

# Developmental and Social-Emotional Screening and Referral - Accessible Slide Notes

These notes accompany the [Developmental and Social-Emotional Screening and Referral Slides (www.health.state.mn.us)](https://www.health.state.mn.us/docs/people/childrenyouth/ctc/devscreen/ppdevscreen.pptx). These notes provide more specifics and can serve as a script or discussion guide during a presentation. For more information, refer to the [instructions (www.health.state.mn.us)](https://www.health.state.mn.us/docs/people/childrenyouth/ctc/devscreen/ppinstruct.pdf).

## Slide 1:

No notes.

## Slide 2:

No notes.

## Slide 3:

No notes.

## Slide 4:

[Programs may want to revise the objectives to meet their needs.]

## Slide 5:

The time during pregnancy and the child’s first 3 years of life is perhaps the most crucial time of development. This graph shows how skills begin to build before we can see them evidenced by the child, and how each developmental skill builds on previous skills. Brain development begins in the womb and continues rapidly in the first few months of life. It’s easy to see here how early intervention is so important for vision and hearing problems – if we don’t catch these issues early, they impact later development in a way that we can’t “take back”. Even though it may be harder to physically see, the impact of early social-emotional development is equally important. As staff in one of Minnesota’s screening programs, your role is so important to help support families in their child’s development, and to identify any concerns early so that they can get evaluated and treated.

More information on the science of early child brain development is available from the Harvard Center on the Developing Child

## Slide 6:

As with any condition, when a developmental or social-emotional concern is found and treated early, the child is more likely to have better health and educational outcomes.

In the first 3 years of life, the child’s brain is more sensitive both to harm (for example, lead in the environment) AND to help (like early intervention services).

Universal screening programs for infants, toddlers, and young children help us make sure we identify children who might benefit from early intervention.

[For Early Childhood (preschool) Screening programs: This is why screening at 3, rather than waiting for 4 or 5 years, is so important. We can connect with children who may not have received screening earlier, and those who may have developed something new since their previous screening at a clinic or through another program. It also helps make sure the child has enough time before kindergarten to benefit from school readiness supports and services.]

## Slide 7:

What exactly are we looking for when we provide developmental screening? When you talk with parents about why you are screening, here are some ways you can explain what we are looking for – both skills that the child is already doing, and things that they might not be doing yet. It helps us figure out whether we should take a closer look at a certain area, provide some extra resources, and what we can do to support things that are going well.

The updated Minnesota Help Me Grow website has more information and videos for parents about developmental milestones.

## Slide 8:

Social-emotional development is a very important part of a young child’s development and requires a separate screening instrument. Social-emotional development is also known as infant and early childhood mental health. It’s “the developing capacity of the young child to experience, regulate, and express emotions, form close and secure interpersonal relationships, and explore the environment and learn, in the context of a caregiving environment that includes family, community, and cultural expectations for young children.” Zero to Three is the leading national organization for infant and early childhood mental health. More information for both parents and professionals are available on their website.

Both parents and professionals tend to know more about and feel more comfortable with general developmental concepts like brain development, speech, and motor milestones. However, social-emotional development is the basis for a child’s later relationships, behavior, and mental health.

[Interactive activity: What do you notice about the children in this picture? What interactions do you notice between the parent and the preschooler? What about the toddler? Does she feel safe to explore in this environment with her dad nearby? When you are with a child at work, what are signs of emotional regulation? (Examples: crying and going to the parent for safety, thumb-sucking to calm themselves, saying “I’m scared” …]

## Slide 9:

Development happens in the context of relationships. The child’s parent (or other primary caregiver – maybe a grandparent or foster parent) is their main partner in healthy development. The child’s relationship and interaction with that parent literally help wire healthy brain development. One of our most important jobs is to partner with parents to support them, as they support their child’s development. In a minute, we’ll take a quick look at resources for parents.

You can help support parents by doing the following as you work with them:

* Recognize them as the expert on their child
* Explain in plain (but not condescending) language what you would like to do and why
* Always ask about parent concerns, and usually ask more than once. Parent concerns are very telling, and sometimes it takes a while for them to feel comfortable enough to share with you what they may be worried about.
* After the screening process is finished, have a conversation with the parent about the results, and offer resources and referrals. Find out what fits best with the child’s and family’s needs and priorities.

When you take this approach, it helps validate the parent’s role and concerns, and helps build the trust that is needed to move to the next step if a concern is identified.

## Slide 10:

Even though we’re a program that works hard to identify concerns and make sure families get referrals and services their child needs, we’re not just focused on problems. We’re in a good position to promote healthy development.

There are some ways that you can do this even during your short visit with the family:

[Use examples of ages or situations appropriate for your screening program setting.]

* Use the screening instrument as a tool to have a conversation about typical child developmental milestones at this age, and what the parent can expect over the next few months as the child continues to develop.
* Model how interacting face-to-face with the infant or child helps wire their brain for healthy social and emotional development: Talk to the baby as you check him or her over: look in their eyes, talk back when they coo. Encourage the parent to keep talking, reading and playing with their baby face to face every day.
* During the visit, reinforce healthy parent-child interactions by noticing and commenting on the positive ways the parent interacts with their child: “I noticed that when \_\_\_\_ started fussing, you smiled at him and hugged him a little closer. That seemed to really make him feel secure.”
* Share resources and ideas with the parent about how they can support healthy social-emotional development. You may have some favorite take-home materials to share with parents; others will prefer to go to the web for more information. Some key resources and links are listed at the end of this module.

## Slide 11:

Help Me Grow Minnesota’s newly updated website offers a wealth of information for families and providers about early childhood development. Parents can watch videos that show developmental milestones for different ages and learn what they can do to encourage their child’s healthy development. This website is also a point of referral for early intervention and preschool special education services in Minnesota.

## Slide 12:

The Centers for Disease Control and Prevention, better known as the CDC, offers both website resources and free downloadable developmental information for families and professionals.

This includes milestones, free materials, a Watch Me! Training for early care and education providers, what to do if you’re concerned about your child’s development, multimedia tools, and an autism case training.

## Slide 13:

The CDC also offers downloadable handouts on positive parent tips, for children age birth through 17 years.

## Slide 14:

No notes

## Slide 15:

The new Zero to Three Parent Portal has information especially for parents of infants and toddlers about social-emotional development, behavior, and positive parenting.

## Slide 16:

[Include other parent supports and resources that are available in your community.]

## Slide 17:

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## Slide 18:

Biological exposures:

* Prenatal alcohol or drug use, lead exposure
* Loss of a parent or primary care giver for any reason: death, abandonment, or inconsistent availability perhaps due to mental illness or substance use
* Exposure to trauma (domestic violence, neighborhood violence, abuse, or neglect)
* Social or environment stressors on the child and family - like poverty, homelessness, racism, decreased access to quality childcare or education or medical services

All of these can negatively affect brain development and long-term health outcomes, especially if the child doesn’t have consistent, nurturing care or environment.

## Slide 19:

No notes.

## Slide 20:

[OPTIONAL SECTION] (Through slide 25)

## Slide 21:

No notes.

## Slide 22:

Research over the past decade on the long-term health consequences of adverse childhood experiences (ACEs) helps us understand how crucial it is to pay attention to the experiences of our youngest children.

## Slide 23:

Studies on ACEs – both nationally and in Minnesota – asked adults to look back on experiences they had during childhood, including exposure to verbal, physical or sexual abuse; drinking problems, drug use, or mental illness in the household; incarceration of a member of the household; parent separation or divorce; and witnessing domestic violence.

## Slide 24:

Data in Minnesota was similar to national data: almost a third of respondents reported exposure to at least one ACE.

## Slide 25:

Studies showed that exposure to ACEs has long-term health, mental health, and behavioral health consequences. Those adults who reported exposure to greater numbers of ACEs also reported significantly increased rates of asthma and other physical health conditions, depression, anxiety, drinking and smoking.

Work by Jack Shankoff and others showed that simply paying attention to ACEs – asking about exposure, listening and caring – helps provide immediate relief. Additionally, pediatric clinicians are in a position to help prevent, identify, and mitigate some adverse childhood experiences early – before health consequences set in.

[NOTE: behavioral health includes substance abuse]

## Slide 26:

No notes. Begin new section: Standardized Screening

## Slide 27:

The goal of screening is to identify as early in a child’s life as possible any developmental or social-emotional concerns, and to help the family connect to meaningful services and supports that help the child do better in their health, education, and social interactions.

* Standardized screening is designed to help us identify developmental or social-emotional concerns – especially more mild concerns that might not be obvious even to professionals.
* Standardized screening instruments have been tested on thousands of children to make sure they are accurate in identifying real concerns, and reliable in different situations.
* Screening is universal: all children should be screened, not just ones that we’re concerned about.
* The purpose of screening is both to show child’s developmental progress, AND to pick up on hints that a child may need a closer look with more comprehensive evaluation. Screening does not diagnose.

## Slide 28:

[OPTIONAL: Programs should be clear about definitions that are pertinent in their setting.]

* Screening, evaluation, and assessment mean different things. Screening is a BRIEF, standardized approach that is designed to identify developmental concerns early. It is used for a whole program population (NOT just those with concerns), at routine age intervals, as children get older. It answers the question, “Which children need a more comprehensive evaluation?”
* Evaluation is a more in-depth, comprehensive look at a child when concerns are raised during screening. In the medical setting, it answers the question, “What is the diagnosis?” In the educational setting, it is used to determine if a child is eligible for early intervention or preschool special education services.
* Assessment is different still. It is an ongoing or recurring process to decide what an individual child’s learning or curriculum needs are.

## Slide 29:

If we explain screening well ahead of time, parents have an easier time with it, and we get more helpful information. Some parents may be nervous about screening – like it’s a test, or that we will be judging how good of a parent they are. These tips can help calm these worries, and help parents understand how important their role is, as “expert” on their child.

## Slide 30:

For families who are less familiar with preventive health and developmental screenings, trust is a huge factor, along with explaining the purpose of screening.

In this video, Asli talks about this, in relation to the Somali population. [[LINK TO THE YOUTUBE VIDEO](https://www.youtube.com/watch?v=bBvwOmG72Hs&list=PLqPfFYYbtBZjkeFkeVwUKz-iciPB8HpPi&index=9)]

[DISCUSSION: Some potential questions for group discussion:

* What are ways we can establish a trusting relationship with families in our setting/program?
* Besides trust, what are other issues that Asli raises for us to pay attention to in our approach with families?]

## Slide 31:

[QUESTIONS TO CONSIDER DISCUSSING: How do we address these challenges?]

* What cultural or ethnic groups do we serve? How do our screening rates or ages screened differ by race?
* How easy is it for a parent to request an appointment or ask a question if English is not their preferred language?
* How closely does our staff match the population we serve?
* If it’s not a close match, what could we do to address that? (Examples: paraprofessional staff, volunteers, community/cultural liaisons, interpreters, other ways?)
* Are we using the best screening instrument(s) for the population we serve? Are there particular questions or items that are problematic?
* What are ways that you’ve been successful in trusting and effective screening relationships, even across cultures and languages?

## Slide 32:

Provide a professional interpreter; do not try to screen without or use family members (children or adults).

How do you decide if an interpreter is needed?

* Less effective: Do you need an interpreter?
* More effective: In what language are you most comfortable talking about your child’s health and development? (This is closer to the level of language they will need to use to talk with you about their child’s development.)

Take a few minutes ahead of time to explain the tools you are using; ask them not to provide answers for the parent; request direct translation; and give them permission to raise concerns (like if something isn’t culturally appropriate, or something else they notice).

[If desired: Refer to Minneapolis Public Schools interpreter handout as an example – handout and next slide.]

## Slide 33:

[Optional – refer to handout – used with permission. Consider developing something similar for your program.]

## Slide 34:

No notes. Beginning of section: Screening Instruments

## Slide 35:

All public screening programs in Minnesota should refer the website of the Minnesota Interagency Developmental Screening Task Force for information about recommended screening instruments. Many other resources are also available on this website.

[REVIEW WHAT INSTRUMENTS ARE USED IN YOUR PROGRAM. For example:

* For Early Childhood Screening, state statute requires an observational developmental screening instrument, but also a parent report instrument – different ECS programs use different developmental tools, but most programs use the Ages and Stages Questionnaires: Social-Emotional (ASQ:SE-2) to meet that 2nd requirement.
* Follow Along Program uses ASQ-3 and ASQ:SE (or ASQ:SE-2).
* MIECHV family home visiting programs report on ASQ-3 and ASQ:SE screening.
* Clinics that provide Child and Teen Checkups usually use the ASQ-3 or PEDS parent report developmental screening instruments, for practical reasons.]

## Slide 36:

This is a screen shot of the website where the Minnesota Interagency Developmental Screening Task Force posts recommended instruments and other information for public screening programs for ages birth through 5 years. **[**Direct link to webpage, if you would like to explore it with your training group: <http://www.health.state.mn.us/divs/cfh/topic/devscreening/resources.cfm>]

Left navigation panel: point out “Recommended Instruments”, “Referral”, and “Resources”.

The Resources page (shown here) has links to help you find local programs that support healthy early childhood development, as well as links to state and national resources.

## Slide 37:

What type of screening is *required* or *allowed* for your program?

Developmental and social-emotional screening require separate instruments.

Parent report (answered by a parent or primary caregiver) vs. observational instruments (administered by a staff person or professional)

What staff qualifications does the tool require?

Refer to the screening instrument manual.

What instrument best meets your population’s needs?

Age range

Validated for a diverse population

Is it translated into needed language(s)? Is it validated in those languages? Are there different cut-off scores?

## Slide 38:

[Optional slide – to compare requirements across programs]

There are many public screening programs in Minnesota: Child and Teen Checkups, Head Start and Early Head Start, Early Childhood Screening, Child Protection, Family Home Visiting, and the Follow Along Program. Each of these programs has specific screening recommendations or requirements.

This is helpful to know in order to choose an instrument, but also means there may be more opportunities for children to be screened, and opportunities for different programs to coordinate to decrease duplication of services.

## Slide 39:

[OPTIONAL: Even if your program’s tool is pre-determined, staff may like to know that the MN Interagency Developmental Screening Task Force uses certain criteria to select high quality instruments recommended for public screening programs.]

Instrument purpose: Does the tool accurately screen for conditions we are trying to address?

Developmental domains: Instruments for Minnesota’s screening programs should at least cover the following areas:

* Gross motor
* Fine motor
* Language/communication
* Cognitive
* Social-emotional (separate instrument)

Sensitivity/specificity, validity: Is the tool ACCURATE? (it actually finds what we are looking for)

Reliability: Is the tool RELIABLE, from one time to the next, or from one administrator to the next?

Recent standardization: Was the tool developed and tested within the last 10-15 years?

Additional considerations:

* Practicality: How long does it take to complete?
* Population and age span targeted by the instrument: Has it been validated on a diverse population, at the ages that matter for our programs?
* Cultural, ethnic, and linguistic sensitivity: Has the tool been translated into other languages? If so, was that translation validated in that population? (Note: this is a big challenge – some tools have been validated in Spanish, but very few in other languages.)
* Minimum expertise of screeners: What kind of staff person can administer and interpret the tool?
* Cost

## Slide 40:

[OPTIONAL – Shows currently recommended instruments.]

* Light blue are developmental screening tools.
* Purple are social-emotional screening tools.
* The columns show whether these recommended tools are appropriate for different age groups and different programs in Minnesota.

## Slide 41:

No notes.

## Slide 42:

[OPTIONAL: Some screening providers question the validity of parent-report instruments; this is to address that concern.]

Many professionals wonder if we can we rely on parent-completed instruments. Research shows that parent report instruments perform as well or better than tools that rely on professionals making real-time observations of skills at a specific time and location. Parents or caregivers spend the most time with their child and can most often capture many more subtle behaviors in their children. Other benefits of using a parent-report instrument:

* You can identify both how the child is doing with development, and what the parent’s concerns are.
* You can more quickly focus your visit on what concerns the parent (and what they are most motivated to act on.)
* Parents feel respected as the expert on their child.
* Parents have the chance to learn about child development during the screening process – use the screening instrument as a teaching tool, and a tool to start a conversation about concerns.

Regardless of what instrument you use, an essential part of screening is asking parents about any concerns they have about their child and following up on those concerns.

## Slide 43:

[OPTIONAL: There is often confusion about the ASQ-3 versus the ASQ:SE]

* Both are parent-report instruments.
* The ASQ-3 covers general development, including the areas listed here.
* The ASQ:SE covers specific areas of social-emotional development.
* The 2nd edition just came out in fall of 2015 and is called the ASQ:SE-2. Programs who use the ASQ:SE should transition to the 2nd edition no later than July 1, 2017.

## Slide 44:

[OPTIONAL – for programs that use the ASQ:SE, this slide outlines the main changes in the 2nd edition (ASQ:SE-2). According to the publishers, people who are familiar with using the original ASQ:SE should not need special training to use the ASQ:SE-2.]

## Slide 45:

No notes. Beginning of section: Making meaning out of screening

## Slide 46:

* Even though using a standardized screening tool is much more effective than not, no screening instrument is 100% accurate. Any concerning result requires action
* Ask parent/caregiver for clarification about missed or concerning answers
* Screening must be interpreted in the context of the child and family’s experience, culture, and everything else you know about the child.
* Consider the following:
* Opportunity – give the child an opportunity to try a new skill if it hasn’t been offered before.
* Health and developmental factors, such as recent illness or hospitalization; history of vision, hearing or other factors that could affect development. Screen again when those issues have been addressed.
* Family and cultural factors – including family or cultural expectations around parenting, discipline

## Slide 47:

No notes.

## Slide 48:

If screening results are within cut-off range (“pass” or typical development), this is our opportunity to provide education about what to expect next in the child’s development and give ideas about how the parent or caregiver can support healthy development at home.

If screening results are borderline or in the monitoring zone, more information is needed. Talk more with the family to see if there are programs or other things that could support the child’s healthy development and follow up sooner rather than later with the family to re-screen the child.

If the child’s screening results are beyond cut-off (concerning), more information is needed. Discuss the concerns with the family and develop a plan together for next steps. We’ll talk in a minute about what those next steps might be.

Remember, *even if screening results are “normal”, if either the parent or you have a concern about the child’s development, they may still need a referral* for a more comprehensive evaluation or supportive services.

## Slide 49:

There are some ways NOT to approach screening results with parents.

* Do not use the word “fail”: Screening is not a test. Screening helps us both see what is going well for a child, and it helps us find areas where we might want to take a closer look.
* Don’t use any diagnosis words: Screening is not a diagnosis. If there is an area of concern, more information is needed.
* Take the “wait and see” approach

## Slide 50:

DO use screening as a tool to start conversation. Give specific examples of the child’s strengths, and any areas of concern.

* The screening showed that she’s doing \_\_\_\_ very well. However, it looks like she isn’t doing \_\_\_\_ yet like most other children her age.

DO address parent concerns and learn more about what they think.

* What do you think? What have you noticed about this?

DO offer to provide recommendations for next steps. Use family-centered decision making principles to develop a plan together.

## Slide 51:

No notes. Beginning of section: Referrals: When concerns are identified

## Slide 51:

Whenever general developmental concerns are identified, the family should be offered a DUAL referral (to both, simultaneously):

* To the child’s primary care clinic for MEDICAL evaluation to determine possible cause and treatment. This can also result in better health insurance for the child.
* To the child’s local school district for EDUCATIONAL evaluation to see whether the child is eligible for early intervention services that are free to the family.

We’ll talk more in a minute about why both of these referrals are important.

In every community, there are programs that may help support the child’s healthy development and the family’s well-being. This might include things like high quality childcare or Head Start, Early Childhood Family Education (ECFE), evidence-based family home visiting, or other supportive services.

## Slide 53:

A child with developmental concerns should always be referred for more evaluation by their primary health care provider or helped to connect to a clinic if they don’t have one.

The health care clinician will provide a comprehensive medical evaluation to help see if there really is a delay, and if so, how much of a delay. They can help see why the delay may be happening. Medical evaluation will include a careful health and family history and physical exam, and may include testing for hearing, vision, lead exposure, thyroid problems or other conditions. Untreated chronic health conditions like asthma, allergies, or under-nutrition can result in developmental or behavioral problems. The primary care provider may decide to refer the child to medical specialists such as an audiologist, ophthalmologist, developmental pediatrician, geneticist for more evaluation.

A medical diagnosis may mean that the child qualifies for more early childhood special education services and may help the child qualify for better health insurance or social services.

## Slide 54:

While the primary care provider is responsible for medical diagnosis and treatment, it’s essential to ALSO refer the child right away for an educational evaluation. In Minnesota, the local school districts provide Infant and Toddler Intervention and Preschool Special Education Services. The school district will contact the family and offer more screening or comprehensive evaluation to see if the child is eligible for free early intervention services.

## Slide 55:

To referral a child to for an educational evaluation to see if they are eligible for services, you can either refer them directly to the local school district by phone, fax or secure electronic means,

Or refer them via the statewide Help Me Grow website or toll-free phone number.

Click on the “Refer a Child” button to make the referral. [Optional: brief website demo]

## Slide 56:

Referral to Help Me Grow is important, at any age before kindergarten – the sooner, the better! This gives the child more time to benefit from early childhood special education services, if they qualify.

There are some differences between Infant and Toddler Intervention services for 0-2 years and Preschool Special Education for 3-5 years.

Top reasons to refer before 3 years of age:

* Earlier intervention is more effective, as we’ve talked about
* Easier to qualify for ECSE services – the threshold to qualify for services under 3 years of age is lower
* Services are year-round
* Services provided in child’s “natural environment” – meaning in the child’s home or daycare

While referral at any age is important, there are some important changes once the child turns 3 years old. Beginning at age 3:

* The child must show an educational need, not just a developmental delay or concern. It is harder to qualify for early childhood special education services.
* Services are usually provided in integrated preschool setting, rather than at home or daycare.

## Slide 57:

Just like with developmental concerns, social-emotional concerns are most easy and effective to treat when we identify and act early.

For this reason, a child with social-emotional concerns should be also referred for medical and educational evaluation.

An additional important referral to make is to a local mental health provider that has special skills and training in working with the youngest children (birth to 5 years) and their families.

## Slide 58:

Early Childhood Mental Health professionals are specially trained to work with parents and caregivers when an infant, toddler, or young child shows behavioral or other social-emotional delays or concerns. They also recognize and support the mental health of the parent. These professionals have specialized training in evidence-based assessment and treatment of a broad range of social-emotional concerns. Their work supports the relationship between the parents and infant or young child, and their services support positive parenting. As with any developmental concern, it’s best to refer for mental health services sooner, rather than waiting until behaviors or relationships are at a point of crisis.

## Slide 59:

[[VIDEO link](https://www.youtube.com/watch?v=CNeYRFuZAbA&index=6&list=PLqPfFYYbtBZh-wSpPl3-JDyOywMUUEXWY)]

Casey Ladd, an early childhood mental health professional, talks about how important it is to intervene early for social-emotional concerns

## Slide 60:

Minnesota is fortunate to have mental health professionals that specialize working with families of infants, toddlers, and young children. These professionals have special training to provide evidence-based mental health services that work with parents and caregivers to support parenting and healthy development.

[HANDOUT: map and contact information for early childhood mental health providers/grantees.]

The Minnesota Department of Human Services supports early childhood mental health grantees in all counties and some tribes. Other local agencies may be available as well in your area – get to know your local resources.

## Slide 61:

[[optional video: 2:16 minutes](https://www.youtube.com/watch?v=SZNgyfCGRsw&list=PLqPfFYYbtBZgdBhtKrxFAgsQPQgSIntNz&index=4)]

Emily Wolfe is a social worker. She describes the family-centered approach she takes to talking about referrals. In this case, she is talking about referral for social-emotional concerns, but the same principles may apply to other types of referrals as well.

[LEARNING STRATEGY: Delete text from slide. Watch video together and ask participants to identify strategies for effective referral.]

## Slide 62:

[Training recommendation: Group discussion]

* How do we put families at the center of how our screening and referral process works? How could we improve? [This can also be a good time to recognize that “family” means different things to different people – talk about how you learn from the child’s caregiver about the important people in that child’s life – who help with decisions, childcare, and daily logistics like getting to appointments.]
* Once we’ve developed a follow-up plan with the family, we can use the *“teach back”* method to ensure understanding and unearth any remaining questions or concerns. Ask the parent/caregiver to explain in their own words what they understand to be the next step. This is the same information they can share at home with other important adults in the child’s life.
* What are expectations for follow-up in our program, when concerns are identified, and a referral is made? How can we do a better job of making sure families are supported to get to the next step?

## Slide 63:

[Point out the child and family in the middle of a complex system]

The child will have better outcomes, and the family will have a smoother and less frustrating process, if we coordinate with other programs who are serving or will be working with the family.

Questions:

* Where else does the child receive screening, besides our program? How can we best coordinate with them?
* What information do other providers need after referral to do their job well, and meet the needs of the family?
* Note: explain to the family why sharing information is helpful to decrease duplication (repeated screening) and improve the services their child can get; make sure to follow federal and state privacy laws and obtain signed consent when it’s required. [an example of when consent is needed is provided on the next slide]
* Screening results: clinics, schools and mental health providers can use screening results to inform their evaluation (and they don’t have to duplicate screening)
* Other information about the child and family that may help inform the evaluation (e.g. homelessness, pertinent health or social history)

## Slide 64:

This fact sheet was developed by MDH and MDE to clarify the importance of sharing information and coordinating care between clinics and early childhood special education programs when it comes to early childhood screening and evaluation. It clarifies HIPAA and FERPA requirements for sharing information.

This can serve as an example for other programs as well. Contact information is available on the back side of the fact sheet, for questions.

## Slide 65:

Many families will benefit from the non-clinical programs in the community that support them as parents, and that promote their child’s healthy development.

Most communities have these types of programs available through the county, school district, or other community-based programs:

* The Follow Along Program is available in most counties and some tribes in Minnesota. Public health nurses or other staff send out Ages and Stages developmental and social-emotional questionnaires and follow up with families when there is a concern.
* Family Home Visiting is an evidence-based program of intensive home visiting by nurses or other trained personnel offered by many counties and tribes, usually starting prenatally and continuing until the child is 2-3 years old. This program is good to consider especially for young or first-time parents, or for families where there are significant risk factors for the family or the child’s development.
* Early Childhood Family Education, or ECFE, is a program available through community education for parents and children 0-5 years old. These parent groups are facilitated by child development professionals, and are designed to support positive parenting, healthy child development, and school readiness.
* Early Head Start for infants and toddlers is available in many communities, and includes high quality early care and education, along strong family engagement and support.
* Various types of voluntary and district pre-K programs are available, as well as School Readiness programs.

For more information about finding these programs in your area of the state, [Developmental Screening Resource website (www.health.state.mn.us)](https://www.health.state.mn.us/people/childrenyouth/ctc/devscreen/resources.html).

Parents can also find high quality childcare in their area by going to [Parent Aware website (www.parentaware.org)](http://www.parentaware.org/).

## Slide 66:

No notes.

## Slide 67:

[Optional discussion: Review your program’s resources and process for referral for the following:]

* Medical evaluation and treatment – if a child is not already connected to a primary healthcare provider, what are some local clinics that provide high quality pediatric care?
* Educational evaluation and services – how do we make the referral for ECSE evaluation? [for example, Help Me Grow online, directly to ECSE staff in our building, other…]
* Mental health evaluation and services – who are the local early childhood mental health agencies and professionals? Have we met them? Can we set up a time to meet, and develop a referral process?
* Other local programs that support healthy development – especially if a child doesn’t qualify for ECSE services, what are other programs we can recommend? [e.g. quality child care, Head Start/Early Head Start, Follow Along Program, Family Home Visiting, local parenting support groups…]
* Materials and resources for families – What resources do we offer to parents to support healthy development at home?
* Methods to follow-up with families – How do we/can we ensure that families make it to the next step when concerns are identified?

## Slide 68:

During COVID-19 your program may be offering more screening using a virtual method. Here are some helpful tips.

## Slide 69:

No notes.

## Slide 70:

Although this link was created for educational setting, health care settings may benefit from reviewing these same best practices. This is one in a series of guidance documents.

## Slide 71:

Summarize the most important points of the training. [Discussion suggestion: ask attendees to elaborate on each of these.]

* Family-centered care means recognizing parents/caregivers as children’s most important partner in healthy development; building our services and processes around what works for families; listening first to parent/family concerns; and partnering with families to develop a plan when concerns are identified.
* Minnesota recommends specific developmental and social-emotional screening instruments that are sensitive, specific, valid, reliable, and practical. Recommended instruments should be used in all of Minnesota’s public screening programs. These instruments are listed online, along with more detailed information.
* When developmental concerns are identified, make a dual referral (refer the child for both medical and educational evaluation). When social-emotional concerns are identified, make a triple referral (for medical, educational, and mental health evaluation). [Review referral resources and processes for your specific program.]
* Make an active referral by sending referral and related information directly rather than asking the parent to call or bring the information. Coordinate and communicate with the program to which the child is being referred, with appropriate parent/guardian permission. Follow-up to make sure the family was able to make it to the next step.

## Slide 72:

[Please add your contact information]

Minnesota Department of Health
Minnesota Interagency Developmental Screening Task Force
health.childteencheckups@state.mn.us
[www.health.state.mn.us](http://www.health.state.mn.us/)

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To obtain this information in a different format, call: 651-201-3650.