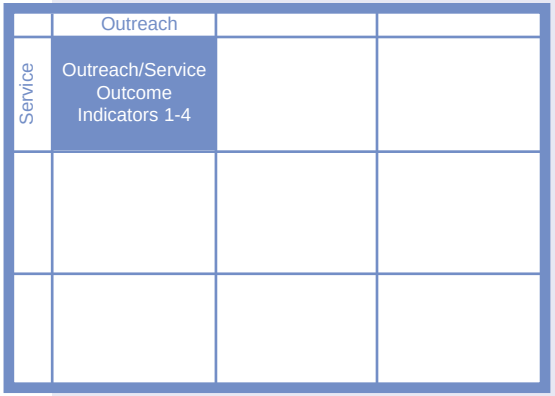
Catch 3 reports – Child and Teen Checkups / EPSDT

Outreach, Service Delivery

Outcome: All eligible children participate in community-based health and developmental screening within recommended timeframes.

3

INDICATOR:
Families are offered assistance with interpretive services, as needed.



Criteria for Full Implementation of Indicator

Health and developmental screeners or outreach staff:

- are knowledgeable about available interpreter services
- make interpreter services available to families needing them
- assist families to access interpreter services, as appropriate
- follow program guidelines, requirements and timelines for assistance with interpretive services

Suggested Strategies for Implementation and Possible Data Sources

Maintain an updated list of available interpretive services or providers.

Include offers of assistance with interpreters in outreach contacts to eligible children and their families as appropriate.

Develop a means to identify families and/or children who need interpreter assistance.

Identify resources to pay for interpreter services.

Identify procedures for obtaining interpreter services.

Data Sources

Organization program protocol

Family and individual participant surveys

Interpreter provider lists

Annual screening report data on use of interpreter services

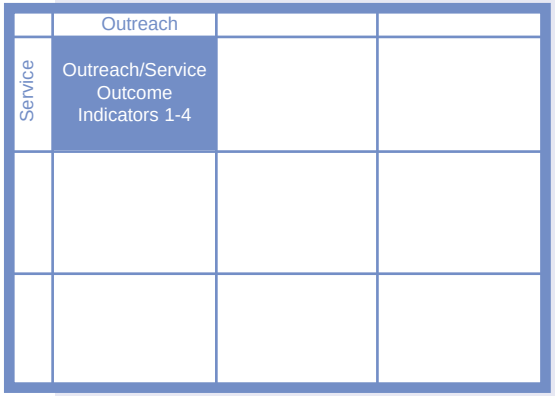
Catch 3 reports – Child and Teen Checkups/EPSDT

Outreach, Service Delivery

Outcome: All eligible children participate in community-based health and developmental screening within recommended timeframes.

4 INDICATOR:

Families have choices in health and developmental screening providers and hours of service.



Criteria for Full Implementation of Indicator

Health and developmental screeners or outreach staff:

- are knowledgeable about available screening providers
- inform eligible children and families of available screening providers
- include outreach strategies which inform families of screening sites that offer flexible hours to reduce barriers to participation
- identify and assist eligible children and families, as needed and appropriate, with access to screening services
- follow program guidelines, requirements and timelines for assistance with choices of screening providers and access to screening providers.

Suggested Strategies for Implementation and Possible Data Sources

Maintain an updated list of screening providers and service times. Include those with flexible hours.

Communicate screening and provider options including hours and locations to families.

Promote the use of extended hours based on community assessment results.

Offer assistance with finding a screening provider, making an appointment, etc. in all outreach contacts to eligible children and their families, as appropriate.

Data Sources

Survey

Participation rates

Screening schedules

Screening provider lists

Catch 3 reports – Child and Teen Checkups/EPSDT

Data tracking program – *PROVIDE*

3 **CHECKLIST** Component: Outreach Level: Service Delivery

Outcome: ***All eligible children participate in community-based health and developmental screening within recommended timeframes.***

Rating Code:
1= Full Implementation with ongoing evaluation; program meets or exceeds criteria for the indicator
2= Implementation in process; program partially meets criteria or implementation of strategies is emerging
3= Not yet; efforts to meet this indicator have not yet emerged
4= Not applicable or not enough information to respond

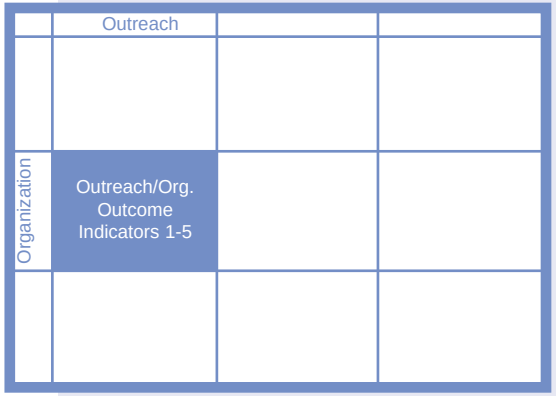
INDICATOR	1	2	3	4	Priority for planning & improvement strategies	Action Plan:
1. Families of eligible children are effectively informed of age appropriate health and developmental screening services.						
2. Families are offered assistance with county or community transportation as needed and available.						
3. Families are offered assistance with interpretive services, as needed.						
4. Families have choices in health and developmental screening providers and hours of service.						

Outreach, Organization

Outcome: The organization has an effective process and sufficient resources to work with other screening-related providers to ensure all eligible children participate in health and developmental screenings.

1 INDICATOR:

The organization implements a comprehensive outreach plan that includes evaluation.



Criteria for Full Implementation of Indicator

The organization has a working knowledge of critical components of effective outreach strategies and these are incorporated into the written plan.

The organization develops an outreach plan according to program requirements and in coordination with other school, public health agency, and other community plans that emphasize outreach in Child and Teen Checkups/EPSDT, Early Childhood Screening, Head Start, WIC and child find public awareness and outreach (e.g. Interagency Early Intervention Committee Plan and Maternal Child Health Plan).

The organization's management actively promotes and supports screening program objectives, outreach objectives, and strategies identified in the written plan.

The organization examines current community assessment information to determine language and literacy levels and cultural, racial, and ethnic demographics of the population. These results are incorporated into the plan.

The organization implements recommendations for changes to the outreach plan.

The organization participates in appropriate data sharing to improve outreach.

Suggested Strategies for Implementation and Possible Data Sources

Identify essential elements of program specific required outreach activities and incorporate them into the outreach plan.

Identify additional outreach activities that are responsive to community demographics and needs.

Coordinate outreach activities with screening providers as appropriate.

Utilize outreach strategies identified in community assessment plan.

Utilize all opportunities at the management level to promote program outreach objectives.

Identify effective methods for culturally responsive outreach to eligible populations that includes:

- Working with cultural leaders and cultural/ethnic organizations in order to develop partnerships for coordinated efforts and determine the most effective means of community outreach
- Reviewing current literature on best practices for working with diverse and hard-to-reach populations

Incorporate written data sharing agreements regarding outreach between participating agencies/providers.

Discuss relevant outreach data analysis at planning meetings to eliminate gaps and enhance coordination.

Develop interagency data sharing agreements in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Data Sources

Organizational outreach plan

Family/ individual participant surveys

Non-participant surveys

Tracking data (for example):

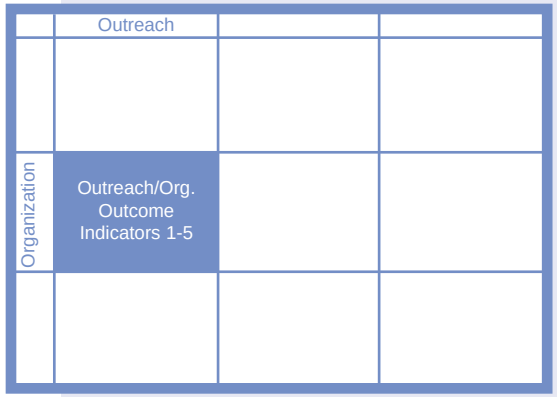
- Health Care Financing Administration (HCFA-416), Centers for Medicare and Medicaid Services (CMS)
- CATCH 3 reports – Child & Teen Checkups/EPSDT
- Early Childhood Screening Annual Report
- Head Start Program Information Report (PIR)
- Data tracking program – *PROVIDE*

Outreach, Organization

Outcome: The organization has an effective process and sufficient resources to work with other screening-related providers to ensure all eligible children participate in health and developmental screenings.

2 INDICATOR:

The organization promotes health and developmental screenings.



Criteria for Full Implementation of Indicator

The organizational leadership:

- initiates and participates in outreach efforts to promote health and developmental screenings for targeted populations through a variety of methods
- maximizes opportunities to promote screening (e.g. media events, publications, public forums, reports to the community, etc.)
- maximizes all available revenue sources to support appropriate outreach staff, promotional materials and other outreach activities
- identifies and maximizes all available resources to promote outreach activities
- assigns a staff position with decision-making authority and designated percentage of time to work with the community partners on outreach activities

Outreach, Organization

Suggested Strategies for Implementation and Possible Data Sources

Promote screening through:

- sharing promotional materials and resources
- media campaign
- phone calls
- personalized letters
- community events through all agencies serving this age group

Use clear, non-technical language no higher than a 7th grade reading level in all written communication with eligible children and families.

Define and promote a consistent educational message (e.g. the importance of screening, early identification, prevention, child find activities) for families through joint screening provider meetings.

Budget appropriate funds annually to provide outreach (e.g. staff time, office supplies, telephone, postage).

Organization designee participates with community partners to:

- regularly attend appropriate outreach / screening planning meetings
- share in meeting facilitation planning, location, agenda, follow-up etc.
- develop a community based outreach model

Identify mechanism to jointly share resources among partners for promotion of screening.

Data Sources

Budget

Financial reports

Meeting minutes

Position descriptions

Promotional materials

Partnership written agreement

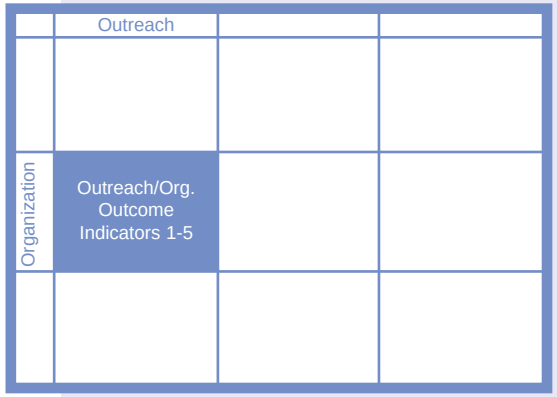
Time sheets

Outreach, Organization

Outcome: The organization has an effective process and sufficient resources to work with other screening-related providers to ensure all eligible children participate in health and developmental screenings.

3

INDICATOR:
The organization recruits, hires and retains appropriate and adequate staff FTEs to meet outreach objectives.



Criteria for Full Implementation of Indicator

Personnel policies define the recruitment and hiring process.

Organizational policies support staff retention.

Outreach staff reflects the cultural/ethnic/linguistic diversity of the community.

Sufficient FTEs are assigned to conduct all required and additional outreach activities to meet family needs based on community assessment.

Outreach, Organization

Suggested Strategies for Implementation and Possible Data Sources

Develop and maintain human resource policies and practices that support retention of staff.

Identify and provide the outreach staff to support outreach objectives.

Develop detailed position descriptions including specific time allocation for outreach activities and program responsibilities.

Provide support and resources for staff to successfully carry out outreach objectives.

Develop assurances that staff time allocation for providing outreach activity is met.

Data Sources

Outreach and / or screening staff position descriptions

Budget with line item allocation for staff position(s)

Financial reports with line expenditures for staff position(s)

Personnel policy manual

Demographic data

Personnel records

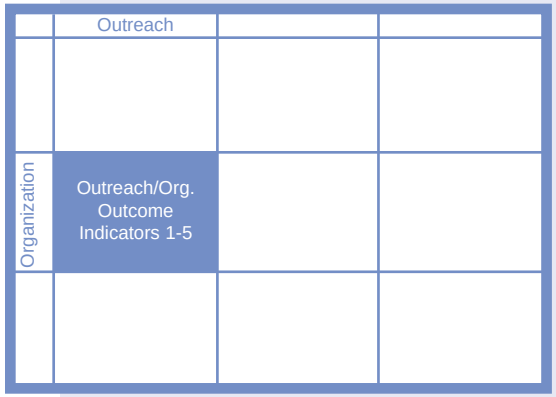
Time sheets

Outreach, Organization

Outcome: The organization has an effective process and sufficient resources to work with other screening-related providers to ensure all eligible children participate in health and developmental screenings.

4 INDICATOR:

The organization ensures staff development on effective outreach strategies to families.



Criteria for Full Implementation of Indicator

Annual staff development plan reflects an assessment of the organization's staff development needs.

Staff development includes:

- complete orientation for new staff
- cultural / ethnic and linguistic responsiveness components
- methods for assessing language and literacy needs of the service population
- best practices for effective outreach based on research
- program / state / federal policies and procedures for outreach
- community demographics

Organization provides staff development at regular intervals on appropriate and effective outreach techniques.

Organization's budget reflects allocation of resources for ongoing staff development.

Organization promotes coordinated or integrated staff development within community screening programs.

Suggested Strategies for Implementation and Possible Data Sources

Create and implement an annual staff development plan that includes the assessment of staff development needs.

Assess staff development needs related to performing effective outreach strategies.

Plan budgets to support staff development.

Require outreach staff attendance at workshops and periodic agency in-services that focus on outreach techniques.

Promote staff development on outreach in partnership with other organizations.

Develop and promote a coordinated mentoring system for staff that may include other organizations involved in outreach and screening.

Data Sources

Staff development records

Staff development plan

Budget with line item allocation for staff development

Financial reports with line expenditures for staff development

Performance evaluations

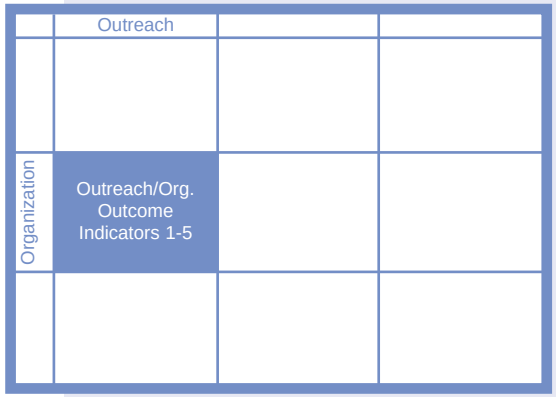
Workshop objectives and attendance

Outreach, Organization

Outcome: The organization has an effective process and sufficient resources to work with other screening-related providers to ensure all eligible children participate in health and developmental screenings.

5

INDICATOR:
The organization evaluates outreach to eligible children and their families annually.



Criteria for Full Implementation of Indicator

Comprehensive outreach plan is reviewed annually as part of the total organizational strategic planning.

Outreach efforts are evaluated at least annually and updated plans are modified accordingly.

Evaluation plan of outreach efforts includes, but may not be limited to:

- review of outreach plan
- review of staff development plan
- participation rates
- age at which children are screened
- family surveys to determine impact of outreach on participation
- analysis of participation and non-participation data (e.g. no shows) and includes numbers and percents of those who received other screening services.
- analysis of community demographic data to determine the effectiveness in reaching target populations
- multi-year trend analysis
- recommendations for improvement

Identification of target rates and other indicators of success.

Suggested Strategies for Implementation and Possible Data Sources

Identify and implement an ongoing process for the organization's outreach evaluation.

Review outreach plan as community changes are identified.

Develop baseline data for ongoing evaluation.

Gather and analyze local screening data for factors such as screening age and participation rates compared to past local results for total eligible and specific populations.

Gather, analyze and compare local screening data to state-wide benchmarks or targets for total eligible and specific populations.

Formulate and implement recommendations for improving outreach.

Data Sources

Written evaluation report

Survey

Tracking data (for example):

- Health Care Financing Administration (HCFA-416), Centers for Medicare and Medicaid Services (CMS)
- CATCH 3 reports – Child and Teen Checkups / EPSDT
- Early Childhood Screening Annual report
- PIR – Head Start Program Information Report
- Data tracking program – *PROVIDE*

3 CHECKLIST Component: Outreach Level: Organization

Outcome: ***The organization has an effective process and sufficient resources to work with other screening-related providers to ensure all eligible children participate in health and developmental screenings.***

Rating Code:
1= Full Implementation with ongoing evaluation; program meets or exceeds criteria for the indicator
2= Implementation in process; program partially meets criteria or implementation of strategies is emerging
3= Not yet; efforts to meet this indicator have not yet emerged
4= Not applicable or not enough information to respond

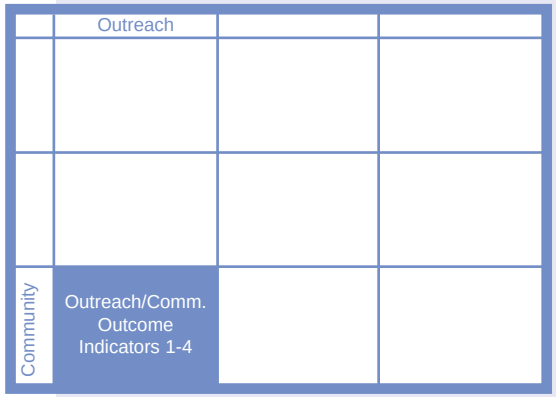
INDICATOR	1	2	3	4	Priority for planning & improvement strategies	Action Plan:
1. The organization implements a comprehensive outreach plan that includes evaluation.						
2. The organization promotes health and developmental screenings.						
3. The organization recruits, hires, and retains appropriate and adequate staff FTEs to meet outreach objectives.						
4. The organization ensures staff development on effective outreach strategies to families.						
5. The organization evaluates outreach to eligible children and their families annually.						

Outreach, Community

Outcome: The community works together to ensure that all children participate in health and developmental screening within the recommended timeframes.

1 INDICATOR:

The community develops and operationalizes a comprehensive plan for outreach to all eligible families. (This plan is part of a comprehensive community-based screening plan that includes screening and referral and follow-up components.)



Criteria for Full Implementation of Indicator

Community partners develop, implement, and annually revise a comprehensive outreach plan that is adapted by screening organizations in order to reach all eligible children. Plan includes but not limited to:

- community demographics and assessment
- identification of and input from all screening organizations and other stakeholders
- roles, responsibilities, and agreements for outreach identified by stakeholder groups
- targets for child and family participation as a result of outreach
- specific outreach methods
- inclusive of state and federal screening requirements
- mechanism to engage additional community stakeholders in community outreach process
- effective evaluation of outreach methods and results

Community partners have a working knowledge of the critical components of effective outreach methods.

Comprehensive community outreach plan is reviewed annually as a part of the total community strategic plan.

Community outreach efforts are evaluated annually and plans are modified accordingly.

Suggested Strategies for Implementation and Possible Data Sources

Identify stakeholders within the community including those who represent various cultural, linguistic, and hard-to-reach populations. (Examples: community cultural leaders, faith communities, health care providers, home visitors, social workers, home school liaisons, family support workers, child care resource and referral agencies, extension services, food shelf programs, transient housing, etc.)

Identify and work with community leaders who represent cultural and ethnic groups.

Systematically identify, analyze and report community needs and resources particularly for hard-to-reach populations using existing data, community forums, focus groups, surveys, interviews, etc.

Review existing community assessments and identify gaps, duplication, and opportunities to improve efficiency.

Develop and implement a comprehensive outreach plan that integrates results and recommendations of the community assessment(s) and includes action steps that address specific needs and maximize existing resources.

Develop timeline to operationalize outreach plan.

Review plan utilization efforts at least once a year.

Data Sources

Current comprehensive community outreach plan

Community assessment report

Demographic data

Meeting minutes from various community/cultural groups

Annual school district, county, state and federal report data on participation

Data tracking program – *PROVIDE*

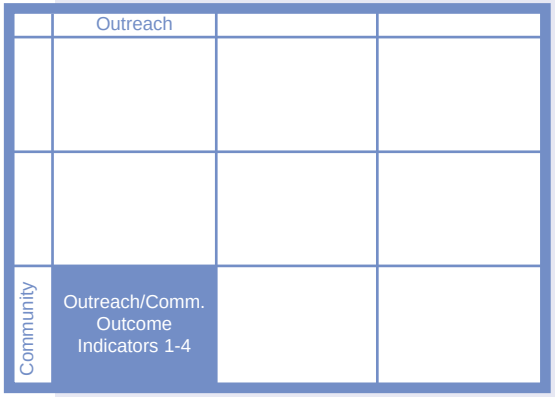
Catch 3 reports – Child and Teen Checkups/EPSDT

Outreach, Community

Outcome: The community works together to ensure that all children participate in health and developmental screening within the recommended timeframes.

2 INDICATOR:

The Community uses common and consistent messages regarding health and developmental screening programs.



Criteria for Full Implementation of Indicator

Community partners identify and/or develop and use common/consistent messages to eligible families that include but are not limited to:

- the value of health and developmental screening programs
- the importance of preventive health care and early intervention services
- the availability of screening services e.g. times, dates, locations
- the assistance with accessibility e.g. transportation and interpreters
- the requirements for screening participation for public school kindergarten entrance
- the screening program components and periodicity
- additional information based on community needs

Community partners identify and/or develop and use common/consistent messages for the broader community that may include any of the above with particular focus on:

- the value of health and developmental screening programs
- the importance of preventive health care and early intervention services

Outreach, Community

Suggested Strategies for Implementation and Possible Data Sources

Identify and convene the screening partners to create public awareness and outreach materials.

Maximize the use of existing public awareness and outreach materials. For example, state-developed Child and Teen Checkups brochures, Early Childhood Screening brochures, and other child find public awareness materials.

Develop new or adapt existing materials to reflect local information.

Compile and distribute marketing packet (that consists of information based on the criteria identified under full implementation of indicator).

Data Sources

Public awareness materials

Marketing packet

Meeting minutes

Surveys

Other outreach materials

Participation rates

Annual community evaluation

Outreach, Community

Outcome: The community works together to ensure that all children participate in health and developmental screening within the recommended timeframes.

3 INDICATOR:

The community conducts outreach activities and uses public awareness materials that are sensitive to culture, language, literacy, and family needs.

Criteria for Full Implementation of Indicator

Community partners implement outreach activities that address cultural and linguistic diversity and special needs populations.

Community partners engage cultural leaders as active participants in identifying most effective and respectful outreach activities and public awareness materials to be used with specific populations.

Community partners use alternatives to print materials to effectively reach families with limited literacy skills or who are English language learners.

Community partners are responsive to diverse family needs and adjust outreach accordingly.

Community partners evaluate outreach activities and public awareness materials for sensitivity to culture, language, literacy, and family needs.

	Outreach		
Community	Outreach/Comm. Outcome Indicators 1-4		

Outreach, Community

Suggested Strategies for Implementation and Possible Data Sources

Identify and convene meetings with appropriate cultural leaders representing specific populations within the community.

Make available materials translated for each language represented within the community to the extent possible.

Implement specific outreach communication for each language and culture represented in the community to the extent possible.

Evaluate literacy level of outreach materials and adjust accordingly.

Use a variety of outreach methods to address limited literacy skills, limited English proficiency and cultural preferences (e.g. face-to-face, telephone contacts, faith community connections and cultural community centers).

Develop outreach methods that are sensitive to family situations where the primary caregiver is someone other than a parent.

Data Sources

Public awareness materials

Meeting minutes

Evaluation

Translated materials

Participation rates

Demographics

Family surveys

Media texts

Data tracking program – *PROVIDE*

Catch 3 reports – Child and Teen Checkups/EPSDT

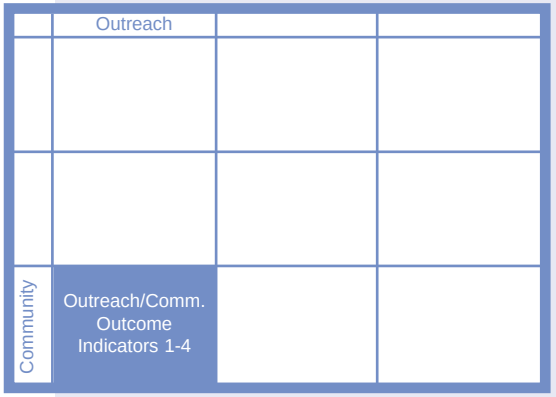
Special reports

Outreach, Community

Outcome: The community works together to ensure that all children participate in health and developmental screening within the recommended timeframes.

4 INDICATOR:

The community evaluates outreach to eligible children and their families annually.



Criteria for Full Implementation of Indicator

Community partners conduct comprehensive annual evaluation which includes but is not limited to:

- participation rates
- age at which children are screened
- effectiveness of outreach marketing / public awareness (e.g. print materials, media and other approaches) for all eligible children and families
- the roles, responsibilities, and outreach activities of the community partners
- recommendations for improvement

Community partners understand the importance of the evaluation process for improving outreach results.

Suggested Strategies for Implementation and Possible Data Sources

Identify an ongoing process for the community evaluation.

Develop baseline data for ongoing evaluation.

Gather and analyze local screening data for factors such as screening age and participation rates and nonparticipation rates compared to past local results for total eligible and specific populations.

Gather, analyze and compare local screening data to state-wide benchmarks or targets for total eligible and specific populations.

Formulate and implement recommendations for improving community outreach.

Data Sources

Written evaluation report

Surveys

Tracking data (for example):

- Health care Financing Administration (HCFA-416), Centers for Medicare and Medicaid Services (CMS)
- CATCH 3 reports – Child and Teen Checkups / EPSDT
- Early Childhood Screening Annual Report
- PIR – Head Start Program Information Report
- Data tracking program – *PROVIDE*

3 CHECKLIST Component: Outreach Level: Community

Outcome: ***The community works together to ensure that all children participate in health and developmental screening within the recommended timeframes.***

Rating Code:
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4= Not applicable or not enough information to respond

INDICATOR	1	2	3	4	Priority for planning & improvement strategies	Action Plan:
1. The community develops and operationalizes a comprehensive plan for outreach to all eligible families. (This plan is part of a comprehensive community based screening plan that includes screening and referral and follow-up components).						
2. The Community uses common and consistent messages regarding health and developmental screening programs.						
3. The community conducts outreach activities and uses public awareness materials that are sensitive to culture, language, literacy, and family needs.						
4. The community evaluates outreach to eligible children and their families annually.						

Screening Component

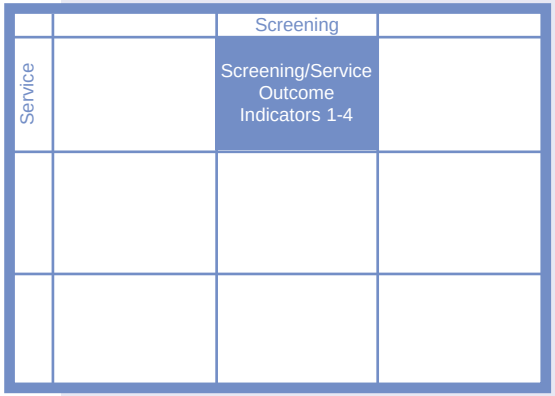
	Service Delivery Level	Organization Level	Community Level
OUTCOMES	All eligible children receive age-appropriate and complete health and developmental screening to identify potential health and developmental concerns in a family-friendly, culturally and linguistically responsive way.	The organization participates in community-based health and developmental screening efforts to effectively identify children who need further assessment, evaluation, and referral for services.	All children in need of assessment, evaluation, diagnosis, and/or treatment are identified through a comprehensive, non-duplicative community-wide health and developmental screening process.
QUALITY INDICATORS	1. Children have complete access to health and developmental screening services.	1. The organization implements a comprehensive screening plan that addresses gaps, reduces duplication, and contains costs to improve service delivery of health and developmental screening services among agencies.	1. The community partners assure all children receive a health and developmental screening by 3 1/2 - 4 years of age as required for public school kindergarten entrance.
	2. Children receive health and developmental screening in an environment which is safe, respectful, and family-friendly.	2. The organization selects, uses, and maintains valid health and developmental screening tools, methods, and equipment.	2. The community partners assure all children receive well-child screening according to periodicity schedules and program standards.
	3. Children receive health and developmental screenings that are responsive to the issues of ethnicity, culture and language.	3. The organization assures that qualified and appropriately trained staff conducts health and developmental screening components.	3. The community partners develop and operationalize a coordinated community health and developmental screening plan for children. (This plan is part of a comprehensive community-based screening plan that includes outreach and referral and follow-up components).
	4. Children receive appropriate and timely health and developmental screening according to current program standards and schedules.	4. The organization assures staff development on effective screening for children.	4. The community partners evaluate health and developmental screening services annually.
		5. The organization's budget allots sufficient staff, equipment, supplies, and resources to provide optimal health and developmental screenings.	

Screening, Service Delivery

Outcome: All eligible children receive age-appropriate and complete health and developmental screenings to identify potential health and developmental concerns in a family-friendly, culturally and linguistically responsive way.

1

INDICATOR:
Children have complete access to health and developmental screening services.



Criteria for Full Implementation of Indicator

Screening providers are available to provide needed screening services.

Various days, times, and locations convenient for families are available, including non-traditional locations and hours.

Screening program guidelines, requirements, and timelines are followed.

County or community transportation is provided to families as needed.

Qualified interpreters are provided as appropriate.

Other barriers to access (e.g., cultural beliefs, public perceptions), specific to community populations, are addressed as needed.

Suggested Strategies for Implementation and Possible Data Sources

Offer screenings during day, evening and/or weekend hours.

Offer screenings at non-traditional locations such as apartment complexes, places of worship, shopping malls, homeless and women's shelters, child care centers, libraries, community centers, etc.

Arrange for transportation and interpreters as needed during appointment scheduling.

Use updated resource list of volunteer drivers and options for low cost/free public transportation.

Use resource list of qualified interpreters periodically updated (include phone-link language line resources).

Provide ongoing orientation for interpreters.

Use community assessment to identify and address additional barriers to access screening services.

Data Sources

Participation rates

Screening schedules including times and locations

Participant surveys

Transportation utilization forms or records

Transportation lists

Screening provider lists

Interpretive service utilization forms

Orientation records for interpreters

Interpreter provider lists

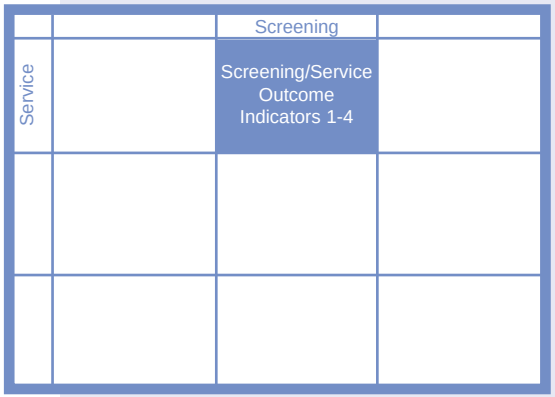
Community Assessment Reports

Screening, Service Delivery

Outcome: All eligible children receive age-appropriate and complete health and developmental screenings to identify potential health and developmental concerns in a family-friendly, culturally, and linguistically responsive way.

2

INDICATOR:
Children receive health and developmental screening in an environment which is safe, respectful, and family-friendly.



Criteria for Full Implementation of Indicator

A family-friendly environment consists of a facility and staff which welcomes children and parents, provides clear, consistent communication, responds positively to child and parent questions, and is respectful of diversity.

All screening areas are private, quiet, clean, safe, childproof, and child-focused with access to bathroom facilities.

The screening environment is in compliance with Americans with Disabilities Act (ADA) and Occupational Safety and Health Administration (OSHA) requirements.

All waiting areas:

- are clean, safe, childproof
- are equipped with safe and age-appropriate play materials
- provide a variety of parenting, health, child development, and community resource materials in languages and literary levels appropriate to community demographics
- have volunteers or paid staff to welcome, provide direction and answer questions

Provisions for sibling care are available.

Parents are consistently informed of the purpose of the developmental screening components and the variability in children's performance.

Suggested Strategies for Implementation and Possible Data Sources

Provide informational signs that communicate clearly and politely.

Learn and apply skills related to customer service and cultural responsiveness.

Identify and implement safety procedures and policies.

Assess screening location and environment to be in accordance with ADA and OSHA requirements.

Implement state or federal approved infection control standards for young children.

Review parenting, health, child development, and community resource materials periodically for appropriateness to screening population.

Conduct a focus group or survey for community input on screening environment.

Data Sources

Agency inspection report

Incident report

Family survey

Focus group results

Safety procedures and policies

ADA compliance manual

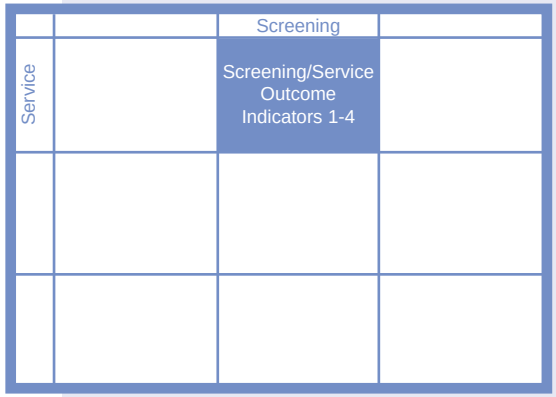
Infection control standards

Screening, Service Delivery

Outcome: All eligible children receive age-appropriate and complete health and developmental screenings to identify potential health and developmental concerns in a family-friendly, culturally and linguistically responsive way.

3

INDICATOR:
Children receive health and developmental screenings that are responsive to the issues of ethnicity, culture and language.



Criteria for Full Implementation of Indicator

Screening tools are used that have been validated for the ethnicity and culture of the population being screened to the extent possible.

Screening tools are used that have been validated for the language of the population being screened.

Screening tools are normed (scored) for diverse populations.

Screening and interpreter staff work in partnership to facilitate communication and understanding of screening process and activities.

Staff who conduct screening reflect the population screened.

Suggested Strategies for Implementation and Possible Data Sources

Research current screening tools appropriate to population screened.

Learn and apply skills related to cultural responsiveness.

Provide families with forms and materials in the family's primary language.

Provide materials at the 7th grade reading level for eligible children and their families.

Learn and apply skills to effectively work with interpreters.

Encourage the interpreters to provide feedback if staff have communicated with the family in a culturally inappropriate manner.

Identify the duties and vital roles of interpreters and other team members.

Provide the interpreter a glossary that clearly defines terms used in screening.

Data Sources

Forms and materials in multiple languages

Staff development records

Documentation of use of interpreters

Screening tools and instruments

Interpreter glossary

Parent survey

Screening, Service Delivery

Outcome: All eligible children receive age-appropriate and complete health and developmental screenings to identify potential health and developmental concerns in a family-friendly, culturally and linguistically responsive way.

4 INDICATOR:

Children receive appropriate and timely health and developmental screening according to current program standards and schedules.

		Screening	
Service		Screening/Service Outcome Indicators 1-4	

Criteria for Full Implementation of Indicator

Staff:

- are knowledgeable about current state and federal standards for health and developmental screening components
- are knowledgeable about current program requirements, e.g. periodicity schedule, Head Start Performance Standards, Early Childhood Screening Rules, etc.
- appropriately use state-approved screening instruments in accordance with current standards
- periodically evaluate inter- and intra-screener reliability
- follow recommended screening protocols
- use instruments and equipment that follow standards and schedules for calibrations
- document appropriately

Screening includes performing and documenting all components required according to the periodicity schedule.

Suggested Strategies for Implementation and Possible Data Sources

Complete screenings in compliance with current program standards, requirements, and policies.

Attend regular inservice sessions and maintain skills and knowledge on current screening standards and protocols.

Access current information sources regarding screening updates such as Web sites, listservs, memos, emails, regional networking groups, etc.

Follow appropriate screening program documentation requirements.

Data Sources

Data reports:

- Health Care Financing Administration (HCFA-416) Centers for Medicare and Medicaid Services (CMS)
- CATCH 3 reports - Child and Teen Checkups / EPSDT
- PIR – Head Start Program Information report
- Early Childhood Screening Annual Report
- Health plan / managed care

School census report

Periodic chart / school record audits

Family survey

3 CHECKLIST Component: Screening Level: Service Delivery

Outcome: ***All eligible children receive age-appropriate and complete health and developmental screenings to identify potential health and developmental concerns in a family-friendly, culturally and linguistically responsive way.***

Rating Code:
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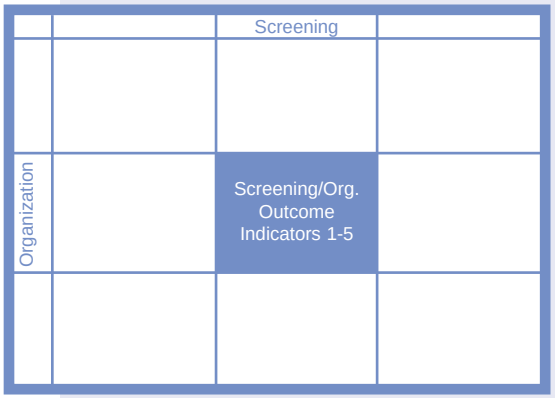
INDICATOR	1	2	3	4	Priority for planning & improvement strategies	Action Plan:
1. Children have complete access to health and developmental screening services.						
2. Children receive health and developmental screening in an environment which is safe, respectful, and family-friendly.						
3. Children receive health and developmental screenings that are responsive to the issues of ethnicity, culture and language.						
4. Children receive appropri-ate and timely health and developmental screening according to current program standards and schedules.						

Screening, Organization

Outcome: The organization participates in community-based health and developmental screening efforts to effectively identify children who need further assessment, evaluation, and referral for services.

1 INDICATOR:

The organization implements a comprehensive screening plan that addresses gaps, reduces duplication and contains costs to improve service delivery of health and developmental screening services among agencies.



Criteria for Full Implementation of Indicator

The organization has working knowledge of critical components of effective screening strategies and these are incorporated into the comprehensive screening plan.

The organization develops a screening plan according to program requirements and in coordination with other school, public health agency and other community programs that provide screening (e.g. Child and Teen Checkups/EPSDT, Early Childhood Screening, Head Start, and private providers).

The organization's management promotes and supports screening program objectives and strategies identified in the comprehensive screening plan.

The organization periodically evaluates effectiveness of screening program including program specific requirements.

The organization participates in appropriate data sharing to address gaps and reduce duplication of screening.

The organization actively demonstrates leadership in community collaborations and contributes resources to support coordinated screening.

The organization develops an ongoing strategic plan with all community partners to address the development and implementation of collaborations and shared resources.

Suggested Strategies for Implementation and Possible Data Sources

Identify essential elements of program specific required screening activities and incorporate them into the comprehensive written screening plan.

Hold periodic meetings with partners to ensure ongoing collaboration.

Use state interagency endorsed screening forms including but not limited to:

- Child Health and Developmental History
- Child Health and Developmental Screening Summary
- Parent Consent – Child Health and Developmental Screening
- Information Collection, Use and Release Consent – Child Health and Developmental Screening
- MDH Immunization Form

Establish a protocol for appropriate data sharing with screening partners that is in compliance with HIPAA regulations.

Identify additional screening components that are responsive to community demographics and needs.

Identify effective methods for culturally responsive screening to eligible populations that includes:

- Contacting cultural leaders and cultural/ethnic organizations in order to develop partnerships for coordinated efforts and determine the most effective means of community screening
- Reviewing current literature on best practices for working with diverse and hard-to-reach populations
- Analyze revenue and expenditure budgets

Data Sources

Data sharing agreements

Comprehensive screening plan and budget

Meeting minutes

Community partners' survey

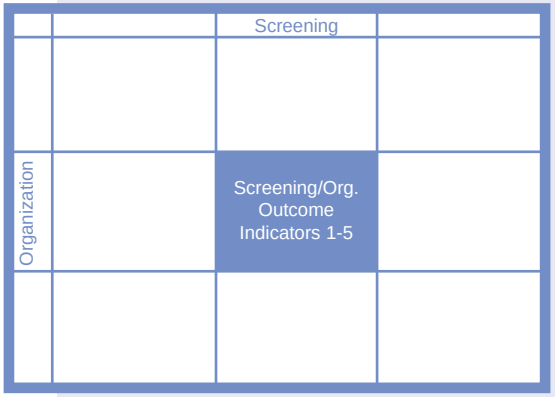
Annual school district, county, state and federal report data on participation

Screening, Organization

Outcome: The organization participates in community-based health and developmental screening efforts to effectively identify children who need further assessment, evaluation, and referral for services.

2 INDICATOR:

The organization selects, uses, and maintains valid health and developmental screening tools, methods, and equipment.



Criteria for Full Implementation of Indicator

The organization assures that valid and reliable screening tools are used by staff.

The organization has a system to assure compliance with screening protocols, standards, and other measures of quality.

Screening instruments and equipment are maintained and calibrated according to instrument/equipment standards.

Suggested Strategies for Implementation and Possible Data Sources

Develop and implement policies and procedures that specify the selection and utilization of standardized tools and equipment.

Assign staff to review tools and methods to determine appropriateness for eligible population.

Develop and implement procedures to monitor compliance with screening protocols, standards, and quality measures that include a documentation system.

Calibrate equipment such as audiometers, scales, etc. according to manufacturer's guidelines and state and federal standards.

Data Sources

Policy and procedure manuals

Periodic chart / school record / file audits

Data reports (confirmation of identified potential problems and / or referrals):

- CATCH 3 reports – Child and Teen Checkups / EPSDT
- PIR – Head Start Program Information Report
- Early Childhood Screening Annual Report
- Health plan / managed care
- Incidence and prevalence of health and developmental conditions

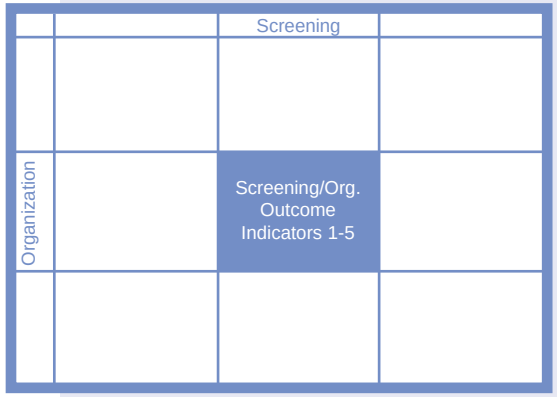
Documentation of equipment calibration

Screening, Organization

Outcome: The organization participates in community-based health and developmental screening efforts to effectively identify children who need further assessment, evaluation, and referral for services.

3 INDICATOR:

The organization assures that qualified and appropriately trained staff conducts health and developmental screening components.



Criteria for Full Implementation of Indicator

The organization recruits and engages staff that meet qualification standards as determined by Minnesota Departments of Health, Education and Human Services and Head Start.

The organization assures that staff maintains their skill level in completing screenings.

The organization recruits and engages staff who work with children in community-based early education and child care programs to conduct and/or assist with screening and sibling care.

The organization recruits and provides culturally diverse staff to conduct and support screening activities.

Suggested Strategies for Implementation and Possible Data Sources

Provide bilingual screening staff as needed.

Assure that managers are knowledgeable about current staff qualifications as required by federal and state statutes and rules and current best practices.

Provide job descriptions that reflect qualification standards for staff and volunteers.

Assure that staff attend required orientation and other inservices.

Conduct inter- and intra-rater reliability checks on a periodic basis.

Develop a relationship with a variety of organizations that work with:

- early education programs
- family child care providers
- child care center programs
- special education programs
- nutrition programs
- cultural communities

Provide outreach to community providers to ensure compliance with screening and program requirements.

Provide coordination of training as needed and appropriate to community providers to ensure availability of adequately trained screening providers.

Data Sources

Federal and state statutes, rules and qualification standards

Staff position description

Certification of completed staff development

Educational background of staff

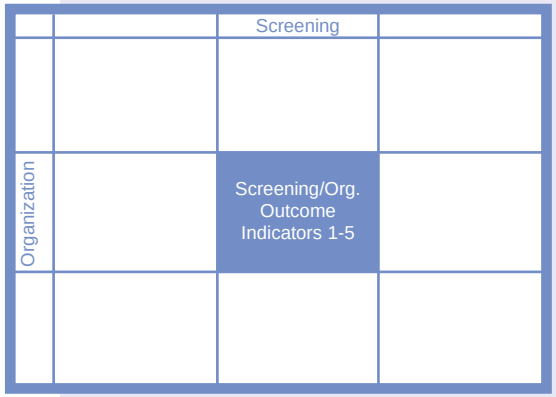
Annual staff evaluation

Screening, Organization

Outcome: The organization participates in community-based health and developmental screening efforts to effectively identify children who need further assessment, evaluation and referral for services.

4 INDICATOR:

The organization assures staff development on effective screening for children.



Criteria for Full Implementation of Indicator

Annual staff development plan reflects the assessment of staff development needs.

The organization assures staff development that includes:

- complete orientation for new staff
- cultural, ethnic, and linguistic responsiveness components
- methods for assessing the language and literacy needs of the service population
- best practices for effective screening based on research
- program / state / federal policies and procedures for screening
- use of valid and reliable tools and instruments
- current research on child development, child health, and parent education

The organization allocates resources to assure that all screening staff receive ongoing staff development.

The organization promotes coordinated or integrated staff development across community-based screening programs.

Suggested Strategies for Implementation and Possible Data Sources

Conduct an assessment of staff development needs through a survey, meeting, etc.

Assign staff to review staff development expenditures and make annual budget recommendations.

Arrange for periodic inservice workshops to maintain or enhance screening skills and knowledge on current program requirements and best practices.

Include ongoing staff development requirements in staff position descriptions.

Coordinate inservice activities with community partners.

Data Sources

Staff development assessment

Certification of completed staff development

Staff development budget and expenditures

Staff position descriptions

Interagency agreements for coordinated inservices

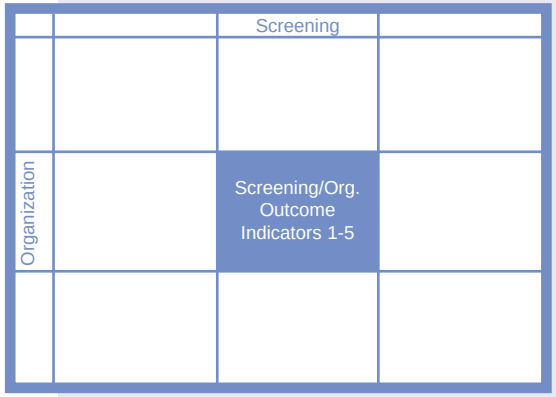
Participant survey

Screening, Organization

Outcome: The organization participates in community-based health and developmental screening efforts to effectively identify children who need further assessment, evaluation and referral for services.

5 INDICATOR:

The organization's budget allots sufficient staff, equipment, supplies, and resources to provide optimal health and developmental screenings.



Criteria for Full Implementation of Indicator

The organization annually reviews and modifies the budget to meet the screening needs of the eligible population.

The organization secures an appropriate site for the health and developmental screening activities including but not limited to ADA requirements.

The organization maximizes use of multiple public and private funding sources to provide comprehensive community-based screening services, e.g. Local Collaborative Time Study (LCTS), third-party reimbursement, foundation aid, civic organizations.

The organization procures supplies and equipment in advance of screening activities.

The organization provides sufficient staff time to organize and prepare for screening activities.

The organization has a sufficient number of staff on hand to meet the needs of children and parents scheduled for screening appointments.

Suggested Strategies for Implementation and Possible Data Sources

Assign staff to review screening expenditures and make annual budget recommendations.

Foster and maintain relationships with community partners to integrate or share resources.

Identify and seek funding from multiple funding sources.

Foster cooperation with other departments within the organization to support screening activities with in-kind contributions.

Data Sources

Screening budget including revenues and expenditures

Documentation of in-kind support

List of public and private funding sources

Payroll and invoices

3 CHECKLIST Component: Screening Level: Organization

Outcome: ***The organization participates in community-based health and developmental screening efforts to effectively identify children who need further assessment, evaluation and referral for services.***

Rating Code:
1= Full Implementation with ongoing evaluation; program meets or exceeds criteria for the indicator
2= Implementation in process; program partially meets criteria or implementation of strategies is emerging
3= Not yet; efforts to meet this indicator have not yet emerged
4= Not applicable or not enough information to respond

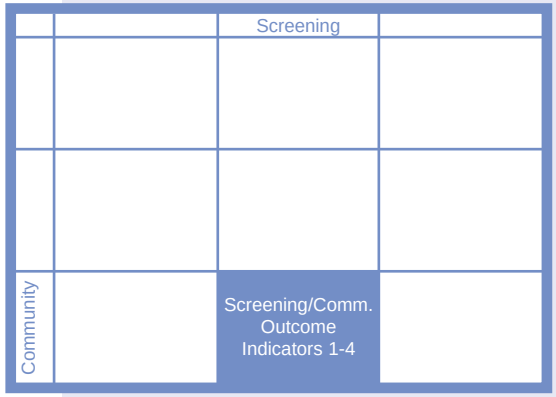
INDICATOR	1	2	3	4	Priority for planning & improvement strategies	Action Plan:
1. The organization implements a comprehensive screening plan that addresses gaps, reduces duplication and contains costs to improve service delivery of health and developmental screening services among agencies.						
2. The organization selects, uses, and maintains valid health and developmental screening tools, methods, and equipment.						
3. The organization assures that qualified and appropriately trained staff conducts health and developmental screening components.						
4. The organization assures staff development on effective screening for children.						
5. The organization's budget allots sufficient staff, equipment, supplies, and resources to provide optimal health and developmental screenings.						

Screening, Community

Outcome: All children in need of assessment, evaluation, diagnosis and/or treatment are identified through a comprehensive, non-duplicative community-wide health and developmental screening process.

1 INDICATOR:

The community partners assure all children receive a health and developmental screening by 3 1/2 - 4 years of age as required for public school kindergarten entrance.



Criteria for Full Implementation of Indicator

All children receive a health and developmental screening by 4 years of age as required for public school kindergarten entrance.

Community partners identify a process to coordinate screening of children 3 1/2 to 4 years of age.

Community partners assure all children are screened for potential social, emotional or behavioral concerns according to current screening program standards.

Community partners are using best practices guided by current research and technologies to provide optimal screening results. For example, using the Centers for Disease Control and Prevention (CDC) growth charts based on the most current National Health and Nutrition Evaluation (NHANES) data.

Suggested Strategies for Implementation and Possible Data Sources

Analyze Early Childhood Screening and census data to compare the number of eligible children to the number and age of children screened.

Identify gaps and duplications in screening activities among community partners.

Identify mechanism for all community screeners to share screening summary results with public schools as required for public school enrollment in accordance with data practices.

Data Sources

Birth records

School census data

Demographic survey

Immunization registries

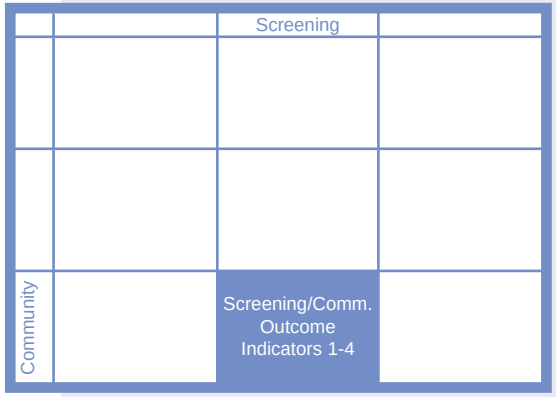
Summary Form

Screening, Community

Outcome: All children in need of assessment, evaluation, diagnosis and/or treatment are identified through a comprehensive, non-duplicative community-wide health and developmental screening process.

2

INDICATOR:
The community partners assure all children receive well-child screening according to periodicity schedules and program standards.



Criteria for Full Implementation of Indicator

All community partners have knowledge about and follow current early childhood screening state and/or federal program requirements each year.

All community partners follow recognized guidelines for comprehensive, preventative routine well-child care, such as the American Academy of Pediatric Recommendations for Preventive Health Services, Bright Futures, or Child and Teen Checkups/EPSDT.

Community partners assure all children are screened for potential social, emotional, or behavioral concerns according to current screening program standards.

Community partners are using best practices guided by current research and technologies to provide optimal screening results. For example, using the Centers for Disease Control and Prevention (CDC) growth charts based on the most current National Health and Nutrition Evaluation Survey (NHANES) data.

Suggested Strategies for Implementation and Possible Data Sources

Analyze existing data to compare the number of eligible children to the number and age of children screened.

Identify gaps and duplications in well-child screening activities among community partners.

Identify mechanism for all community screeners to share screening summary results in accordance with data practices in order to reduce duplication and facilitate preventative health care.

Provide all community partners with up-to-date periodicity schedule and program standards for Child & Teen Checkups/EPSDT, Head Start and Early Childhood Screening.

Integrate social, emotional, behavioral health screen within current screening practices, such as the use of a health and developmental history to determine potential concerns.

Keep current on research and recommendations regarding screening using listservs, recognized professional or government Web sites, and other professional literature resources.

Data Sources

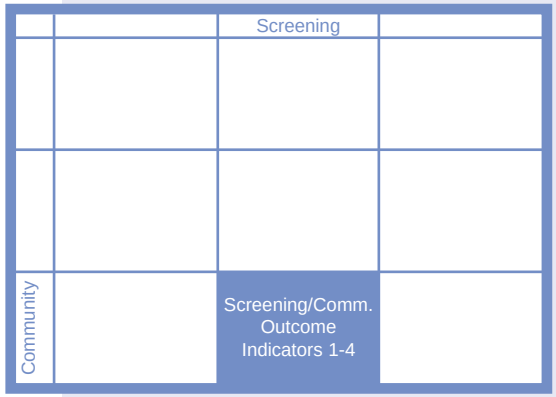
- Birth records
- School census data
- Demographic survey
- Immunization registries
- Early Childhood Screening Annual Report
- Catch 3 reports – Child and Teen Checkups/EPSDT
- Health Care Financing Administration (HCFA –416), Centers for Medicare and Medicaid Services (CMS)
- Summary Form
- Documentation records
- Chart audits

Screening, Community

Outcome: All children in need of assessment, evaluation, diagnosis and/or treatment are identified through a comprehensive, non-duplicative community-wide health and developmental screening process.

3 INDICATOR:

The community partners develop and operationalize a coordinated community health and developmental screening plan for children. (This plan is part of a comprehensive community based screening plan that includes outreach and referral and follow-up components).



Criteria for Full Implementation of Indicator ***(continued on page 70)***

Community partners develop, implement, and annually revise a comprehensive screening plan that is adopted by all screening organizations in order to screen all eligible children. Plan includes but is not limited to:

- community demographics and assessment
- identification of and input from all screening organizations and other stakeholders
- mechanism to engage additional community stakeholders
- roles responsibilities and agreements for screening identified by stakeholder groups
- targets for child and family participation
- specific screening models
- inclusive of state and federal screening requirements
- effective evaluation of screening methods and results

Community partners have a working knowledge of effective models and practices.

Suggested Strategies for Implementation

Identify stakeholders within the community including those who represent various cultural, linguistic, and hard-to-reach populations. (Examples: community cultural leaders, faith communities, health care providers, home visitors, social workers, home school liaisons, family support workers, child care resource and referral agencies, extension services, food shelf programs, transient housing etc.)

Identify and work with community leaders who represent cultural and ethnic groups.

Systematically identify, analyze, and report community needs and resources particularly for hard-to-reach populations using existing data, community forums, focus groups, surveys, interviews, etc.

Review existing community assessments and identify gaps, duplication, and opportunities to improve efficiency.

Develop and implement a comprehensive screening plan that integrates results and recommendations of the community assessment(s) and includes action steps that address specific needs and maximize existing resources.

Develop timeline to operationalize screening plan.

Data Sources

Participant survey

Current comprehensive community screening plan

Community assessment reports e.g., Interagency Early Intervention Committee (IEIC) plan, Head Start Community Assessments, School Readiness Program Plan, C&TC County 416 report, county public health assessment, Maternal Child Health Plans, CCSSA plans, collaborative assessment plans, CATCH 3 reports - Child and Teen Checkups/EPSDT.

Demographic data

Meeting minutes from various community/cultural groups

WIC data

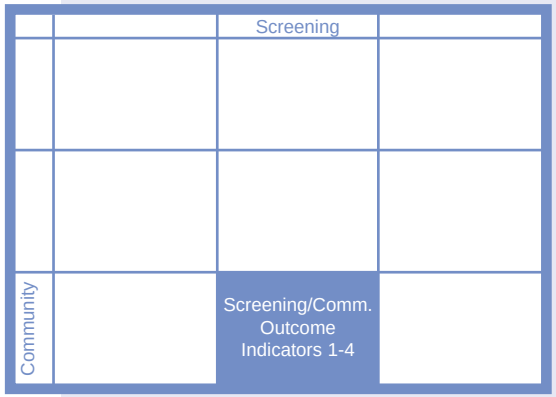
Annual school district, county, state and federal report data on participation.

Screening, Community

Outcome: All children in need of assessment, evaluation, diagnosis and/or treatment are identified through a comprehensive, non-duplicative community-wide health and developmental screening process.

3 INDICATOR:

The community partners develop and operationalize a coordinated community health and developmental screening plan for children. (This plan is part of a comprehensive community based screening plan that includes outreach and referral and follow-up components).



Criteria for Full Implementation of Indicator ***(continued from page 68)***

Comprehensive community screening plan is reviewed annually as a part of the total community strategic plan and other relevant plans.

All families requiring special assistance will have received it during their screening appointment. Special assistance may include qualified interpretive and accessibility services that are available to aid in communication with persons of all languages, cultures, and abilities in the community.

Community partners have a process to eliminate duplicative screening.

Parents receive culturally and linguistically appropriate information regarding early intervention and referral services.

Community partners use standardized state-developed forms that comply with data practices. These forms may include, but are not limited to, consent to release information, consent to screen, screening summary results, health and developmental history form, and other documentation forms.

Suggested Strategies for Implementation

Identify stakeholders within the community including those who represent various cultural, linguistic, and hard-to-reach populations. (Examples: community cultural leaders, faith communities, health care providers, home visitors, social workers, home school liaisons, family support workers, child care resource and referral agencies, extension services, food shelf programs, transient housing etc.)

Identify and work with community leaders who represent cultural and ethnic groups.

Systematically identify, analyze, and report community needs and resources particularly for hard-to-reach populations using existing data, community forums, focus groups, surveys, interviews, etc.

Review existing community assessments and identify gaps, duplication, and opportunities to improve efficiency.

Develop and implement a comprehensive screening plan that integrates results and recommendations of the community assessment(s) and includes action steps that address specific needs and maximize existing resources.

Develop timeline to operationalize screening plan.

Data Sources

Participant survey

Current comprehensive community screening plan

Community assessment reports e.g., Interagency Early Intervention Committee (IEIC) plan, Head Start Community Assessments, School Readiness Program Plan, C&TC County 416 report, county public health assessment, Maternal Child Health Plans, CCSSA plans, collaborative assessment plans, CATCH 3 reports - Child and Teen Checkups/EPSDT.

Demographic data

Meeting minutes from various community/cultural groups

WIC data

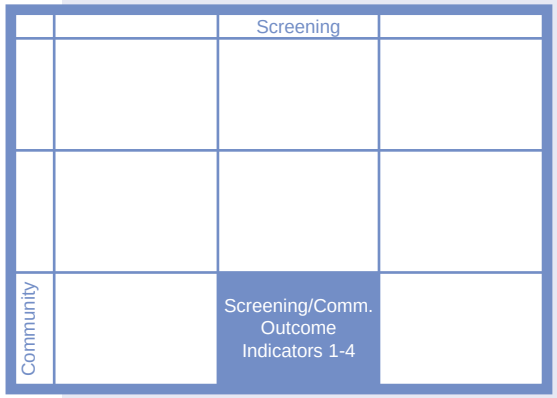
Annual school district, county, state and federal report data on participation.

Screening, Community

Outcome: All children in need of assessment, evaluation, diagnosis and/or treatment are identified through a comprehensive, non-duplicative community-wide health and developmental screening process.

4 INDICATOR:

The community partners evaluate health and developmental screening services annually.



Criteria for Full Implementation of Indicator

Community partners understand the importance of the evaluation process for improving screening services and reaching targeted benchmarks.

Community partners conduct comprehensive annual evaluation which includes but is not limited to:

- coordination of health and developmental screening
- participation rates
- age at which children are screened
- the composition, roles, and responsibilities of screening partners
- recommendations for improvement
- analysis of gaps and duplication

Suggested Strategies for Implementation and Possible Data Sources

Identify an ongoing process for the community evaluation.

Develop baseline data for ongoing evaluation.

Gather and analyze local screening data for factors such as screening age and participation rates compared to past local results for total eligible and specific populations.

Analyze effectiveness of partnerships to improve screening results.

Gather, analyze and compare local screening data to state-wide benchmarks or targets for total eligible and specific populations.

Formulate and implement recommendations for improving community screening.

Data Sources

Written evaluation report

Surveys of community partners

Tracking data (for example):

- Health Care Financing Administration (HCFA-416), Centers for Medicare and Medicaid Services (CMS)
- CATCH 3 reports – Child and Teen Checkups/EPSDT
- Early Childhood Screening Annual report
- PIR – Head Start Program Information Report

3 CHECKLIST Component: Screening Level: Community

Outcome: ***All children in need of assessment, evaluation, diagnosis and/or treatment are identified through a comprehensive, non-duplicative community-wide health and developmental screening process.***

Rating Code:
1= Full Implementation with ongoing evaluation; program meets or exceeds criteria for the indicator
2= Implementation in process; program partially meets criteria or implementation of strategies is emerging
3= Not yet; efforts to meet this indicator have not yet emerged
4= Not applicable or not enough information to respond

INDICATOR	1	2	3	4	Priority for planning & improvement strategies	Action Plan:
1. The community partners assure all children receive a health and developmental screening by 3 1/2- 4 years of age as required for public school kindergarten entrance.						
2. The community partners assure all children receive well-child screening according to periodicity schedules and program standards.						
3. The community partners develop and operationalize a coordinated community health and developmental screening plan for children. (This plan is part of a comprehensive community based screening plan that includes outreach and referral and follow-up components).						
4. The community partners evaluate health and developmental screening services annually.						

Referral Follow-up Component

	Service Delivery Level	Organization Level	Community Level
OUTCOMES	Children and their families who are referred through health and developmental screening receive appropriate and timely assessment, evaluation, and/or services to meet their identified potential need(s).	The organization has an effective process and sufficient resources to work with other screening-related providers to ensure effective, family-friendly, culturally, and linguistically responsive assessment, evaluation, and/or referral and follow-up services for children and their families.	The community has an effective follow-up and referral process in place to ensure appropriate and timely services will be provided to any child whose screening indicates a need for further evaluation, assessment, and/or treatment.
QUALITY INDICATORS	1. Families are informed of the referral/follow-up process.	1. The organization implements a comprehensive plan and process for referral and follow-up.	1. The community partners assure that a plan is developed for coordination of the community referral and follow-up process. (This plan is part of a comprehensive community-based screening plan that includes outreach and screening components).
	2. Families are given comprehensive information regarding all available providers for specific referral and child and/or family needs.	2. The organization partners with community agencies to provide adequate funding for referral and follow-up in the community.	2. The community partners assure that referral resources are appropriate, available, accessible, and culturally sensitive to meet family needs.
	3. Families receive complete and easy-to-understand information about their right to privacy and who may receive information about their child's screening results.	3. The organization recruits, hires, and retains appropriate and adequate staff FTEs to meet referral and follow-up objectives.	3. The community partners evaluate the referral and follow-up process and referral resources for availability and effectiveness.
	4. Families receive follow-up services subsequent to the referral made at health and developmental screening.	4. The organization evaluates referral and follow-up to participating children and their families annually.	
	5. Children and their families receive assistance as needed to access referral and follow-up services.		

Referral & Follow-up, Service Delivery

Outcome: Children and their families who are referred through health and developmental screening receive appropriate and timely assessment, evaluation, and/or services to meet their identified potential need/s.

1 INDICATOR:

Families are informed of the referral/follow-up process.

			Referral
Service			Referral/Service Outcome Indicators 1-5

Criteria for Full Implementation of Indicator

Health and developmental screeners inform families about referral and follow-up process including:

- reason for referral
- when the referral/follow-up should occur
- contact information for referral sources
- any specific information regarding the referral process

Suggested Strategies for Implementation and Possible Data Sources

Maintain knowledge about the referral and follow-up process.

Follow organizational written policy regarding the sharing of information about the referral and follow-up process with families.

Provide information about the referral and follow-up process sensitive to culture, literacy, income levels, and other characteristics of family needs.

Document on health and developmental screening record or chart that the family was informed about the referral and follow-up process.

Data Sources

Consent to release information form

Health and developmental screening record or chart

Policy manual

Family survey

Staff training records

Head Start Performance Standards

Referral & Follow-up, Service Delivery

Outcome: Children and their families who are referred through health and developmental screening receive appropriate and timely assessment, evaluation, and/or services to meet their identified potential need/s.

2

INDICATOR:
Families are given comprehensive information regarding all available providers for specific referral and child and/or family needs.

			Referral
Service			Referral/Service Outcome Indicators 1-5

Criteria for Full Implementation of Indicator

Health and developmental screeners provide families comprehensive contact lists for referrals to resources which include all available community programs and services to meet identified or requested needs.

Resources may include any state or local programs available (e.g. state or national advocacy groups, Web sites, local mental health providers, health care providers, social service agencies, educational programs, child care, assistance with obtaining health care coverage, locating a medical home).

Referral & Follow-up, Service Delivery

Suggested Strategies for Implementation and Possible Data Sources

Maintain knowledge about referral resources including community programs and services prior to screening.

Follow organizational and program written policy regarding the sharing of appropriate referral information with families.

Make available current information about providers at each screening.

Provide referral information sensitive to culture, literacy, income levels, and other characteristics of family needs.

Provide documentation of referral in the health and developmental screening record or chart.

Data Sources

Health and developmental screening record or chart

Policy manual

Family survey

Staff training records

Provider lists

Referral & Follow-up, Service Delivery

Outcome: Children and their families who are referred through health and developmental screening receive appropriate and timely assessment, evaluation, and/or services to meet their identified potential need/s.

3 INDICATOR:

Families receive complete and easy-to-understand information about their right to privacy and who may receive information about their child's screening results.

Criteria for Full Implementation of Indicator

Staff use the most effective way to explain the consent to release information form and how the information will be used following Health Information Portability and Accountability Act (HIPAA) and program guidelines.

Interpreters and/or interpretive materials are used as needed.

			Referral
Service			Referral/Service Outcome Indicators 1-5

Suggested Strategies for Implementation and Possible Data Sources

Inform staff about HIPAA requirements.

Use the state interagency universal consent to release information form.

Make available interpreters and/or interpretive materials based on community needs survey and demographics.

Use interpreters knowledgeable in the referral/follow-up process and the consent to release information form.

Data Sources

Family survey

Community demographic data

Community needs survey

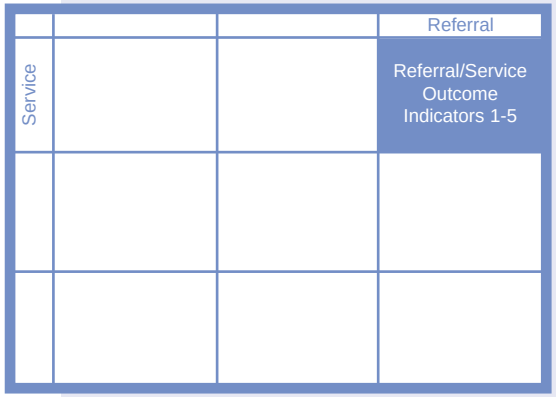
Staff development records

Referral & Follow-up, Service Delivery

Outcome: Children and their families who are referred through health and developmental screening receive appropriate and timely assessment, evaluation, and/or services to meet their identified potential need/s.

4 INDICATOR:

Families receive follow-up subsequent to the referral made at health and developmental screening.



Criteria for Full Implementation of Indicator

Health and developmental screeners or outreach staff follow organizational and program written policy regarding the tracking and follow-up of referrals.

Staff document that the follow-up process was completed (e.g. health and developmental screening record, CATCH).

Referral & Follow-up, Service Delivery

Suggested Strategies for Implementation and Possible Data Sources

Use appropriate methods to identify those children with referrals.

Provide follow-up according to program requirements.

Use a consistent process for tracking referral and follow-up.

Include as a part of the tracking process contacting parents by phone, letter or home visit or other face-to-face contacts to determine results of the referral. If the referral is incomplete, identify and seek solutions to barriers in order to complete the referral.

Data Sources

State / Federal reports

CATCH 3 reports - Child and Teen

Checkups / EPSDT

Health and developmental screening record

Family survey

Head Start Performance Standards

Referral & Follow-up, Service Delivery

Outcome: Children and their families who are referred through health and developmental screening receive appropriate and timely assessment, evaluation, and/or services to meet their identified potential need/s.

5 INDICATOR:

Children and their families receive assistance as needed to access referral and follow-up services.

			Referral
Service			Referral/Service Outcome Indicators 1-5

Criteria for Full Implementation of Indicator

Health and developmental screeners or outreach staff:

- provide assistance for children and their families to access referral and follow-up services as needed
- are knowledgeable about available transportation services
- are knowledgeable about available interpreter services
- follow all program guideline requirements and timelines for providing assistance to families and children

Referral & Follow-up, Service Delivery

Suggested Strategies for Implementation and Possible Data Sources

Identify those children and their families needing assistance with accessing referral and follow-up services.

Maintain an updated list of referral providers to assist with finding a provider, making an appointment, etc.

Data Sources

State / Federal reports

CATCH 3 reports - Child and Teen Checkups / EPSDT

Health and developmental screening record

Family survey

Head Start Performance Standards

3 CHECKLIST Component: Referral & Follow-up Level: Service Delivery

Outcome: ***Children and their families who are referred through health and developmental screening receive appropriate and timely assessment, evaluation, and/or services to meet their identified potential need(s).***

Rating Code:
1= Full Implementation with ongoing evaluation; program meets or exceeds criteria for the indicator
2= Implementation in process; program partially meets criteria or implementation of strategies is emerging
3= Not yet; efforts to meet this indicator have not yet emerged
4= Not applicable or not enough information to respond

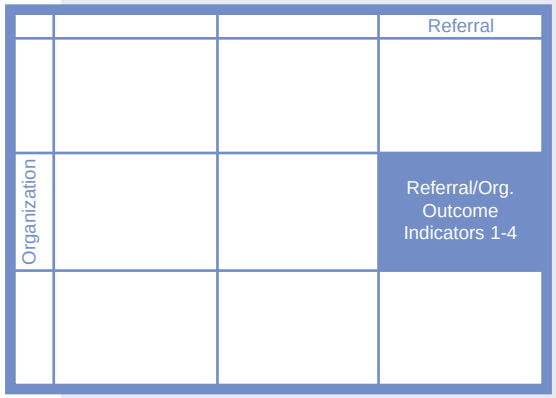
INDICATOR	1	2	3	4	Priority for planning & improvement strategies	Action Plan:
1. Families are informed of the referral / follow-up process.						
2. Families are given comprehensive information regarding all available providers for specific referral and child and / or family needs.						
3. Families receive complete and easy-to-understand information about their right to privacy and who may receive information about their child's screening results.						
4. Families receive follow-up subsequent to the referral made at health and developmental screening.						
5. Children and their families receive assistance as needed to access referral and follow-up services.						

Referral & Follow-up, Organization

Outcome: The organization has an effective process and sufficient resources to work with other screening-related providers to ensure effective, family-friendly, culturally, and linguistically responsive assessment, evaluation, and/or referral and follow-up services for children and their families.

1

INDICATOR:
The organization implements a comprehensive plan and process for referral and follow-up.



Criteria for Full Implementation of Indicator

The organization has working knowledge of critical components of effective referral and follow-up strategies and these are incorporated into the comprehensive written plan.

The organization develops a referral and follow-up plan according to program requirements and current medical and education practice in coordination with other school, public health agency, and other community plans that conduct follow-up to referrals.

The organization's management actively promotes and supports referral and follow-up objectives and activities identified in the written plan.

The organization examines current community assessment information to determine language and literacy levels and cultural, racial, and ethnic demographics of the population. These results are incorporated into the plan.

The organization implements recommendations for changes to the referral and follow-up plan.

The organization participates in appropriate data sharing to improve referral and follow-up.

The organization utilizes a clearly defined referral and follow-up protocol for staff.

Suggested Strategies for Implementation and Possible Data Sources

Develop comprehensive written procedures for referrals.

Organization inservices staff on referral and follow-up protocol.

Develop comprehensive written procedures for follow-up on referrals.

Identify essential elements of program specific required referral and follow-up activities and incorporate them into the referral and follow-up plan.

Coordinate referral and follow-up activities with community service providers as appropriate.

Identify effective methods for culturally responsive referral and follow-up for children and their families that include:

- contacting cultural leaders and cultural/ethnic organizations in order to develop partnerships for coordinated efforts and determine the most effective means of referral and follow-up
- reviewing current literature on best practices for working with diverse and hard-to-reach populations

Incorporate written data sharing agreements regarding referral and follow-up between participating agencies/providers in accordance with Health Information Portability and Accountability Act (HIPAA) requirements.

Discuss relevant referral and follow-up data analysis at planning meetings to eliminate gaps and enhance coordination.

Timelines for follow-up to referrals are identified and incorporated into protocols.

Data Sources

Organizational referral and follow-up plan

Family/ individual participant surveys

Tracking data (for example):

- Health Care Financing Administration (HCFA-416), Centers for Medicare and Medicaid Services (CMS)
- CATCH 3 reports - Child and Teen Checkups/EPSDT
- Early Childhood Screening Annual Report
- Head Start Program Information Report (PIR)

Demographic data

Community Needs Assessment

Meeting minutes from various community/cultural groups

Data sharing agreements

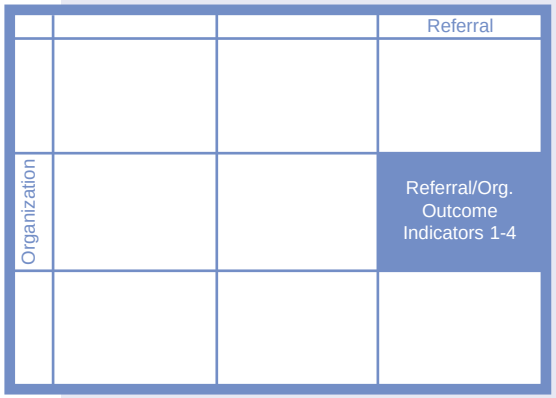
Staff development records

Referral & Follow-up, Organization

Outcome: The organization has an effective process and sufficient resources to work with other screening-related providers to ensure effective, family-friendly, culturally, and linguistically responsive assessment, evaluation, and/or referral and follow-up services for children and their families.

2

INDICATOR:
The organization partners with community agencies to provide adequate funding for referral and follow-up in the community.



Criteria for Full Implementation of Indicator

The organization maximizes use of multiple public and private funding sources to provide comprehensive community-based referral and follow-up services (e.g. Local Collaborative Time Study (LCTS), third-party reimbursement, foundation aid, civic organizations).

The organization annually reviews and modifies the budget to meet the referral and follow-up needs of children and their families.

Suggested Strategies for Implementation and Possible Data Sources

Secure funding from service organizations or other sources for identified needs of children and their families (e.g., children who need glasses or dental work).

Assign staff to review referral and follow-up expenditures and make annual budget recommendations.

Foster and maintain relationships with community partners to integrate or share resources.

Foster cooperation with other departments within the organization to support referral and follow-up activities with in-kind contributions.

Data Sources

Referral and follow-up budget including revenues and expenditures

Documentation of in-kind support

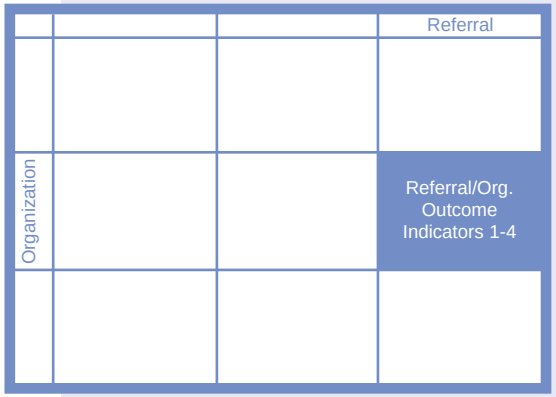
List of public and private funding sources

Referral & Follow-up, Organization

Outcome: The organization has an effective process and sufficient resources to work with other screening-related providers to ensure effective, family-friendly, culturally, and linguistically responsive assessment, evaluation, and/or referral and follow-up services for children and their families.

3 INDICATOR:

The organization recruits, hires, and retains appropriate and adequate staff FTEs to meet referral and follow-up objectives.



Criteria for Full Implementation of Indicator

The organization assigns a staff position with decision-making authority and designated percentage of time to work with the community partners on referral and follow-up activities.

Personnel policies define the recruitment and hiring process.

Organizational policies support staff retention.

Referral and follow-up staff reflect the cultural, ethnic, and linguistic diversity of the community.

Sufficient Full Time Equivalents (FTEs) are assigned to conduct all required and additional referral and follow-up activities to meet family needs.

Suggested Strategies for Implementation and Possible Data Sources

Analyze staff work schedules to determine the amount of time previously spent on referral and follow-up activities.

Identify barriers to follow-up completions.

Develop and maintain human resource policies and practices that support retention of staff.

Identify staff needed to support referral and follow-up requirements.

Develop detailed position descriptions including specific time allocation for referral and follow-up responsibilities.

Develop assurances through performance reviews and program evaluation that staff time allocation for providing referral and follow-up activity is met.

Data Sources

Position descriptions

Budget

Financial reports

Personnel policy manual

Demographic data

Personnel records

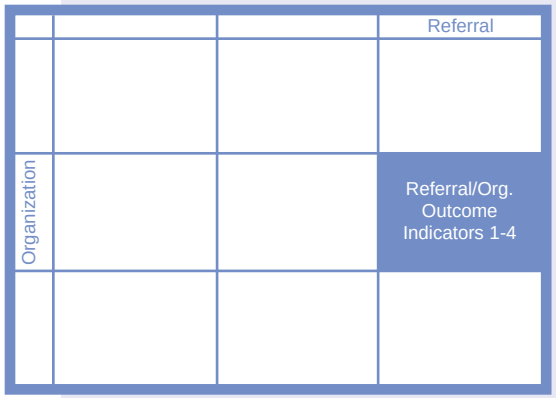
Time sheets

Referral & Follow-up, Organization

Outcome: The organization has an effective process and sufficient resources to work with other screening-related providers to ensure effective, family-friendly, culturally, and linguistically responsive assessment, evaluation, and/or referral and follow-up services for children and their families.

4

INDICATOR:
The organization evaluates referral and follow-up to participating children and their families annually.



Criteria for Full Implementation of Indicator

Comprehensive referral and follow-up plan is reviewed annually as part of the total organizational strategic planning.

Referral and follow-up efforts are evaluated at least annually and updated plans are modified accordingly.

The organization's aggregated referral and follow-up data is shared with appropriate policy makers to improve health and developmental outcomes for children and their families.

Evaluation plan of referral and follow-up efforts include, but may not be limited to:

- review of referral and follow-up plan
- referral completion rates
- family surveys to determine quality and timeliness of referral and follow-up process in meeting identified needs
- analysis of community demographic data to determine the effectiveness of referral programs and services
- multi-year trend analysis
- recommendations for improvement

Analysis of referral results, e.g., eligibility for special education services, attainment of health care coverage, completion of immunizations, placement in Head Start and School Readiness services, resolution of identified health concerns.

Referral & Follow-up, Organization

Suggested Strategies for Implementation and Possible Data Sources

Identify an ongoing process for the organization's referral and follow-up evaluation.

Identify barriers to follow-up completions.

Review and update referral and follow-up plan as community changes are identified.

Develop baseline data for ongoing evaluation.

Gather, analyze, and compare local referral and follow-up data to state-wide data to determine over-referrals, under-referrals, effectiveness of community outreach efforts, and to plan for subsequent services or programs based on the needs of children.

Formulate and implement recommendations for improving referral and follow-up.

Report referral and follow-up data to community partners and leaders, e.g., health care providers, early childhood programs, county commissioners, city councils, and school boards.

Data Sources

Written evaluation report

Participant Survey

Tracking data (for example):

- Health care Financing Administration (HCFA-416), Centers for Medicare and Medicaid Services (CMS)
- CATCH 3 reports – Child and Teen Checkups/EPSDT
- Early Childhood Screening Annual Report
- PIR – Head Start Program Information Report

Local and State Reports

3 CHECKLIST Component: Referral & Follow-up Level: Organization

Outcome: ***The organization has an effective process and sufficient resources to work with other screening-related providers to ensure effective, family-friendly, culturally, and linguistically responsive assessment, evaluation, and/or referral and follow-up services for children and their families.***

Rating Code:
1= Full Implementation with ongoing evaluation; program meets or exceeds criteria for the indicator
2= Implementation in process; program partially meets criteria or implementation of strategies is emerging
3= Not yet; efforts to meet this indicator have not yet emerged
4= Not applicable or not enough information to respond

INDICATOR	1	2	3	4	Priority for planning & improvement strategies	Action Plan:
1. The organization implements a comprehensive plan and process for referral and follow-up.						
2. The organization partners with community agencies to provide adequate funding for referral and follow-up in the community.						
3. The organization recruits, hires and retains appropriate and adequate staff FTEs to meet referral and follow-up objectives.						
4. The organization evaluates referral and follow-up to participating children and their families annually.						

Referral & Follow-up, Community

Outcome: The community has an effective follow-up and referral process in place to ensure appropriate and timely services will be provided to any child whose screening indicates a need for further evaluation, assessment, and/or treatment.

1

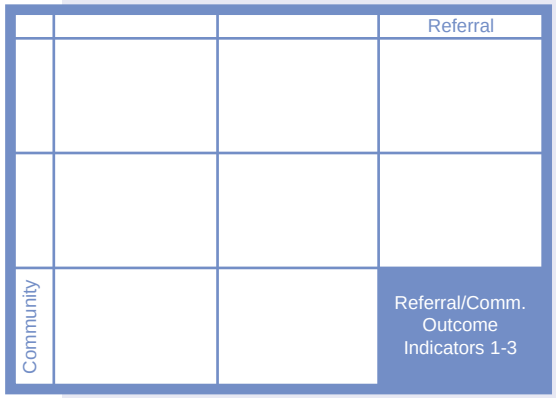
INDICATOR:
The community partners assure that a plan is developed for coordination of the community referral and follow-up process. (This plan is part of a comprehensive community based screening plan that includes outreach and screening components.)

Criteria for Full Implementation of Indicator

Community partners referral and follow-up plan includes but is not limited to:

- mechanism to engage community stakeholders in the referral and follow-up process
- identify components of a quality community-based referral and follow-up system
- identification of existing community resources
- inclusion of organizational, state, and federal requirements
- clarification of community partners' roles and responsibilities
- develop a system that eliminates gaps and promotes a seamless referral and follow-up process
- effective evaluation of referral and follow-up methods and results

The community implements recommendations for changes to the referral and follow-up plan.



Suggested Strategies for Implementation and Possible Data Sources

Include all referral providers in the plan development.

Identify stakeholders within the community including those who represent various cultural, linguistic and hard to reach populations. (Examples: community cultural leaders, faith communities, health care providers, home visitors, social workers, home school liaisons, family support workers, child care resource and referral agencies, extension services, food shelf programs, transient housing).

Identify and work with community leaders who represent cultural and ethnic groups.

Meet with community partners to plan and develop communication, referral and follow-up procedures.

Participate with community partners in joint planning/communication and implementation of referral and follow-up procedures.

Review existing community assessments and identify gaps, duplication, and opportunities to improve efficiency of the referral and follow-up process.

Systematically identify, analyze and report community needs and resources particularly for hard-to-reach populations using existing data, community forums, focus groups, surveys, interviews, etc.

Develop and implement a comprehensive referral and follow-up plan that integrates results and recommendations of the community assessment(s) and includes action steps that address specific needs and maximize existing resources.

Develop timeline to operationalize referral and follow-up plan.

Review referral and follow-up plan at least once a year and modify as indicated.

Data Sources

Meeting agenda and minutes.

Referral and follow-up aggregate data

Current comprehensive community referral and follow-up plan

Community assessment report

Demographic data

Meeting minutes from various community/cultural groups

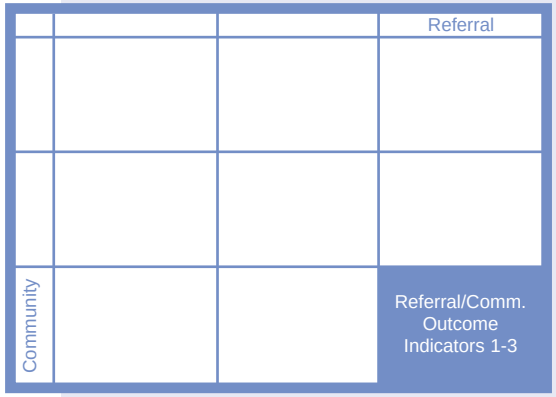
Annual school district, county, state, and federal report data on referral and follow-up

Referral & Follow-up, Community

Outcome: The community has an effective follow-up and referral process in place to ensure appropriate and timely services will be provided to any child whose screening indicates a need for further evaluation, assessment, and/or treatment.

2

INDICATOR:
The community partners assure that referral resources are appropriate, available, accessible, and culturally responsive to meet family needs.



Criteria for Full Implementation of Indicator

The community examines current community assessment information to determine language and literacy levels and cultural, racial, and ethnic demographics of the population. These results are incorporated into the plan.

The community partners:

- assure that resources exist for the successful completion of referral and follow-up activities for all families
- connect families to referral resources that are appropriate, accessible, and culturally sensitive to meet family needs
- have available and provide culturally and linguistically appropriate information regarding referral, follow-up
- implement follow-up strategies that address cultural and linguistic diversity and special needs populations
- engage cultural leaders as active participants in identifying most effective and respectful referral and follow-up activities and materials to be used with specific populations
- use alternatives to print materials as part of referral procedures, such as an advocate or liaison to effectively reach families with limited literacy skills or who are English language learners
- are responsive to diverse family needs and adjust referral and follow-up approaches accordingly

Suggested Strategies for Implementation and Possible Data Sources

Review and maintain list of current community resources for referral and follow-up according to program requirements.

Allocate collaborative funds to develop and enhance a comprehensive resource and referral system.

Engage cultural and ethnic leaders to identify and implement specific cultural approaches for referral and follow-up.

Address barriers related to availability and accessibility of community resources and develop recommendations for successful follow-up.

Identify or develop and make available culturally and linguistically appropriate information for families residing within the community.

Assess community resources available for transportation, interpreters, and alternative communication and make recommendations to improve availability.

Report on the status of referral resources to organizational leaders responsible for service provision, funding, and recruitment.

Secure alternative funding sources to support referral resources appropriate to family needs.

Data Sources

Resource and referral materials

Policy and procedure manuals

Meeting minutes

Evaluation

Translated materials

Participation rates

Demographics

Family surveys

Media texts

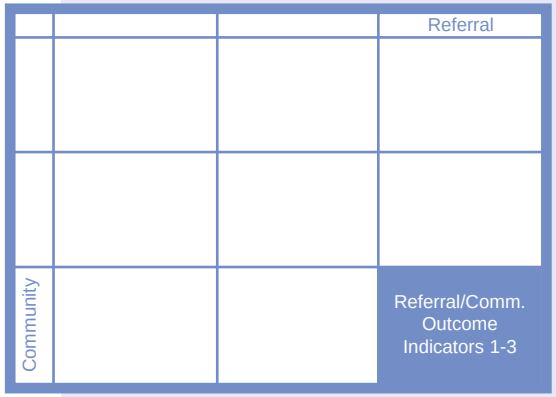
Special reports

Referral & Follow-up, Community

Outcome: The community has an effective follow-up and referral process in place to ensure appropriate and timely services will be provided to any child whose screening indicates a need for further evaluation, assessment, and/or treatment..

3

INDICATOR:
The community partners evaluate the referral and follow-up process and referral resources for availability and effectiveness.



Criteria for Full Implementation of Indicator

The community partners:

- evaluate referral and follow-up approaches and materials for sensitivity to culture, language, literacy, and family needs
- periodically evaluate whether the community referral resources are readily available
- evaluate the effectiveness of meeting the identified needs of the referred children and families
- understand the importance of the evaluation process for improving referral and follow-up services

Community partners conduct comprehensive annual evaluation which includes but is not limited to:

- coordination of the referral and follow-up process and procedures
- referral completion rates
- the composition, roles, and responsibilities of coordinating organizations
- recommendations for improvement
- analysis of gaps and duplication

Suggested Strategies for Implementation and Possible Data Sources

Survey families to determine access to needed referral services.

Evaluate referral and follow-up policies and procedures at least annually and make changes as appropriate.

Analyze referral and follow-up data with community partners.

Review and update referral services and resource lists to include community and state organizations, local and state services or programs, Web sites, etc.

Conduct a periodic review of resource utilization and identify prevalence rates of types of referrals.

Document needed changes to referral and follow-up process and procedures.

Develop and implement a plan in response to identified process and procedural changes.

Data Sources

Written evaluation report

Surveys of community partners

Tracking data (for example):

- Health Care Financing Administration (HCFA-416), Centers for Medicare and Medicaid Services (CMS)
- CATCH 3 reports – Child and Teen Checkups/EPSDT
- Early Childhood Screening Annual Report
- PIR – Head Start Program Information Report

State agency reports

3 **CHECKLIST** Component: Referral & Follow-up Level: Community

Outcome: ***The community has an effective follow-up and referral process in place to ensure appropriate and timely services will be provided to any child whose screening indicates a need for further evaluation, assessment, and/or treatment.***

Rating Code:
1= Full Implementation with ongoing evaluation; program meets or exceeds criteria for the indicator
2= Implementation in process; program partially meets criteria or implementation of strategies is emerging
3= Not yet; efforts to meet this indicator have not yet emerged
4= Not applicable or not enough information to respond

INDICATOR	1	2	3	4	Priority for planning & improvement strategies	Action Plan:
1. The community partners assure that a plan is developed for coordination of the community referral and follow-up process. (This plan is part of a comprehensive community-based screening plan that includes outreach and screening components).						
2. The community partners assure that referral resources are appropriate, available, accessible, and culturally responsive to meet family needs.						
3. The community partners evaluate the referral and follow-up process and referral resources for availability and effectiveness.						

GLOSSARY

ADA - Americans with Disabilities Act

AAP - American Academy of Pediatrics

Assessment - Determines the existence of a specific health disability, possible cause of the condition, and to propose intervention or remediation strategies. For education: ongoing procedures used throughout a child's eligibility for special education services to identify (1) the child's unique strengths and needs and services appropriate to meet those needs; and (2) resources, priorities, and concerns of the family and services necessary to enhance family capacity to meet the developmental needs of their child

Benchmarking - The act of systematically defining the best systems, processes, procedures, and practices for the purposes of improving outcomes for children and their families.

CATCH 3 - A personal computer based software system for tracking a portion of the required administrative services of the C&TC Program. It uses a Windows format. The software is used to track enrolled children eligible for C&TC services to assist C&TC Coordinators and outreach staff in conducting and documenting outreach and follow-up activities to those families and children.

CSSA - Community Social Services Act

C & TC/EPSDT - Child & Teen Checkups (C&TC) is the name for Minnesota's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. C&TC is a comprehensive child health program provided to children and teens from newborn through the age of 20 who are enrolled in Medical Assistance or MinnesotaCare.

CDC - Centers for Disease Control and Prevention

Child Find - Programs and process designed to inform parent of the availability of screening, evaluation, and the eligibility for intervention services for children who may have developmental or learning problems.

CHS Agencies - A board of health established, integrated and eligible for a subsidy from the Commissioner of Health. The board has general responsibility to develop and maintain an integrated system of community health services under local administration and within a system of state guidelines and standards.

CHS Funds - Funds from a variety of sources allocated to Community Health Boards to support and promote an integrated system of community health services under local administration and within a system of state guidelines and standards.

Collaboration - Separate organizations form a durable structure with full commitment to a common mission, comprehensive planning, and well-defined governance and communication. Partners retain some separate identity and administrative functions, but contribute their reputation, pool or jointly secure resources, and share the results, rewards and much greater risk.

Community - Any group united by geography, population, practice, religion, business, or other form of shared culture.

Community indicators - Measuring systems that are designed, developed and researched by the community members themselves. They help civic leaders clarify key issues and challenges, and help point a community toward specific initiatives or policy changes that will have a positive effect on the quality of life of its citizens. They don't just monitor progress; they make it happen.

Community-wide effort - The inclusion of a comprehensive group of individuals and organizations within a community for producing a benefit to, or improve the ways of servicing the community's needs.

GLOSSARY

Continuous Quality Improvement (CQI) - A management approach to the continuous study and improvement of the processes providing services to meet the needs of target populations. Continuous Quality Improvement focuses on making the entire system's outcomes better by constantly adjusting and improving the system itself.

Community Health Clinic - a clinic that provides services by or under the supervision of a physician that is incorporated as a non-profit corporation, is exempt from federal income tax, is established to provide health services to low-income population groups. These clinics have written policies describing the services provided by the clinic and medical management of health problems, including problems that require referral to physicians, emergency health services and health maintenance, and review of health records by the physician.

Consolidation - Separate programs combine into one comprehensive operation with its own governance and administration.

Cooperation - An informal relationship between organizations for the purposes of information sharing without any clearly defined mission, structure, or planning effort. Each organization retains authority and keeps resources separate so virtually no risk exists.

Coordination - A formal, long-term relationship between organizations for the purpose of a specific joint project, that includes planning, division of responsibility, ongoing communication, exchange of resources, mutual benefits, and greater risk. Each organization retains its own authority.

CMS - Centers for Medicare and Medicaid Services - federal agency, formerly known as Health Care Financing Administration (HCFA)

Data sharing agreements - Written agreements between agencies, clinics, individuals, etc. designed to outline the extent to which data may be shared between both parties.

DHS - The Minnesota Department of Human Services

Diagnosis - The identification and determination of the nature or cause of a disease or abnormality through the use of health history, physical, developmental and psychological examination and laboratory tests.

ECFE - Early Childhood Family Education provides parent/child learning opportunities and parent education that enhances the ability of parents to successfully parent their children from birth to kindergarten enrollment.

ECS - Early Childhood Health and Developmental Screening assists parents and communities in improving the educational readiness and health of young children through the early detection of factors that may impede children's learning, growth, and development.

ECSE - Early Childhood Special Education provides young children with identified disabilities a free and appropriate public education in order to maximize their potential.

Effectiveness measures - Measures that gauge the degree to which your outputs from activities satisfy the mission of the program or organization, or customer expectations.

Efficiency Measures - Measures that evaluate how well your services minimize effort, expense, and waste, while producing the desired results.

ELL - English Language Learners

Evaluation - The procedures used to determine a child's initial and continuing eligibility under the federally mandated Individuals with Disabilities Education Act (IDEA).

GLOSSARY

Fee-for-Service - Health care provided to eligible children not enrolled in managed care, which is paid for as services are rendered.

Follow Along Program - A program administered through MDH designed to track children birth through 36 months who may be at risk for developmental delay. Funded by Part C/Early Childhood Intervention.

Follow-up - Efforts by a local agency to ensure that a screening requested for a child is provided to that child and that diagnosis and treatment indicated as necessary by a screening are also provided to that child.

Framework - A structure or system for organizing and understanding ideas or concepts.

FSC - Family Services Collaborative – a formalized, collaborative structure bringing together different organizational partners, who contribute their individual resources, jointly secure others, and share a full commitment to a common mission within the family services arena.

FTE - Full time equivalent

HCFA - Health Care Financing Administration, now known as CMS (Centers for Medicare and Medicaid Services)

Head Start - Helps economically disadvantaged families break the cycle of poverty by improving the health, social competence, and school readiness of young children and to promote economic self-sufficiency for parents.

HIPAA - Health Information Portability and Accountability Act

HMO - Health Maintenance Organization

IDEA - Individuals with Disabilities Education Act

IEIC - Interagency Early Intervention Committees

Indicators - Also called "benchmarks" or "performance measures." Indicators are quantitative or qualitative measures of the extent to which goals/outcomes/results are being achieved. Several are typically needed to approximate whether the state, community or program is achieving its goals/outcomes/results and objectives.

Integration - Similar programs working together to create something new that allows various programs to retain their distinct identities while sharing expertise and common functions.

Inputs - Resources dedicated to or consumed by the program in delivering services, such as money, labor, buildings and offices, and materials and equipment.

Input indicators - Measures resources, human and financial, devoted to a particular program.

LCTS - Local Collaborative Time Study

MDE - The Minnesota Department of Education

MDH - The Minnesota Department of Health

Medical Assistance (MA) - Medical Assistance means the program authorized under Title XIX of the Social Security Act and Minnesota Statutes, chapter 256B. Medical Assistance, or MA, is the name of the Medicaid Program in the State of Minnesota.

MinnesotaCare - A health care program available for uninsured children in Minnesota.

NHANES - National Health and Nutrition Examination Survey

OSHA - Occupational Safety & Health Administration

Outcomes - May be referred to as "goals" or "results." Outcomes are broad statements of

intent reflecting the desired bottom-line conditions of well-being for children, families, and communities. Outcomes are framed in language that has broad, common understanding.

Outcome Measures - Measures that indicate the impact of services provided to the user/consumer of those services.

Outputs - What the program aims to provide; the quantity of services or goods produced.

O**utput indicators -** Measure the quantity of services provided and/or the efficiency of production.

Outreach - Efforts to inform eligible persons about Early Childhood Screening, C&TC, and other screening programs.

Part C/Interagency Early Intervention - Provides comprehensive interagency family-centered services to eligible children with disabilities, ages birth through age two, and their families based upon identified need.

Partnerships - An association of two or more who agree to work together go improve programs and services for children and their families. This partnership may vary from community to community dependent upon geographic regions, resources, or purposes. Effective partnerships include broad representation of all stakeholders who have an interest in children's health and development.

PIR - (Head Start) Program Information Report

PMAP - Prepaid Medical Assistance Program

Private/Public Clinics - An entity enrolled in the Minnesota Medical Health Care Program that provides rural health clinic services, public health clinic services, community health clinic services, or the health services of two or more physicians or dentists.

Process indicators - Measures ways in which program services are provided.

Process Measures - Measures that describe the degree to which your organization achieves its operating objectives; they answer the question: Did your organization get better because of your continual oversight?

Program Performance Measures - Measures that describe the external effects a program has on a population or problem. Indicate the degree to which a program is achieving its objectives and may be defined for efficiency or effectiveness.

Provider/health care provider - Eligible provider means a health care provider who provides covered health services to medical assistance recipients under rules established by the commissioner for that program. -OR - Provider means a vendor as specified in Minnesota Statutes, section 256B.02, subdivision 7, that has signed an agreement approved by the DHS for the provision of health services to a recipient.

Public Health Agencies - An entity enrolled in the Minnesota Health Care Program that provides physician services, preventive health services, family planning, prenatal care, dental and C&TC Checkups and tuberculosis case management and directly observed therapy.

Public Health Nursing C&TC/EPS Program - Child and Teen Checkups/Early and Periodic Screening direct services to enrolled children and teens from birth to age 21, which are provided by trained, local public health agency staff.

Quality assurance - The total integrated process of planned and systematic actions necessary to provide adequate confidence

that services will satisfy established requirements.

Quality indicators - Are evidence that a certain condition exists or certain results have or have not been achieved; they assess progress towards the achievement of intended program outputs, outcomes, goals, and objectives.

Readiness tests - Focus on a child's current skill achievement and performance.

Referral - Means the child needs to be seen again by the screening provider or another provider for further assessment, diagnosis and/or treatment of a problem or a concern that was identified during a screening.

Reliability - An indicator of how consistently or how often identical results can be obtained with the same instrument.

School Readiness - Provides children with needs identified through the Early Childhood Screening process, opportunities to participate in child development programs that promote future success in school.

Screening - is a brief, simple procedure used to identify children who may have health and developmental risks that need to proceed to a more intensive level of health assessment or diagnostic evaluation. It also provides an opportunity for children and their families to gain access to a wide variety of services. Screening serves as the first step in an evaluation and intervention process as part of Child Find efforts and helps to meet federal obligations to serve children with disabilities.

Screening components - The individual tests or parts of a screening which are required or which are age-appropriate for that screening.

Sliding fee scale - A payment methodology usually based on the annual income of a person requesting services.

Standards - Procedures or protocols established by authority as a rule for the measure of quality.

Treatment - The prevention, correction, or amelioration of a disease or abnormality identified by screening or diagnosis.

Validity - Is an indicator of the accuracy of a test and of the inferences that can be drawn from it.

WIC - Women, Infants and Children Program

Service Delivery Level

	Outreach	Screening	Referral and Follow-up
OUTCOMES	All eligible children participate in community-based health and developmental screening within recommended timeframes.	All eligible children receive age-appropriate and complete health and developmental screening to identify potential health and developmental concerns in a family-friendly, culturally and linguistically responsive way.	Children and their families who are referred through health and developmental screening receive appropriate and timely assessment, evaluation, and/or services to meet their identified potential need(s).
QUALITY INDICATORS	1. Families of eligible children are effectively informed of age appropriate health and developmental screening services.	1. Children have complete access to health and developmental screening services.	1.Families are informed of the referral/follow-up process.
	2. Families are offered assistance with county or community transportation as needed and available.	2. Children receive health and developmental screening in an environment which is safe, respectful and family-friendly.	2. Families are given comprehensive information regarding all available providers for specific referral and child and/or family needs.
	3. Families are offered assistance with interpretive services, as needed.	3. Children receive health and developmental screenings that are responsive to the issues of ethnicity, culture, and language.	3. Families receive complete and easy-to-understand information about their right to privacy and who may receive information about their child's screening results.
	4. Families have choices in health and developmental screening providers and hours of service.	4. Children receive appropriate and timely health and developmental screening according to current program standards and schedules.	4. Families receive follow-up subsequent to the referral made at health and developmental screening.
			5. Children and their families receive assistance as needed to access referral and follow-up services.

Organization Level

	Outreach	Screening	Referral and Follow-up
OUTCOMES	The organization has an effective process and sufficient resources to work with other screening-related providers to ensure all eligible children participate in health and developmental screenings.	The organization participates in community-based health and developmental screening efforts to effectively identify children who need further assessment, evaluation, and referral for services.	The organization has an effective process and sufficient resources to work with other screening-related providers to ensure effective, family-friendly, culturally, and linguistically responsive assessment, evaluation, and/or referral and follow-up services for children and their families.
QUALITY INDICATORS	1. The organization implements a comprehensive outreach plan that includes evaluation.	1. The organization implements a comprehensive screening plan that addresses gaps, reduces duplication and contains costs to improve service delivery of health and developmental screening services among agencies.	1. The organization implements a comprehensive plan and process for referral and follow-up.
	2. The organization promotes health and developmental screenings.	2. The organization selects, uses and maintains valid health and developmental screening tools, methods and equipment.	2. The organization partners with community agencies to provide adequate funding for referral and follow-up in the community.
	3. The organization recruits, hires, and retains appropriate and adequate staff FTEs to meet outreach objectives.	3. The organization assures that qualified and appropriately trained staff conducts health and developmental screening components.	3. The organization recruits, hires, and retains appropriate and adequate staff FTEs to meet referral and follow-up objectives.
	4. The organization ensures staff development on effective outreach strategies to families.	4. The organization assures staff development on effective screening for children	4. The organization evaluates referral and follow-up to participating children and their families annually.
	5. The organization evaluates outreach to eligible children and their families annually.	5. The organization's budget allots sufficient staff, equipment, supplies and resources to provide optimal health and developmental screenings.	

Community Level

	Outreach	Screening	Referral and Follow-up
OUTCOMES	The community works together to ensure that all children participate in health and developmental screening within the recommended timeframes.	All children in need of assessment, evaluation, diagnosis, and/or treatment are identified through a comprehensive, non-duplicative community-wide health and developmental screening process.	The community has an effective follow-up and referral process in place to ensure appropriate and timely services will be provided to any child whose screening indicates a need for further evaluation, assessment, and/or treatment.
QUALITY INDICATORS	1. The community develops and operationalizes a comprehensive plan for outreach to all eligible families. (This plan is part of a comprehensive community-based screening plan that includes screening and referral and follow-up components).	1. The community partners assure all children receive a health and developmental screening by 3 1/2 - 4 years of age as required for public school kindergarten entrance.	1. The community partners assure that a plan is developed for coordination of the community referral and follow-up process. (This plan is part of a comprehensive community-based screening plan that includes outreach and screening components).
	2. The community uses common/consistent messages regarding health and developmental screening programs.	2. The community partners assure all children receive well-child screening according to periodicity schedules and program standards.	2. The community partners assure that referral resources are appropriate, available, accessible, and culturally sensitive to meet family needs.
	3. The community conducts outreach activities and uses public awareness materials that are sensitive to culture, language, literacy, and family needs.	3. The community partners develop and operationalize a coordinated community health and developmental screening plan for children. (This plan is part of a comprehensive community-based screening plan that includes outreach and referral and follow-up components).	3. The community partners evaluate the referral and follow-up process and referral resources for availability and effectiveness.
	4. The community evaluates outreach to eligible children and their families annually.	4. The community partners evaluate health and developmental screening services annually.	

Child Health and Developmental Screening

Family Survey

This family survey is intended to help us improve the early childhood screening process you recently went through with your child. We are interested in knowing whether the screening program helped you to better understand your child.

This survey is confidential. Your answers will not be directly connected to your family.

If you do not wish to participate in this survey, it will not prevent you or your child from participating in any programs or services.

Thank you for your help in improving these programs.

1. On what date was your child screened? (Estimate as close as you can if you don't remember the exact date.)

Screening date:
_____ / _____ / _____
Month Day Year

2. At what location was your child screened?

r School
r Community center
r Clinic
r Public health clinic
r Head Start program
r Other: _____
_____

3. How did you learn about this screening location?

r From school staff
r From county staff
r From a friend or neighbor
r From an early childhood program (ECFE, School Readiness or Head Start)
r From a child care provider
r From a healthcare provider
r From the newspaper or radio
r From the Follow Along Program
r From a web site
r From a other, please indicate: _____
_____
_____

4. What is the birth date of the child who was screened?

Birth date: _____ / _____ / _____
Month Day Year

5. Were you offered transportation to the screening location?

r Yes r No r Not sure

5a. Did you use the transportation offered?

r Yes r No r No, did not need

5a-1. Did the transportation make it easier to get to the screening location?

_____
_____
_____

6. What language do you mostly speak at home?

r English
r Arabic

r Cambodian (Khmer)
r Hmong
r Laotian
r Oromo
r Russian
r Serbo-Croation
r Somali
r Spanish
r Vietnamese
r Other: _____

6a. (If non-English spoken at home) Were you provided an interpreter?

r Yes r No r No, did not need

7. Were there any other things that made it hard to get the screening done?

r Schedule
r Location
r Time
r Fear
r Difficulty contacting them
r Difficulty with language issues while setting up appointment
r Other: _____

8. How welcomed did you feel at the screening visit?

r Very welcomed
r Somewhat welcomed
r Not very welcomed
r Not at all welcomed
r Not sure

8a. If you did not feel welcomed, can you describe what made you feel this way?

_____
_____
_____
_____
_____
_____
_____
_____

9. Before you went to the screening location, did some someone explain to you what would happen at the screening?

r Yes r No r No, did not need

10. After the screening, did someone explain the results so that you clearly understand them?

r Yes r No r No, did not need

11. As a result of the screening visit, do you have a better understanding of your child's health?

r Much better understanding

r Somewhat better understanding r No Change

r Understand less well r Not sure

12. As a result of the screening visit, do you have a better understanding of your child's learning and development?

r Much better understanding

r Somewhat better understanding r No Change

r Understand less well r Not sure

13. As a result of the screening visit, do you have a better understanding about community programs and services available to your child and family?

r Much better understanding

r Somewhat better understanding r No Change

r Understand less well r Not sure

14. As a result of the screening visit, do you have a better understanding about what you can do as a parent to support your child's learning and preparation for school?

r Much better understanding

r Somewhat better understanding r No Change

r Understand less well r Not sure

15. Because of the screening visit were you or your child referred to any other programs or services?

r Yes r No r No, did not need

15a. If yes, where?

_____

_____

15b. Were you provided assistance to contact these programs or services?

r Yes r No r No, did not need

15c. Have you contacted these programs or services?

r Yes r Not yet, but I plan to

r No, don't plan to r None were needed

16. Would you say the screening visit was a positive experience or a negative experience for your child?

r Very positive r Somewhat positive

r Not sure r Somewhat negative

r Very negative

16a. In what ways was it a negative experience?

_____

_____

17. Would you say the screening visit was a positive experience or a negative experience for you?

r Very positive r Somewhat positive

r Not sure r Somewhat negative

r Very negative

17a. In what ways was it a negative experience?

18. Do you have any suggestions for how the screening experience can be improved for other parents and their children?

19. What was the most helpful part of the screening visit?

Thank you
for your time and help.

Additional Resources

The following selected resources are provided to assist communities in the implementation of the *Quality Indicators Framework.*

Minnesota State Agency Resources

Minnesota Department of Education (MDE)

Web site – **http://education.state.mn.us**
Phone – 651.582.8200

The following materials and information about Early Childhood Screening are available on the MDE Web site:

- Early Childhood Screening forms in pdf available in six languages including the parent consent for screening, consent to release information, and the health and developmental history **(http://education.state.mn.us/html/intro_screening.htm)**
- Early Childhood Screening brochures in pdf available in 11 languages **(http://education.state.mn.us/content/02686.pdf)**
- Publications Order Form for the Early Childhood Screening Brochures, Early Childhood Screening Administrators Manual, Early Childhood Screening Health and Developmental History Interview Guide **(http://education.state.mn.us/content/026552.pdf)**
- General information about Early Childhood Screening (**http://education.state.mn.us/html/intro_screening.htm)**
- Early Childhood Screening Interactive Coordinator Directory **(http://education.state.mn.us/intro_early_learning.htm)**
- Early Childhood Screening Annual Report and Request for Reimbursement Data Submission Site (**http://education.state.mn.us/intro_data_reporting.htm)**

Information about Part C/Early Childhood Intervention including *Your Link Newsletter* and link to Minnesota's directory for early intervention services are available on the MDE Web site **(http://education.state.mn.us/html/intro_speced_eci.htm)**

Minnesota Department of Health (MDH)

Web site – **http://www.health.state.mn.us**

- Child and Teen Checkups Education. For questions, training, or additional information, contact the Child and Teen Checkups Training Coordinator.
  - Phone – 651.215.8960
  - MDH Web site (http://www.health.state.mn.us)
- Hearing and Vision Conservation Program
  - Phone – 651.281.9950
  - Web site- http://www.health.state.mn.us/divs/fh/mch/hlth-vis/index.html
- MDH Health Library
  - Phone - 612.676.5274
- Minnesota Immunization Hotline
  - Phone – 1.800.657.3970, Twin Cities – 612. 676.5237
- Minnesota Vaccines for Children Program
  - Phone – 1.800.657.3970

Minnesota Department of Human Services (DHS) – Child and Teen Checkups/EPSDT

Web site – **http://www.dhs.state.mn.us/default.htm**

- Your Growing Child (Series of 12 Brochures for parents with children ages newborn through ten years)
- "Child and Teen Checkups Documentation Forms" and "Criteria Guidelines for Child and Teen Checkups Provider Documentation"
- Child and Teen Checkups Provider Information Guide

Minnesota State Head Start Collaboration Office

Phone – 651.634.2203

National Resources

- **Bright Futures -** Bright Futures is a national health promotion initiative dedicated to the principle that every child deserves to be healthy and that optimal health involves a trusting relationship between the health professional, the child, the family, and the community as partners in health practice. http://www.brightfutures.org/
- **Center for Disease Control and Prevention (CDC) -**The lead federal agency for protecting the health and safety of people - at home and abroad, providing credible information to enhance health decisions, and promoting health through strong partnerships. www.cdc.gov
- **Centers for Medicare and Medicaid Services (CMS) -** The Centers for Medicare & Medicaid Services (CMS) is a Federal agency within the U.S. Department of Health and Human Services. Programs for which CMS is responsible include Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), HIPAA, and CLIA. www.cms.hhs.gov
- **Head Start Bureau -** Head Start serves the child development needs of preschool children (birth through age five) and their low-income families. The Head Start Performance Standards are available on this site. http://www2.acf.dhhs.gov/programs/hsb/
- **Maternal Child Health Library -** The MCH Library is a virtual guide to MCH information. It offers a combination of MCH information compiled by library staff and pathways to the best MCH information available on other Web sites, from organizations, and in libraries. The MCH Library is funded under a cooperative agreement with the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services. http://www.mchlibrary.info/
- **No Child Left Behind -** The No Child Left Behind Act of 2001 (No Child Left Behind) is an education reform act designed to improve student achievement and change the culture of America's schools. http://www.ed.gov/nclb/landing.jhtml
- **ZERO TO THREE -** To promote the healthy development of our nation's infants and toddlersby supporting and strengthening families, communities, and those who work on their behalf. - http://www.zerotothree.org/

State Statutes and Rules and Federal Regulations

- **Child and Teen Checkups/EPSDT**
  - o From federal statute for the EPSDT Program (Federal Code of Regulations 42CFR441.50 - 441.62): http://frwebgate5.access.gpo.gov/cgibin/waisgate.cgi?WAISdocID=289719231895+1+0+0&WAISaction=retrieve
  - o Federal State Medicaid Manual on EPSDT (gives more detail than statute): http://www.hcfa.gov/pubforms/45_smm/sm_05_5_5010_to_5360with_toc.htm
  - o Minnesota Statutes on EPSDT: http://www.revisor.leg.state.mn.us/stats/256B/04.html http://www.revisor.leg.state.mn.us/stats/256B/0625.html
  - o Minnesota Rule, 9505.0275, Table of Chapters on EPSDT: http://www.revisor.leg.state.mn.us/arule/9505/0275.html
- **Early Childhood Screening**
  - o Purpose of Early Childhood Screening http://www.revisor.leg.state.mn.us/stats/121A/16.html
  - o Requirements for Early Childhood Screening and school district responsibilities http://www.revisor.leg.state.mn.us/stats/121A/17.html
  - o Reimbursement aid to school districts http://www.revisor.leg.state.mn.us/stats/121A/19.html
  - o Program Definitions - http://www.revisor.leg.state.mn.us/arule/3530/3000.html
  - o Screening program staff requirements http://www.revisor.leg.state.mn.us/arule/3530/3300.html
  - o Developmental screening requirements http://www.revisor.leg.state.mn.us/arule/3530/3400.html
- **Head Start**
  - o Head Start Act - http://www2.acf.dhhs.gov/programs/hsb/budget/index.htm#head
  - o Performance Standards http://www2.acf.dhhs.gov/programs/hsb/performance/index.htm

Quality Improvement Resources

- **Agency for Child Health Research and Quality.** Child Health Tool Box, Measuring Performance in Child Health Programs Access, Quality, and Health Service Delivery. - http://www.ahrq.gov/chtoolbx/
- **The Child and Adolescent Health Measurement Initiative (CAHMI).** Works to facilitate health care quality measurement and improvement for children and adolescents. - http://www.facct.org/facct/site/CAHMI/CAHMI/home

Cultural Diversity Resources

- ***The Providers Guide to Quality and Culture***. Designed to assist health care organizations throughout the US in providing high quality, culturally competent services to multi-ethnic populations. http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English
- **Centro Campesino - Entro Campesino Farm worker Center, Inc.** is a rural development organization dedicated to improving the quality of life and self-sufficiency of migrant and seasonal farm workers, their children and other low-income families of all ethnic and racial backgrounds. http://www.centrocampesino.org/
- **IRSA -**Develops and manages education and assistance programs that help refugees resettle in the U.S. These programs help refugees recover from past trauma, gain personal independence and economic self-sufficiency, become contributing members of their new communities, and able participants in all aspects of American life. http://www.refugeesusa.org/
- **SPIRAL -** Selected Patient Information Resources in Asian Languages - A joint initiative of the South Cove Community Health Center and Tufts University Health Sciences Library is supported by a grant from the New England Region of the National Network of Libraries of Medicine under contract NLM-00-101/SMS. http://www.library.tufts.edu/hsl/spiral/
- **Minnesota Department of Health, Office of Minority and Multi-Cultural Health -** The mission is to strengthen the health and wellness of racial/ethnic, cultural, and tribal populations of the state of Minnesota by engaging diverse

populations in health systems, mutual learning, and actions essential for achieving health parity and optimal wellness. (Additional resources can be accessed from this Web site). http://www.health.state.mn.us/ommh/index.html

- **The Early Childhood Research Institute on Culturally and Linguistically Appropriate Services (CLAS) -** The CLAS Institute identifies, evaluates, and promotes effective and appropriate early intervention practices and preschool practices that are sensitive and respectful to children and families from culturally and linguistically diverse backgrounds. - http://clas.uiuc.edu/
- **Getting the Word Out Effective Health Outreach to Cultural Communities, 2000 -** A outreach resource developed by the Medtronic. http://www.medtronic.com/downloadablefiles/outreach_brochure.pdf

Links to Other Resources

- Advocates for Youth - http://www.advocatesforyouth.org
- American Academy of Pediatrics - http://www.aap.org/
- American Academy of Pediatric Dentistry - http://www.aapd.org/
- American Medical Association - http://www.ama-assn.org/
- American Speech-Language-Hearing Association (ASHA) - http://www.asha.org/default.htm
- Bright Futures Home Page - http://www.brightfutures.org/
- Center for Mental Health Services Knowledge Exchange Network (KEN) - http://www.mentalhealth.org/
- Children's Defense Fund - http://www.childrensdefense.org/
- Children Youth and Family Consortium - http://www.cyfc.umn.edu/
- Coalition for America's Children - http://www.kidscampaigns.org/
- Commonwealth Fund - http://www.cmwf.org/
- Cover All Kids Coalition - http://www.coverallkids.org/

- Johnson & Johnson Pediatric Institute- http://www.JJPI.com/
- Minnesota Alliance with Youth ñ http://www.mnyouth.org
- MCH Information Resource Center - http://www.mchirc.net/
- National Association for the Education of Young Children (NAEYC) - http://www.naeyc.org/
- The National Association of Pediatric Nurse Associates and Practitioners - http://www.napnap.org/
- National Council on Family Relations (NCFR) - http://www.ncfr.org
- National Guideline Clearinghouse - http://www.guideline.gov/index.asp
- National Health Law Program - http://www.healthlaw.org/
- National Heart, Blood and Lung Institute - http://www.nhlbi.nih.gov/index.htm (blood pressure screening info)
- Occupational Safety & Health Administration (OSHA) - http://www.osha.gov/
- Pampers Parenting Institute - http://www.totalbabycare.com/
- Put Prevention Into Practice Campaign - http://www.ahcpr.gov/ppip
- Robert Wood Johnson Foundation - http://www.rwjf.org/index.jsp

For more information about
the *Minnesota Quality Indicators for Child Health and Developmental Screening: A Comprehensive Framework to Build and Evaluate Community-Based Screening Systems* document, contact a member of the
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