Mid-level Developmental Assessment

The MLDA Framework

November 2014

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AN OVERVIEW OF **MLDA**

Scientists can now credibly say that the foundation for academic success, economic productivity and a lifetime of sound health and healthy relationships is laid down in the early years of children's lives. Consequently, early childhood experts emphasize the critical need to identify and address developmental, behavioral, and psychosocial issues in young children as early as possible for optimal child development.[1] According to the literature, 12 to 16 percent of children below age three in the United States have developmental delay in at least one area, including behavioral health. Yet nearly one-half of affected children will not be identified by kindergarten entry. Physical and mental health related issues, alone or in combination, account for all but 6% of the children each year who are not ready for kindergarten.[2] Children living below the poverty line are 1.3 times more likely to have developmental delays or behavioral problems than those not living in poverty.[3]

Some of these young children are born with low birth weight or are at risk for poor developmental and behavioral outcomes due to an accumulation of factors known as "toxic stress." These factors include poverty, child abuse and neglect, domestic and community violence, caregiver depression and substance abuse, homelessness, health problems, and barriers to care among many other environmental risks. The damaging effects of toxic stress are cumulative and are known to lead to major developmental and mental health problems, substance abuse, cognitive disability, and physical illness which last throughout the lifespan.[4] We know that 80% of brain growth is completed by three years of age and toxic stress from sustained and aggregated adverse experiences has been shown to impact the brain and impair developmental and behavioral functioning.[5,6] The older the child, the more difficult it is to change brain structure, the greater the expense, and the poorer the outcome [See Figure 1].

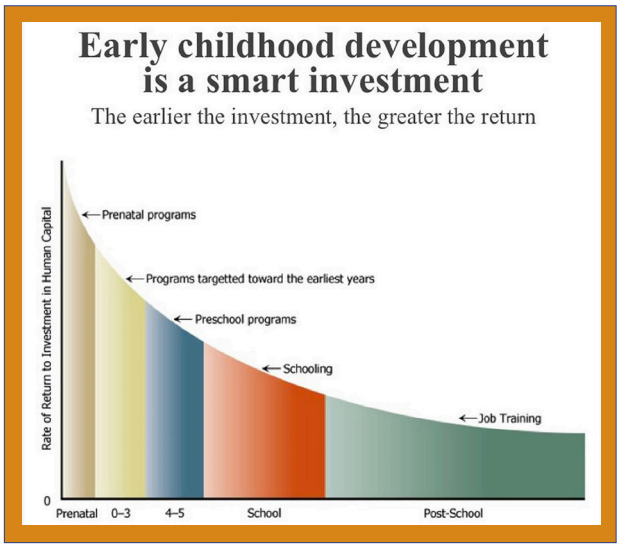

Figure 1
Source: James Heckman, Nobel laureate in economics

[1] Shonkoff, J. From Neurons to Neighborhoods: The Science of Early Childhood Development, 2000

[2] Macrides, P., DO, Southern Illinois University School of Medicine, Quincy Family Medicine Residency Program, Quincy, Illinois, Ryherd, S. Ed.M, Southern Illinois University School of Medicine, Center for Clinical Research, Springfield, Illinois, "Screening for Developmental Delay," *American Family Physician*. 2011 Sep 1;84(5):544-549

[3] Alliance For Excellent Education, U.S. Census, National Center for Education Statistics, The New York Times, American Graduate

[4] Adverse Childhood Experience Study, Centers of Disease Control and Kaiser Permanente, 1998-2011

[5] Shonkoff, J et al., "Lifelong Effects of Childhood Adversity and Toxic Stress", Journal of the American Academy of Pediatrics, 2012;129;e232

[6] Shonkoff, J, From Neurons to Neighborhoods: the Science of Early Child Development. 2000

To address the earliest possible identification of children at risk for or with developmental and behavioral concerns, a new level of care known as **'mid-level developmental assessment'** has emerged to meet a growing service need.

MLDA was first noted in a 2006 report by the Commonwealth Fund that identifies mid-level assessment as bridging the gap between developmental screening and high level tertiary evaluations. The high-end tertiary services are typically costly and often unnecessary. These services include hospital- or clinic- based multidisciplinary assessment or specialty evaluations by neurologists, psychiatrists, psychologists, and others.

Mid-level developmental assessment is described as a key strategy for enhancing early care and education, pediatric and behavioral health practice linking developmental services and supports.[7] The authors suggest that having mid-level assessment resources in place encourage providers to more quickly refer children with concerns, making it more likely that children with mild to moderate delays will receive timely and appropriate intervention. At the community systems level, increased utilization of mid-level assessment likely results in high-end tertiary level services being freed up for children with the greatest and more complex needs.

The Child Health and Development Institute of Connecticut (CHDI) published '*A Framework for Child Health Services: Supporting the Healthy Development and School Readiness of Connecticut's Children*' in 2009. The Framework articulates the full continuum of services from primary health care to the highly specialized care needed in a comprehensive system of child health services.[8] In the category of "selective services" or "services available to all children and families and likely to be accessed by some to promote early intervention for health and developmental problems," the Framework identifies the need for MLDA [See Figure 2].

CHILD HEALTH SERVICES BUILDING BLOCKS

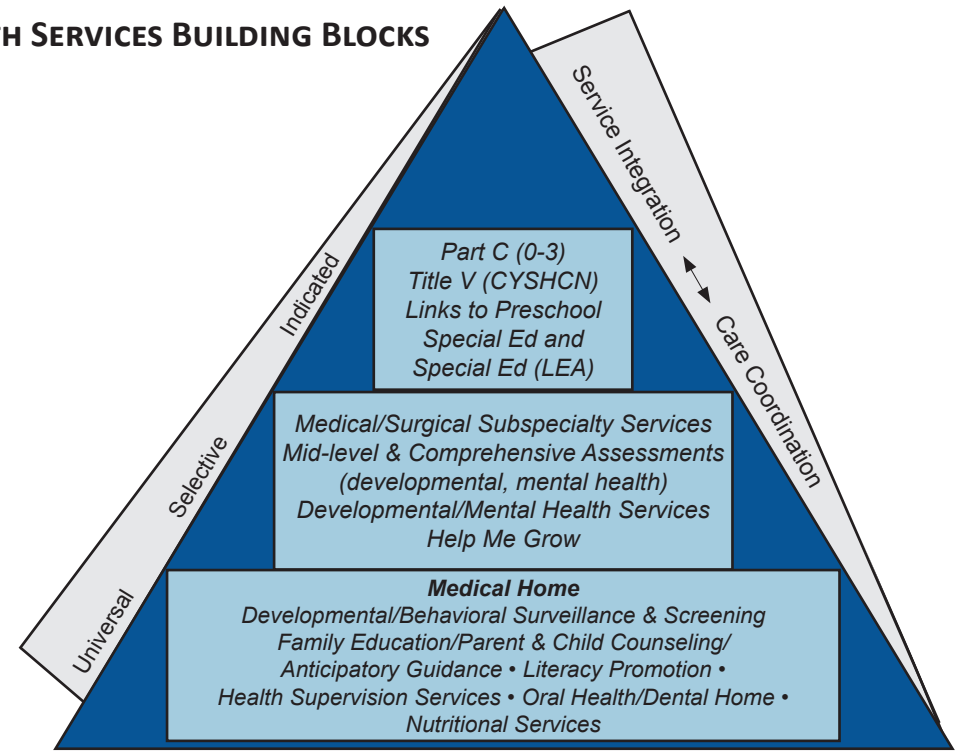

Figure 2

[7] Fine, A, & Mayer, R, Beyond Referral: Pediatric Care Linkages to Improve Developmental Health. The Commonwealth Fund. December 21, 2006. Volume 42

[8] Dworkin, P. ,Honigfeld, L. & Meyers J. "A Framework for Child Health Services." Farmington, CT: CHDI, March 2009.

> The authors describe MLDA as the expedient assessment of a child with a behavioral or developmental health concern identified through screening "**aiming to provide the right child with the right service at the right time.**"[9]

MLDA, then, is a new level of care; briefer and more affordable than a full multi-disciplinary or behavioral/ mental health evaluation and can be community-based. It addresses the identified service gap by assessing and carefully triaging children to existing community based programs and service in a timely, effective manner with the goal of improving the developmental trajectories of the children in this population.

Mid-level Developmental Assessment within an Existing Service System

Universal Services

The Framework describes Universal Services as "services provided to all children and families to support optimal healthy development and early identification of health and developmental concerns, ideally through a 'medical home.'"

In Connecticut, as in other states, many children are enrolled in 'Universal' services including early care and education, family support programs, and routine pediatric care. Children are considered at risk for developmental delays or behavioral problems when parents express concern or developmental surveillance and screening raise questions about a child's development (language, fine or gross motor, learning, adaptive skills), or social/emotional behavior. In many 'Universal' service sites, developmental and behavioral screening is done at regular intervals to monitor development, learning, and behavior through developmental surveillance and formal developmental screening. Formal screening measures such as the Ages and Stages Questionnaire (ASQ), Ages and Stages Questionnaire-Social Emotional (ASQ-SE), or the Pediatric Evaluation of Developmental Status (PEDS) are often administered in these settings.

However, when there is a "red flag" as a result of screening, it is often unclear what the next step can and should be.

When Screening Findings are Positive, What is the Next Step?

When screening results are positive, there are clear options for referral to developmental evaluation and/or to Part B or Part C early intervention services. Referrals may also be made for tertiary-level multidisciplinary developmental evaluation for diagnosis and treatment. These evaluation, treatment, and early intervention services are classified in the Framework document as "Indicated" services.

9 Honigfeld, Chandhok, Fenick, Martini Carvell, Vater, Ward-Zimmerman, "Mid-level Developmental and Behavioral Assessments: Between Screening and Evaluation". Farmington, CT:CHDI, May 2012

Indicated Services

The Framework document describes Indicated Services as "such as those available through Birth to Three or Title V (for children with special health care needs), provided to those children that have identified difficulties and fulfill certain eligibility criteria." A diagnosis is needed in order to prescribe treatment services by providers such as neurologists, psychologists or psychiatrists. In Connecticut, as in most states, the availability of these specialists is insufficient to meet the growing demand for comprehensive tertiary-level assessments.

For Birth to Three and preschool Special Education services (such as IDEA Part C and Part B) eligibility criteria must be met in order to qualify. Children at risk or with some level of mild to moderate developmental or behavioral concerns may not qualify for these services and may be lost for follow up assessment or other services.

In summary, national policy and data from the Connecticut *Help Me Grow* program are consistent with reporting gaps in connecting young children to services. Large numbers of children may not have severe enough challenges to qualify for existing programs, yet still are at risk of growing up with untreated developmental and behavioral challenges. Many children with developmental, mental health and behavioral concerns are not receiving services within the optimal time frame. [See Figure 3]

The Mid-Level Developmental Assessment (MLDA) Model

When developmental screening identifies children in need of further evaluation, an MLDA provides a comprehensive global developmental assessment with caregivers as partners throughout the process. The assessment is based in the community and addresses the needs of children with mild and moderate levels of delay and behavior concerns. It ensures that children identified through developmental surveillance and screening will receive timely evaluations. MLDA promotes earlier intervention for these children by allowing a majority of them to avoid the delay of awaiting full diagnostic tertiary level evaluations, allowing appropriate services to commence in a more timely fashion.

> The MLDA is a more abbreviated assessment that confirms the areas and levels of delay and behavioral concerns. **It identifies children with developmental or behavioral challenges as early as possible and provides recommendations for and connection to appropriate and existing service(s).** [Appendix A]

Because the MLDA results in a timely Family Service and Recommendation Plan it expedites referral to lesser intensity community-based services such as family resource centers, parent education, home visiting services, and developmental and therapeutic play groups. A two-year pilot of the mid-level developmental assessment model funded by the Connecticut Child Health and Development Institute (CHDI) determined that it is effective, low-cost, and largely covered by third-party reimbursement for both mental health care and primary health care providers. Using conservative estimates, MLDA can save an average of $540 per child.[10]

10 Honigfeld, Chandhok, Fenick, Martini Carvell, Vater, Ward-Zimmerman, "Mid-level Developmental and Behavioral Assessments: Between Screening and Evaluation". Farmington, CT:CHDI, May 2012

Standard of Care for Screening and Assessment

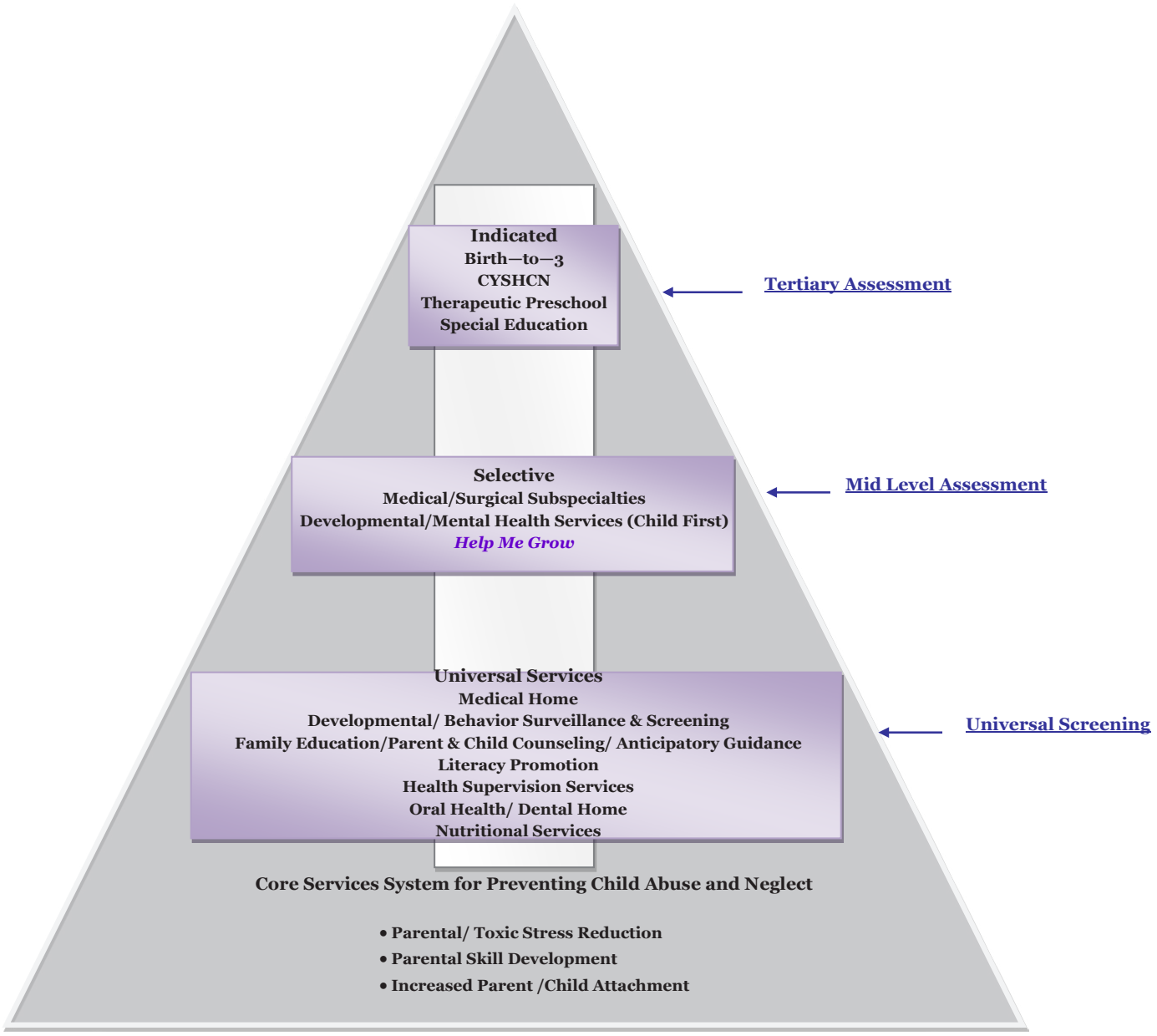

Figure 3

Figure Credit: Hector Glynn

The Model

MLDA is a set of protocols with both *process/procedures and formal assessment tools* that are global measures across all domains of the developing young child. It is designed to deepen understanding of a child's competencies, resources of the care giving and learning environments, and related health and wellness factors.

The assessment results in the determination of developmental and behavioral delays in each domain, and develops strategies for intervention that most likely will help a child make fullest use of his or her developmental potential.

MLDA Core Principles

The MLDA model recognizes the unique challenges of assessing young children from birth through age five:

- Young children have limited or no verbal skills and limited expressive language skills so they cannot simply "tell you what they know or think."
- Each area of development is influenced by–and interacts dynamically with–every other domain of development, so it is difficult to tease apart where a delay may occur.
- Young children are developing and changing at a rapid rate.
- Children's behavior reflects the values and culture in which they are raised and any judgment about child development must be done with sensitivity to cultural influences and values.
- Developmental problems in young children can be subtle, so it takes experience and broad knowledge of infant through early childhood development to build acute observation and interpretation skills.

MLDA Requirements

1. Partner organization

MLDA is conducted in programs or practices based in the community and embedded in community networks such as behavioral health, or pediatric practices.

The partner organization provides clinical, fiscal, and administrative oversight.

2. A *Help Me Grow* (*HMG*) Centralized Access Point

- The *HMG* Access Point provides referral to MLDA
- The Access Point then provides referral and linkage to MLDA-recommended services and supports.

3. Identified MLDA target population

The MLDA target population is typically children from birth through age five years suspected of having mild to moderate developmental delays and/or behavioral concerns and in need of assessment and timely linkage to community based services. MLDA is not for children who have already received extensive evaluation services.

4. Assessment of current and potential funding and reimbursement options for MLDA target population

- Third Party Reimbursements
- Part B, Part C
- Foundations/Grants

See page 12 for more information

MLDA Components

1. A staff of two early childhood professionals

These professionals thoroughly understand child development (e.g., health, child development, behavioral health clinicians) and are credentialed in a developmental discipline. They provide an interdisciplinary assessment (see protocols below).

2. A partnership between parents/caregiver and staff

Parents/caregivers are integral partners in the MLDA assessment process. MLDA acknowledges parents' expertise about their own children and builds on specific family strengths for service planning.

3. A protocol consisting of:

- **Collateral information review.** The MLDA providers work with and expand upon existing collateral information about the child, e.g., previous screenings and/or concerns expressed by pediatric, early care and education and other providers, and/or family members.

- **Formal information sharing and planning** with child's pediatric health care provider.

- **Parent/caregiver interview and parent stress/functioning measure** such as the Parent Stress Index (PSI)[1]

- **Developmental play-based assessment** that covers the full range of development including developmental skills, behavior and psycho-social development: the assessment

1 Parent Stress Index: http://www4.parinc.com/products/Product.aspx?ProductID=PSI-4

utilizes instruments that are reliable and valid, used for their specified purposes, and appropriate for specific cultural/ethnic groups and specific ages.

- The Infant Toddler Developmental Assessment (IDA)[2] and the Developmental Assessment of Young Children (DAYC 2)[3] meet the instrument criteria.
- The assessment is conducted in non-threatening settings in the presence of the parents, guardian or, if neither is available, another trusted, familiar person.

- **Weekly case conference meetings**. At these meetings, staff complete an interdisciplinary assessment review as needed, integrate findings, and make recommendations for service All information is integrated, resulting in identification of the specific area(s) of developmental and/or behavioral concern and challenges faced by the child and family, as well as identification of the need for any further evaluation.

- **A Family Feedback Session** that shares MLDA findings and care coordination that connects, children and families' to community based recommended services.

4. A Family Service and Recommendation Plan

This plan includes "selective" mid-level developmental or behavioral services (e.g., developmental play groups, parenting education) and/or "indicated" services (e.g., Birth to Three, preschool Special Education).

See page 13 for more information

2 Infant-Toddler Developmental Assessment: http://www.proedinc.com/customer/productView.aspx?ID=4513
3 Developmental Assessment of Young Children–Second Edition: http://www.proedinc.com/customer/productView.aspx?id=5157

DEVELOPING AN **MLDA** SITE

MLDA Requirements

Partner Organization

MLDA is conducted in community-based agencies or practices that provide clinical, fiscal and administrative oversight, such as behavioral health, or pediatric practices.

MLDA sites need to have demonstrated strong ties to pediatrics and to a range of early childhood and family development programs (i.e. early care and education, home visiting and case management). The community base gives support to families with easy access in familiar surroundings. It is essential for facilitating referrals at the time of request for a MLDA, and also at the time referrals are made for services as recommended based on the MLDA findings.

Help Me Grow (*HMG*) Central Access Point

REFERRALS

Referrals for MLDA are made by parents, pediatric providers and other early childhood and family service providers when there is a question about the child's development, learning, and/or behavior.

Often a formal developmental screening process has yielded a "red flag" highlighting areas of developmental or behavioral risk. Such developmental screening tools can include the Ages and Stages Questionnaire (ASQ), which is frequently administered in early care and education and family support programs. In pediatric practices, screening routinely includes observation, developmental surveillance, and use of formal screening tools such as the Pediatric Evaluation of Developmental Status (PEDS). Based upon the screening results, those children at risk for developmental or behavioral concerns are referred for MLDA.[11]

HELP ME GROW CENTRAL UTILITY

The MLDA is embedded within the central utility access/*Help Me Grow* system. Referrals for Mid-level Developmental assessment are made directly through the central utility access and forwarded to the MLDA provider. Upon completion of the assessment, families are connected through the central utility/ Help Me Grow system to the MLDA recommended services and supports. This single point of entry connects the "right child, to the right supports, at the right time."

11 Dworkin P.H., McKay K, Vater S. Infants and Young Children, 2006 19:4 371-377

Target Population

The MLDA population is typically children from birth to 60 months in need of assessment and timely linkage to community based services. Crucially, these children have not already received extensive evaluation services. The MLDA target population can be those children who are currently ineligible for categorical programs and/or not in need of tertiary level evaluation and diagnosis. MLDA works best for children who have a developmental and/or behavioral health concern in the mild to moderate range, and for those children dealing with high levels of stress that may affect their development negatively.

Funding and Reimbursement

Each site will assess current and potential funding and reimbursement options for the identified MLDA target population. For example, existing pediatric and mental health insurance or medicaid reimbursement may be in place for conducting a developmental assessment.

In Connecticut, MLDA is largely reimbursed through third party payment. Supplemental private funding has been used to support MLDA before going to scale. The Connecticut experience is a 70/30 reimbursement package (70 third party, 30 private). MLDA should become cost neutral when one provider can do 500 assessments a year.

MLDA Components & Protocols

MLDA provides a common frame of reference to organize complex information, from multiple sources, into a comprehensive recommendation and service plan.

This plan is based on developmental findings that are considered in the context of the child's family and health. The plan may include additional consultation and/or assessment.

MLDA is provided in a program or practice with supervisors and staff that have early childhood clinical experience and expertise. Weekly MLDA team meetings support staff's ongoing development and refinement of skill. MLDA providers also receive reflective individual supervision to address areas of bias and challenges with cultural norms and expectations that may reveal staff's developmental assumptions.

Staff and Supervision

STAFF

A team of two professionals from the early childhood developmental fields, such as psychology, child development, early childhood special education, nursing and others, conducts the MLDA. One professional must be a Master's-level clinician; the other is a Bachelor's-, Master's- or above-level (or equivalent) developmental evaluator. Both

must have expertise in young children's development and experience working with young children.

Given the considerable variation in the normal range of development during the early years, professionals must have sound knowledge of the typical developmental sequence ***and*** of the various timetables for different areas of development. This knowledge allows the assessor to recognize what should emerge next in the child's development; to discern if the child is making adequate progress in obtaining new skills; and to understand the quality of the child's skills in a given area. The professional(s) also need to determine the appropriate strategy for making developmental gains and meeting developmental challenges.

It is important to create a team of two professionals that will yield optimal reimbursement for the assessment services. The Connecticut model uses licensed clinicians to conduct the family interview, while child assessment is done by a range of professionals, including developmental educators, psychologists, and social workers.

SUPERVISION

Ongoing reflective supervision is essential for the delivery of high quality services. Reflective supervision with staff is a critically important best practice in the child-family field; these principles guide the case discussion and are critical for assuring quality and fidelity to the MLDA model.

The personal and intense nature of this work often elicits strong emotions, especially when children and families are under stress. In Reflective Supervision, staff process thoughts, values, reactions, and feelings in order to build strong and supportive professional relationships. These relationships help prepare staff for work with with young children and family members.

Team leadership consists of a senior-level experienced clinician/supervisor responsible for clinical and report-writing oversight, as well as implementation of training and staff development. The clinician/supervisor has substantial background in clinical work with young and very young children and their families. The clinician/supervisor or another assigned team member is responsible for case assignments, coordination, and monitoring of case flow.

The Parent/Caregiver Partnership

Parents/caregivers are integral partners in the MLDA assessment process. The process acknowledges their expertise of their own children; builds on specific family strengths for service planning; and encourages their full participation in the entire services continuum. Engaging parents in the assessment process is immensely valuable in providing cultural norms and developmental expectations for their child. Without parent input, child behavior is assessed without context.

MLDA Protocols

MLDA is a set of protocols with both *process/procedures and formal assessment tools*. Each step builds upon the previous one. All aspects are integrated into the developmental findings and service recommendations.[12]

MLDA PROTOCOLS

Three Family Contacts

1. Parent/caregiver interview and parent stress measure
2. Play-based child assessment
3. Family feedback session

Weekly Case Conference Meetings

The assessment team meets weekly throughout the MLDA process. The Family Service and Recommendation Plan is developed in these meetings. (Note that the Plan is finalized in the family feedback session.)

Assessment Case Management

Members of the assessment team provide case management from referral to MDLA through assessment and up to connection to recommended services. One team member assumes responsibility for each aspect of assessment case management, including:

- contact with the child's primary health care provider, early care/ education and other providers;
- confirming scheduled appointments with the family and MLDA team; and
- participation in agency meetings as indicated.

Following the Family Feedback Session, the MLDA team forwards the Family Service and Recommendation Plan to the *HMG* Central Access Point. *Help Me Grow* then assumes care coordianation responsibilities, which include helping families gain access to the services specified in the Recommendations and Family Service Plan.

12 The MLDA model is anchored in the Infant and Toddler Developmental Assessment (IDA) best practice process as described in Erikson, J "The Infant and Toddler Developmental Assessment (IDA); A Family Centered Transdisciplinary Assessment Process" in S.J. Meisels & E. Fenichel (Eds.), New Visions for the Developmental Assessment of Infants and Young Children (pp.147-166). Washington, D.C.: Zero to Three, 1997

MLDA Implementation

Once a referral to MLDA has been made, the process is typically implemented in these steps.

I. Collateral information review

Prior to the play based developmental assessment, one of the MLDA providers gathers data from the child's health and other service providers This protocol guards against inappropriate conclusions drawn from a one-time assessment. Children may appear and behave differently in various settings and with different people; they may be better able to demonstrate their competencies or vulnerabilities under certain conditions and not others.

Data is gathered from health care providers, teachers, social service and other providers. The information may include observations, verbal or written reports, rating scales, checklists, previous screenings and/or concerns expressed by providers, and/or family members.

II. Formal information sharing & planning with child's pediatric health care provider

Health information from the child's pediatric care provider is routinely considered, recorded and incorporated by the Team as part of the MLDA process. Plans for health care follow up as well as referral services, with parent permission, are discussed and shared with the child's primary health care provider. This planning, communication, information-sharing with the child's pediatric health care provider is essential to the success of the MLDA process.

III. Parent/caregiver interview & parent stress measure

The parent/cargiver interview is completed by the team Family Interviewer/ Clinician in 1-1.5 hours and is family-centered. Parents/caretakers are engaged as full partners in the assessment process sharing their concerns, observations, and helping set assessment and service priorities. Parents are recognized as experts on their children and as partners in the assessment process. Their needs, priorities, and perceptions play a central role in all aspects of the assessment.

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A child's relationship and interactions with his or her caregiver form the cornerstone of the assessment. Children typically reveal higher skill levels in the context of spontaneous, motivated, supported interactions with caregivers. The evaluator builds on these interactions by coaching the parents to elicit certain behaviors or skills or by joining in the interaction.

In addition, parents or caregivers are each asked to complete a normed and validated parenting stress/ parenting functioning measure. The results from the measure are used to corroborate the parent's verbal report.

IV. Play-based assessment covering the full range of development including developmental skills, behavior and psycho-social development

ASSESSMENT

The Developmental Evaluator conducts a comprehensive play-based developmental assessment that encompasses developmental, behavioral, and psychosocial health in the areas of gross and fine motor, cognition, adaptive, communication, psycho-social development, and behavior.

The assessment instrument(s) must cover the full range of development and behavior, are reliable and valid, designed for specified purposes and are appropriate for specific cultural/ethnic groups and specific ages.

In Connecticut, the Provence Profile of the Infant and Toddler Developmental Assessment (IDA) is administered for children from birth to age three, and the Developmental Assessment of Young Children (DAYC) is administered to children ages 3-6. (Appendix E). It is important to choose a measure that takes into account the interrelationship of all the developmental domains.

SETTING

Children more reliably demonstrate their competencies when they are in a place that is secure and familiar, and with people they know and trust.

The MLDA assessment takes place in a natural, non-threatening setting and involves tasks that are familiar to the child and family. Activities and materials reflect the experiences and objects that are relevant to the family's daily life.

MLDA may be conducted on site at the partner organization, in the child's home, or may be co-located within area pediatric or behavioral health care sites.

V. Weekly case conference meetings

A key component of the MLDA process is a weekly case conference meeting held with all team members and led by the Clinical Supervisor. Team members bring together all information gathered about the child being presented, from the assessment and other sources, integrate that information, and form service recommendations or further evaluation recommendations to be outlined in a Family Service & Recommendation Plan.

Interdisciplinary Rounds

For some of the more vulnerable, multi problem families served by many clinical settings, interdisciplinary consultation may need to augment routine MLDA assessment in order to formulate a family recommendation & service plan.

Interdisciplinary consultations happen for approximately 20% of the MLDA cases. Eighty percent (80%) of the MLDA cases can be reviewed, integrated and completed by the two-member Team. Twenty percent need a higher level of review. The 80/20 model is similar to how cases are discussed in hospital rounds.

In this kind of consultation, staff attend a weekly meeting during which the MLDA clinical supervisor presents the MLDA case, including referral question/concerns, assessment findings, and service options in a rounds type format. Providers already connected to the family (i.e. early education, pediatrics and/or child welfare/social services) are invited to attend or call into the case conference and contribute to the case discussion. [Appendix F]

Other participants at Interdisciplinary Rounds may already be part of the provider agency but often work in other program areas (i.e. nurses, pediatricians, child psychiatrists, speech and language specialists, occupational therapists, early childhood educators, social workers, and psychologists).

The clinical supervisor guides the integration of input by all parties, with the end goal of creating clear content and understandable findings to be presented to the family during the final feedback session.

Rounds can be scheduled at regular intervals or on as-needed basis depending on case flow. They can be done in person or via distance learning formats.

In some circumstances, it will be clear from the initial interview and developmental assessment that a particular case would benefit from the interdisciplinary rounds format. Other times, it will only become clear during the routine case conference that additional input would be helpful which the clinical supervisor schedules.

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No matter the complexity of the case, MLDA work will likely improve when primary health care providers or other clinicians already working with the family add their important perspective. These overlapping, but not identical, levels of expertise serve as vital quality control of the model.

Use the Guidelines for Review of Findings [Appendix G] to determine whether services, intervention, additional consultation, or further assessment may be indicated. These guidelines will also help determine whether this further work will be part of the MLDA process or included in recommendations for services.

VI. Family Feedback Session & Family Service and Recommendation Plan

A member of the MLDA assessment team conducts a feedback session with the family to share and discuss the MLDA findings in a clear, unbiased and supportive manner.

The Assessment builds on the specific family strengths for service planning, and encourages full participation with the parents/caregivers in goal-setting, and decision-making around the resulting recommendations. The primary goal of the family feedback session is to validate family's concern with their child's development and empower them with a recommendation plan for ongoing support. The Developmental Specialist ensures that the MLDA results and recommendations are understood and agreed to.

FAMILY SERVICE AND RECOMMENDATION PLAN

The Family Service and Recoommendation Plan is formed after integration and synthesis of all data at the Case Conference. The service recommendations are finalized in the Family Feedback meeting and are summarized in a Family Service and Recommendation Plan. The plan includes recommendations for both child and family services.

VI. Care Coordination: Central Utility

Upon completion of the Mid-level Developmental Assessment, the MLDA staff forwards the Family Service and Recommendation Plan to the central utility/ *Help Me Grow* center to link families to the recommended services.

APPENDICES

APPENDIX A

Case Example

Referral

Eighteen-month-old Mara was referred for a Mid-level Developmental Assessment by her pediatrician at the CCMC Primary Care Center's based on the Pediatric Evaluation of Developmental Status (PEDS) developmental screening results that showed 'red flags' about her behavior and language skills. Based on the pediatric provider's previous experience, he believed that Mara was not likely eligible for the State's Birth to Three Program, given the requirement of 50% delay, or two standard deviations below the mean. CCMC instead referred Mara to The Village for MLDA.

Parent Interview

Mara's mother, Ms. Lopez, brought her eighteen-month old-daughter for a Mid-level Developmental Assessment due to concerns about her behavior and speech. Ms. Lopez reported that Mara used few words and those that she used were often difficult to understand. Ms. Lopez reported that Mara was very active and often gets angry. When she didn't get her way, she'd kick, bite, and throw herself on the floor, hitting herself against the wall. Her aggressive behavior began to worry Ms. Lopez about a month ago when Mara was fighting with her three -year old brother at home every day, biting and kicking him.

Mother completed a Parent Stress Index (PSI) questionnaire as part of the evaluation. Her scores suggested that she experienced only average levels of stress (35th percentile) in her role as a parent. However, she reported clinically significant levels of stress in her relationship with Mara (approaching the 99th percentile) and in her perception of Mara as a difficult child (over the 99th percentile). Her overall stress level was also measured to be over the 99th percentile.

Pediatric Provider contact

Mara saw Dr. Brown at the Connecticut Children's Medical Center s Pediatric Care Center for regular pediatric visits. Dr. Brown reported that she is up to date with well-child visits and immunizations. She had always enjoyed good health, had no accidents or major illnesses, and took no medications other than an occasional application of topical cream for mild eczema. Dr. Brown confirmed that there were no health concerns, but noted that developmental screening using the PEDS indicated communication and behavioral concerns.

Developmental Findings

Mara was evaluated with the Infant and Toddler Developmental Assessment (IDA) Provence Profile. Findings reported that Mara had a mild delay (25%) in Language and her play schema was somewhat immature for her age. This placed her in the category of mild to moderate behavioral concern.

Individualized Family Service Plan

Recommendations

1. Mara parents would like parent education and support and will be connected to these services at The Village RAMBUH Family Center.
2. Mara will be enrolled in a child development play group also at The Village RAMBUH Family Center to address both her communication and behavior challenges
3. Mara's developmental and behavioral progress will be monitored in her CCMC Medical Home.

As the pediatric health care provider had surmised, Mara was not eligible for any 'categorical' programs. **Without the availability of Mid-level Developmental Assessment and connection to services, this case would have become another, all-too-common example of a child falling through the cracks after routine developmental screening.**

APPENDIX B

Literature Review and Key Informant Interviews

Literature Review

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U.S. Department of Health and Human Services, Head Start Bureau. (1996). Revised Head Start Program Performance Standards. Washington D.C.

Key Informant Interviews

Nancy Close Ph.D., Assistant Professor in the Child Study Center; Associate Director of the Yale Program in Early Childhood Education; Lecturer in Psychology, New Haven, CT

Lois M. Davis Ph.D., Professor Emeritus, Saint Joseph College, Chair Early Childhood Special Education Department, Hartford, CT

Paul H. Dworkin M.D., Professor and Chair, Department of Pediatrics, University of Connecticut School of Medicine, Executive Vice President - Community Child Health and Physician-in-Chief, Connecticut Children's Medical Center Hartford, CT

Delbert Hodder M.D. Medical Director, Bristol Pediatric Associates, Bristol, CT

Desmond Kelly M.D., Medical Director, Division of Developmental and Behavioral Pediatrics, Donald A. Gardner Family Center of Developing Minds, Children's Hospital in Greenville, South Carolina

Samuel J. Meisels Ed.D., President, Erikson Institute and Nelson Harris President's Chair, Chicago, IL

Kyle D. Pruett M.D., Clinical Professor of Psychiatry at Yale University School of Medicine

Jennifer Rosinia Ph.D., Professor, Erikson Institute and President, Kids Link Inc., Chicago, IL

Carlos H. Salguero, M.D., M.P.H, Medical Director, Psychiatry Department, The Village for Families & Children, Inc. Hartford, CT

Barbara Ward Zimmerman Ph.D. , Consultant Psychologist, Bristol Pediatric Associates, Bristol, CT

APPENDIX C

Job Descriptions

MDLA Clinical Manager/Supervisor

Family Interviewer/Clinician

Developmental Evaluator

MLDA CLINICAL MANAGER/SUPERVISOR

Role

To provide clinical oversight and supervision to the extended developmental testing program and work collaboratively with the Director around administering the program. The clinical manager ensures all core competencies are met by evaluators, clinicians, and case managers, and ongoing training is provided to enhance the overall skills of the Early Childhood evaluation team. The clinical manager works to ensure fidelity to the mid level model, as well as explores areas for program development and research. Materials generated as a result of the mid level process are reviewed by the Clinical Manager to ensure their level of quality is commensurate with the agency's requirements.

Responsibilities

- To provide clinical review of referrals to the MLDA program and screen for appropriateness and urgency of need.
- To review all documentation generated in the electronic medical record and ensure billing accuracy.
- To review the reports generated as a result of the MLDA testing to determine accuracy of scoring and integration of information gathered from collateral sources.
- To provide weekly individual clinical supervision to all full time staff members of the Mid-level program.
- To provide group supervision to all Mid Level staff via the Early Childhood evaluation team meeting. The supervision entails a detailed clinical review of each case upon the completion of testing and gathering of preliminary data.
- To promote and demonstrate utilization of a wraparound philosophy for all mid level cases via the development of the Family Service Plan.
- To provide clinical support to staff members as they work within the community to provide feedback to the family and involved parties (i.e., schools PPTs).
- To provide short-term follow-up after the evaluation has been completed and ensure that clinical and educational recommendations have been provided to the family.

- To work with the Director to address administrative issues as they come to impact the clinical work of mid levels.
- To provide and develop internal and external training opportunities that build on the Mid-level model and/or enhance the skills of the staff who are part of the mid-level model.
- To assist with the development of research on the mid level program and to be a part of the writing and/or presentation process.
- To continually monitor and address program development issues that arise that could enhance the model and/or the clinical materials utilized for the model

FAMILY INTERVIEWER/CLINICIAN

Role

Responsible for providing family interview and assessment in coordination with other agency and community services and documentation of services as required by program policies and funding sources.

Responsibilities

To provide direct services to children and their families. Duties include the following.

- Implementation best practice models and/or evidence-based practice in both clinical office and community settings.
- Child and family developmental interview and engagement.
- Bio-psychosocial formulation and contact for services or comprehensive treatment planning.
- Community outreach, linkage, and supports for children and families.
- Discharge and planning services (including the Individualized Family Service Plan) for follow up treatment and/or linkages to community support services.
- Case management as indicated during period of MDLA process and follow-up
- Timely clinical documentation and reports, as well as any other documentation and reports required by agency and program policies and funding sources.
- Building and maintenance of collaborative relationships with other community agencies and organizations (i.e. schools, courts, hospitals, etc.) in consultation with supervisor, in order to provide comprehensive and effective treatment services for clients.
- Teaming with other clinical and administrative staff to respond to client and programmatic needs.
- Autonomy in day-to-day responsibilities and routine clinical situations, while identifying needs for consultation/supervision.
- With supervisor and program supports, consultation and training to interns and/or other staff.
- Ongoing knowledge and implementation of agency policies and procedures.
- Partnering with supervisor to identify areas and develop plans for professional growth.
- With supervisors approval, partnering with other program or agency clinical staff, identifying and developing approaches to address clients unmet needs or service gaps.

- Assuming responsibility for special tasks or leadership in special projects as appropriate in order to contribute to program functioning.
- Representing the umbrella agency (i.e., The Village) in community groups or committees and/or giving community presentations, as assigned by supervisor, in order to promote agency visibility and develop community linkages.
- Fulfilling other duties and responsibilities as determined by management.

Minimim Qualifications

- MSW/MA from an accredited program with valid Professional License.
- Non-licensed MSW/MA may be substituted if program regulations allow for substitution or license is obtained within agreed upon time period. A non-licensed MSW/MA must include a minimum of 3 years experience in a comparable position in a child/family serving human services agency.
- Excellent oral and written skills. Ability to communicate comfortably with children from birth to age eight; parents; and school personnel.
- Ability to work independently with minimal supervision.
- Ability to be flexible, organized, and comfortable multitasking.
- Cultural competency to serve targeted populations. (Bilingual skills may be required.)
- Experience working with inner-city children and their families.
- Commitment to Results/Performance Based Accountability.
- Proficiency with word processing and spreadsheet applications.
- General computer skills, including ability to work in a Windows XP environment. Familiarity with specific applications used by the umbrella agency (i.e. The Village) a plus.
- Physical ability to perform the essential functions of the position, with or without reasonable accommodations.
- Ability to function safely in a therapeutic situations, including provision of services in clients homes or host settings.
- Ability to travel to various sites throughout agency service area (i.e. greater Hartford). Potential requirement to maintain valid driver's license and ability to drive or otherwise obtain transportation to provide services throughout the service area.

DEVELOPMENTAL EVALUATOR

Role

Responsible for providing Mid-level Developmental Assessment services to children and families, in coordination with other agency and community services and documentation of services as required by program policies and funding sources.

Responsibilities

To provide direct Mid-level Developmental Assessment services to children and their families. Duties include the following.

- Implementation of best practice models and/or evidence-based models of developmental assessment and engagement in both clinical office and community settings.
- Development and documentation of a comprehensive Individualized Family Service Plan
- Report writing outlining the assessment findings and IFSP
- Case management as indicated
- Provision of developmental assessment services in the office, home and/or at host settings, to meet the unique needs of families served.
- Accurate and timely completion of clinical documentation and reports, as well as any other documentation and reports required by agency and program policies and funding sources.
- Development and maintenance of collaborative relationships with other community agencies and organizations as indicated and in consultation with supervisor (i.e. schools, courts, hospitals, etc.), in order to recommend comprehensive and effective treatment services for clients.
- Teaming with other clinical and administrative staff to respond to client and programmatic needs.
- Autonomy in day-to-day responsibilities and routine clinical situations, while identifying needs for consultation/supervision.
- Ongoing knowledge and implementation of agency policies and procedures.
- Participation in supervision on a programmatic level and beyond as deemed appropriate.
- Other duties and responsibilities as determined by management.

Minimum Qualifications

- MSW/MA, APRN, PA, from an accredited program.
- Formal training in the developmental assessment measures used.
- Excellent oral and written skills. Ability to communicate comfortably with children from birth to age eight; parents; and school personnel.
- Ability to work independently with minimal supervision.
- Ability to be flexible, organized, and comfortable multitasking.
- Cultural competency to serve targeted populations. (Bilingual skills may be required.)
- Experience working with inner-city children.
- Commitment to Results/Performance Based Accountability.
- Proficiency with word processing and spreadsheet applications.
- General computer skills, including ability to work in a Windows XP environment. Familiarity with specific applications used by the umbrella agency (i.e. The Village) a plus.
- Physical ability to perform the essential functions of the position, with or without reasonable accommodations.
- Ability to function safely in a therapeutic situations, including provision of services in clients homes or host settings.
- Ability to travel to various sites throughout agency service area (i.e. greater Hartford. Potential requirement to maintain valid driver's license and ability to drive or otherwise obtain transportation to provide services throughout the service area.

APPENDIX D

Physician Letter

The Village
So every child believes in tomorrow

Date: _____

Address: _____

_____

RE: _____ (D.O.B. _____)

Dear _____,

We recently contacted your office about this child undergoing a Mid-Level Developmental Assessment at The Village. As part of the process, we routinely work closely with the child's primary care provider to obtain a thorough understanding of the child's medical status to build a comprehensive assessment.

In an effort to obtain this information, we ask that you answer the questions on the following page and return your responses by fax to me at (###) ###-####.

The Mid-level Assessment turnaround is 10 days. Please return your responses in a timely manner so that we can include your valuable information in the Mid-level Developmental Assessment.

Along with this letter, you should have received a release of information. If you have questions or concerns, please contact me at (###) ###-#### x###.

Thank you for your time and efforts.

Sincerely,

APPENDIX D continued

Physician Questionnaire

The Village
So every child believes in tomorrow

Child: _____ D.O.B.: _____

Name of Person Completing this Form: _____

Primary Care Provider Questionnaire

1. When was the child first seen in your practice?

2. When was their last appointment?

3. Are the child's immunizations up to date?

4. Do you have any concerns about the child's development?
   If so, please describe.

(continued on next page)

APPENDIX D continued

5. Please indicate whether the child has any of the following (for yes responses, please describe in the adjacent box):

Acute medical condition(s)	Yes No	
Chronic medical condition(s)	Yes No	
Requires medication daily	Yes No	
Vision Difficulties	Yes No	Date of Last Screening
Hearing Difficulties	Yes No	Date of Last Screening
Accidents/Injuries/Traumas	Yes No	

6. Do you have any information that you feel would be important for us to take into account as we are conducting this evaluation? If so, please detail below.

APPENDIX E

Family Assessment Measures

Early Childhood Family Assessment

Based on the information obtained in the interview process, the Interviewer completes the Early Childhood Assessment which was designed and piloted[13] to be used as a part of the MLDA process. It covers information given by the parents including pertinent birth, health, and developmental history.

Parent Stress Index/Parenting Functioning Measure/PSI

During the family Interview, the parent or caretaker completes a parent stress measure, the Parent Stress Index (PSI),[14] which is available in English and in Spanish.

Developmental Assessment Measures

Developmental assessment measures must be chosen based on a review of measures that cover the multiple domains of development. The MLDA measures used in the pilot program meet these criteria and continue to be used.

Developmental Assessment of Young Children (DAYC 2)

The DAYC 2 measures cognition, communication, social-emotional development, adaptive behavior and physical development in children ages 0 to 5.[15]

Infant-Toddler Developmental Assessment (IDA) Provence Profile

The IDA measures motor skills, cognitive ability, language/communication, self-help, relationship to persons, affects, and coping behavior in children ages 0 to 3.[16]

As indicated, other measures may be added in specific domains to enhance the global assessment instruments described above.

13 Early Childhood Assessment, Kyriakopoulos, S. The Village for Families and Children, 2009

14 PSI: Parent Stress Index

15 DAYC: Developmental Assessment of Young Children

16 IDA Provence Profile

APPENDIX F

Interdisciplinary Rounds: Integration of the Assessment Information

The typical weekly MLDA case conference meeting serves as a working session for the family interviewer/case manager and developmental evaluator to integrate their findings and present their recommendations for the Family Services and Recommendation Plan. Routine cases are presented at this conference.

At the team meetings, both the developmental evaluator and the family interviewer should receive ongoing reflective supervision from the clinical supervisor of the MLDA program (or his or her designee). This supervision occurs more frequently at the beginning of their clinical work in MLDA

This team meeting provides the forum for the case manager and developmental evaluator to integrate developmental findings with information gathered from all sources; to finalize the Family Services and Recommendation Plan; and/or to consider the need for further consultation and/or more in-depth evaluation in one or more of the developmental or behavioral areas. The process of considering more in-depth evaluation builds upon the findings of the mid-level assessment and identifies program options and/or a plan for further assessment in one or more developmental domains.

For some of the more at-risk families served by many clinical settings,
routine MLDA assessment will need to be augmented by interdisciplinary consultation to formulate an appropriate family service/treatment plan.

In this consultation, providers already connected to the family (i.e. early education, pediatrics and/or child welfare/social services) are invited to attend or call in and contribute to the case discussion. Other participants may already be part of the provider agency but work in other program areas (i.e. nurses, pediatricians, child psychiatrists, speech and language specialists, occupational therapists, early childhood educators, social workers, and psychologists).

Whenever possible, primary health care providers or other clinicians–therapists or early childhood educators already working with the family–are invited to be present to add their important perspective. The overlapping but not identical levels of expertise from these disciplines serve as vital quality control of the model, given its signature timely turn-around and practical problem/intervention focus.

The MLDA clinical supervisor presents the MLDA case in a rounds type format, including referral question/concerns, assessment findings, and service options. The clinical supervisor guides the integration of input by all parties, with the end goal of creating clear content and understandable findings to be presented to the family during the final feedback session.

In some circumstances, it will be clear from the initial interview and developmental assessment that a particular case would benefit from the interdisciplinary rounds format. Other times, it will only become clear during the routine case conference that additional input would be helpful, which the clinical supervisor will schedule.

Rounds can be scheduled at regular intervals, or on as-needed basis depending on case flow. They can be done in person or via distance learning formats.

Interdisciplinary Rounds: Steps

1. **The MLDA Team convenes to review and discuss cases prior to the Family Feedback Meeting. Participants in this meeting include at a minimum the Family Interviewer, Developmental Evaluator, and Clinical Supervisor.**

2. **With parent permission, the referring person and other providers are invited and often participate in person or through a conference call or video link.**

3. **The meeting proceeds with the following protocol**

Family Interviewer/Clinician presents:

- child and family information including gender, age, family composition, referring person/organization, reason for referral;
- relevant history including current and prior services received;
- and assessment findings from the family interview/assessment.

Developmental Evaluator presents:

- PSI findings for both mother and caregiving partner/father;
- child and family observations (including behavior when separated from guardian);
- developmental assessment findings in each area (via DAYC, IDA or similar assessment tool);
- and information from the child's health care provider, early care/education and other providers

Clinical Discussion Guide

- Is information from the observations, developmental assessment and collateral sources sufficient to determine areas and levels of delay and/or concern?

  -Is more information needed from additional sources (e.g. school, child care or other providers)?

  -Would this case benefit from discussion at 'rounds'?

  -How, by whom, and when will this information be obtained and integrated into the final family conference?

- What are the possible health factors that may be contributing to the developmental delays (health history including prenatal, current issues, medications)?

  -Is more information or follow up needed with the health care provider (e.g., for vision or hearing screening, updated medication information etc)?

  -How will additional information be obtained and by whom?

- What family/environmental factors may be contributing to the developmental delays/concerns?

  -What follow up information or service recommendations are needed?

- Does the child have/present a concern not originally a part of the referral that requires further attention?

  -If yes, what is the extent of the problem? What are possible contributing factors?

  -Can the additional information or assessment be provided by team member(s) as part of the MLDA?

  -How will this information or assessment be obtained/ completed?

  -What additional services and resources could best support the child's healthy development? Specifically:

Early intervention	Medical/Dental
Early care/education	Case Management
Mental health Services (child and/or family)	Other (job training, housing, etc.)
Family Support Services	

Use the Guidelines for Review of Findings [Appendix G] to determine whether services, intervention, additional consultation, or further assessment may be indicated and whether this will be included as part of the MLDA or as recommendations for services.

Sample questions from the Clinician/Supervisor to help facilitate the discussion

Does the MLDA profile appear to be a good picture of the child the team observed and the parents have described?

Does the assessment support or confirm the parents' concerns?

Why was the child unable to perform? For example, was the child unable to succeed with one item and so became afraid to try again?

Were unscored items the result of trying and failing or refusal to engage in the item?

How do the domains interrelate?

How can we resolve the discrepancies in the findings with the report by the school?

Does the child have a problem that requires attention?

Does the problem require further assessment?

Have we done a sufficient job incorporating the child and family's strengths–developmental and cultural–into our recommendations?

Have we enough input from both parents (even though they may not be living together) to balance our understanding of this child's vulnerabilities and strengths?

What type of support/intervention will support the child's and the family's development?

Have we formed a sufficiently clear picture of child's needs from the MLDA or should we refer for more extensive specialized evaluation at a tertiary setting?

Who on the team will be responsible for follow-up on the family's follow-through with the recommendations?

4. Plans for next steps are made based on the integration of findings and team discussion, and may result in one or more of the following:

- Development is progressing as expected, no further assessment indicated;
- Monitor (emerging skills, development, behaviors); follow-up assessment may be indicated;
- Further developmental evaluation in one or more areas is needed in order to determine an intervention/ treatment plan; and
- Referral for child and/or family members to service(s).

Next steps are noted on the Individualized Family Service Plan.

APPENDIX G

MLDA Additional Consultation or Evaluation[17]

At the weekly Case Conference team meetings, team members consider whether and when to seek consultation or further assessment. In many instances, four factors guide this decision: the nature of the questions posed in the referral; the disciplines of the team members; the wishes of the family; and the resources of the agency.

Generally, the agency that will be doing the intervention further develops the recommendations for specific interventions and therapies, or for a treatment plan or instructional objectives. The needs of parents and child are kept in mind, as is consideration of how the referral for treatment or further assessment can be effected in the most efficient and timely way.

In some circumstances, consultation or further evaluation is incorporated into the MLDA process as team members draw upon their basic discipline and add a specialty consultation to the assessment. For example, if the practitioner is a physical therapist, additional observation or assessment in his or her specialty area may be included. If the team member is a nurse or a physician, some medical information may be incorporated. A social worker may wish to add a more in-depth family assessment. Additional observations or assessments conducted by team members are included in the MLDA report and recommendations.

Other times, recommendations for additional assessment are part of the referral for services. For example, a child who demonstrates delays in several areas may show a particular delay in motor development. This child will almost certainly be referred to an early intervention program with a physical therapist on staff. It is most efficient for this therapist to complete the PT evaluation, as he or she will have an ongoing relationship with the child and family. In this situation, the evaluator should describe his or her findings and include notation that they indicated the need for additional assessment in the motor area.

17 Modified from the Infant and Toddler Developmental Assessment –IDA Procedures, Provence et al, (1995)

Guidelines for Review of Findings

Developmental Findings	Follow-up Plan
Gross Motor and Fine Motor Mild delays, seen as part of generalized developmental delay, do not necessarily require further specialty evaluation. The findings should be described and noted as part of the plan for intervention and/or monitoring. However, the following findings most often should be regarded as requiring consultation from or referral to a physician or an occupational or physical therapist: • generalized hypo/hypertonicity; • unusual or poorly controlled body movements, such as tremors or tics; • poor coordination; uneven performance; generalized weakness; and • significant delays in gross and/or fine motor.	
Language/ Communication Mild language delays and articulation difficulties, if seen as part of generalized mild delay, do not necessarily require further specialty evaluation. The findings should be described and noted as part of the plan for intervention and monitoring. Consultation from a speech and language pathologist is indicated if findings show any of the following: • significant delays in expressive language; • significant delays in receptive language; • significant articulation difficulties; and • disturbances of oral-motor function, prosody and coordination. Consultation is especially important if any or all of the above concerns are found in the presence of normal or near normal functions in problem-solving abilities and social relatedness. Disturbances in oral-motor function and coordination also are within the purview of occupational and physical therapists, and nutritionists. The choice of professional depends on the child's presenting problem and the therapist's interests, expertise, and availability.	
Social-Emotional Depending on the degree and nature of the concerns, there may be a need for consultation by professionals with child mental health expertise including developmental pediatrics, child psychiatry, psychology, social work, psychiatric nursing, or others. The specific concerns should be described and noted as part of the recommendations for intervention and/or monitoring. For children with less pronounced problems in relationships, affect, temperament, or coping, addressing these areas should be an important part of the recommended strategies for any treatment or intervention.	

Assessment Components Review	Follow up Plan
Family Factors Family issues are considered in terms of their influence on the child's developmental findings. Those relevant findings that have bearing on the child's physical, psychological, or environmental needs, including strengths and concerns are noted and included in follow-up planning. Special note is made when the following family or environmental concerns are identified and are not currently being addressed. Generally, they will require consultation and/or referral for further evaluation or services from mental health or social service providers. • Unsafe child care environment • Unmet basic needs, i.e., food, clothing, housing • Parental physical illness • Active and untreated mental health problems (depression, anxiety, inappropriate behavior, and/or personality problems or mood disorders which interfere with ability to care for the child adequately) • Limited intellectual capacity (interfering with ability to care for the child adequately) • Active substance abuse • Active family relationship problems or interpersonal/domestic violence • Suspected physical, sexual, or emotional abuse or neglect Some findings are indications for referral to an official child welfare or protective services agency. As with all cases, professionals should follow child protection mandates and guidelines for reporting, as well as the policies of the agency in which they are working in.	
Health Factors When the following findings are identified and it is determined that they are not currently under treatment, special note should be made, and the findings be reviewed with a developmentally trained health professional. The findings may indicate the need for a pediatrician, a nurse practitioner, a family physician, a nutritionist, or a pediatric specialist (geneticist, endocrinologist, ophthalmologist, neurologist, ear, nose, and throat specialist). Indications for further medical consultation must be reviewed with the child's primary health care provider, and any referral must be made in collaboration with him or her about the following: **HEARING** • any questions about hearing ability • if the child is identified as at risk for hearing impairment and has not been screened • recurrent or chronic otitis media	

VISION • questions about visual acuity in either eye • strabismus or questions of amblyopia • unusual eye movements **NEUROMOTOR** • uneven, discrepant, or ambiguous neuromotor findings, e.g., persistent asymmetry of motor performance after 4 months of age (by history) • overt neuromotor difficulties, e.g., hypo-/hypertonicity, weakness, paresis, paralysis, tremors, atrophies, repetitive non-purposeful movements • unusual or poorly controlled body movements (head, neck, trunk, extremities) • changes or deterioration of neuromotor findings Other health/medical problems identified during the evaluation, including those (if not under treatment) that require consultation referral or follow-up: • inadequate/inconsistent health care; need for primary health care provider • any medical condition that is not under treatment or surveillance • loss of previously acquired skills • unexplained scars or bruises • growth problems, poor nutrition (failure to thrive, obesity) • dysmorphic features • micro-/macroencephaly • signs of acute physical distress (irritability and/or lethargy)	

Appendix H

Training Outline and Resources

Observation, Screening and Assessment		
Key Concepts	**Hours**	**Competencies**
Development of observational skills with infants and young children Use of observational information Use of screening tools When to make referrals for more comprehensive assessment How to make a referral, including following through or assisting family with initial contacts Introduction to major assessment instruments and processes	60	Demonstrates an understanding of assessment as intervention. Successfully uses a wide range of strategies in varied settings to reach and engage families. Demonstrates an understanding of how to use observation, screening and assessment to determine necessary components for the individual infant, young child and family. Selects and uses screening and assessment practices appropriate to pregnant and postpartum parents, including screening for depression. Incorporates observations of the infant and young child in multiple settings including play, child- parent interactions, early care and education settings and home into every assessment of the child. Demonstrates an understanding of and ability to integrate a multidimensional assessment of an infant or young child, utilizing information from other providers and caregivers as appropriate, inclusive of health, physical, social, emotional, psychological and cultural aspects from a developmental and relational perspective. Understands how to select and use specific components of assessments for birth to five-year-olds and their caregivers within scope of practice and training.

Prepared by Kimberly Martini Carvell M.A.

Appendix I

Model Development and Research

The methodology for developing the MLDA consisted of three parts: review of the relevant literature, key informant interviews and a two-year pilot and study of the model.

A Literature Review was conducted to gain an understanding of the context and landscape of existing developmental assessment services and best practice.

Key Informant Interviews were conducted with experts in the fields of pediatrics, developmental and behavioral pediatrics, psychology, psychiatry, child development, developmental assessment, psychometrics, public health, and social policy to explore key issues, concepts around gaps in assessment and the need for a new level of care, specifically, "mid-level" developmental assessment. The key informants were selected to include a broad range of experts and innovators at the local, state, national and international levels working on strategies and practices for identifying children at risk for developmental and behavioral problems and facilitating access to needed resources and services. Their combined historical, conceptual and practical knowledge provided an understanding of the early childhood development landscape and guided the MLDA model development;

The MLDA Pilot was conducted. With the MLDA design firmly in place, a team was formed to guide a two year pilot funded by the Connecticut Child Health and Development Institute (CHDI) to implement and study the model. The team included renowned Yale Child Psychiatrist, Kyle Pruett M.D., Kimberly Martini-Carvell, M.A., Susan Vater, Ed.M, and Sandy Kyriakopoulos, Psy.D, at The Village for Families and Children in Hartford Connecticut working in partnership with Paul Dworkin, M.D., Executive Vice President, Community Child Health and Physician-in-Chief of the Connecticut Children's Medical Center. The team worked with pediatricians, parents, child welfare, and community partners to pilot the MLDA model that ensures children identified through developmental surveillance and screening receive timely, efficient and effective evaluations;

Research findings from the two-year pilot demonstrated the feasibility and effectiveness of a Mid-level Developmental Assessment (MLDA) model as designed to address the needs of children with mild and moderate levels of delay and behavioral concerns, and to enable children with more severe delay to access tertiary-level assessment in a timely fashion. Findings included:

- MLDA referrals were solicited from child health, early care and education, mental health, and social service providers, and parents;
- The MLDA was conducted by an early childhood clinician and developmental specialist with case management support; and
- Model components are (a) solicitation and integration of data from the child health and other service providers; (b) parent interview; (c) child evaluation; (d) integration of the evaluation information; (e) family/caregiver feedback; (f) development of an Individualized Family Service Plan (IFSP); and (g) case management during the evaluation period.

- Furthermore, MLDA Pilot results show that of 80 children from an at-risk, urban population who received MLDA during a 22-month pilot period:
  - 82% were found to have mild to moderate delays;
  - 18% were referred for tertiary evaluation and were found eligible for categorical programs (e.g., Part C and Part B);
  - all were typically seen within one week of referral and MLDA was completed within two weeks of initial interview;
  - all were connected to community-based programs and services; and
  - MLDA was largely covered by third-party reimbursement.

The pilot demonstrated that the Mid-level Developmental Assessment is a feasible and effective model for the timely assessment of children suspected of developmental delay on the basis of surveillance and screening. The MLDA is more affordable than a full developmental, behavioral, or mental health evaluation and addresses the identified service gap by assessing and carefully triaging children to community based programs and services in a timely, effective manner with the goal of improving the child's developmental trajectory. The MLDA pilot demonstrated, using conservative estimates, that MLDA saves an average of $540 per child compared to a tertiary-level evaluation while also freeing up availability of tertiary level evaluation services for those who really need them.[18]

18 Honigfeld, Chandhok, Fenick, Martini Carvell, Vater, Ward-Zimmerman, "Mid-level Developmental and Behavioral Assessments: Between Screening and Evaluation". IMPACT, Farmington, CT:CHDI, May 2012