GRANTEE UPdate

October 26, 2009

The Update is a bi-weekly Web newsletter published by the Iowa Department of Public Health's Bureau of Family Health. It is posted the second and fourth week of every month, and provides useful job resource information for departmental health care professionals, information on training opportunities, intradepartmental reports and meetings, and additional information pertinent to health care professionals.

The Burden of Obesity in Iowa

Overweight and obesity have tremendous consequences on our nation's health and economy. Both are linked to a number of chronic diseases, including coronary heart disease, stroke, diabetes and some cancers. Most American communities are characterized by unhealthy options when it comes to diet and physical activity. We need public health approaches that make healthy options easy, affordable and available for all Americans.

The Burden of Obesity in Iowa

Iowa's estimated 2007 total population is almost 3 million with 2.2 million adults. Of those adults, approximately 37 percent are considered overweight and another 28 percent are considered obese, according to 2007 Behavioral Risk Factor Surveillance data. Problems are also seen in factors related to obesity and other chronic diseases.

- Approximately one-in-five Iowa adults report no leisure time physical activity over the past month.
- Only one-in-five adults report eating fruits and vegetables five or more times a day.

Also, the National Immunization Survey shows that Iowa is not meeting any of the five Healthy People 2010 goals for breastfeeding, based on children born in 2005.

The problem is not limited to adults alone. Approximately 11 percent of Iowa youth (9th-12th grades) are considered obese and another 13 percent are considered overweight, according to 2007 Youth Risk Behavior Survey data.

continued on next page

The Burden of Obesity in Iowa

continued

- Only half of Iowa youth are meeting current physical activity recommendation levels.
- Only 19 percent eat fruits and vegetables five or more times a day.
- One quarter watch three or more hours of television a day.
- Almost one third drink at least one non-diet soda each day.

What is Iowa doing about obesity?
The state has combined state and federal funding to develop a community wellness grant opportunity. Many communities have been funded so far: 28 in 2006, and 24 new communities in 2008-2009. Community projects include activities such as: creating wellness centers to provide access to information, holding lifestyle challenges for community residents to lose weight, building community trails, or getting local grocers to label healthy food choices.

Iowans Fit for Life piloted an intervention project in 12 rural Iowa elementary schools. This project is testing and evaluating various combinations of interventions such as the Free Fruit and Vegetable Program (USDA) and an Iowa Department of Public Health school and community program (Pick a Better Snack and Act). The Pick a Better Snack program has been implemented in multiple states and is now directly connected to USDA's Free Fruit and Vegetable Program.

Iowa passed the Healthy Kids Act, which is set to be implemented in 2010. This legislation requires that every student get 30 minutes of physical activity each day, schools should comply with nutrition content standards for foods sold/provided on school grounds, and Area Education Agencies should employ or contract with a licensed dietician. Through these activities, Iowa and the CDC are addressing obesity by creating places where residents can make healthy choices about nutrition and physical activity.

For more information, contact Dennis Haney, Program Coordinator, IDPH, at (515) 281-7501 or dhaney@idph.state.ia.us.

Data in Action - New Medical Home and Title V Data Resources

The Data Resource Center—funded by the Maternal and Child Health Bureau, Health Resources and Services Administration—is partnering with the American Academy of Pediatrics to help state and family leaders quickly access data on how children and youth in each state experience receiving care within a medical home.

You can click on a U.S. map to view your state's medical home performance profile for all children or children with special health care needs. You can also compare across all states or view state ranking maps by clicking on the green map of the US.

For more information, go to http://medicalhomedata.org/content/Default.aspx.

Program Management

Revised Iowa Recommendations for *Care for Kids* Screenings

Iowa's recommendations for scheduling *Care for Kids* screenings (Periodicity Schedule) has recently been revised to more closely align with ***Bright Futures, Guidelines for Health Supervision of Infants, Children, and Adolescents***, American Academy of Pediatrics, 3rd Edition, 2008. You will find two sizes of the schedule on pages 7-8 of **The Update**, 8 1/2 x 11 (letter size) and 8 1/2 x 14 (legal size). Note that these documents are also posted on the IDPH EPSDT *Care for Kids* Web site at www.idph.state.ia.us/hpcdp/epsdt_providers.asp.

Among the modifications to the Periodicity Schedule is the 'Development and Behavioral Assessment' section. In this section, guidelines are specified for the following categories:

- developmental surveillance
- developmental screening
- autism screening
- psychosocial/behavioral assessment
- alcohol and drug use assessment

To assist Title V agencies with understanding the distinctions among these categories, you will find two supporting documents included in this edition of **The Update**.

1. Iowa Recommendations for Scheduling *Care for Kids* Screenings: Development and Behavioral Assessment for Title V Child Health Agencies (on pages 9-10 of **The Update**): This document was designed to provide Title V child health agencies with a brief summary of each of the five categories within the 'developmental and behavioral assessment' section of Iowa's Periodicity Schedule. The summaries include reference to tools, billing guidelines and documentation requirements.

2. Screening Tools Summary' (on pages 11-14 of **The Update**): This chart was designed to provide more definition and detail regarding screening tools available for developmental screening, autism screening, psychosocial/behavioral assessment, and alcohol and drug use assessment. Note that the Denver II is no longer recommended as a developmental screening tool for child health contract agencies.

NC Program a Model for Overhaul?

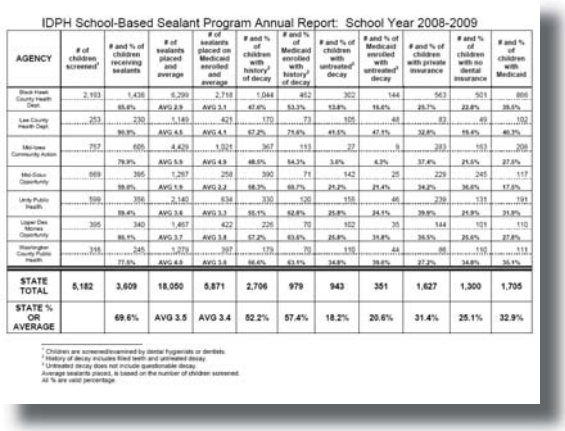
As lawmakers wrangle over the best way to overhaul the health care system, a program in North Carolina is getting attention. The state Medicaid program can be viewed at:

www.npr.org/templates/story/story.php?storyId=113816621.

W O R T H N O T I N G

IDPH School-Based Sealant Program Annual Report: School Year 2008-2009

by Mary Kay Brinkman, RDH, BS, Oral Health Bureau



IDPH School-Based Sealant Program Annual Report: School Year 2008-2009

AGENCY	# of children screened[1]	# and % of children receiving sealants	# of sealants placed and average	# of sealants placed on Medicaid enrolled and average	# and % of children with history[2] of decay	# and % of Medicaid enrolled with history[2] of decay	# and % of children with untreated[3] decay	# and % of Medicaid enrolled with untreated[3] decay	# and % of children with private insurance	# and % of children with no dental insurance	# and % of children with Medicaid
Black Hawk County Health Dept.	2,193	1,436	6,299	2,718	1,044	462	302	144	543	501	886
		65.6%	AVG 2.9	AVG 3.1	47.4%	53.3%	13.8%	16.4%	25.7%	22.8%	39.5%
Lee County Health Dept.	253	230	1,149	421	170	73	105	44	83	49	152
		90.9%	AVG 4.5	AVG 4.1	67.2%	75.4%	41.5%	47.1%	32.8%	19.4%	60.3%
Mid-Iowa Community Action	757	605	4,429	1,021	367	113	27	9	283	163	299
		79.9%	AVG 5.9	AVG 4.9	48.5%	54.3%	3.6%	4.3%	37.4%	21.5%	27.8%
Mid-Sioux Opportunity	669	395	1,257	258	390	71	142	25	229	245	117
		59.6%	AVG 1.9	AVG 2.2	58.3%	69.7%	21.2%	21.4%	34.2%	36.6%	17.5%
Unity Public Health	599	356	2,140	634	330	120	155	46	239	131	193
		59.4%	AVG 3.6	AVG 3.3	55.1%	52.8%	25.8%	24.1%	39.9%	21.9%	33.9%
Upper Des Moines Opportunity	395	340	1,467	422	226	70	102	35	144	101	110
		86.1%	AVG 3.7	AVG 3.8	57.2%	63.6%	25.8%	34.8%	36.5%	25.6%	27.8%
Washington County Public Health	316	245	1,279	397	179	70	110	44	86	110	113
		77.5%	AVG 4.9	AVG 3.6	56.6%	63.1%	34.8%	39.6%	27.2%	34.8%	35.1%
STATE TOTAL	5,182	3,609	18,050	5,871	2,706	979	943	351	1,627	1,300	1,705
STATE % OR AVERAGE		69.6%	AVG 3.5	AVG 3.4	52.2%	57.4%	18.2%	20.6%	31.4%	25.1%	32.9%

[1] Children are screened/examined by dental hygienists or dentists.
[2] History of decay includes filled teeth and untreated decay.
[3] Untreated decay does not include questionable decay.
Average sealants placed, is based on the number of children screened.
All % are valid percentage.

The Centers for Disease Control and Prevention (CDC) recommend dental sealants as a key public health preventive intervention. During the 2008-2009 school year, seven sealant program contractors provided 18,050 sealants for 3,609 children. There were an additional 1,574 children screened.

For children participating in the program, the untreated decay rate has continued to decrease. The percentage of children with untreated decay has dropped from 25 percent in the 05-06 school year, 21 percent in 07-08 and only 18 percent this past school year.

Privately insured children have historically had the best chance of being cavity free. The data from this year's program show that children insured with ***hawk-i*** have about the same rate, or better, of untreated decay as those with private insurance. (15 percent of children on ***hawk-i*** had untreated decay compared to 16 percent of children with private insurance.) Medicaid enrolled children continue to have the highest rate of untreated decay at 21 percent.

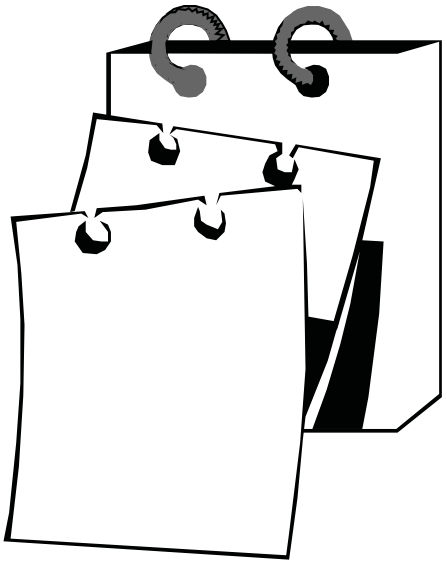
Oral health prevention and education are the goals of the IDPH Oral Health Bureau, and continued efforts will be made to expand the school based sealant program throughout the state.

The report can be viewed on pages 15-16 of **The Update**.

Children's Safety Network (CSN) Newsletter

The October 15 edition of the CSN Newsletter is now available and can be viewed at www.childrenssafetynetwork.org/news/default.asp. One of the articles is a study on the physician's role in reducing Sudden Infant Death Syndrome (SIDS). This study can be viewed at www.childrenssafetynetwork.org/news/shownews.asp?newsID=1359.

CALENDAR OF EVENTS



November 12, 2009

Off to a Good Start

8:30 a.m. - 4:30 p.m., Science Center of Des Moines
401 West Martin Luther King Jr. Parkway
Des Moines

*January 21, 2010

Bureau of Family Health Grantee Committee Meeting

9 a.m. - 11:30 a.m., ICN

GRANTEE UPdate

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Area code is 515

Iowa Recommendations for Scheduling *Care for Kids* Screenings

Revised 10/2009

KEY

- ● To be performed
- S Subjective, by history
- ✻ High risk
- ● To be performed at every visit
- ⊛ Screen at least once during time period indicated
- ○ Objective, by standard testing method

		AGE																			
		Infancy							Early Childhood					Late Childhood					Adolescence			
		2-3[1] days	by 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 yr	3 yr	4 yr	5 yr	6 yr	8 yr	10 yr	12 yr	14 yr	16 yr	18 yr	20+ yr
History	Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Physical exam	As part of each screening	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Measurements	Length/height & weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
	Head circumference	●	●	●	●	●	●	●	●	●	●											
	Body Mass Index										●	●	●	●	●	●	●	●	●	●	●	●
	Blood pressure	risk assessment										●	●	●	●	●	●	●	●	●	●	●
Nutrition	Assess/educate	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Oral Health	Assessment - Dental history; recent concerns, pain or injury; visual inspection of hard and soft tissues of oral cavity; dental referral based on risk assessment	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Development and behavioral assessment	Developmental screening[2]						●			●		●										
	Autism screening[3]									●	●											
	Developmental surveillance[2]	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●
	Psychosocial/behavioral assessment	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
	Alcohol and drug use assessment	risk assessment to be performed with appropriate action to follow if positive →																●	●	●	●	●
Sensory screening	Vision	S	S	S	S	S	S	S	S	S	S	○	○	○	○	○	S	○	○	S	○	○
	Hearing	○	S	S	S	S	S	S	S	S	S	S	○	○	S	○	S	○	S	S	○	S
Immunization	Perform an immunization review at each visit; administer immunizations at recommended ages, or as needed	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anticipatory Guidance	Provided at every visit	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES	**Dyslipidemia**										✻		✻		✻	✻	✻	✻	✻	✻	●	●
	Hemoglobin/ hematocrit Perform once between 9-month and 12-month visits for children at risk; also annually for adolescents if risk factors are present						⊛	⊛										●	●			
	Gynecologic testing Screen for cervical dysplasia as part of a pelvic exam within 3 years of onset of sexual activity or age 21, whichever comes first. Pregnancy testing done as indicated.																✻	✻	✻	✻	✻	●
	Lead screening Assess and test all children at 12 months and 2 years of age. In addition, assess and test high-risk children at 18 months, 3 years, 4 years and 5 years**							●		✻	●	✻	✻	✻								
	Metabolic screening The Iowa Neonatal Metabolic Screening Program tests every newborn for all disorders on the American College of Medical Genetics and March of Dimes screening panels. See www.idph.state.ia.us/genetics.	⊛																				
	Sexually transmitted infections Screen as appropriate. People with a history of, or at risk for STIs should be tested for chlamydia and gonorrhea																	as appropriate				
	Tuberculin test For high risk groups, annual testing is recommended. High risk groups include household members of persons with TB or others at risk for close contact with the disease; recent immigrants or refugees from countries where TB is common; migrant workers; residents of correctional institutions or homeless shelters; persons with certain underlying disorders	annual testing for high risk groups																				

[1]For newborns discharged within 24 hours or less after delivery. [2]AAP Council on Children with Disabilities, AAP Section on Developmental Behavioral Pediatrics, AAP Bright Futures Steering Committee, AAP Medical Home Initiaitives for Children With Special Needs Project Advisory Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. *Pediatrics*, 2006;118:405-420.
[3]Gupta VB, Hyman SL, Johnson CP, et al. Identifying children with autism early? *Pediatrics*. 2007:119:152-153.

**For additional information, call the Bureau of Lead Poisoning Prevention at 1-800-972-2026.

Iowa Recommendations for Scheduling *Care for Kids* Screenings

Revised 10/2009

KEY

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History	Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Physical exam	As part of each screening	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Measurements	Length/height & weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
	Head circumference	●	●	●	●	●	●	●	●	●	●											
	Body Mass Index										●	●	●	●	●	●	●	●	●	●	●	●
	Blood pressure	risk assessment										●	●	●	●	●	●	●	●	●	●	●
Nutrition	Assess/educate	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Oral Health	Assessment - Dental history; recent concerns, pain or injury; visual inspection of hard and soft tissues of oral cavity; dental referral based on risk assessment	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Development and behavioral assessment	Developmental screening[2]						●			●		●										
	Autism screening[3]									●	●											
	Developmental surveillance[2]	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●
	Psychosocial/behavioral assessment	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
	Alcohol and drug use assessment	risk assessment to be performed with appropriate action to follow if positive →																●	●	●	●	●
Sensory screening	Vision	S	S	S	S	S	S	S	S	S	S	O	O	O	O	O	S	O	O	S	O	O
	Hearing	O	S	S	S	S	S	S	S	S	S	S	O	O	S	O	S	O	S	S	O	S
Immunization	Perform an immunization review at each visit; administer immunizations at recommended ages, or as needed	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anticipatory Guidance	Provided at every visit	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES	**Dyslipidemia**										✻		✻		✻	✻	✻	✻	✻	✻	●	●
	Hemoglobin/ hematocrit Perform once between 9-month and 12-month visits for children at risk; also annually for adolescents if risk factors are present						⊛	⊛										●	●			
	Gynecologic testing Screen for cervical dysplasia as part of a pelvic exam within 3 years of onset of sexual activity or age 21, whichever comes first. Pregnancy testing done as indicated.																✻	✻	✻	✻	✻	●
	Lead screening Assess and test all children at 12 months and 2 years of age. In addition, assess and test high-risk children at 18 months, 3 years, 4 years and 5 years**							●		✻	●	✻	✻	✻								
	Metabolic screening The Iowa Neonatal Metabolic Screening Program tests every newborn for all disorders on the American College of Medical Genetics and March of Dimes screening panels. See www.idph.state.ia.us/genetics.	⊛																				
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**For additional information, call the Bureau of Lead Poisoning Prevention at 1-800-972-2026.

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Iowa Recommendations for Scheduling *Care for Kids* Screenings
Development and Behavioral Assessment for Title V Child Health Agencies

Iowa Recommendations for Scheduling *Care for Kids* Screenings (EPSDT Periodicity Schedule) was revised in October 2009 to better align with *Bright Futures* Third Edition, the American Academy of Pediatrics Guidelines for Health Supervision of Infants, Children, and Adolescents. The revised schedule includes delineation of the development and behavioral assessment section into five categories: developmental surveillance, developmental screening, psychosocial/behavioral assessment, autism screening, and alcohol and drug use assessment. This document is designed to provide Title V Child Health agencies with a brief summary for each category within the 'development and behavioral assessment' section of Iowa's Periodicity Schedule.

For more detailed information about developmental and behavioral surveillance and screening tools, see the Iowa EPSDT *Care for Kids* Provider Website at www.iowaepsdt.org. A chart of screening tools found on this website is attached. Helpful information is also provided in the Medicaid Screening Center Provider Manual at http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/scenter.pdf under Developmental Screening and Mental Health Assessment.

1. **Developmental surveillance:**
    - For agencies completing the full well child exam: Developmental surveillance is a component of the full well child exam. If you are using the **Iowa Child Health and Developmental Record (CHDR)** forms, these questions would be found in the 'Developmental' section. There is no separate billing for this service, as it would be included as part of the physical exam. (See http://www.iowaepsdt.org/ScreeningResources/CHDR.htm for the Iowa CHDR forms.)

    - For agencies referring to a medical home for the well child exam: Completion of the of the **CHDR**'s 'Developmental', 'Social History', and 'Anticipatory Guidance' sections have been approved for billing as a care coordination service. Documentation in CAReS for the care coordination service must report use of the **CHDR** and reflect the scope of the service, findings from the family, and any referrals that may result.

2. **Developmental screening:**
    - In Iowa, there are several tools that are recommended. Our Title V Child Health programs were offered training and tools for the **Ages and Stages Questionnaire (ASQ)** and **Ages and Stages S-E (ASQ SE)**. There are other developmental screening tools listed at www.iowaepsdt.org such as **Bayley Infant Neurodevelopment Screener**, **Brigance Infant and Toddler Screen**, and **Parents' Evaluation of Developmental Status (PEDS)**.

    - The developmental screen may be billed to Medicaid by Title V Child Health agencies using Code 96110. It is billed separately from a well child exam. This service requires the administration of a recommended tool, interpretation and report of the results of the screening, anticipatory guidance, and any referrals that may result from the screen. Documentation of each of these elements must be included in the client chart.

3. **Autism screening:**
    - In Iowa, there are two recommended tools, the **Modified Checklist for Autism in Toddlers (M-CHAT)** and the **Pervasive Development Disorders Screening Test II (PDDST II).** (See www.iowaepsdt.org.)

    - The autism screen may be billed to Medicaid by Title V Child Health agencies using Code 96110. (Note that this code can only be billed once per visit (so at 18 months when both the developmental screen and autism screen are due, you could only bill one 96110 for the screenings provided). The autism screen is billed separately from a well child exam. This service requires the administration of a recommended tool, interpretation and report of the results of the screening, anticipatory guidance, and any referrals that may result from the screen. Documentation of each of these elements must be included in the client chart.

4. **Psychosocial/behavioral assessment:**
    - **Psychosocial/behavioral surveillance**
        - For agencies completing the full well child exam, psychosocial/behavioral surveillance is provided at each visit as a component of the full well child exam. If you are using the **Iowa Child Health and Developmental Record (CHDR)** forms, these questions would be found in the 'Social History' section. There is no separate billing for this service, as it would be included as part of the physical exam. (See http://www.iowaepsdt.org/ScreeningResources/CHDR.htm for the Iowa CHDR forms.)

        - For agencies referring to a medical home for the well child exam: Completion of the of the **CHDR**'s 'Developmental', 'Social History', and 'Anticipatory Guidance' sections have been approved for billing as a care coordination service. Documentation in CAReS for the care coordination service must report use of the **CHDR** and reflect the scope of the service, findings from the family, and any referrals that may result.

    - **Psychosocial/behavioral screening**
        - Psychosocial/behavioral screening may be provided using the **Pediatric Symptom Checklist** (See http://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf.) There are two versions, a parent report and a youth self report (Y-PSC) for adolescents ages 11 – 18. The **Pediatric Symptom Checklist, Youth Self-Report (Y-PSC)** may be used to provide a mental health screen for 11-18 year old patients during well visits, sports physicals, and other routine office visits.

          Psychosocial/behavioral screening may be billed to Medicaid by Title V Child Health agencies using Code 96110. It is billed separately from a well child exam. This service requires the administration of a recommended tool, interpretation and report of the results of the screening, anticipatory guidance, and any referrals that may result from the screen. Documentation of each of these elements must be included in the client chart.

5. **Alcohol & drug use assessment:**
    - *Bright Futures* recommends the **CRAFFT Screening Tool**. The **CRAFFT** is a behavioral health screening tool for use with children under the age of 21 and is recommended by the American Academy of Pediatrics' Committee on Substance Abuse for use with adolescents. It consists of a series of 6 questions developed to screen adolescents for high risk alcohol and other drug use disorders simultaneously. It is a short, effective screening tool meant to assess whether a longer conversation about the context of use, frequency, and other risks and consequences of alcohol and other drug use is warranted. (See http://www.ceasar-boston.org/CRAFFT/index.php).

      Use of the **CRAFFT Screening Tool** may be billed to Medicaid by Title V Child Health agencies using Code 96110. It is billed separately from a well child exam. This service requires the administration of a recommended tool, interpretation and report of the results of the screening, anticipatory guidance, and any referrals that may result from the screen. Documentation of each of these elements must be included in the client chart.

Screening Tools	Age Range Covered	Areas Screened	Format	Who Can Complete It	Administration Time	Validity and Reliability	Scoring	Languages	Purchase/Obtainment Information
Developmental Screening Tools									
Ages and Stages Questionnaire (ASQ)	4-60 mo	communication, gross motor, fine motor, problem-solving, and personal-social	Series of 19 age-specific questionnaires	Parents	10-15 min	Normed on 2,008. Sensitivity (0.70-0.90: moderate to high) specificity (0.76-0.91-moderate to high)	Scored by professionals. results in pass/fail domain. Provides a cutoff score in 5 domains that indicate possible need for further evaluation	English, Spanish, French, Korean and Others	Paul H. Brookes Publishing Co: 800/638-3775; www.brookespublishing.com
Ages and Stages Questionnaire S-E (ASQ)	6-60 mo	Social-emotional (self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people)	Series of 8 age-specific questionnaires	Parents	10-15 min	Normed on 3,000.Very good validity and reliability	Scored by professionals.	English and Spanish	Paul H. Brookes Publishing Co: 800/638-3775; www.brookespublishing.com
Bayley Infant Neurodevelopment Screener	3-24 mo	neurologic functions, receptive functions (visual, auditory, and tactile input), expressive functions (oral, fine, and gross motor skills), and cognitive processes	Series of 6 item sets	Directly administered	10 min	Normed on ~1,700. Sensitivity (0.7-0.86: moderate) specificity (0.75-0.86 moderate)	Graded as low, moderate, or high risk in each of 4 conceptual domains by use of 2 cutoff scores	English and Spanish	Psychological Corp: 800/211-8378; www.harcourtassessment.com
Brief Infant-Toddler Social and Emotional Assessment (BITSEA)	12-36 mo	assess emerging social-emotional development	42 items	Directly administered	7-10 min	National sample of 600 children. Clinical groups included language delayed, premature, and other diagnosed disorders.	Problems total score and competence total score	English and Spanish	www.harcourtassessment.com
Brigance Infant and Toddler Screen	0-90 mo	articulation, expressive and receptive language, gross motor, fine motor, general knowledge, personal social skills, and academic skills (when appropriate)	Series of 9 forms	Directly administered	10-15 min	Normed on 1,156 children from 29 clinical sites in 21 states. Sensitivity (0.70-0.80: moderate) Specificity (0.70-0.80: moderate)	All results are criterion based. No normative data are presented.	English and Spanish	Curriculum Associates Inc. 800/225-0248; www.curriculumassociates.com
Child Development Review	18 mo- 5 yr	social, self-help, motor, and language	6 open-ended questions and a 26 item possible-problems checklist to be completed by the parent	Parent	10-20 min	Standardized with 220 children 3-4 yrs from primarily white, working class families in south St. Paul, MN; sensitivity (0.68: low) specificity (0.88: moderate)	Responses are classified as indicating: (1) no problem, (2) a possible problem, or (3) a possible major problem	English and Spanish	Behavior Science Systems Inc.

Screening Tools	Age Range Covered	Areas Screened	Format	Who Can Complete It	Administration Time	Validity and Reliability	Scoring	Languages	Purchase/Obtainment Information
Developmental Screening Tools									
Denver Developmental Screening Test (Denver II)**	0-6 yr	expressive and receptive language, gross motor, fine motor, and personal-social skills	125 items	Directly administered	10-20 min	Normed on 2,096 term children in Colorado. sensitivity (0.68: low) specificity (0.0.43-0.80: low to moderate)	pass/fail then compared with age-based norms to classify as normal, suspect or delayed	English and Spanish	Denver Developmental Materials: 800/419-4729; www.denverii.com
Infant Development Inventory	0-18 mo	social, self-help, motor, and language	4 open-ended questions followed by 87 items crossing the 5 domains	Parent	5-10 min	Studied in 86 high-risk 8 mo-olds seen in perinatal follow-up program and compared with Bayley scales. Sensitivity (0.85: moderate) specificity (0.77: moderate)	delayed or not delayed	English and Spanish	Behavior Science Systems Inc.
Parents' Evaluation of Developmental Status (PEDS)	0-8 yr	developmental and behavioral problems needing further evaluation (may be useful as a surveillance tool)	single response form used for all ages	Interview of parent	2-10 min	Standardized with 771 children from diverse ethnic and socioeconomic backgrounds. Sensitivity (0.74-0.79: moderate) specificity (0.70-0.80: moderate)	provides algorithm to guide need for referral, additional screening, or continued surveillance	English, Spanish, Vietnamese, Arabic, Swahili, Indonesian, Chinese, Taiwanese, French, Somali, Portuguese, Malaysian, Thai, and Laotian	Ellsworth & Vandermeer Press LLC: 888/729-1697; www.pedstest.com

** Recent studies have shown the specificity of the Denver II to be lower than some of the other tools currently on the market. The Denver II does not include the social/emotional criteria at the same level as the other tools recommended by the ABCD II panel.

Screening Tools	Age Range Covered	Areas Screened	Format	Who Can Complete It	Administration Time	Validity and Reliability	Scoring	Languages	Purchase/Obtainment Information
Autism Screening Tools									
Modified Checklist for Autism in Toddlers (M-CHAT)	16-48 mo	autism	23 questions (average)	Parent	5-10 min	Standardized sample included 1,293 children screened, 58 evaluated, and 39 diagnosed with an autistic spectrum disorder. Sensitivity (0.85-0.87: moderate) specificity (0.93-0.99: high)	risk categorization pass/fail	English, Spanish, Turkish, Chinese and Japanese	Public domain: www.firstsigns.com
Pervasive Developmental Disorders Screening Test II (PDDST II)	12-48 mo	autism	22 questions (average)	Parent	10-15 min	Validated using extensive multi-method diagnostic evaluations on 681 children at risk of autistic spectrum disorders and 256 children with mild-to-moderate other developmental disorders. Sensitivity (0.85-0.92: moderate to high) specificity (0.71-0.91: moderate to high)	risk categorization pass/fail	English	Psychological Corp
Parent/Caregiver Screening Tools									
Edinburgh Postnatal Depression Scale (EPDS)	mothers	postnatal depression	ten item scale	Self-administered	5 min	sensitivity (0.86) specificity (0.78)	max score of 30, score of 10+ may indicate depression	many languages	UIC Perinatal Consultation: 800/573-6121
Parenting Stress Index Short Form	parents of children 1 mo-12 yr	Identify parent-child problem areas in parents	36 items	Self-administered	10 min	reliability (0.78-0.90) validity (0.50-0.92)	Total Stress score from three scales: parental distress, parent-child dysfunctional interaction, and difficult child.	many languages	www3.parinc.com
Pediatric Intake Form (PIF) from Bright Futures	parent/ family history	parental depression, substance use, domestic violence, history of abuse, social supports, and other risk factors	66 questions (average)	Self-administered	10-20 min	no data	A score of 4 or more risk factors indicates child should be referred for early stimulation programs	no data	www.brightfutures.org

Screening Tools	Age Range Covered	Areas Screened	Format	Who Can Complete It	Administration Time	Validity and Reliability	Scoring	Languages	Purchase/Obtainment Information
Psychosocial/behavioral Screening Tools									
Pediatric Symptom Checklist	4 - 18 yr	problem behaviors including both externalizing (conduct, attention, etc.) and internalizing (depression, anxiety, adjustment, etc.)	35 short statements	Parents	10 min	no data	Ratings of never, sometimes or often are assigned a value of 0,1,or 2. Scores totaling 28 or more suggest referrals. For children 4 - 5 years of age, several items referring to academic performance are omitted and a cutoff of 24 is used.	Spanish and Chinese	http://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf
Pediatric Symptom Checklist, Youth Self-Report	adolescnt ages 11 -18	problem behaviors including both externalizing (conduct, attention, etc.) and internalizing (depression, anxiety, adjustment, etc.)	35 short statements; 37 with 2 suicide screening questions	Self-administered	10 min	no data	Ratings of never, sometimes or often are assigned a value of 0,1,or 2. Scores totaling 28 or more suggest referrals. (30 or more with the 2 suicide screening questions)	Spanish and Chinese	http://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf
Alcohol and Drug Use Screening Tool									
CRAFFT	adolescents under age 21	screens for high risk alcohol and other drug use disorders	3 questions followed by 6 additional questions depending upon response	Provider or self-administered	5 min	no data	Determines whether a longer conversation about the context of use, frequency, and other risks and consequences of alcohol and other drug use is warranted.	English, Spanish, and Portuguese	Recommended by AAP www.brightfutures.org http://www.ceasar-boston.org/CRAFFT/index.php

IDPH School-Based Sealant Program Annual Report: School Year 2008-2009

AGENCY	# of children screened[1]	# and % of children receiving sealants	# of sealants placed and average	# of sealants placed on Medicaid enrolled and average	# and % of children with history[2] of decay	# and % of Medicaid enrolled with history[2] of decay	# and % of children with untreated[3] decay	# and % of Medicaid enrolled with untreated[3] decay	# and % of children with private insurance	# and % of children with no dental insurance	# and % of children with Medicaid
Black Hawk County Health Dept.	2,193	1,438	6,299	2,718	1,044	462	302	144	563	501	866
		65.6%	**AVG 2.9**	**AVG 3.1**	**47.6%**	**53.3%**	**13.8%**	**16.6%**	**25.7%**	**22.8%**	**39.5%**
Lee County Health Dept.	253	230	1,149	421	170	73	105	48	83	49	102
		90.9%	**AVG 4.5**	**AVG 4.1**	**67.2%**	**71.6%**	**41.5%**	**47.1%**	**32.8%**	**19.4%**	**40.3%**
Mid-Iowa Community Action	757	605	4,429	1,021	367	113	27	9	283	163	208
		79.9%	**AVG 5.9**	**AVG 4.9**	**48.5%**	**54.3%**	**3.6%**	**4.3%**	**37.4%**	**21.5%**	**27.5%**
Mid-Sioux Opportunity	669	395	1,287	258	390	71	142	25	229	245	117
		59.0%	**AVG 1.9**	**AVG 2.2**	**58.3%**	**60.7%**	**21.2%**	**21.4%**	**34.2%**	**36.6%**	**17.5%**
Unity Public Health	599	356	2,140	634	330	120	155	46	239	131	191
		59.4%	**AVG 3.6**	**AVG 3.3**	**55.1%**	**62.8%**	**25.8%**	**24.1%**	**39.9%**	**21.9%**	**31.9%**
Upper Des Moines Opportunity	395	340	1,467	422	226	70	102	35	144	101	110
		86.1%	**AVG 3.7**	**AVG 3.8**	**57.2%**	**63.6%**	**25.8%**	**31.8%**	**36.5%**	**25.6%**	**27.8%**
Washington County Public Health	316	245	1,279	397	179	70	110	44	86	110	111
		77.5%	**AVG 4.0**	**AVG 3.6**	**56.6%**	**63.1%**	**34.8%**	**39.6%**	**27.2%**	**34.8%**	**35.1%**
STATE TOTAL	**5,182**	**3,609**	**18,050**	**5,871**	**2,706**	**979**	**943**	**351**	**1,627**	**1,300**	**1,705**
STATE % OR AVERAGE		**69.6%**	**AVG 3.5**	**AVG 3.4**	**52.2%**	**57.4%**	**18.2%**	**20.6%**	**31.4%**	**25.1%**	**32.9%**

[1] Children are screened/examined by dental hygienists or dentists.
[2] History of decay includes filled teeth and untreated decay.
[3] Untreated decay does not include questionable decay.
Average sealants placed, is based on the number of children screened.
All % are valid percentage.

IDPH School-Based Sealant Program Annual Report: School Year 2008-2009

AGENCY	# and % with a History of Decay (filled teeth and untreated decay) relative to Child's Payment Source for Dental Care					# and % with Untreated Decay (does not include questionable decay) relative to Child's Payment Source for Dental Care				
	Medicaid	***hawk-i***	**Self**	**Other**	**Insured**	**Medicaid**	***hawk-i***	**Self**	**Other**	**Insured**
Black Hawk County Health Dept.	462	55	212	77	238	144	12	54	38	54
	53.3%	**50.5%**	**42.3%**	**50.3%**	**42.2%**	**16.6%**	**11.0%**	**10.8%**	**24.8%**	**9.6%**
Lee County Health Dept.	73	11	30	1	55	48	6	19	0	32
	71.6%	**64.7%**	**61.2%**	**50.0%**	**66.3%**	**47.1%**	**35.3%**	**38.8%**	**0%**	**38.6%**
Mid-Iowa Community Action	88	18	60	69	132	3	1	8	10	5
	49.7%	**64.3%**	**37.0%**	**61.6%**	**46.8%**	**1.7%**	**3.6%**	**4.9%**	**8.9%**	**1.8%**
Mid-Sioux Opportunity	71	25	138	23	133	25	7	52	16	42
	60.7%	**59.5%**	**56.3%**	**41.8%**	**58.1%**	**21.4%**	**16.7%**	**21.2%**	**29.1%**	**18.3%**
Unity Public Health	102	10	55	6	119	42	3	32	4	61
	60.7%	**55.6%**	**50.0%**	**54.5%**	**56.7%**	**25.0%**	**16.7%**	**29.1%**	**36.4%**	**29.0%**
Upper Des Moines Opportunity	70	14	48	8	86	35	6	21	5	35
	63.6%	**58.3%**	**47.5%**	**47.1%**	**60.1%**	**31.8%**	**25.0%**	**20.8%**	**29.4%**	**24.5%**
Washington County Public Health	70	0	60	6	43	44	0	36	5	25
	63.1%	**0%**	**54.5%**	**66.7%**	**50.0%**	**39.6%**	**0%**	**32.7%**	**55.6%**	**29.1%**
STATE TOTAL	**936**	**133**	**603**	**190**	**806**	**341**	**35**	**222**	**78**	**254**
STATE %	**56.7%**	**55.9%**	**47.2%**	**52.9%**	**50.5%**	**20.7%**	**14.7%**	**17.4%**	**21.7%**	**15.9%**

Children screened that participate on free/reduced lunch program	Children receiving sealants that participate on free/reduced lunch program	Sealants placed on children that participate on free/reduced lunch program
2,600 (50.2%)	1,906 (73.4%)	9,458 (AVG 3.6)