Screening Tools Workgroup Recommendations To The Early Learning Council

courtesy of Bruce Ely of The Oregonian

ELC Screening Tools Workgroup
Oregon Early Learning Council
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Table of Contents

Executive Summary ... 3
Introduction ... 4
History of screening in Oregon ... 4
Definitions ... 5
Process ... 6
Vision ... 6
Guiding Characteristics ... 6
Recommendations for screening tools ... 7
Domain: Maternal Health/ Mental Health ... 9
Domain: Family Well-Being ... 10
Domain: General Development ... 11
Domain: Behavioral/Psychosocial Relational ... 12
Domain: Physical Health ... 13
Conclusions ... 14
Next Steps ... 14
Appendix A – Workgroup Members ... 16
Appendix B - Oregon Statewide Early Childhood Screening Domains and Periodicity ... 17

Workgroup members (see Appendix A for additional information)

David Allen, Lory Britain, Janet Carlson, Janet Dougherty-Smith (chair), Caroline Cruz, Laurie Danahy, Donalda Dodson, Charles Gallia, Jennifer Gilbert, Dana Hargunani, Nakeshia Knight-Coyle, Sandra Potter- Marquardt, Holly Remer, Eva Rippeteau, Donna Schnitker, Betty Shuler, Bill Stewart, Teri Thalhofer, Dawn Woods

Executive Summary

There have been many screening mandates and local screening efforts in Oregon for more than twenty years. The charge of the Screening Tools Workgroup was to develop a plan for universal statewide screening for young children in Oregon. Based on the work of the Health Matters Screening Tools Workgroup from 2011, this Workgroup created a suite of screening tools and periodicity recommendations. In general, the recommendations parallel those of Bright Futures from the American Academy of Pediatrics. The required domains of Maternal Health/Mental Health, General Development, and Psychosocial/Relational are as listed in the domain tables. The Physical Health domain will be implemented with the understanding that the risk assessments completed by health care providers may be more formal than those completed by other providers. For the Family Well-Being domain, none of the tools recommended by Health Matters Screening Tools Workgroup met all of the desired requirements. The Workgroup recommends further research and development for this very important domain of Family Well-Being.

The overarching goal is for universal statewide screening to begin now. Newer and better tools are emerging in several areas, and should be evaluated as the process moves forward. However, the goal of universal statewide screening in Oregon should begin as soon as possible with the option of improving and modifying the process for the future.

Introduction

The Early Learning Council (ELC) directed the Screening Tools Workgroup to provide recommendations for statewide screening tools for children five and younger and their families. Based on HB 4165, the charge of the Workgroup was to refine the list of screening tools identified in the Early Learning Council SB 909 Report and forward recommendations to the ELC regarding one or more screening tools for statewide implementation. The Workgroup used the guiding characteristics from the charge and the SB 909 report. In addition, the Workgroup developed a vision to guide its work.

Universal screening tools represent a crucial link in the state's redesign of early childhood health, education and social services. In order to meet the expectation that all children enter kindergarten ready to succeed, standardized screening will identify strengths and needs of Oregon's children and families. Use of statewide screening tools are an important step to link every child and family with the appropriate level of care, attention, and support needed to remain on their individual trajectory for lifelong success.

Statewide early screening should result in a seamless system with appropriate referrals made for all children and families with identified needs and strengths. Ultimately universal statewide screening will link families to resources as early as possible. Timely intervention is critical to ensure all children with developmental concerns receive optimal services that will address delays and increase the likelihood that they will be successful learners in kindergarten and beyond.

Workgroup members unanimously stress the importance of considering capacity of resources for children and families who are identified through screening. The Workgroup recognizes that different communities have varying levels of early childhood resources, and encourages collaboration between local and state entities to enhance limited resources that will improve families' access to services. Without these services or support options, the use of screening tools can be seen as a dead end for families leaving them frustrated and angry, and children without the means to achieve school readiness.

In addition, while the charge of the Workgroup was focused on the selection of screening tools, it became clear that tool selection is closely linked to implementation issues. For that reason, the Workgroup recommends careful review of the implications of various implementation strategies, including but not limited to, workforce training and resource capacity.

History of screening in Oregon

For nearly two decades, Oregon has had requirements to conduct developmental screenings for young children and their families. Since 2001, universal screening of all young children has been required in statute, and some communities and organizations have made excellent progress. Screening sites and resources available to some children include the Special Supplemental Nutrition Program for Women, Infants and Children program (WIC), primary care clinics, community or public health clinics, child care, Healthy Start, Early Intervention/Early Childhood Special Education (EI/ECSE), Oregon Head Start Prekindergarten, Early Head Start,

Relief Nurseries, Public Health Nurse Home Visiting Program, and local screening organizations (such as Healthy Beginnings in Deschutes County) among others.

However, among these opportunities and policy initiatives, there are neither consistent practices or procedures nor consistent sharing of information. For these reasons some children and families receive no screenings and some children, and families may be screened several times in the same domain.

When Governor John Kitzhaber entered office in January 2011, one of his top priorities was kindergarten readiness for all children. He convened the Early Learning Design Team (ELDT) which appointed members to a Health Matters Screening Tools Workgroup. Members reviewed existing national and emerging national standards for prenatal, perinatal, early childhood, and family risk/strength screening tools. The Health Matters Screening Tools Workgroup relied upon the recommendations of earlier efforts including the 2008 Oregon Assuring Better Child Health and Development (ABCD) Early Childhood Screening Initiative and the House Bill 2666 Maternal Mental Health Workgroup.

Over the past several years, ABCD III partners have worked to increase the use of evidence-based, standardized screening tools by primary care providers to identify developmental, behavioral and/or family psychosocial needs among children birth through five years old and their families.

Also within the healthcare delivery system, the rate of screening (using standardized screening tools) for potential delays in social and emotional development is part of the Initial Core Set of Children's Healthcare Quality Measures used by Medicaid and Children's Health Insurance Program (CHIP) Programs. In addition, Oregon has tentatively adopted this measure for monitoring quality of care for children within Coordinated Care Organizations.

Definitions

The terminology surrounding screening of children and families is often confusing and inconsistent depending on the setting. Public health, health care, and education often utilize the terms screening, assessment, surveillance, and evaluation differently. In addition, these words may have negative connotations to some. The Screening Tools Workgroup believed strongly in the importance of consistent, family-friendly terminology. Also the Workgroup attempted to create terminology consistent with the recommendations from the Council's Kindergarten Readiness Assessment (KRA) Workgroup.

For the purpose of this report, the Screening Tools Workgroup operationalized the following definitions:

Screening: A brief process which identifies well-recognized risk and protective factors to identify certain children and families who would benefit from additional assessment for early support services.

Assessment: A thorough, more in-depth process of examining the strengths and needs of a child or family in order to identify the need for additional services. (Of note, this term is used interchangeably with evaluation in some, but not all, settings. Based on the existence of the Kindergarten Readiness Assessment, the Workgroup chose the term "assessment" instead of evaluation to describe a more in-depth process.)

Process

The Screening Tools Workgroup consisted of 19 members representing education, health care, and social services, from across the state including early education specialists, primary care providers, non-profit representatives, researchers, public health professionals and Early Learning Council members. The group represented a wide variety of experience and expertise (see Appendix A for member list and expertise).

This Screening Tool Workgroup met six times over a period of three months. Members initially reviewed each of the recommended tools in the five domains from the prior Health Matters Screening Tools Workgroup. In addition the Workgroup solicited the opinions from a number of screening tool researchers in their domain of expertise.

The Workgroup used the guiding characteristics from its charge and the SB 909 report to focus its work. The Workgroup created a vision for its work intended to provide the Council with a context to better understand its recommendations as the Council moves forward with screening implementation and evaluation.

Vision

All young children in Oregon have access to screening opportunities that:

- identify strengths and needs;
- facilitate referrals to support services;
- promote kindergarten readiness.

Guiding Characteristics

The Council charged the Workgroup with narrowing the identified screening tools from the Early Learning Council SB 909 Report to one or more screening tools for statewide implementation. More specifically, the Workgroup was charged with the following:

1) Utilization of the guiding characteristics, as delineated in the SB 909 Report for tool selection:

a. System-wide tools that can be used in diverse and multiple settings
b. Ease of implementation statewide
c. Tool should be evidence-based
d. Level of expertise in Oregon exists
e. Penetration and/or capacity to scale statewide to serve children and families
f. Potential to link results with a unified data system and provide information about the status of the state's young population
g. Current support from organizations, professionals, and payers

h. Tool can be modified over time to reflect emerging evidence and best practice
i. Sensitive to the diversity of families – multiple languages and culturally sensitive, to meet the needs of the population that is growing

2) Identification of screening tool(s) for all young children selected from those listed in the SB 909 Report which may be a composite of various items from different screening tools. If a composite measure is chosen, however, issues of validation were to be considered. Screening tool(s) must:

a. Address the five developmental domains in SB 909 report and developmental stages of children/families.
b. Be research-based, age-appropriate, culturally and gender appropriate, and be appropriate in programs and services of the voluntary statewide early learning system (HB 4165 Requirement).
c. Be able to be administered in myriad early childhood settings (including by parents).

3) Address issues of tradeoffs among guiding characteristics when choosing a specific tool for implementation. For example, there is a very little "norming" of many tools on diverse populations. Determine gaps that may exist with the adopted tool and strategies for screening to be used (e.g., communities of color or those with limited English proficiency).

4) Recommend connection to early learning data system and kindergarten readiness assessment (KRA).

Recommendations for screening tools

The five screening tool domains and list of screening tools were determined by the Health Matters Screening Tool Workgroup. The Screening Tools Workgroup could not identify a suitable, single tool that addressed each required domain at all ages. For this reason the Workgroup recommends a suite of tools.

The rationale for each tool is discussed below by domain. Source, description and typical use, population, languages available, cost, and periodicity are included in the individual domain tables.

In the development of the periodicity table (see Appendix B), the Workgroup developed minimum interval requirements for each screening tool. The Workgroup stresses that these recommendations should not limit screening at more frequent intervals based on parental concerns or program standards. Of note, periodicity standards are not available for the majority of the tools reviewed.

Maternal Health/Mental Health

Maternal mental and physical health are critical to the well-being of young children. Prenatally the Workgroup recommends the Screening, Brief Intervention, and Referral to Treatment tool (SBIRT) and the Patient Health Questionnaire-9 (PHQ-9). The SBIRT is a brief four-question screening tool for drug and alcohol misuse. Currently there is ongoing SBIRT training in primary care residencies throughout the state through an Oregon Health and Science University (OHSU)

initiative. The PHQ-9 is recommended prenatally also in order to screen for depression in the mother, or the caregiver.

In addition the Workgroup recommends the Edinburgh Postnatal Depression Scale (EPDS) for screening of the mother at two and four months postpartum. Both the EPDS and the PHQ-9 are endorsed by the Oregon Maternal Mental Health Workgroup and the Oregon ABCD III Initiative. EPDS is also endorsed by the American Academy of Pediatrics.

Family Well-Being

This domain was originally termed Family Risk by the Health Matters Screening Tools Workgroup. The ELC Screening Tools Workgroup believed strongly that tools should identify both protective factors (strengths) and risk factors of families, so the domain was renamed Family Well-Being.

The Workgroup carefully reviewed all of the previously recommended tools from the Health Matters Screening Tools Workgroup including the New Baby Questionnaire and the Parenting Stress Index-Short Form. The Workgroup concluded that neither addresses the desired characteristics of a statewide screening tool. However, this is not to imply that providers currently using either tool should discontinue using them.

The Workgroup does recommend the implementation of a two-question Food Insecurity screening tool during the development of a new Family Well-being tool as described on that domain/periodicity page.

General Development

General development for children birth through age five encompasses fine motor, gross motor, cognitive, communicative, and social-emotional skills. The Workgroup recommends the Ages and Stages Questionnaire, 3rd Edition (ASQ-3) as the preferred general developmental screening tool. However, the Parents' Evaluation of Developmental Status (PEDS) may be used if infrastructure already exists or it represents preferred tool for the population being served.

Behavioral/Psychosocial health

For behavioral and psychosocial health, the Workgroup recommends the Modified Checklist for Autism in Toddlers (M-CHAT) and the Ages and Stages Questionnaire –Social/Emotional (ASQ-SE). The Workgroup recommends screening with the M-CHAT at 18 and 24 months, which is consistent with the American Academy of Pediatrics (AAP)/Bright Futures recommendations.

Physical Health

The recommendations for hearing, vision, oral health, and growth are in accordance with the AAP/Bright Futures recommendations as adopted by the Oregon Health Authority. In an attempt to remain consistent with these recommendations, the Workgroup has used the term "risk assessments" between screening intervals. Some physical health screening tools require the use of specialized equipment and expertise.

Domain: Maternal Health/ Mental Health

Tool	Source	Description/ Use	Population/Languages	Administration	Cost/Time
Screening, Brief Intervention, & Referral to Treatment (SBIRT)	www.samhsa.gov/prevention/sbirt/	General screening tools for substance abuse - initial screen = 4 questions	Universal English Translated into 10 other languages	Health professionals such as physicians, nurses, social workers, health educators and paraprofessionals	Free 5- 10 minutes
Patient Health Questionnaire -9 (PHQ – 9)	http://www.phqscreeners.com/overview.aspx	Screening for mental health disorders	Universal Translated into multiple languages; most translations are linguistically valid; few of the translations have been psychometrically validated	Primary care settings	Free 5 minutes or less
Edinburgh Postnatal Depression Scale (EPDS)	http://www.perinataldepression.org/pdf/edinburgh.pdf	Screening for postpartum maternal mental health disorders	Women who have given birth English Translated into multiple languages	Outpatient care and home visiting services	Free 5- 10 minutes by mother; 2 minutes to score

Periodicity	Prenatal	Birth	1 mo	2 mo	4 mo	6 mo	9 mo	1 yr	15 mo	18 mo	2 yrs	3 yrs	4 yrs	5 yrs
SBIRT	✓													
PHQ - 9	✓													
EPDS				✓		✓								

Domain: Family Well-Being

Tools	Source	Description/ Use	Population/Languages	Administration	Cost/Time
To be identified[1]					
Food Insecurity 2-Item Screen[2]	http://pediatrics.aappublications.org/content/126/1/e26.abstract	A valid two-question tool which identifies families with food availability concerns	all	Any provider setting	Free 1 minute

[2]*The Workgroup recommends implementation of this tool prior to the creation of the composite Family Well-Being tool.*

Periodicity	Prenatal	Birth	1 mo	2 mo	4 mo	6 mo	9 mo	1 yr	15 mo	18 mo	2 yrs	3 yrs	4 yrs	5 yrs
To be identified														
Food Insecurity	✓					✓		✓			✓	✓	✓	✓

`[1]**Proposed Characteristics for New Family Well-Being Tool**

1. Family Strengths
   a. Concrete support in times of need/ Social connections (extended family, friends, neighbors, communities of faith)
   b. Knowledge of parenting and child development
   c. Parental resources and resilience
   d. Shared family activities (i.e., Does the family eat meals together?)
   e. Known strengths and special needs of children
2. Family challenges
   a. Unidentified special needs of children
   b. Inadequate health insurance for children/parents
   c. Lack of medical home
   d. Domestic violence/personal safety
   e. Current substance abuse (smoking/drugs/alcohol)
   f. History of abuse, incarceration, substance abuse
   g. Guns in the home and whether they are locked up
   h. Criminal justice involvement
   i. Mental health needs including depression
   j. Food security/insecurity
   k. Family income (poverty /unemployment/low income)
   l. Housing
   m. Literacy
   n. Access to transportation
   o. Access to communication (phones, computers)
   p. English Language Learners

Domain: General Development

Tool	Source	Description/ Use	Population/Languages	Administration	Cost/Time
Ages & Stages Question-naire, Third Edition (ASQ – 3)	Oregon parents: http://www.asqoregon.com/ Others: http://products.brookespublishing.com/ASQ-3-Starter-Kit-P574.aspx	Designed to help parents check their child's development, detect developmental delays, and initiate referrals to Early Intervention	Normative sample was educationally, economically, and ethnically diverse; was nationally representative Translated in other languages	Parents and caregivers can complete and share with primary care provider and other providers as part of screening efforts	$225: CDR, manual, and forms which may be copied Completed in 10-15 minutes by parent or caregiver; scored 1-3 minutes
Parents' Evaluations of Develop-mental Status (PEDS)	http://www.pedstest.com/default.aspx	Relies on 10 questions to elicit parents' concerns. Domains include: global/cognitive, expressive language and articulation, receptive language, fine motor, gross motor, behavior, social-emotional, self-help, and school	Birth - 8 yrs old Translated into several languages; Cultural differences and current events may well affect parents' responses.	Parents can complete and share with primary care provider	$36: 50 response forms, interpretation forms, and 1 brief guide Completed in 2 – 10 minutes; scored in 2 minutes

Periodicity[1]	Prenatal	Birth	1 mo	2 mo	4 mo	6 mo	9 mo	1 yr	15 mo	18 mo	2 yrs	3 yrs	4 yrs	5 yrs
ASQ-3, PEDS[2]					✓		✓			✓	30 months		✓	✓

[1]Optimal screening points based on expert opinion including ASQ developers. If a child misses an interval, please see the administration manual for optional intervals. Bright Futures/ American Academy of Pediatrics (AAP) recommends general developmental screening at 9, 18, and 30 months.

[2]ASQ is preferred tool; PEDS may be used if infrastructure already exists or represents preferred tool for population being served.

Domain: Behavioral/Psychosocial Relational

Tool	Source	Description/ Use	Population/Languages	Administration	Cost/Time
Ages and Stages Questionnaire –Social/ Emotional (ASQ-SE)	http://products.brookespublishing.com/ASQSE-Starter-Kit-P581.aspx	Personal-social (self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people)	3 - 66 mos. English and Spanish	Parents/caregivers complete questionnaires; professionals score them	$175: manual, CD-ROM and forms which may be copied Completed in 10 -15 minutes by parent or caregiver scored 1-3 minutes.
Modified Checklist for Autism in Toddlers (M-CHAT)	https://www.firstsigns.org/downloads/m-chat.PDF	Identifies children who should receive a more thorough assessment for possible early signs of autism spectrum disorder (ASD) or developmental delay.	Toddlers 16 - 30 mos. Translated into many languages with validation studies in progress	Parent completes; scored by a trained health care professionals	Free Completed in 10-15 minutes; scored in 2 minutes

Periodicity	Prenatal	Birth	1 mo	2 mo	4 mo	6 mo	9 mo	1 yr	15 mo	18 mo	2 yrs	3 yrs	4 yrs	5 yrs
ASQ-SE						✓		✓			✓	✓	✓	✓
M-CHAT										✓	✓			

Domain: Physical Health[1]

Tool	Source	Description/ Use	Population/ Languages	Administration	Cost[2]/Time
Otoacoustic Emissions (OAE) testing **Automated Auditory Brainstem Response (ABR)**	http://www.infanthearing.org/audiology/index.html	ABR or an OAE hearing test is done when a baby is born or a child is very young -both tests intended only to determine whether further, more accurate hearing testing is needed OAE may be used for ongoing risk assessments and screenings	all	Specialized training required	Cost of equipment varies OAE and ABR: 10 minutes minimum
Audiometric screening	Hearing Assessment in Infants and Children: Recommendations Beyond Neonatal Screening	Determines hearing levels, but may also measure ability to discriminate between different sound intensities, recognize pitch, or distinguished speech from background noise	Children who can respond to cues	Specialized training required	Cost of equipment varies 10 minutes minimum
Oral Health (4 Elements)	http://brightfutures.aap.org/pdfs/RiskAssessmentTool.pdf	Oral health risk assessment by 6 mos. and screens for infants and young children identified as having significant risk of caries	all	Specialized training required	Free Usually 1-2 minutes
Vision	http://www.uspreventiveservicestaskforce.org/uspstf11/vischildren/vischildrs.htm	AAP recommends age-appropriate risk assessment at all well-child checks	all	Specialized training required	Cost and time vary by equipment
Height/Weight **Body Mass Index (BMI)**	http://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html#How is BMI used with children and teens	Measures height-to-weight ratio Younger than 2 yrs: Height, Weight Older than 2 yrs: Height, Weight, BMI	all	Specialized training required	Free 5 minutes

<table>
<tr><th>Periodicity</th><th>Prenatal</th><th>Birth</th><th>1 mo</th><th>2 mo</th><th>4 mo</th><th>6 mo</th><th>9 mo</th><th>1 yr</th><th>15 mo</th><th>18 mo</th><th>2 yrs</th><th>3 yrs</th><th>4 yrs</th><th>5 yrs</th></tr>
<tr><td>Hearing</td><td></td><td>✓[3]</td><td colspan="10">[1]Risk assessments at well child checks; monitoring by other providers</td><td>✓</td><td>✓</td></tr>
<tr><td>Oral Health</td><td></td><td></td><td></td><td></td><td></td><td colspan="9">[1]Risk assessments at well child checks and referral to dental home</td></tr>
<tr><td>Vision</td><td></td><td colspan="10">[1]Risk assessments at well child checks; monitoring by other providers</td><td>✓</td><td>✓</td><td>✓</td></tr>
<tr><td>Ht/Wt (BMI for $\geq$ 2 yrs)</td><td></td><td colspan="9">[1]Risk assessments at well child checks; monitoring by other providers</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td></tr>
</table>

[1]Recommendations, including age-appropriate risk assessments at well child checks, are in accordance with the Bright Futures/ American Academy of Pediatrics.
[2]Costs vary based on provider and family resources including insurance.
[3]Per Oregon HB 3246 effective 2000, all hospitals or birthing centers with greater than 200 live births per year must ensure newborn hearing screening within one month of age.

Conclusions

1 Currently there is no single screening tool which addresses all of the required domains and age ranges required in the SB 909 report. There is no single, stand alone tool that is easily administered in a variety of settings by screeners with varying training and experience. For this reason the Workgroup is recommending a suite of tools for the first universal screening implementation in Oregon to address the following:

   a) Implementation of the Maternal Health/Mental Health, General Development, Behavioral/Psychosocial Relational, domains as listed in the domain tables.
   b) Implementation of the Physical Heath domain with the understanding that the risk assessments completed by health care providers may be more formal than those completed by other providers. Also, some of the suggested screenings and assessments may only be provided by properly credentialed or licensed providers.
   c) Implementation of a family well-being screening after further research and development of measures for this domain can be determined (formerly Family Risk). None of the previously suggested tools address the whole domain. As noted by the Health Matters Screening Tool Workgroup, there are currently limited tools but there are some promising emerging tools. We recommend more research on tools used successfully elsewhere (outside of Oregon), consideration of emerging tools, or the development of an Oregon measure.

2. A review of the usefulness and effectiveness of the adopted screening tools should be completed on a regular basis. For example, although many of the tools have been translated, not all of the tools are validated for cultural sensitivity or relevance. As new screening tools emerge, consideration should be given to replacing current tools with those which prove to more effective and culturally appropriate.

3. Parent feedback on the tools should be collected by the many programs currently working with young children during the first year of implementation. This feedback could be gathered by electronic means or written questionnaires. Questions would include whether they are aware of the availability of screening, their experiences with their screening, and suggestions for improvement.

Next Steps

1. Tools should be administered in a family-centered manner that:
   a. Honors and respects the family as the best advocates for children's success for readiness to learn at kindergarten and beyond;
   b. Is voluntary;
   c. Explains the reason for each tool prior to screening;
   d. Involves families as the primary observers of children's development.

2. The screening tools should be used to link families to available, accessible resources and supports. In communities with limited resources for local families, the Workgroup recommends local and state collaboration to enhance resources.

3. Local, regional, and state roles and responsibilities should be clarified for workforce development, training, evaluation, and administration of the tools. The process must recognize the wide variation in training and experience of the many who will conduct screening.

4. Screening tools data should be included in the Early Childhood Data System to facilitate efficient referral practices, reduce duplication of efforts, and encourage timely sharing of screening information among service providers. This data should help to determine if early identification and screening led to positive outcomes for Oregon's children and families.

5. In order for families to more easily recognize and connect with screening opportunities, a unique, common symbol, logo or icon for all providers of early childhood screening services in Oregon should be developed and adopted.

Implementation of these recommendations will require changing community norms for children, families, and providers. In the future Oregon families should expect and recognize the universal screening tool process as an integral part of their child's success. Broad outreach efforts should be developed so families can easily recognize and connect with screening opportunities and to raise awareness in Oregon communities of the importance of ongoing screening for the welfare of Oregon's most precious asset: our children.

Appendix A – Workgroup Members

Name	City of Residence	Title
David Allen	Portland	Assistant Professor, Department of Special Education, Portland State University
Lory Britain	Eugene	Director of Replication and Quality Assurance, Relief Nursery, Inc., Eugene
Janet Carlson	Salem	Marion County Commissioner
Caroline Cruz	Warm Springs	General Manager, Health and Human Services, Confederated Tribes of Warm Springs
Laurie Danahy	Wilsonville	Early Childhood Education Specialist, Oregon Department of Education
Donalda Dodson	Salem	Executive Director, Oregon Child Development Coalition
Janet Dougherty-Smith	Cedar Mill	Early Learning Council Member, Workgroup Chair
Charles Gallia	Oregon City	Senior Policy Advisor, Division of Medical Assistance Programs, Oregon Health Authority
Jennifer Gilbert	Portland	Preventive Medicine Resident, OHSU; pediatrician
Dana Hargunani	Portland	Child Health Director, Oregon Health Authority; pediatrician; Early Learning Council Member
Nakeshia Knight-Coyle	Salem	State Home Visiting Coordinator, Oregon Health Authority
Sandra Potter-Marquardt	Portland	State Early Childhood Policy and Systems Development, Oregon Health Authority
Holly Remer	Bend	Executive Director, Healthy Beginnings
Eva Rippeteau	Portland	Political Coordinator, AFSCME**;** Early Learning Council Member
Donna Schnitker	Burns	Early Childhood Center Director, Harney Education Service District
Betty Shuler	Sisters	Early Care and Education Director, Neighbor Impact
Bill Stewart	Beavercreek	Curriculum/ Assessment, Gladstone School District
Teri Thalhofer	The Dalles	Director, North Central Public Health District; Early Learning Council Member
Dawn Woods	Silverton	Quality Projects Manager, State Child Care Division

Among these members, additional affiliations, experience, and expertise were identified in these areas: Alcohol/drug prevention and treatment, author/ illustrator, child care, children's literacy, college or university instructor, community action agency, education service district, evaluation for services, Even Start, foster parent, Great Start, Head Start/Early Head Start, Healthy Beginnings, home visiting, intergenerational training (including cultural competency and poverty), K-12 assessment and accountability, kindergarten readiness, local service district, mental health, migrant services, minority services, nurse, parent or grandparent of a young child, physician, policy maker, private non-profit, public employee, public health, public/private board of directors, registered dietician, relief nursery, research (early childhood education and health care), rural/urban/suburban residences, screening activities, special education services (EI/ECSE), teacher of early childhood education, training/ technical assistance, tribal affiliation, union affiliation, Supplemental Nutrition Program for Women, Infants and Children (WIC).

Appendix B - Oregon Statewide Early Childhood Screening Domains and Periodicity

<table>
<tr><th></th><th>Prenatal</th><th>Birth</th><th>1 mo</th><th>2 mo</th><th>4 mo</th><th>6 mo</th><th>9 mo</th><th>1 yr</th><th>15 mo</th><th>18 mo</th><th>2 yrs</th><th>3 yrs</th><th>4 yrs</th><th>5 yrs</th></tr>
<tr><td colspan="15">Maternal Health/ Mental Health</td></tr>
<tr><td>SBIRT</td><td>✓</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>PHQ - 9</td><td>✓</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>EPDS</td><td></td><td></td><td></td><td>✓</td><td></td><td>✓</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="15">Family Well-Being[1]</td></tr>
<tr><td>To be identified</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Food Insecurity</td><td>✓</td><td></td><td></td><td></td><td></td><td>✓</td><td></td><td>✓</td><td></td><td></td><td>✓</td><td>✓</td><td>✓</td><td>✓</td></tr>
<tr><td colspan="15">General Development</td></tr>
<tr><td>ASQ - 3, PEDS[2]</td><td></td><td></td><td></td><td></td><td>✓[3]</td><td></td><td>✓[3]</td><td></td><td></td><td>✓[3]</td><td colspan="2">✓[3]</td><td>✓[3]</td><td>✓[3]</td></tr>
<tr><td colspan="15">Behavioral/Psychosocial (Relational)</td></tr>
<tr><td>ASQ - SE</td><td></td><td></td><td></td><td></td><td></td><td>✓</td><td></td><td>✓</td><td></td><td></td><td>✓</td><td>✓</td><td>✓</td><td>✓</td></tr>
<tr><td>M - CHAT</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>✓</td><td>✓</td><td></td><td></td><td></td></tr>
<tr><td colspan="15">Physical Health[4]</td></tr>
<tr><td>Hearing</td><td></td><td>✓[5]</td><td colspan="10">Risk assessments at well child checks; monitoring by other providers</td><td>✓</td><td>✓</td></tr>
<tr><td>Oral Health</td><td></td><td></td><td></td><td></td><td></td><td colspan="9">Risk assessments at well child checks and referral to dental home</td></tr>
<tr><td>Vision</td><td></td><td colspan="10">Risk assessments at well child checks; monitoring by other providers</td><td>✓</td><td>✓</td><td>✓</td></tr>
<tr><td>Ht /Wt (BMI)</td><td></td><td colspan="9">Risk assessments at well child checks; monitoring by other providers</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td></tr>
</table>

[1]A validated two-question food insecurity screening tool is already available and can be implemented in a variety of settings. The Workgroup recommends implementation of this tool prior to the creation of the composite Family Well-Being tool.
[2]ASQ is preferred tool; PEDS may be used if infrastructure already exists or represents preferred tool for population being served.
[3]Optimal screening points based on expert opinion including ASQ developers. If a child misses an interval, please see the administration manual for optional intervals. Bright Futures/ American Academy of Pediatrics (AAP) recommends general developmental screening at 9, 18, and 30 months.
[4]Recommendations, including age-appropriate risk assessments at well child checks, are in accordance with Bright Futures/ American Academy of Pediatrics (AAP).
[5]Per Oregon HB 3246 effective 2000, all hospitals or birthing centers with greater than 200 live births per year must ensure newborn hearing screening within one month of age.