



## **Components of Best Practice Developmentally Oriented Primary Care for Infants and Toddlers Birth to Three Years**

The Enhancing Developmentally Oriented Primary Care Project (EDOPC) is a resource for healthcare providers in Illinois. It contains up-to-date information on child development and mental health issues, including screening, referral and coding/billing for screenings. Through the EDOPC web site, you can also enroll in online training on care coordination, developmental screening, domestic violence screening, perinatal maternal depression screening, and social/emotional screening.

EDOPC is a partnership of the Advocate Health Care, Healthy Steps Program and Illinois Chapter, American Academy of Pediatrics. Together, we work to improve the delivery and financing of preventive health and developmental services for children birth to age three.

For an overview of EDOPC and a list of contributors to the original December 2007 version of this document, please [click here](#).

For additional information contact:

### **EDOPC**

[www.edopc.org](http://www.edopc.org)

888/270-0558

### **Advocate Health Care, Healthy Steps Program**

205 W. Touhy, Suite 125

Park Ridge, IL 60068

Phone: 847/384-3313

Fax: 847/283-3316

[anita.berry@advocatehealth.com](mailto:anita.berry@advocatehealth.com)

### **Illinois Chapter,**

### **American Academy of Pediatrics**

1400 W Hubbard, Suite 100

Chicago, IL 60642

Phone: 312/733-1026

Fax: 312/733-1791

[info@illinoisAAP.com](mailto:info@illinoisAAP.com)

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## **I. Executive Summary**

In January 2005, the Enhancing Developmentally Oriented Primary Care (EDOPC) project began a three-year initiative to increase primary care providers' use of validated screening tools to implement developmental, social-emotional, maternal depression, and autism screening into pediatric well-child visits in the first three years of life. In 2007 EDOPC added domestic violence screening as another major family risk factor. During that time EDOPC has conducted 336 trainings throughout the state of Illinois at nearly 164 different sites on the core topics. More than 2,800 individuals including physicians, nurse practitioners, physician assistants, nurses, medical assistants, social workers, and office staff attended these trainings. These professionals reach approximately 239,000 children birth to three years of age in the state of Illinois. Based on the 2005 census data, which estimates 539,978 children younger than three years live in Illinois, EDOPC has reached approximately 45 percent of the birth to three population through primary care providers. One of the goals of the EDOPC project for 2008–2010 is to reach 75 percent of the birth to three population in the state of Illinois.

Federally Qualified Health Centers (FQHCs)—which traditionally serve a large portion of the Medicaid population, the underserved, and the uninsured—have been a substantial focus of EDOPC training. Eight sites received intensive interventions that also included technical assistance and training in developmentally oriented primary care using the Healthy Steps for Young Children<sup>1</sup> approach. Six of these eight sites have successfully implemented their own continuing training on these topics delivered by their own trainers. EDOPC also worked closely with five of the eleven pediatric residency programs, two of the twenty-eight family medicine programs, one of the eight pediatric nurse practitioner programs, and one of the four physician assistant programs in the state. Faculty members in these programs have been trained in EDOPC as well as Healthy Steps topics. These programs reach approximately 250 residents, five nurse practitioners, and sixty physician assistant interns each year. Surveys showed that residents at three sites increased their knowledge and confidence in their ability to practice using a more developmentally oriented approach to well-child care, and more than 95 percent planned to incorporate what they had learned into routine practice when they left training.

EDOPC has worked closely with the Illinois Department of Healthcare and Family Services (IDHFS) to clarify policies and develop incentives for early childhood and depression screening through the Medicaid program because nearly all primary care providers participate in Medicaid, and private insurance policies often follow the lead of Medicaid. Currently, developmental screening is “unbundled” (and paid in addition to a well-child visit) for Illinois Medicaid providers. Medicaid will allow for two developmental screenings and one risk assessment at each well-child visit. Illinois Medicaid will pay for a postpartum depression screen on the mother during the child's visit when billed as a risk assessment. Private insurance companies vary in reimbursement for these services.

EDOPC staff worked with other state systems such as Family Case Management, Early Intervention, and others to improve linkages and communication among programs and primary care providers.

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<sup>1</sup>Healthy Steps for Young Children is a national initiative that focuses on the importance of the first three years of life and has developed training materials on dozens of early childhood topics, which complement EDOPC trainings. For more information, see [www.healthysteps.org/](http://www.healthysteps.org/).

EDOPC worked closely with many organizations including the Erikson Institute Fussy Baby Program, Positive Parenting DuPage, Voices for Illinois Children, the Illinois Maternal and Child Health Coalition, the March of Dimes of Greater Chicago, the Illinois Children's Mental Health Partnership, the University of Illinois Chicago (UIC) Perinatal Mental Health Project, Evanston Northwestern Healthcare (ENH) Jennifer Mudd Houghtaling Postpartum Depression Program, and others. Since 2004, the EDOPC project has been featured through posters and presentations at many prominent national conferences including those of the American Academy of Pediatrics (AAP), the National Initiative for Children's Healthcare Quality (twice), the National Association of Pediatric Nurse Practitioners (twice), the Mid America Public Health Summer Institute, the Society of Teachers of Family Medicine, the National Center for Children in Poverty, the Pediatric Academic Society, Zero to Three, and the Association for Maternal and Child Health Programs.

EDOPC staff contributed significant expertise to three major national initiatives: 1) they served on panels of the American Academy of Pediatrics Bright Futures revision project, and EDOPC training materials were used as models by AAP staff; 2) they participated in the Assuring Better Child Health and Development (ABCD) II project coordinated by the National Academy for State Health Policy (NASHP) and the Commonwealth Fund, and products of the Illinois ABCD II and EDOPC projects are now shared nationally at [www.abcdresources.org](http://www.abcdresources.org); and 3) they were solicited to serve as consultants, speakers, and technical advisers to the NASHP Screening Academy project, which is seeking to develop developmental screening initiatives in twenty states in 2007–2008. EDOPC has consulted individually with Medicaid agencies, children's hospitals, and AAP chapters in more than ten states.

## **II. Introduction**

Much has been written recently about the importance of early identification and referral of children with developmental delays and related concerns. The EDOPC project assists practices to become more developmentally oriented by providing educational materials for health care providers and their staff, handouts for parents, information on materials for screening, systems for referrals, and linkages to community resources.

All pediatric providers are trained in child development and use their often excellent clinical skills to provide surveillance at well-child visits. However, prior to the past few years, few providers used screening tools to screen children routinely at well-child visits. Providers may not be using the most up-to-date validated tools, may believe screening is occurring when it is not, and do not have the office systems in place to support use of screening tools or referrals for the families they serve.

Changing systems and changing practice are part of the quality-improvement process. Although change is difficult for many people, the rewards are great. Parents want and expect the kind of care that EDOPC trains providers to deliver.

Between 2004 and 2007, the EDOPC project worked with primary care sites throughout the state of Illinois. This experience at many diverse sites yielded an understanding of “best practices” in developmentally oriented pediatric primary care.

In addition to the Components of Best Practice information included, there are strategies to incorporate these components into practice. PowerPoint presentations for the five core topics are included and are available on the EDOPC Web site at [www.edopc.org](http://www.edopc.org). Technical assistance is available by contacting EDOPC at [www.edopc.org](http://www.edopc.org) or 888/270-0558.

### **III. How to Use the Components of Best Practice Document**

The Components of Best Practice document is used most appropriately by practices, clinics, and training programs as a checklist. It is recommended that health care providers work through the recommendations step-by-step, taking action when the health care team is not adhering to the recommended best practice.

The document not only lays out steps and criteria for best practices but often includes specific recommendations for practices. For instance, implementing a policy for routine developmental screening is a best practice. Screening once both in the first and second years of life is a specific EDOPC recommendation that a practice might adopt to meet this recommended best practice. Tool selection, visits at which screenings will occur, and staff to be involved all require group decision making by the practice. The best practices are intended to be timeless and serve providers for many years to come. Specific recommendations offered in this document are current as of 2008 and may change over time with the development of new tools, additions to the professional literature around early childhood development, recommendations of national provider groups, and other factors. Users of this document are encouraged to stay alert, periodically review the literature, and consult with early childhood experts such as developmental and behavioral pediatricians to ensure they are implementing best practices as effectively as possible.

Similarly, many resources are listed in the document and can be easily accessed by primary care providers. Such resources may change over time. Users of this document are encouraged to keep a list of the resources referred to in the following pages and others that are discovered while moving toward a developmental orientation. The tools and resources recommended in this document will meet the needs of most providers; however, only your practice team can determine what works best for you and your practice population. Experiment, integrate, and evaluate to find the best fit for your practice.

Throughout the document, best practices are noted with a **BP** symbol. Other strategies and recommendations may follow each best practice to give providers additional direction.

#### **What Is System-Based Practice?**

System-based practice (SBP) is a model of health care delivery that optimizes both resources and outcomes. It promotes a basic understanding of the complex operational, regulatory, and fiscal parameters of the various hospital and health care systems (i.e., the connections among patients, providers, payers, and governing bodies). Your operational understanding of SBP will ultimately guide your practice and highlight systemic improvements that can be made to enhance the safety, efficiency, access, cost, and overall patient and provider experience.<sup>2</sup> It involves practicing quality health care and advocating for patients within the health care system.<sup>3</sup>

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<sup>2</sup>New York University School of Medicine, *System Based Practice*, [www.med.nyu.edu/housestaff/sbp/index.html](http://www.med.nyu.edu/housestaff/sbp/index.html) (accessed January 26, 2008).

<sup>3</sup>American Board of Pediatrics, *American Board of Pediatrics Booklet of Information November 2006–October 2007*, <https://www.abp.org/ABPWebSite/> (accessed January 26, 2008).

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## **Best Practices Summary**

### **General Office Systems**

- The practice assesses its general office systems comprehensively and on an ongoing basis.
- The practice is able to analyze its own quality-improvement needs and seek out opportunities for improvement.
- Core guidelines/practices for developmental screening and related risk assessments are integrated into practice quality-improvement activities.
- The practice's self-evaluation of current policies and practices is ongoing, and timely and appropriate revisions are made as necessary.
- Current evidence-based practices from scientific studies are routinely sought out by staff, discussed as a group, and used in policy/procedure.
- The practice becomes familiar with and actively uses tools to collect data and assess practices.
- The practice identifies a staff champion/leader.
- Regular team meetings are established to facilitate communication and advance practice systems.
- Multiple-site organizations and large health care systems implement system changes and policies uniformly across all sites.

### **Screening Policies, Procedures, and Tools**

- The practice establishes formal policies and guidelines regarding screening.
- The practice uses validated screening tools.
- Practice staff understands and reinforces the need for developmental surveillance at all well-child visits.
- Practice staff develops and applies a formal policy regarding documentation in medical records across all providers.
- The practice develops and implements a system to alert staff when a screening is due, based on the practice's policy, during a well-child or sick visit.

### **Staff Education**

- The practice has designated staff education time.
- The learning needs of all staff are considered in developing and selecting training opportunities.
- Training is more than a simple didactic exercise and is coordinated with quality-improvement processes.
- Early childhood–development expertise is sought and developed internally to enhance primary care services.
- The practice provides comprehensive, quality training on developmental screening.
- Training on early childhood development is recurrent.

### **Patient/Parent Education**

- All practice staff members develop expertise in communicating to parents about the purpose and processes of developmental screening.
- Screening results are delivered in a timely and sensitive manner that is ultimately positive, focuses on strength and resiliency, and does not cause undue alarm.
- Families are counseled/educated on age-appropriate child development routinely at each well-child visit.
- Providers actively listen and respond to parent concerns and provide positive reinforcement so that parents are confident in their ability to care for their child.
- The practice provides clear and useful information to parents about child development, including written materials.

### **Referral to Community Agencies and Other Resources**

- The practice uses a Universal Early Intervention Referral Form (see tools T) for referrals to Early Intervention services.
- The practice has linkages to community resources that can assist culturally and socioeconomically diverse families with a range of concerns.
- Parents are given comprehensive information about the referral process and supported in their attempts to ask questions or gather additional information.

- Referrals for developmental delays and other concerns are processed, tracked, and followed up on in a manner similar to other medical referrals.
- Referrals are timely, seamless, and made in the best interest of the patient and family.
- All families receive services that are appropriate and necessary to their situation.

### **Coding and Billing**

- The practice uses appropriate codes and billing procedures to obtain appropriate payment for services.
- Insurers allow the recommended number of developmental screenings that can be conducted on a child or at a specific visit.
- Insurers provide payment for screening mothers during the child's visit.
- Insurers allow use of multiple, validated tools for each type of screening.

## **Best Practices Detail**

### **General Office Systems**

BP: The practice assesses its general office systems comprehensively and on an ongoing basis.

- The practice completes a Practice Needs Assessment (see tools A) or other related tool.
- Practice leaders in collaboration with staff at all levels choose strategies to assess the practice.
- Periodic repeat assessments of the general office systems are undertaken after significant changes to practice ownership or staff, or at least every three to four years.
- As part of the assessment of general office systems, the practice reviews the educational needs of the group with regard to early childhood development and developmental screening.

BP: The practice is able to analyze its own quality-improvement needs and seek out opportunities for improvement.

- Chart audits are completed regularly.
- Results of chart audits are included in clinical quality-improvement initiatives.
- Results are discussed with the practice's staff in monthly meetings or other forums.
- Opportunities to improve the processes are identified and discussed in monthly meetings.
- Parent surveys are done on a regular basis and results discussed in monthly meetings with all staff to seek out opportunities for improvement.

BP: Core guidelines/practices for developmental screening and related risk assessments are integrated into practice quality-improvement activities.

- The practice regularly assesses adherence to its screening policies, using chart reviews/audits on all practice clinical staff. Other strategies may include claims data reviews, parent satisfaction surveys, and analyses of screening and referral logs, if used.
- The practice uses regular staff meetings/educational sessions to assess implementation of its screening policies.
- The practice establishes Plan-Do-Study-Act (PDSA) cycles to address gaps in implementation of the screening policies.
- The practice advocates with insurers, Medicaid, and regulatory or licensing bodies to develop quality-improvement activities related to early childhood development that qualify for licensing, pay-for-performance programs, and other incentive programs.

BP: The practice's self-evaluation of current policies and practices is ongoing, and timely and appropriate revisions are made as necessary.

- Practice leadership actively monitors literature and policy statements from the AAP and other sources.
- The practice reviews insurer and Medicaid contracts and handbooks on a regular basis to assess for allowances regarding child-developmental screenings and risk assessments and changes to policies.

BP: Current evidence-based practices from scientific studies are routinely sought out by staff, discussed as a group, and used in policy/procedure.

- The practice leader or medical director and managers discuss the importance of evidence-based practice at monthly team meetings or other forums.
- Professional literature pertaining to screening and early childhood development, patient satisfaction, and reimbursement are posted on staff bulletin boards and distributed in monthly meetings or other forums.
- The practice utilizes external organizations such as the EDOPC Technical Assistance Center and Web site, the National Initiative for Children’s Healthcare Quality, the DBPeds Web site ([www.dbpeds.org](http://www.dbpeds.org)), and other resources for information and questions on evidence-based, developmentally oriented practices.
- The practice champion or external experts as appropriate (through EDOPC and/or local academic medical programs) are utilized to deliver periodic in-services related to developmentally oriented primary care, focusing on evidence-based practices.

BP: The practice becomes familiar with and actively uses tools to collect data and assess practices.

- A Chart Audit Protocol (see tools G) is written, and plans are put into place to perform chart audits on a regular basis. EDOPC practices have found that quarterly audits provide quality feedback to practice staff without being overwhelming.
- Chart Audit Forms (see tools H) are used to help staff track screenings.
- Parent surveys (see tools I) of children birth to three years are completed to assess needs in the areas of child-developmental and social-emotional health, autism awareness, postpartum depression, and domestic violence issues affecting children.
- The practice has access to and utilizes data from educational interventions. The practices or clinics participating in office-based programs ensure that evaluation tools such as pre-intervention needs assessments, pre/post tests, and other tools are used, and they actively seek summary reports from the provider of the educational program.
- The practice conducts practice-wide Post Practice Needs Assessment (see tools J) to identify future training needs.
- Feedback is given on an individual basis for those who are not in compliance with agreed-upon practice policies.

BP: The practice identifies a staff champion/leader.

- The person assigned to be practice champion is knowledgeable regarding the project.
- The practice champion has access to resources that will encourage continued learning and growth around child development. These might include technical assistance experts engaged with the EDOPC project, Healthy Steps for Young Children professionals, experts at the national AAP and its related committees, faculty at academic medical centers, and Early Intervention staff. The champion maintains a resource list of such experts as well as journals, Web sites, and other resources.
- The practice champion should be a physician, advance practice nurse, or physician assistant. The champion should have expertise in clinical issues as well as practice systems but does not need to be the senior physician. Often, particularly with child-development issues, the practice champion will be a parent with young children or a recent graduate of a medical/nursing training program.

- The practice may establish small committees or teams to assist the practice champion in developing policies, arranging educational experiences, and assessing progress in meeting goals.
- Larger practices, clinic systems, and hospitals invest time and resources into training for the practice champion(s) in order for the champion to become a trainer/teacher within the practice system. This allows the champion to develop enhanced expertise and meet the practice's or clinic's needs during times of staff transition and turnover.
- All practice staff respect and honor the staff champion's opinion and direction on child-development issues regardless of his or her position within the practice or educational background. The assigned person is given the necessary authority to schedule meetings, arrange training, and suggest changes to policy and procedure.

BP: Regular team meetings are established to facilitate communication and advance practice systems.

- Team meetings are scheduled regularly, and all staff attend. Monthly team meetings work well for many practices and clinics.
- Meetings include brief, concise agendas to keep discussion on track and ensure productivity.
- A meeting schedule is developed and promoted to all staff to ensure commitment to the concept of meeting regularly.
- A designee maintains minutes of each meeting. After the meeting, minutes are available to staff who were unable to attend. The practice may consider requiring staff, particularly those not present for the discussion, to "sign off" on minutes after reading them to ensure all staff are in agreement.
- Other stakeholders are invited to participate in meetings regularly and when agenda issues warrant outside input. Such stakeholders may include parents, other health care providers such as specialists, and community partners from Early Intervention or other agencies.
- The practice may consider identifying one or two staff members to become "facilitators." By reading about facilitation strategies or taking advantage of local professional-development activities, these staff can become proficient at moving discussion along, resolving disagreements, summarizing discussion, and other helpful skills.

BP: Multiple-site organizations and large health care systems implement system changes and policies uniformly across all sites.

- Commitment is present in the system to implement developmental screening and consistent referral at the highest level, including the president/CEO and/or medical director.
- Instruments such as memos, newsletters, and e-mails are used to communicate policies and changes to procedures across all sites. Follow-up or acknowledgment of receipt is used to ensure that individual clinic site leaders read and adhere to any changes in policy or practice.
- Individual sites that develop new or innovative strategies are encouraged to share them with other sites in the network.

## **Screening Policies, Procedures, and Tools**

BP: The practice establishes formal policies and guidelines regarding screening.

- Formal policies are preferable to using clinical judgment to determine when a child needs a screening. Planning to use a validated screening at each well-child visit or at specified visits increases consistency and is less confusing than trying to implement screenings based on perceived need. Children are less likely to be missed, and parents come to appreciate the need and importance of screening if a formal policy is in place.
- Practice leadership reviews the current policy and recommendations for standard practice on developmental, social-emotional, perinatal depression, autism, and domestic violence screening. This includes the current policies and guidelines recommended by national medical authorities such as the AAP, the American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), and others.
- All clinical practice staff members review the AAP policy statement “Identifying Infants and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening,” *Pediatrics* 118, no. 1 (July 2006), doi:10.1542/peds.2006-1231.
- A policy for screening for family factors affecting children is established in addition to screening children for developmental and social-emotional concerns. This policy is also implemented at designated well-child visits.
- Illinois practice staff members are aware of Medicaid requirements for screening, recommendations of the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program, and recommendations of Illinois Health Connect (IHC), the state’s primary care case-management program. Illinois Medicaid recommends objective screening should be administered regularly at the nine-, eighteen-, and twenty-four- to thirty-month visits. IHC will assess providers based on developmental screening recommendations.
- The practice adopts the EDOPC recommended schedule of screening. See screening table at the end of this section.

BP: The practice uses validated screening tools.

- The practice prohibits clinicians from using “homemade” screening tools or from altering commercially developed and validated tools.
- The practice discusses the need to use validated tools during the hiring process and with new staff to ensure commitment.
- The practice purchases or photocopies tools according to the publishers’ requirements, budgeting for the expense as necessary and valid to provide high-quality care. Payment for screening may be available to offset the cost of the tools. Many validated tools are available at no cost and may meet the needs of practices with limited budgets, or when payment for screening is not available.
- Before committing to a specific tool, practice leaders collect background information and verify the specificity/sensitivity of the tool. Resources to determine the appropriateness of a tool include the professional literature such as *Pediatrics*, the *Mental Measurement Yearbook*, or Medicaid or insurer handbooks, which often include only validated tools. Other resources might include lists of local developmental/behavioral pediatricians, which can be accessed through the national office of the AAP or at [www.dbpeds.org](http://www.dbpeds.org).

- EDOPC has collaborated with IDHFS to recommend tools for Illinois providers. EDOPC recommends that Illinois practices review the list of tools approved for reimbursement in the *Healthy Kids Handbook*, which is accessible at [www.hfs.illinois.gov](http://www.hfs.illinois.gov).
- Based on input from hundreds of Illinois practices and clinics, EDOPC has identified quality tools that work well in diverse practices. Practices might adopt the EDOPC recommended screening tools as follows:

Perinatal depression screening	Edinburgh Postnatal Depression Scale Patient Health Questionnaire (PHQ-9)
Developmental screening	Ages and Stages Questionnaire (ASQ): Parents Evaluation of Developmental Status (PEDS): Parents Observation of INfants and Toddlers (POINT)
Social-emotional screening	Ages and Stages Questionnaire: Social Emotional
Autism screening	Modified CHEcklist for Autism in Toddlers (M-CHAT)
Domestic violence screening	Routine Screening for Pediatric Patients and Their Families, the HITS—Hurts, Insults, Threatens, Screams

BP: Practice staff understands and reinforces the need for developmental surveillance at all well-child visits.

- Distinctions between developmental screening and surveillance are made in the practice’s screening policy.
- Developmental surveillance is conducted at all well-child and sick visits regardless of whether a formal screening is done.
- Practice staff is aware of the need to use validated screening tools routinely and whenever surveillance indicates risk for delay.

BP: Practice staff develops and applies a formal policy regarding documentation in medical records across all providers.

- The practice consults with Medicaid and other insurers regarding documentation for screening and referral.
- Illinois Medicaid requires documentation of screening in the patient medical record when a developmental screen is conducted and billed using code 96110. Encounter rate clinics, which do not bill code 96110, have a policy that requires documentation in the chart that a screen was conducted and indication of the screen on the patient encounter form.
- The practice discusses screening for postpartum depression during the well-child visit and develops an internal policy that meets the needs of the practice and, as necessary, its parent health care system. In family practices, both the new baby and the mother are likely to be patients, eliminating the need for unique record-keeping procedures. In other situations, EDOPC is recommending that the hard copy of the screening tool is shredded (or given to the mother directly, if she desires). Practices should indicate in the child’s chart “anticipatory guidance and referral” as necessary.
- The practice should consult with its attorney or practice-management consultant on record-keeping procedures as necessary.

BP: The practice develops and implements a system to alert staff when a screening is due, based on the practice's policy, during a well-child or sick visit.

- The practice flags the child's paper chart or develops an indicator in the electronic medical record that tells providers when screenings are due and which screenings are needed.

## EDOPC RECOMMENDED SCREENINGS

<b>SCREENING</b>	<b>GENERAL RECOMMENDATION</b>	<b>SPECIFIC RECOMMENDATION <i>For a quality practice</i></b>	<b>SPECIFIC RECOMMENDATION <i>For a high-quality, motivated practice or practice with high-risk patients</i></b>
Perinatal depression screening	Once each trimester of pregnancy At least twice in the six months postpartum	2-month and 4-month visits	2-month, 4-month, and 9-month visits
Developmental screening	At least once in the first and once in the second year of life	9-month and 24-month visits	6-month, 12-month, 24-month, and 36-month visits
Social-emotional screening	At least once in the first and once in the second year of life	4-month and 18-month visits	4-month, 15-month or 18-month visit and 24/30-month or 36-month visit
Autism screening	Twice in the second year of life	15-month and 24-month visits	15-month or 18-month visit and 24/30-month visit
Domestic violence screening	Once in the first year of life and then annually	First visit to practice	First visit to practice and again at subsequent (6-month, 18-month, 24/30-month, 36-month) visits

## **Staff Education**

BP: The practice has designated staff education time.

- Hospital-based practices make full use of grand rounds, resident education programs, and other academic medical center offerings. Practice staff actively provides input to program leaders, suggesting that topics such as challenging issues related to early childhood development and screening (social-emotional issues, discipline, referral resources) be addressed.
- Clinics coordinate activity across their networks, encouraging administrative staff to designate a staff physician (pediatrician or family physician) to serve as leader of educational programming.
- Private practices designate the lunch hour, periodic staff meetings, or special evening/weekend sessions for group education on at least a monthly basis.
- Practice staff members are supported, both financially and with appropriate time relieved from duty, to attend off-site local and national educational programs.

BP: The learning needs of all staff are considered in developing and selecting training opportunities.

- Practice selects a multidisciplinary process-improvement team with key areas represented including administrators, primary care providers, nurses, social service staff, clerical workers, medical assistants, and others.
- By having all staff included in educational interventions and discussions regarding practice changes, staff will be more likely to be invested in a successful implementation.
- Academic detailing (office- or practice-based training) is used as an effective and convenient method of involving all staff in training. The EDOPC model uses on-site training to teach about early childhood development.
- Orientation of new staff includes review of EDOPC presentations; overview of the practice policy on implementation of developmental, social-emotional, perinatal depression, autism, and domestic violence screening; and education on community resources and referral processes.
- Veteran staff members are not exempt from training because of established processes and preconceptions. Training for veteran staff in the area of child development and developmental screening occurs as it does for all staff. Veteran staff are encouraged to review recent literature on child development.

BP: Training is more than a simple didactic exercise and is coordinated with quality-improvement processes.

- Team selects a process-improvement model such as the Plan-Do-Study-Act Model ([www.ihl.org](http://www.ihl.org)) to test practice change by developing a plan to test the change (plan), carrying out the test (do), observing and learning from the consequences (study), and determining what modifications should be made to the test (act). This model, or a similar model, will help the practice to begin implementation slowly with suggestions such as implementing one screening tool, one age group, one day, and one provider at a time. The team would then review the results and the process to make any changes before implementing on a larger scale.

- The process-improvement team reports to the entire staff regarding plans and process, receives feedback, listens to suggestions, makes needed changes, implements changes, gets feedback, and discusses at next team meeting.

BP: Early childhood–development expertise is sought and developed internally to enhance primary care services.

- Practice staff knowledgeable in the area of child development are involved in developing and selecting training opportunities.
- Practice staff knowledgeable in family factors affecting children, particularly postpartum depression and domestic violence, are involved in developing and selecting training opportunities.
- The practice accesses EDOPC training programs and uses EDOPC slide/script presentations (see tools R).
- The practice utilizes technical assistance as needed from resources such as the EDOPC technical assistance center, periodic EDOPC teleconference calls, and the EDOPC Web site at [www.edopc.org](http://www.edopc.org).

BP: The practice provides comprehensive, quality training on developmental screening.

- All practice staff members are trained in the core EDOPC curricula (see disk in toolkit for PowerPoint presentations: “Developmental Screening and Referral,” “Social/Emotional Screening and Referral,” “Early Autism Detection and Referral,” “Perinatal Maternal Depression Screening and Referral,” and “Domestic Violence Effects on Children”).
- All staff involved in scoring and interpretation of screening tools read and understand the corresponding sections of the manuals for administration of educational materials (screening tools; see tools B) they have selected.
- Staff have the Quick Look for Screens (see tools S) sheet available to them for reference to quickly review when scoring screening tools.
- The practice invites outside experts into the clinical setting to conduct training and provide service overviews. These include local Early Intervention staff (Child and Family Connections), health department staff, and Family Case Management agencies.

BP: Training on early childhood development is recurrent.

- Insurer policies, community resources, eligibility guidelines, and other information are subject to change and require periodic review.
- A practice leader or other identified resource person is responsible for updating information on tools and processes. The Illinois Medicaid *Handbook for Providers of Healthy Kids Services* and IDHFS provider notices are reviewed to determine if changes to the practice screening policy are warranted. Professional literature is reviewed periodically for new articles on early childhood development. Web sites of selected tools are reviewed on a periodic basis for updates, new scoring sheets, and other information that may change practice implementation.
- Proper use and administration of screening tools is part of an annual educational update for all involved in screening processes in the practice.

## **Patient/Parent Education**

BP: All practice staff members develop expertise in communicating to parents about the purpose and processes of developmental screening.

- The practice reviews current patient education tools provided routinely to parents regarding child development issues and determines need for additional or improved and updated materials.
- The practice uses only culturally appropriate materials and makes efforts to incorporate new materials as required to meet the needs of all ethnic and racial groups served. The practice reviews current level of child-development/family materials for appropriateness and determines need for updating. A designated practice staff member such as the office manager or nurse researches and makes contact with community groups that provide services to different ethnic and racial groups, who are likely to have materials to share or recommend.
- Providers are comfortable talking with parents about a range of developmental, social-emotional, perinatal depression, and domestic violence issues that impact care of children and their overall well-being. Practice staff openly discusses challenging and sensitive issues to determine if additional training or skill development is needed. Practice staff with special skills or expertise in addressing sensitive issues such as domestic violence are used effectively in the practice to both advise other clinicians and be available during sensitive patient encounters as needed.
- The practice has access to scripts (see tools C) to explain screens to parents in an informative and sensitive manner.
- Parents are made aware that developmental and social-emotional screening is part of routine well-child care at the practice. Letter to Parents and Caregivers (see tools D) is given to parents as screening begins to be implemented.
- Parent educational materials such as handouts (see tools E) and posters are culturally appropriate, up-to-date, available, and distributed routinely.

BP: Screening results are delivered in a timely and sensitive manner that is ultimately positive, focuses on strength and resiliency, and does not cause undue alarm.

- Providers establish early on in the conversation that they and the family are on the same page and everyone involved wants what is best for the family and child.
- Results are given in person during the visit at which the child was screened. Results are never handed to the parent without discussion or skipped over during discussion, even when the results do not indicate any cause for concern.
- Results of the screening are given by the primary care provider (physician, advanced practice nurse, or physician assistant) and are discussed with parents or caregivers to the extent necessary for the parent or caregiver to feel comfortable with them and fully understand them. Follow-up visits are scheduled if necessary to continue discussion about child development.
- If a developmental delay is identified, the family is reassured about prospects for the child. A family needs to know that early intervention services are the first step to helping the child reach his or her potential.

BP: Families are counseled/educated on age-appropriate child development routinely at each well-child visit.

- Families receive written and verbal age-, developmentally, and culturally appropriate anticipatory guidance materials on child development at each well-child visit, given in the context of a relationship with their health care provider.
- The practice routinely surveys families for feedback on satisfaction.
- Practice provides or is aware of parent groups available in the community.

BP: Providers actively listen and respond to parent concerns and provide positive reinforcement so that parents are confident in their ability to care for their child.

- A practice-wide customer service policy is in place that provides overarching principles for interacting with patients in an attentive and responsive manner.
- All staff who have patient or family interaction are educated on interviewing skills.
- Health care providers use time during the patient encounter, particularly well-child visits, to set the agenda collaboratively with parents or caregivers.
- Health care providers allow parents to ask questions regarding child-development issues and give them options regarding solutions to developmental concerns. Health care providers avoid using dismissive statements such as, “She’ll grow out of that” or “Let’s wait and see.” These devalue the parents’ concerns and waste important opportunities to discuss child development.
- Health care providers use reinforcing statements such as, “I understand that you are concerned” or “Let me understand better what your concerns are,” which stress to parents that their input is valued and instill confidence in them to that they are the experts on their child.
- Cultural or language barriers do not reduce the ability of practice staff to listen and respond to parents or caregivers. Health care providers use written and verbal communication that is culturally sensitive to the patient and parent population.
- All members of the child’s health care team are informed of key points from discussions with the parent or caregiver. Team meetings or sharing of patient records/notes are implemented as strategies to make sure all practice members who work with the family in question are knowledgeable about the child’s development and any caregiver concerns.

BP: The practice provides clear and useful information to parents about child development, including written materials.

- The primary care office is a resource through which parents can receive information regarding Early Intervention (EI) services. Staff—either designated staff or all staff who have patient contact—are educated about local referral agencies, EI guidelines, and other information that can be shared with parents.
- Parents and caregivers who have questions that can’t be answered are assisted by practice staff in finding correct information. If at all possible, office managers or nurses contact EI or other community agencies to get information while the parent is present in the practice. New information learned through this process is documented and shared with other practice staff as part of internal training so future questions can be answered.
- Parents are informed of their rights and their child’s rights to services when referred for further evaluation of developmental or social-emotional delays or concerns.

- Families are made aware that they may be charged fees (based on ability to pay) for some ongoing EI services and that the family's health insurance may be billed for the cost of services. Families are informed that there is a cap on the amount the family may be required to pay in a year.
- Resources recommended by the practice include not only child-development services but also parent resource and support groups. Efforts are made to identify parent groups that serve diverse types of families (single parents, same-sex families, grandparents raising grandchildren) or at a minimum serve the primary audiences of the practice and its community.
- Group well-child visits are used as a strategy to help parents express child-development concerns and learn from each other.

## **Referral to Community Agencies and Other Resources**

BP: The practice uses a Universal Early Intervention Referral Form (see tools T) for referrals to Early Intervention services.

- Use of a universal referral form helps standardize information among providers within the practice and provides consistent information to EI providers.
- The practice is proactive in reaching out to local EI providers and families to solicit input into the universal form to make sure it meets the needs of all parties.

BP: The practice has linkages to community resources that can assist culturally and socioeconomically diverse families with a range of concerns.

- The practice reviews current relationships with community referral resources on a regular basis.
- The practice develops a strong, personal relationship with local referral agencies. Efforts to “put faces with names” are made so that health care providers develop familiarity with their referral sources and express that familiarity and confidence with families. Introductions are made and staff members meet each other through phone calls, visits, or in-services at which local community resource agencies present information on their services to practice staff.
- The practice compiles and continually updates a manual of community resources.
- Providers receive appropriate feedback from referral sources. A system is in place to request feedback if it is not automatically or routinely provided. The practice team regularly evaluates the quality of feedback and services from referral sources. When inadequate, the practice works with the agency to improve feedback and services and/or identifies new sources for referrals. Practice staff considers advocacy with system leaders and policy makers to improve services at the community and state levels part of their responsibilities.
- Relationships include multiple resources to address a range of family concerns.
  - Child developmental or social-emotional delay programs. The recommended local referral program is Early Intervention (EI). In Illinois, practices refer children to local Child and Family Connections (CFC) offices as the entry point to EI. For the name of the local CFC call 800/323-4769. Families are assigned to a CFC based on their zip code of residence. Other secondary referral sources might include developmental/behavioral pediatricians and early childhood specialists.
  - School programs, including special education.
  - Community mental health agencies and other mental health providers.
  - Local departments of public health.
  - Women’s health and mental health resources, such as toll-free information lines and treatment centers. In Illinois, Evanston Hospital operates a 24-hour crisis hotline (866/ENH-MOMS, 866/364-6667, or [www.enh.org/clinicalservices/maternityservices/postpartum/](http://www.enh.org/clinicalservices/maternityservices/postpartum/) for women experiencing perinatal depression. Other resources include the Illinois Department of Human Services (IDHS) Referral Line (800/323-4769), the Illinois Department of Public Health (IDPH) Office of Women’s Health (888/522-1282; TTY: 800/547-0466), the Postpartum Depression Illinois Alliance (847/205-4455), and NAMI (National Alliance for the Mentally Ill) (800/346-4572).

- Resources for domestic violence such as shelters and other supportive services in the area (see tools U).

BP: Parents are given comprehensive information about the referral process and supported in their attempts to ask questions or gather additional information.

- Parents are made aware of need for the referral, what to expect from the referral resource, and the anticipated timing for the referral, evaluation, and initiation of services.
- The practice explains to the parent or appropriate caregiver the services to be provided.
- Parents are given the opportunity to ask questions and receive answers when a child is referred for further evaluation of developmental or social-emotional delay.
- Practice staff members ask parents how they will explain what they have just been told to others at home to see how well parents have understood the information. Parents feel confident in their ability to explain to other family members why their child is being referred.
- The practice delivers parent handout and/or has posters displayed regarding the rights of children. Under federal law, Part C of the Individuals with Disabilities Education Act (IDEA), the state provides assessment and services for children under three years of age who have developmental delays or disabilities. Any child with a suspected delay has the right to a free assessment to determine if he/she is eligible for services. Children with a 30 percent or greater delay are eligible for services. Children eligible for EI services must be experiencing developmental delays in one or more of the following areas: cognitive development; physical development, including vision and hearing; language and speech development; psychosocial development; and self-help skills. Children may also be eligible due to diagnosed physical or mental conditions (such as cerebral palsy or Down syndrome) or certain family circumstances that put them at risk of having substantial delays.
- A process for disagreement or objection is established and communicated to the parent or caregiver. Options for families with objection may include mediation, a request for impartial administrative resolution, or filing of a written complaint to the referral agency or its state oversight body. All disagreements or objections receive a timely resolution.

BP: Referrals for developmental delays and other concerns are processed, tracked, and followed up on in a manner similar to other medical referrals.

- The practice has a system in place to follow up with families, in a timely manner, on referrals made to community resources.
- Each referral is placed on a Referral Follow-Up Worksheet (see tools F).
- A designated professional staff person (physician, physician assistant, advance practice nurse, nurse) makes at least one follow-up telephone call or in-person visit with the family referred for services within one week of the referral. The family is scheduled for a follow-up visit between six and eight weeks after the referral, except in situations where the subject of the referral is not the practice's patient (for instance, when pediatric provider refers women for perinatal depression screening and treatment or domestic violence counseling).
- The practice generates a report system/feedback mechanism to follow up on children referred for further evaluation. Information on the services and determinations of the referral agency are documented appropriately in the patient's chart.

- When pediatric providers refer women for perinatal depression screening and treatment or domestic violence counseling, designated professional staff follow up with the appropriate referral agency or adult health care provider to determine if the referral was completed.

BP: Referrals are timely, seamless, and made in the best interest of the patient and family.

- Referrals are made immediately or no later than one to two days after the identification of potential delay, caregiver mental health issue, or family risk factor.
- With regard to childhood developmental delay, the law in Illinois says referrals must be made within two working days of the identification of potential delay.
- Referrals for further evaluation of developmental or social-emotional delay are seamless. Ideally and whenever possible, practice staff make the referral with the family while the family is on-site at the practice, helping to reinforce the concept of coordinated care through a medical home.
- Referrals, particularly in cases of maternal depression or domestic violence, are confidential as appropriate.
- Communication between the practice and the local EI provider, counseling center, or mental health provider flows freely and does not rely on the parent or caregiver to transfer information. Points of contact (for instance, assigned staff) between the practice and the referral agency are established and utilized.
- Referrals are made to services that operate in the best interest of the family, not the health care provider or health system. Referral agencies should provide comprehensive services that are covered by Medicaid and major insurers and are offered at low or no cost to disadvantaged families.
- In Illinois, referrals should be made to the EI system through the local CFC office. Other referrals, for instance to private specialists within the practice's hospital or health care system, may be attractive because they provide certain benefits, such as location, ease of access or scheduling, and internal record sharing. However, state programs such as EI are available to all Illinois residents and provide free, comprehensive evaluations and free or reduced-cost services to qualifying families. Furthermore, local EI offices are connected to other social and community programs and often help families access those services as part of their case-management services.
- Practice staff advocate for patients within the health care system. The practice has systems in place to follow up and assist families who are not able to maneuver the system on their own.

BP: All families receive services that are appropriate and necessary to their situation.

- CFC works with and supports the family throughout the evaluation process, the determination of eligibility, and the identification of services that will meet individual needs and that are available through the EI system.
- If the child is eligible for services:
  - The CFC service coordinator will facilitate the development of an Individualized Family Service Plan (IFSP), link the family to service providers, and provide the information needed to make informed decisions.

- IFSPs are developed for eligible children and their families by a team that includes the child, parent/caregiver, EI service coordinator, and primary care provider. Other participants might include child care or school representatives.
- All team members including the family are given reasonable notice of the date, time, and location prior to IFSP meeting and reasonable notification of proposed changes to the IFSP.
- The IFSP includes a listing of child's and family's strengths, needs, resources, priorities, and concerns and identifies services agreed to by the IFSP team. The plan outlines the services and supports the family chooses to receive to meet the individual needs of the child.
- Both the families of eligible children and their primary care medical homes receive the IFSP, which lists services the child and family are entitled to receive.
- Service coordinators help families obtain the services identified in the IFSP. Families are linked to a large network of skilled providers.
- The CFC must complete the evaluation and IFSP within forty-five days. CFC agencies arrange for developmental evaluations and assessments. They provide service coordination and develop service plans at no cost to families.
- If the child is ineligible for services, the CFC office will assist the family with linkages to other community resources that may meet the needs of child and family.
- Early intervention services include but are not limited to developmental evaluations and assessments, physical therapy, occupational therapy, speech/language therapy, nutrition services, psychological services, and social work services.
- Privacy is respected, and no information about child and family is shared without written consent. Family may inspect, review, and amend records and may request/receive copies at any time.
- Families are able to refuse any service, at any time, without jeopardizing other services. Refusal of services does not generally warrant a call to the child protective services (i.e., the Illinois Department of Child and Family Services). Families who leave the EI system have the right to reenter the system before the child is age three.

## **Coding and Billing**

BP: The practice uses appropriate codes and billing procedures to obtain appropriate payment for services.

- The practice is knowledgeable regarding current Medicaid and insurer policies on payment for developmental screening, perinatal depression screening, and screening for risk factors including family violence. Enrolled Illinois Medicaid providers follow procedures in the IDHFS *Healthy Kids Handbook* to secure payment for these services.
- Screening codes are included on the practice's encounter sheet.
- Practice staff accesses educational resources to stay up-to-date on coding and billing procedures. Educational resources are available through the AAP (Developmental Screening/Testing Coding Fact Sheet, available at [www.edopc.org/docs/AAPCodingFactSheet.pdf](http://www.edopc.org/docs/AAPCodingFactSheet.pdf)), the DBPeds Web site ([www.dbpeds.org/screening/](http://www.dbpeds.org/screening/)), and the EDOPC Web site ([www.edopc.org](http://www.edopc.org)).

BP: Insurers allow the recommended number of developmental screenings that can be conducted on a child or at a specific visit.

- Providers are free to determine based on the individual child/family when and how many screenings should be conducted.
- At sick visits and well-child visits for patients who do not come in for regular care, providers are able to conduct multiple screens without loss of revenue.

BP: Insurers provide payment for screening mothers during the child's visit.

The IDHFS will reimburse pediatric providers for screening mothers for perinatal depression. Providers may bill for maternal depression screenings until the child is one year old. In order for maternal depression screening claims to be paid, either the mother or the child must receive All Kids benefits. If the mother receives the benefits, providers should use her ID number when billing. If the mother does not receive benefits, but the child receives benefits, providers should use the child's member ID number.

BP: Insurers allow use of multiple validated tools for each type of screening.

- Providers are given flexibility when choosing a screening tool and are able to select and use tools that meet the needs of their practice and patient populations.
- Providers proactively advocate for inclusion of new tools to approved tool lists when appropriate.
- For developmental and social-emotional screening, IDHFS will reimburse for use of more than two dozen tools, listed in the *Healthy Kids Handbook*.
- For maternal depression screening, IDHFS will reimburse for the use of the following approved tools: the Edinburgh Postnatal Depression Scale (EPDS), the Beck Depression Inventory (BDI), and the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD/PHQ).

## Tools

### Description of Tools

**A. Practice Needs Assessment:** Questions for practice to determine current practices and needs in becoming developmentally oriented in order to develop a plan for training

**B. Educational Materials List:** List of screening tools and other developmental educational materials with purchasing information

**C. Script:** Wording to use to explain screens to parents in an informative and sensitive manner; two scripts provided: one for social-emotional screening and one for maternal depression screening

**D. Letter to Parents and Caregivers:** A written explanation for parents of the screening process and reasons for screening

**E. Parent Handouts:** Developmental handouts written at a fourth- to fifth-grade reading level on various child-development topics (can be found at [www.healthysteps.org](http://www.healthysteps.org))

**F. Developmental and Social-Emotional Referral and Postnatal Depression Referral Follow-Up Worksheets:** Flow sheets to track and document follow-up on developmental and social-emotional referrals as well as postnatal depression referrals

**G. EDOPC Chart Audit Protocol:** Guide to help sites do a chart audit using EDOPC chart audit forms and summary

**H. EDOPC Chart Audit Forms:** Forms to assess progress and difficulties in instituting screening in a practice; note: two different forms provided—one for auditing developmental screening, social-emotional screening, and maternal depression and the other for domestic violence screening

**I. Parent Survey:** Survey designed for parents of children birth to three years to assess their needs in the areas of child-development and social-emotional issues, autism awareness, postpartum depression, and domestic violence issues affecting children

**J. Post Practice Needs Assessment:** Questions for practice to determine current practices and needs in becoming developmentally oriented in order to compare to status prior to initiating training and determine further practice needs

**K. Risk Factors Commonly Associated with Perinatal Depression:** Reference to significant and other predictors for perinatal depression

**L. Handout “The ‘Baby Blues’ Support and Resources for New Mothers”:** Simple handout for parents to enhance understanding of postpartum depression signs and symptoms and provide resources

**M. Perinatal Depression Parent Survey (EDOPC survey about the health care experiences of families with young children):** Short parent questionnaire in English and Spanish on availability of culturally sensitive information on perinatal depression in office at well-child visits

**N. Postpartum Depression Protocol:** Guide to postpartum depression screening, referrals, and follow-up using the Edinburgh Postnatal Depression Scale; includes protocol for handling scores and results that require further evaluation as well as specific questions for determining risk of harm in the office setting

**O. Provider Tip Card:** Tip card for providers titled, “Maternal Depression & Child Development: Strategies for Primary Care Providers”; includes information about postpartum mental health, signs of baby blues, and postpartum depression and psychosis, as well as sample questions for interviewing new moms in a culturally sensitive way; also includes general information about treatment (medications)

**P. “HITS”:** A domestic violence screening tool with four questions used to screen in the community

**Q. Routine Safety Screening for Pediatric Patients and Their Families:** A tool to open lines of communication between providers and families around violence; has the “HITS” questions embedded

**R. PowerPoint Presentations (see EDOPC disk)**

“Developmental Screening and Referral”

“Social/Emotional Screening and Referral”

“Perinatal Maternal Depression Screening and Referral”

“Domestic Violence Effects on Children”

“Early Autism Detection and Referral”

**S. Quick Look for Screens:** Reference for staff to quickly review specifics of scoring and interpreting individual screening tools

**T. Universal Early Intervention Referral Form:** Used to communicate with the CFC site of referral

**U. Domestic Violence Resources:** Community referral resources for domestic violence

**V. Self-Study Guidelines: Maternal Depression and Child Development: Strategies for Primary Care Providers:** Guidelines to assist providers to 1) differentiate between “baby blues,” postpartum depression, and postpartum psychosis; 2) gain knowledge about the impact of

postpartum depression on children and families; 3) identify risk and protective factors for maternal depression; 4) become familiar with maternal depression screening tools; 5) learn referral procedures; and 6) implement culturally appropriate care for patients with postpartum depression

**W. Self-Study Guidelines: Social and Emotional Development: Screening Strategies for Primary Care Providers:** Guidelines to assist providers to 1) define and explain some important tasks of social and emotional development in the zero to three period, 2) appreciate the benefits of screening children for social and emotional concerns and learn how to conduct validated screens, 3) describe which screening tools are reimbursed under Medicaid, and 4) report how to contact Early Intervention and other referral resources in practice area

**X. Self-Study Guidelines: Identifying Autism Spectrum Disorders: Guidelines for Screening, Treatment, and Referral:** Guidelines to assist providers to 1) define autistic spectrum disorders (ASD); 2) recognize the earliest signs of autism; 3) gain knowledge about the effects of ASD on children and families; 4) identify common misconceptions about causes and stereotypes of autism; 5) identify risk and protective factors; 6) routinely assess children for ASD; 7) become familiar with screening tools; 8) learn how to refer to the Early Intervention system, special education system, and specialists for children who show signs of autism; and 9) become familiar with the team approach to diagnosis and the importance of evidence-based treatment of ASD ([www.iafp.com](http://www.iafp.com))

#### **Additional Resources**

1. American College of Obstetricians and Gynecologists. For more information please refer to [http://www.hfs.illinois.gov/mch/ppd\\_notice.html](http://www.hfs.illinois.gov/mch/ppd_notice.html) and select the file Screening for Perinatal Mental Health.
2. Illinois Department of Public Aid informational notice on screening for perinatal depression, November 2004. For more information please refer to [http://www.hfs.illinois.gov/mch/ppd\\_notice.html](http://www.hfs.illinois.gov/mch/ppd_notice.html) and select the Screening for Perinatal Mental Health file.
3. Illinois Department of Public Aid informational notice on billing for screenings under the Healthy Kids Program, February 2004 For more information please refer to the IDHFS Healthy kids handbooks at [www.hfs.illinois.gov/handbooks/chapter200.html#hk200](http://www.hfs.illinois.gov/handbooks/chapter200.html#hk200) and scroll to the bottom of the page to find a link to the Healthy Kids Handbook on-line.
4. Information for physician on prescription products to treat perinatal depression, July 2004. Dosages are from the Physicians Desk Reference, 56<sup>th</sup> ed. Table based on Winser et al *Postpartum Depression* Article in N Eng. J Med, Vol. 347, No.3, July 18, 2008, pg 196.