A) PRINCIPLES

The major purpose of developmental screening is to detect problems that are not readily identified by surveillance, which detects only 30-40% of children with and without problems (as contrasted with a norm-referenced developmental screening tool, which identifies 70%-80% of children with and without problems).

Early intervention not only provides for improved outcomes, but there is significant cost savings and societal contributions are also to be expected.

B) RECOMMENDATIONS

1. **Our most important recommendation is that the Guidelines be consistent with AAP Guidelines, use AAP algorithms for developmental and for social-emotional/behavioral screening, and adhere to recommended AAP periodicity for visits.**

2. Screening with a norm-referenced tool must be for *all children* at these ages *that have not yet been identified*, not just for children with a "recognized risk," as the current draft states.

3. In the section, "Administering a Screening Tool", clarify that a developmental screening tool addresses gross *and fine* motor skills.

4. Clarify, under Referral, Treatment and/or Follow-Up, that CHDP providers should refer children with a concern **in any developmental domain** for assessment/evaluation/follow up. The current draft suggests this for "social/emotional/behavioral or cognitive" issues only.

5. Current research supports the early identification of children with ASD, as it increases the probability of successful treatment. An autism specific screening tool should be used at 18 through 30 months.

6. We recommend the list of tools be reduced. Our feedback suggests that physicians do not want a long list of tools, but want flexibility in their selection.

7. We recommend that the AAP list only include screening tools with at least 70% accuracy (specificity and sensitivity); standardized for a broad

cultural/racial/ethnic group of children; that the list is kept up-to-date; and, that the tools be easy and simple to administer. A better alternative would be to link with a pre-existing list/table on the web. North Caroline refers their EPSDT providers to the screening tools found at www.dbpeds.org/, a rich screening resource and is sponsored by the AAP: http://www.dbpeds.org/articles/detail.cfm?textid=539. Oregon's Department of Maternal and Child Health's website also lists recommended tools: http://www.oregon.gov/DHS/ph/ch/abcd_screening.shtml

8. We also suggest the developmental screening tools included on the list cover all of the developmental domains as well as a broad age range. This allows for the developmental screening tools to be used universally.

9. Given that the table is still receiving comments, we will provide the additional recommendations on the table by July 9th. As you recall, Dr. Randle requested that we reorganize the screening tool table.

10. We recommend that CHDP send a letter out advocating the use of validated screening tools, much like the letters sent out by Dr. Duke in Los Angeles and the Michigan Department of Community Health/ Michigan AAP (attached), but more importantly, include information on how to bill and receive reimbursement. Feedback from Dr. Duke and many pediatricians indicates that the majority of providers do not know that there is a reimbursement mechanism (96110 code) in place for using a reliable screening tool.

11. We recommend that the PM 160 include a specific area for documenting what screening tool was used and what the score was.

12. We recommend the HAG be made available electronically with links, e.g., AAP Algorithm, Bright Futures, etc. so that updates can be made easily.

C) RECOMMENDED RESOURCES TO BE INCLUDED IN THE HAG

1. We recommend adding AAP and Bright Future's websites so practitioners will have access to the latest guidelines, screening tools, e.g.

   www.Brightfutures.aap.org

   www.medicalhomeinfo.org/screening

   http://pediatrics.aappublications.org/cgi/content/full/118/1/405 The AAP article, *Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening*. (2006) In Table 1 of the article is a list of developmental tools.

   www.dbpeds.org

2. We recommend that a brief mention/description of Preschool Special Education ("Section 619, Part B of IDEA") for children ages 3-5 under the Referral, Treatment and Follow-Up section be included. This program has different eligibility criteria and is run by school systems rather than Early Start (birth – 36 months) which is implemented through the 21 Regional Centers in California.

3. Depending on the results of the developmental screening tool and the specifics of the clinical situation, consider referrals to Early Start, local schools systems, and community developmental and behavioral resources.

D) RECOMMENDATIONS TO CLARIFY LANGUAGE

1. Make the language more user-friendly by defining terms – such as surveillance, screening, evaluation and assessment – in context, since each has a discrete meaning, but these meanings are frequently confused. This suggestion is especially relevant for the section on Basics of Developmental Surveillance and Screening. In this section, we also suggest listing some of the risk factors as well as protective factors.

2. Provide a brief description of eligibility criteria and services available to children (> 36 months) through the Regional Center System under the Lanterman Act. Children with developmental disabilities can be eligible for services through a school district (IDEA Part B) and a Regional Center (Lanterman Act) simultaneously.

3. Update and clarify the reference to Public Law 99-457 to reflect the most recent reauthorization of the Individuals with Disabilities Education Act.

If it would be helpful, we would be glad to provide some draft language to implement these recommendations.

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We hope these comments are helpful and look forward to working with you further on the Guidelines.