# RHODE ISLAND'S GUIDELINES FOR IMPLEMENTING CHILD OUTREACH SCREENING

JUNE 2018

# TABLE OF CONTENTS

**Introduction to Rhode Island's Child Outreach System ..... 2**
- What is Child Outreach Screening? ..... 2
- What Are the Goals of Child Outreach? ..... 2
- Why is Child Outreach Important? ..... 2
- What are the State/District Responsibilities? ..... 3
- What is the Purpose of the Guidelines? ..... 3

**Child Outreach Screening Availability ..... 4**
- Consent for Screening ..... 4
- Location of Screenings & Requests for Screenings ..... 4
- Screening Non-Residents/Cooperation between Districts ..... 5

**The Basics of the Rhode Island Child Outreach Process ..... 5**
- Child Outreach System Components ..... 5
- Child Outreach Personnel ..... 6
- The Child Outreach Screening Process ..... 7
- Child Outreach Content Areas ..... 7

**Criteria and Process for Rescreens and Referrals ..... 9**
- Rescreens ..... 9
- Referrals ..... 10

**Building Relationships with Families ..... 10**
- Communication & Sharing Information ..... 10

**Establishing Rapport with Young Children ..... 13**
- Strategies for Developing and Maintaining Rapport ..... 13
- The Child Who is Shy or Fearful ..... 14
- The Child Who is Very Active or Has a Short Attention Span ..... 15
- The Child Who Refuses or Cries ..... 15

**Screening Dual Language Learners (DLLs) ..... 16**
- Identifying Language of Screening ..... 16
- Using Culturally and Linguistically Appropriate Tools ..... 16
- Best Practices during the Screening ..... 17
- Using an Interpreter ..... 17
- Accurately Identifying DLLs in Rhode Island ..... 17
- Rhode Island's DLL Screening Process ..... 18

**Child Outreach Targets, Goals, & Improvement Activities ..... 19**

**Data Collection, Usage, and Security—KIDSNET Data System ..... 19**
- Data Collection and Child Outreach Staff Responsibilities ..... 19
- Child Outreach KIDSNET Reports ..... 21
- KIDSNET Confidentiality and Security ..... 22

**Child Outreach Records ..... 22**

**Summary Statement ..... 23**

Appendix A: Screening Instruments and Procedures ..... 24
Appendix B: Screening Letter to Families ..... 34
Appendix C: Parent Consent Form ..... 35
Appendix D: Consent Form for Additional Physicians ..... 36
Appendix E: Family History Questionnaire ..... 37
Appendix F: Child Outreach Personnel Screening Form ..... 39
Appendix G: Out-of-District Screening Protocol ..... 42
Appendix H: Preschool Language Survey ..... 43
Appendix I: Child Outreach Screening Brochure ..... 44
Appendix J: Child Outreach Screening Poster ..... 46
Appendix K: DLL Screening Flowchart ..... 47
Appendix L: KIDSNET Confidentiality Agreement ..... 49
Appendix M: KIDSNET Confidentiality Agreement—Read-Only Access ..... 50
References ..... 51

# ACKNOWLEDGEMENTS

Rhode Island's 2009 Child Outreach Screening Guidelines were updated in 2018 through the hard work of multiple passionate and dedicated early childhood and special education professionals. A leadership team worked with two consultant partners in the development of the 2018 Rhode Island Guidelines for Implementing Child Outreach Screening while providing substantive input, historical content, and editorial support. A committed advisory group supported, advised, and reviewed the work and four national experts from the National Early Childhood Technical Assistance Center served as expert reviewers. In addition, the work was further supported by a wide range of Rhode Island stakeholders.

## LEADERSHIP TEAM

**Holly Ayotte**
*EC Assessment Specialist- Rhode Island Department of Education*

**Muriel Mueller**
*Consultant- Rhode Island Department of Education*

**Ruth E. Gallucci**
*Early Childhood Special Education Coordinator- Rhode Island Department of Education*

## ADVISORY PARTICIPANTS

**Leslie Anderson**
*Director of Pupil Personnel Services- Bristol Warren Regional School District*

**Candace Andrade**
*Director of Pupil Personnel Services- Burrillville School Department*

**Leslie Brow**
*Administrator of Student Services- Narragansett School System*

**Allison Comport**
*RI PreK Coordinator- Rhode Island Department of Education*

**Allynn Grantham**
*Director of Student Services- Newport Public Schools*

**Emily Klein**
*English Learner/Special Education Specialist- Rhode Island Department of Education*

**Sally Mitchell**
*Director of Special Education- Johnston Public Schools*

**Lisa Nugent**
*Early Learning Coordinator- Rhode Island Department of Education*

**Elizabeth Pinto**
*Special Education Coordinator- Rhode Island Department of Education*

## NATIONAL REVIEWERS

**Sharon Ringwalt**
*FPG Child Development Institute at UNC-Chapel Hill*
*ECTA Center*

**Evelyn Shaw**
*FPG Child Development Institute at UNC-Chapel Hill*
*ECTA Center*

**Megan Vinh**
*FPG Child Development Institute at UNC-Chapel Hill*
*ECTA Center*

## CONSULTANT PARTNERS

*Jeffrey Capizzano and Dr. Kelly Etter of the Policy Equity Group, LLC worked to develop and revise the guidance under the Leadership Team's direction.*

*Kristin Lehoullier of Lehoullier Consulting, Inc. served as the project manager and facilitator.*

## INTRODUCTION TO RHODE ISLAND'S CHILD OUTREACH SYSTEM

### What is Child Outreach Screening?

Child Outreach is Rhode Island's universal developmental screening system designed to screen all children ages 3 to 5 annually, prior to kindergarten entry. Developmental screenings sample developmental tasks in a wide range of areas and have been designed to determine whether a child may experience a challenge that will interfere with the acquisition of knowledge or skills. Screening results are often the first step in identifying children who may need further assessment, intervention and/or services at an early age to promote positive outcomes in kindergarten and beyond.

### What Are the Goals of Child Outreach?

Child Outreach provides significant benefits to children, their families, and the communities in which they live. The goals of the program include:

- Community Outreach: Rhode Island aims to screen 100 percent of its 3-, 4-, and 5-year-old children prior to kindergarten entry.
- Promoting Positive Outcomes: Child Outreach helps identify children at an early age who may have a disability or delay and who, therefore, require comprehensive evaluation and, if necessary, special education services.
- Providing Information to Families: Child Outreach serves as a resource to families by providing information about general child development as well as the development of the child being screened. Child Outreach also provides families with information regarding high-quality early childhood education, referrals to agencies and programs within their community, as well as opportunities for family involvement in their child's development and learning.
- Community Collaboration: Given parent consent, Child Outreach responds to requests for screening from primary care providers and early care and education programs and ensures that they are informed of the results. Child Outreach can also serve as a resource to programs in the community by providing information on child development and identifying essential community-based resources.

Results of screening are not used to label a child. They must not be used to place or deny a child's entrance into a school or program or infer a child's readiness. In addition, the screening results alone should not be used to group children for educational purposes. Child Outreach's developmental screening, which focuses on a child's ability to acquire skills, must not be confused with Early Literacy Screening or Readiness testing that has been designed to identify specific early literacy skills and academic readiness skills the child has already acquired. As stated above, Child Outreach screening is a quick assessment intended to identify children who may have a disability or developmental delay and who, therefore, require evaluation to determine eligibility for special education.

### Why is Child Outreach Important?

A tremendous amount of brain development occurs during early childhood, which establishes the foundation for future learning and development.[1] During this period, the trajectory of development is relatively flexible and is powerfully shaped by early experiences.[2] The plasticity of early brain development is particularly relevant for children who have delays or other developmental challenges. When these children are identified early, it is possible to provide high-quality intervention services that can help shift their developmental trajectories.[3] Brain architecture and neural connections consolidate as children grow older and they become more difficult to alter.[4] Thus, research suggests it is more productive and effective to intervene early in life when the developing brain is most capable of change.[5]

It is estimated that as many as one in seven children in the United States ages 2 to 8 experience developmental delays, learning difficulties, or behavioral and social-emotional problems.[6] However, fewer than half of these issues are detected before children enter kindergarten.[7] The outcomes for children with disabilities improve significantly when the disability or developmental delay is detected early and when tailored, high-quality intervention services are offered in response to a child's needs.[8] Furthermore, early identification not only effectively promotes positive outcomes for young children and their families, but also has substantial cost-benefits to our educational systems and society.[9]

It is essential to have a clear and effective process for screening all young children and identifying those who need early intervention or special education services. Maintaining a system for identifying children with disabilities is a required component of the Individuals with Disabilities Education Act (IDEA) and the Rhode Island Special Education Regulations. The Child Outreach Screening Program serves as the vehicle for meeting these requirements for children ages 3, 4, and 5 prior to kindergarten entry in Rhode Island. This document is intended to support compliance with both federal and state regulations while promoting best practice in educating families concerning typical child development, building community awareness of resources, and identifying young children in need of further assessment and, if necessary, special education services. These guidelines have been designed to align with the Division for Early Childhood Recommended Practices (see http://www.dec-sped.org/dec-recommended-practices), specifically those relative to assessment and family engagement.

### What are the State/District Responsibilities?

The responsibility of building capacity for marketing, outreach, and collaboration must be addressed at both the state and school-district levels. In order to locate and make all families aware of the importance and availability of screening services, we must broaden our efforts to include communities presenting access challenges, such as adolescent parents, culturally and linguistically diverse populations, and families with high needs such as those living in poverty. It is also important to ensure that we are finding and screening children in licensed family childcare homes and those children not yet participating in early care and education programs. As well as traditional Child Outreach outlets such as sibling searches, newspaper and media publicity, brochures (see Appendix I), and posters (see Appendix J), the state and local districts should make every effort to enlist the cooperation of and systemize collaborations with relevant state and community programs and agencies. The ongoing development of specific and systemic strategies and resources designed to build opportunities for collaboration and outreach to the community will require sustained state- and district-level commitment.

### What is the Purpose of the Guidelines?

This document has been designed for Child Outreach personnel. It outlines the procedures and protocols by which children are located, screenings are conducted, data is collected and utilized, and communication with families is facilitated. The goals of these policies and procedures are to:

- promote equity by outlining a consistent, universal process so that prior to kindergarten entry all children ages 3 to 5 and their families across Rhode Island have an equal opportunity to receive annual developmental screenings;
- ensure transparency of the screening process;
- support the implementation of high-quality screening practices; and
- ensure that children whose screening results indicate a need for further evaluation are referred to special education.

Given the vital role that screening plays in identifying and supporting children with disabilities, this document provides information and guidance on:

- the timing, availability, content, and process of screening;
- Child Outreach partners and system components;
- qualifications for Child Outreach personnel;
- best practices for assessing young children, including dual language learners;
- criteria for rescreening and referrals;
- guidelines for effectively communicating with families;
- Child Outreach targets, goals, and implementation activities; and
- procedures for data collection, usage, and security.

## CHILD OUTREACH SCREENING AVAILABILITY

### Consent for Screening

Signed parent or legal guardian consent is required prior to the initiation of Child Outreach screening. This is consistent for children in the care of the Department of Children, Youth and Families (DCYF) unless an educational advocate has been appointed by the state to make educational decisions for the child. DCYF caseworkers are available to assist Child Outreach in garnering the appropriate consent prior to screening. Parents (or legal guardians) complete a standardized Child Outreach consent form, which includes three types of consent: consent to screen, consent to share results with the child's primary care provider, and consent to share results with the child's early care and education setting (see Appendix C). In addition to Child Outreach screening consent, districts may also request consent for Medicaid reimbursement.

### Location of Screenings & Requests for Screenings

Screening is offered in a variety of locations such as early care and education settings, public schools, and libraries. All school districts provide ongoing screening throughout the school year and are encouraged to provide at least intermittent screenings during the summer. Families can schedule a screening appointment at any time during the school year by contacting their local Child Outreach office, whose contact information can be found at www.ride.ri.gov/childoutreachcontacts or by calling the Rhode Island Department of Education (RIDE) at (401) 222-4600.

Screenings may be accessed in the following ways:

#### *Direct Requests for Screenings*

Child Outreach programs provide screenings upon parental or local education agency (LEA) request after the completion of a signed parent consent form. Pediatricians, early care and education providers, or others who suspect that a child may have a disability, including a developmental delay, are also encouraged to request a Child Outreach screening. When requests come from someone other than a parent, it is best practice for that individual to communicate their concerns to the family and ensure that the family is aware of the request to screen. As always, Child Outreach must obtain parental consent.

Direct requests for screenings are addressed promptly by the Child Outreach Coordinator. When a request is made due to a concern, the coordinator will make every effort to arrange a screening within 10 school days of the communication with the family, physician, or childcare provider. The screening, however, may be delayed if Child Outreach is unable to garner parent consent. If the screening is requested but no specific concern is noted, it should take place within 30 calendar days.

Before releasing screening results, Child Outreach must ensure that the parent has consented to share the results and recommendations of the screening, including any necessary special education referral and eligibility determination, with the primary care provider and early care and education environment. All consents must be signed on the state-approved Child Outreach parent consent form (see Appendix C). In addition, a release of information must be signed by the child's parent if screening results are to be given to anyone other than the primary care physician or the early childcare center.

A listing of Child Outreach Coordinators and the associated contact information for each school district can be found at ride.ri.gov/childoutreachcontacts.

#### *Screenings in Early Care & Education Settings*

Screenings will be made available in all early care and education programs such as private preschools, center-based childcare centers, state-funded PreKs, Head Start programs, public preschool classrooms, dual language classrooms, licensed family childcare homes, and neighborhood sites that are convenient and familiar to diverse populations within the community. When the on-site facility is inadequate

for screening, appointments should be scheduled for families to participate at another site or the screening should be conducted on a smaller scale (e.g., one or two screeners). For sites that decline on-site screening, it is the responsibility of the Child Outreach Coordinator to work with the program to ensure that children have every opportunity to participate in screening at another location.

Child Outreach programs screen children in state-funded PreK and Head Start programs during the first 45 days of school as required by state/federal policy.

***Community-Wide Screenings***

Large-scale screenings at community sites (e.g., libraries, churches, recreation centers, public health centers) should be considered throughout the year.

### Screening Non-Residents/Cooperation between Districts

Districts are encouraged to work cooperatively to provide screening services at times and locations that benefit children and families. It is therefore best practice for districts to screen all children, including non-residents, when screening in early care and education programs. Screening all children, regardless of district of residence, ensures that as many children as possible have access to screening and, if applicable, the necessary services. Communication between Child Outreach Coordinators is critical to ensure that information is accurately conveyed after the screening and that any required follow-up occurs without delay.

Although LEAs are not required to screen all non-resident children who attend an early childhood program located in their district, according to the *Rhode Island Regulations Governing the Education of Children with Disabilities*, they do have an obligation to screen *all* non-resident students attending an approved elementary school. In Rhode Island, approved elementary schools are defined as any *public or private* school that contains a kindergarten.

See Appendix G for best practices for screening out-of-district-students and sharing results.

## THE BASICS OF THE RHODE ISLAND CHILD OUTREACH PROCESS

### Child Outreach System Components

The screening process consists of seven components:

- **General Program Oversight, Supervision, Training, and Collaboration:** Districts offer personnel training along with ongoing supervision of the screening staff and collaboration and communication with families, early childhood programs, community-based organizations, and RIDE.
- **Clerical:** Consistent and trained clerical staff provide the necessary support for successful implementation of the program. Clerical tasks include managing phone, email, and faxed requests; scheduling screenings; and mailings.
- **Prescreening:** Preparation is necessary to ensure that screenings are organized and efficient. Before screenings in early care and education programs, communication must take place to coordinate screening event details, child rosters, consents, and specific child information. In addition, screening packages must be created based on the number and ages of children. Care must be taken to ensure that parent consents are signed prior to the screenings.
- **Direct Child Screening Activities:** Trained Child Outreach screeners engage children in approximately 45 minutes of game-like activities and record results on screening protocols. Families are welcome to observe the screening activities.
- **Post Screening:** Screening protocols need to be scored and verified, and follow-up steps related to rescreens, referrals, notifications, data entry, and filing need to take place. Organized and efficient post-screening activities ensure accuracy of collected data and appropriate follow-up with families, early care and education programs, primary care providers, and special education.

- **Data Entry:** The Rhode Island Department of Health's KIDSNET System is the state's secure database for critical information about children's health, and includes Child Outreach screening results. In addition to KIDSNET serving as a data collection system, it allows Child Outreach to locate children throughout its district and to collaborate with districts and primary care providers. It also allows Child Outreach to run a variety of reports that assist in program evaluation.
- **Evaluation of Program:** An essential component of a high-quality screening program includes ongoing analysis of data and the creation of data-informed goals and activities designed around improvement efforts. Through KIDSNET, RIDE provides both district- and state-level screening data relevant to multiple aspects of the Child Outreach program.

## Child Outreach Personnel

Each Child Outreach program requires a designated Child Outreach Coordinator and supporting Child Outreach personnel.

### *Child Outreach Coordinator*

The Child Outreach Coordinator should be a licensed/certified special education professional such as a special education teacher, speech/language therapist, psychologist, or social worker with a background in early childhood education. The Child Outreach Coordinator oversees all Child Outreach activities including the creation, implementation, and evaluation of the district's Child Outreach program. Responsibilities include supervision and training of all personnel. To ensure reliable screening results, coordinators should have a plan to monitor inter-rater reliability of screeners. This method should consist of periodic observation of all screeners to ensure that they are implementing the screens as they were validated, that all Child Outreach guidelines are followed, and that they are interacting with young children and families appropriately.

A listing of Child Outreach Coordinators and the associated contact information for each school district can be found at www.ride.ri.gov/childoutreachcontacts.

### *Head Screener(s)*

The role of the Head Screener can be implemented in a variety of ways depending on the size of the district and additional responsibilities of the Child Outreach personnel. In smaller districts, the Child Outreach Coordinator may also serve as the Head Screener, while larger districts may require multiple Head Screeners. The Head Screener is present during screening sessions and has been trained to administer the screening instruments and to handle difficult screening situations. In addition, the Head Screener must be readily available to families during the screening process and possess the knowledge and skills necessary to discuss resources and programs in the community, general child development, and opportunities for family involvement.

It is recommended that the Head Screener oversee the prescreening and post-screening activities, ensuring that these tasks are implemented accurately and completely.

### *Screeners*

Child Outreach screeners should have knowledge, acquired through in-service preparation, of general child development and skills in working with young children. They should also receive formal and comprehensive training in the specific screening tests they are to administer.

Child Outreach programs should make every effort to have screeners available who represent the cultural and linguistic make-up of the community and are able to communicate in the primary language of the child and family.

### *Clerical/Data Entry*

As mentioned above, clerical personnel support the Child Outreach Coordinator's successful implementation of the Child Outreach program by ensuring that telephone calls, emails, and faxes are received and responded to in a timely fashion and that mailings are sent to families notifying them of the availability of screenings. A sample letter notifying families of the opportunity to have their child screened

is available in Appendix B and on the Child Outreach page of the RIDE website. In addition, clerical personnel send out screening results to families, early care and education programs, primary care providers, and special education offices as soon as possible after the screenings.

Data entry personnel enter ongoing data into the Department of Health's KIDSNET database. Responsibilities also include locating children, updating demographic information, and running reports. All users entering data into KIDSNET must complete a RIDE-approved training session and sign an annual KIDSNET confidentiality policy (see Appendices L and M).

The clerical and data entry roles can be implemented by a single person, by multiple staff members, or even by the Child Outreach Coordinator in very small districts, depending on the size of the district and the additional responsibilities of Child Outreach personnel.

### The Child Outreach Screening Process

- **Parent Consents:** Parents or guardians complete a state Child Outreach/KIDSNET consent form. The form includes three types of consent: consent to screen, consent to share results with the child's primary care provider, and consent to share results with the child's early childhood program (see Appendix C).
- **Family History Questionnaire:** Parents or guardians complete brief questionnaires about their child's health history and development as observed at home in everyday activities, as well as languages spoken in the home (see Appendix E).
- **Preschool Language Survey:** Parents or guardians answer questions relative to their child's language exposure and usage to determine the best language in which to perform the screen (see Appendix H).
- **Social–Emotional Screening Questionnaire:** Social–emotional questionnaires are the vehicle for screening social–emotional development and are completed by families. They serve as an integral component of the Child Outreach screening package.
- **Child Screening Activities:** Children engage in a variety of game-like activities, conducted over a period of approximately 45 minutes, by trained personnel from the public school system. Families are welcome to observe the screening activities.
- **Communication of Screening Results:** Screening results should be reviewed and a summary sent to the child's family within two weeks. The summary includes the areas of development that indicate age-appropriate results as well as those that may require a re-screen, referral, or follow-up. Although sharing screening results with the child's pediatrician and early care and education program is very important, no results are shared without parents' permission.

### Child Outreach Content Areas

To obtain a comprehensive picture of children's development, screening is conducted in each of the following areas (described in more detail below):

- Vision
- Hearing
- Speech and language skills
- Social–emotional development
- General development (e.g., gross and fine motor, language, cognition)

#### *Vision*

Vision plays an important role in children's physical, cognitive, and social development. Up to 1 in 20 preschool-age children have a vision disorder.[10] Uncorrected vision problems can impair child development, interfere with learning, and even lead to permanent vision loss.[11,12,13,14,15,16] Early detection and treatment are critical. Visual functioning is a strong predictor of academic performance in children,[17,18,19] and vision disorders in childhood may continue to affect health and well-being throughout the adult years.[20]

Vision screening helps to identify children, including those with learning challenges, who need further evaluation by an eye-care professional. Additionally, many vision disorders lack symptoms, and it is often difficult for a parent to know if their child has difficulty seeing. Most young children do not complain about their eyesight. Children typically believe that the way they see their world is the way everyone

sees, even if their vision is blurry or normal in just one eye. Most eye problems can be corrected if they are detected and treated early. Some eye problems, however, if left untreated for even a short period, can lead to permanent vision impairment. For these reasons, the American Academy of Ophthalmology, the American Academy of Optometry, the American Academy of Pediatrics, the American Association for Pediatric Ophthalmology and Strabismus, the American Association of Certified Orthoptists, and the National Center for Children's Vision and Eye Health at Prevent Blindness agree that vision screenings serve a useful role in identifying children in need of eye care and promoting further evaluation by an eye-care professional.

By helping families meet this recommendation for early, age-appropriate vision screening, Child Outreach programs can help to prevent learning, physical, and social development challenges that could result from undiagnosed and uncorrected vision disorders. Early detection reduces treatment needs and improves vision outcomes.

See Appendix A for a detailed description of the recommended vision screening instruments, administration procedures, and suggested follow-up. It is important to note that screening tools need to be updated as revisions become available.

### *Hearing*

During the early years, when foundational language learning is occurring, it is critical to identify any hearing loss in children. A hearing loss, even in one ear, is significant due to the adverse impact it has on communication skills, learning abilities, psychosocial development, and academic achievement. Children who are hard of hearing have much more difficulty learning vocabulary, grammar, word order, idiomatic expressions, and other aspects of verbal communication than their hearing peers.[21] However, children whose hearing loss is detected early (by six months of age) and who receive high-quality intervention services are likely to have language development that is at or near the rate of peers without hearing loss.[22]

It is estimated that 1 to 6 children per 1,000 are born with congenital hearing loss.[23] Although most of these children can potentially be identified during newborn hearing screenings, some congenital hearing loss may not be evident until later in childhood.[24] Several studies have shown that the assumption that hearing loss can be reliably detected based on children's behavior in everyday situations is faulty. Furthermore, well-child visits may not capture all children who experience hearing problems, emphasizing the need for continuous, periodic monitoring of children's hearing status through high-quality screening programs.[25]

See Appendix A for a detailed description of the recommended hearing screening instruments, administration procedures, and suggested follow-up. It is important to note that screening tools need to be updated as revisions become available.

### *Speech and Language*

The acquisition of speech and language skills is central to a child's learning and development. Language has a critical role in fostering optimal brain development. Delayed speech and language development impacts learning ability, specifically reading and writing skills.[26] Children with speech and language difficulties who are not given help are at increased risk for behavioral and emotional problems during childhood and adolescence[27] and are more likely to experience mental health, financial, and behavioral problems as adults.[28] Early exposure to a large number and variety of words has been found to have a profound impact on vocabulary development during the preschool years, which is positively correlated with reading skills and school success.[29]

It is estimated that nearly 1 in 12 children ages 3–17 in the U.S. has a disorder related to voice, speech, language, or swallowing,[30] although the rate may be much higher among children who live in poverty.[31] Child Outreach programs provide early screening, evaluation, and timely intervention for young children who have disordered or delayed speech/language skills that can have far-reaching effects on the child's success in school.

See Appendix A for a detailed description of the recommended speech and language screening instruments, administration procedures, and suggested follow-up. It is important to note that screening tools need to be updated as revisions become available.

### *Social–Emotional Development*

Research demonstrates that social–emotional skills predict academic achievement with greater consistency than IQ or parent education levels.[32] The early childhood years present a unique opportunity to lay the foundation for future social–emotional development, as this period is a time of tremendous growth but also great vulnerability. Indeed, early experiences that impede social and emotional wellness such as early life stress can affect children's brain development, learning, behavior, and lifelong health outcomes.[33]

Estimates of the prevalence of emotional and behavioral disorders range from approximately 10 to 20 percent, with an even greater number of children having social–emotional and behavioral problems that do not meet the criteria for an official disorder.[34] Current estimates suggest that up to half of emotional and behavioral problems in children go undetected and fewer than one in eight children with identified problems receives treatment.[35]

The need for prevention and intervention of social–emotional problems in young children is a serious concern for early childhood professionals. Social–emotional competence, or the lack thereof, can significantly alter the course of a child's life. Child Outreach programs can make an important contribution by offering high-quality screening in the social–emotional area for all children as the first step to early identification and appropriate intervention services.

See Appendix A for a detailed description of the recommended social-emotional instruments, administration procedures, and suggested follow-up. It is important to note that screening tools need to be updated as revisions become available.

### *General Development*

Although global developmental screening instruments are frequently considered the "core" tests, they should be viewed as an integrated aspect of a comprehensive screening program. Results can only be interpreted in the context of information obtained from other screening activities, such as screening in the vision, hearing, speech/language and social–emotional areas, as well as input gathered from families and other caregivers. Developmental screening instruments focus on a wide range of areas of child development, including language, cognition, as well as gross and fine motor skills. The screening is conducted in a one-on-one, game-like format using manipulatives, questions posed by the screener, and activities where the child moves around and responds to prompts. Although individual screening instruments differ from one another, they generally include items in the following areas:

- **Fine Motor and Visual Perceptual Motor:** items that examine fine motor planning and control, eye-hand coordination, visual memory, sequencing, perception, scanning, copying forms, drawing two-dimensional forms, and reproducing three-dimensional visual structures.
- **Language and Cognition:** items that focus on language comprehension, verbal expression, vocabulary, logical reasoning, quantitative concepts, categorization, completion of analogies, and repetition of auditory sequences.
- **Gross Motor/Body Awareness:** items that focus on balance, large motor coordination, locomotion, patterning, body awareness, and initiating body positions or movements from visual or auditory cues.

These skills together form the foundation for the acquisition of literacy and mathematics skills and future success in school.

See Appendix A for a detailed description of the recommended general developmental screening instruments, administration procedures, and suggested follow-up. It is important to note that screening tools need to be updated as revisions become available.

## CRITERIA AND PROCESS FOR RESCREENS AND REFERRALS

### Rescreens

Although the majority of children will achieve results within an age-appropriate range in all areas, approximately one-third of children screened will require additional consideration in one or more areas. Screening is designed to categorize children into two groups: those who are considered functioning within an age-appropriate range of development and those who require referral for further evaluation. There are children, however, who cannot be categorized into either of these two groups based on the initial screening process. Rescreening

involves taking a second look at the child to clarify questions raised during the initial screening process. Child Outreach programs should have systematic rescreen procedures in place. These procedures are an essential component of a well-structured Child Outreach screening system. Due to the variability in behavior of young children, if possible it is usually in the child's best interest to have the rescreening administered by a different screener. Rescreening should take place within a month of the initial screening. Considerations for rescreens include:

***Concerns with Accuracy of Screening Results***

There are times when the Child Outreach screener is concerned that the child may not have performed at a level commensurate with his or her ability. There are a variety of factors that may affect screening results, including whether the location where the screening occurred was noisy or disruptive or whether the child may have been ill, sleepy, "shy" around unfamiliar adults, uncomfortable in the new testing situation, or simply had an "off day." In these cases, a rescreen should be conducted.

***Concerns Not Demonstrated in Screening Results***

There are other factors that may contribute to the need for a child to be rescreened. There may be children, for instance, who obtain age-appropriate results on the screening, but for whom there are lingering concerns related to the quality of their performance, sub-test scores, observations regarding their social–emotional skills, and/or input fromthe family or teacher. For example, the family or teacher might indicate that a child has difficulty answering questions or engaging with peers, or that he frequently speaks off-topic or "mixes up" words. These could be characteristics of a disability or a delay that may not otherwise have been detected during a screening. These children should also be considered for a referral to special education.

### Referrals

After any necessary rescreens are complete, children who fail developmental screenings in the domains of speech/language, general development, and/or social–emotional development should be referred by Child Outreach to special education.

Children who present with obvious or significant delays or disabilities need not be screened at all and should, with parental consent, be referred directly to special education.[36] Although screenings are frequently an appropriate initial step in identifying children who may need special education, they are not a prerequisite for all referrals. Direct referrals for a special education evaluation may be made at any time by a parent or the LEA.

In addition, passing the Child Outreach screening does not preclude a child from being referred to special education. As noted above, in some cases there may be outstanding concerns that are not demonstrated in screening results.

## BUILDING RELATIONSHIPS WITH FAMILIES

Building a positive relationship with families prior to and after the screening is as important as the screening itself. For many families, Child Outreach screening is their introduction to the public school system. The climate created during screening is critical, not only to the immediate success of the Child Outreach experience but also to the establishment of a cooperative relationship where families and schools are genuine partners in a child's development and education. Child Outreach programs should be characterized by enjoyment of children, respect for families, professionalism, and a calm, organized approach to implementing all aspects of the screening process.

Child Outreach is committed to the three central themes identified by the Division for Early Childhood Recommendations that guide interactions with families: respect, participation, and collaboration. Interactions should be characterized by an individualized approach to each family's unique needs and seek to assist families by providing accurate information regarding screenings, parent educational materials, and opportunities to work together to provide the best possible experience for children and their families.

### Communication & Sharing Information

Child Outreach programs communicate with families throughout the process, even if the families are not present during the screening itself. Both families and Child Outreach staff provide sources of information needed in the screening process. The effectiveness of this ex-

change of information depends on the type of information shared, the manner in which it is exchanged, and how it is used to support the expressed needs of families and children. The ease, accuracy, responsiveness, and sensitivity with which Child Outreach staff communicate with families leaves a lasting impression.

***Information about the Screening Process***

Before screening, parents should be informed about:

- the purpose of screening,
- what areas will be screened (including an explanation of the meaning of each of the named areas and the kinds of activities involved in each area),
- who will conduct the screening,
- where and how it will take place,
- how confidentiality will be respected,
- how results will be communicated; and
- what will happen after screening.

From the beginning, families should have the name and contact information of one person they can call if they have additional questions or comments about the screening process in general or their child in particular. See Appendix I for the Child Outreach brochure that can be shared with families.

***Information Shared by Families***

Families are a primary source of information about their child's development in all areas. By completing the Family History Questionnaire (see Appendix E) and the Social–Emotional Screening instrument, they provide Child Outreach programs with invaluable information. The Family History Questionnaire provides information regarding the child's medical/health status and history, language dominance, developmental milestones, current skill development, as well as any areas of concern. The Preschool Language Survey (see Appendix H) provides critical information regarding use of languages for children exposed to more than one language.

Information obtained from families often:

- provides a perspective of the child from a natural context, over time, in a variety of settings;
- helps to qualify the brief sampling of their child's performance collected during screening;
- contributes contextual information about family culture, child-rearing practices, and their child's habits and experiential background; and
- highlights concerns about their child's development.

Child Outreach programs should respond to any concerns that are expressed about a child on any of these questionnaires, regardless of whether the concerns are confirmed during screening. By discussing areas of concern, programs can provide the guidance, support, and reassurance families may need. For example, the family may be concerned that the child writes his or her name backwards or has temper tantrums at bedtime. Child Outreach staff can provide information about specific strategies or programs through printed materials, suggested websites, or referrals to community-based organizations. Families may also express concerns about behaviors or unmet milestones that may warrant a special education referral but would otherwise have gone unnoticed.

***Information about Screening Results***

Screening results should be communicated promptly within two weeks. In general, providing verbal results immediately following screening is not recommended. Results need to be collected, calculated, reviewed in detail, and integrated prior to communicating with families. An exception to this recommendation is in the case of vision or hearing screening where a family indicates concern. In this case, it is ap-

propriate for the Child Outreach Coordinator or Head Screener to share the results verbally and make a copy of the results for the parent to bring to the primary care provider or specialist.

All parents should receive a written report outlining their child's screening results across the five domains. The screening results report will outline both the domains in which the child scored within age-appropriate expectations and those that require follow-up. Districts are responsible for attaching a letter that explains the child's specific screening results, includes the procedures relative to any necessary follow-up, and provides contact information in case families have questions.

When a child appears to be developing typically in all areas, results are reported by mail with an invitation to contact the Child Outreach Coordinator should the family have additional questions. If a child needs to be rescreened, it is also appropriate to communicate this option via mail; however, the communication should emphasize that screening yields only tentative results following a brief encounter with their child and could be affected by a variety of factors, including illness, fatigue, or just an "off day." It is extremely important that parents do not view this communication as a report card indicating that their child has "passed" or "failed."

If the final screening results in the domains of vision and hearing indicate the need for follow-up, Child Outreach not only notifies the family but, given parent consent, also notifies the child's primary care provider.

If the final screening results in the domains of speech/language, general development, and/or social–emotional development trigger the need for special education referral, the family should be contacted whenever possible by phone. During this conversation, it is important to indicate what the child is doing well in addition to communicating the aspects of screening that remain of question or concern. Families should be reminded that a screening test is not diagnostic. The purpose of screening is to indicate if further evaluation may be needed. It is important to listen carefully to what the family has to say and to work with them to determine what is best for their child. Parents should be made aware that the Child Outreach Coordinator will make a referral to special education and understand the next steps in the process.

After the referral has been made, the evaluation team holds a meeting within 10 school days to review the referral. In some districts, the Child Outreach Coordinator attends this meeting. This practice serves two essential purposes: to provide support to the family as they enter into the evaluation process and to provide clarification to the evaluation team. The Child Outreach Coordinator's role and responsibilities end either with the submission of the referral to special education or after this meeting. Either way, it is important that the Child Outreach Coordinator obtain feedback regarding the outcome of the referral and ensure that it is entered into the KIDSNET database. Such outcomes include being eligible for special education, ineligible for special education, having the team determine that the evaluation was unnecessary, parent refusal, multiple appointments not kept, or the family moving prior to the determination.

When communicating with families, either verbally or in writing, the following should be avoided:

- Any emotionally charged words such as *fail, very low scores, poor results, normal/not normal, problem,* etc.;
- Any reference to percentile scores or explanation of what numerical scores mean (e.g., scores of 17 or higher are considered within "acceptable limits");
- Any reference to possible diagnosis or reason for needed rescreen or follow-up (e.g., fluid in the middle ear, child not feeling good about himself); and
- Any reference to Child Outreach results being used for purposes other than what was intended. Child Outreach screening results should never be used to qualify or disqualify a child for a specific program.

***Information about the Importance of High-Quality Early Childhood Programs***

Early childhood programs offer many benefits to children and families, including support for children's learning and development, the provision of childcare for working families, and connections to other community resources and services. A robust body of research has demonstrated that high-quality early childhood experiences can positively affect children's cognitive, academic, and social skills, which in turn can translate into better adolescent and adult outcomes.[37] However, the quality of early childhood programs varies tremendously and evidence points to beneficial outcomes only at the highest end of the quality spectrum.[38] Child Outreach staff can support families in

identifying early childhood programs available in their area that provide a good match for the family's needs, cultural values, and linguistic preferences. Child Outreach staff can also connect families to BrightStars, Rhode Island's Tiered Quality Rating Improvement System (TQRIS) (available at www.earlyeducationmatters.org), which offers many resources to help guide parents in finding and accessing high-quality early childhood programs.

***Information about Child Development***

Child Outreach staff offer resource information about general child development and the ways in which families can enhance their child's growth and development in the years before school. Child Outreach provides families with objective information about appropriate expectations for their child's age and educational experience. Such information is frequently related to the Rhode Island Early Learning and Development Standards (RIELDS; available at http://rields.com). Specific information about *Fun Family Activities* as well as a link to the family section of the RIELDS website can be found at http://rields.com/families/fun-family-activity-cards/.

***Information about Available Resources***

High-quality Child Outreach programs have a multitude of resources on hand to share with families. Whereas some families may identify specific concerns or needs, other families are identified as possibly needing additional resources based on the screening results. In both cases, conversations should take place with the family prior to sending any information. Information about a variety of resources ranging from community recreation programs, to hand-outs regarding otitis media (ear infections), to strategies to foster development in specific domains such as fine motor skills or early literacy development should be readily available to families. If a recommendation is made for a formal program (e.g., Parents as Teachers Program), Child Outreach Coordinators frequently assist families in accessing those services. Resource information should be useful and respectful of the varying structures, cultures, resources, and needs of individual families.

## ESTABLISHING RAPPORT WITH YOUNG CHILDREN

Establishing rapport with a child prior to screening is essential. The screening experience should be, primarily, enjoyable for the child. Paying attention to the child's enjoyment will generally result in better performance during the screening procedures. For this reason, it is important that this step not be overlooked because of time constraints.

### Strategies for Developing and Maintaining Rapport

The following strategies may help screeners develop and maintain rapport with young children:

- Approach the child calmly at eye level, smile, greet the child by name, and introduce yourself.
- Put the child at ease. Screeners often are guided by their own experiences and judgment to determine the amount of time needed to spend before screening, as some children warm up slowly and some quickly. For some, a brief conversation about their day or something they are wearing may be all it takes before beginning the screening. With other children, it might be necessary to show an engaging toy unrelated to the screening and play for a while.
- Use "game names" whenever possible to introduce the screening activities. For example, say, "Now we're going to play a Looking Game," instead of saying, "Now we're going to test your vision." Other "game names" include *Listening Game, Talking Game, Moving Game, Drawing Game,* etc. The word "test" should never be used.
- Try to follow the child's lead to determine the optimal pace of item administration. The child should never feel rushed, nor lose interest and become distracted because the pace is too slow. Thorough knowledge of the screening test procedure will help to maintain the pace appropriate for each child. Be sensitive to signs that the child needs a break at any point during the screening and ensure that adequate time is provided.
- When transitioning from one type of item to another (requiring a change of materials or task), use language that will help the child sustain attention by arousing his curiosity. Appropriate transition language might be, "Let's see, what we should do next? Let's play the Building Game. We'll need_____ and_____."

- Use statements such as, "Let's look at____" rather than asking, "Do you want to look at _____now?" It is best to avoid questions that the child can respond to with a "no."
- Keep all the materials that are not immediately being used out of sight so that the child can focus on one task at a time. If the child attempts to take other stimulus materials out of the carrying case, remind him or her gently, "We can only play one game at a time," and/or, "We'll play with those things in just a few minutes."
- Show interest in the child's response to tasks as completed but try to sound relaxed and conversational. While every child differs in the amount and kind of reinforcement needed, strive to provide a level of support that will maintain interest and foster his best efforts. Refrain from telling the child if he answers an item correctly. Instead, general statements such as, "Thank you for your careful listening!", or "You worked hard on that one!" are more appropriate.
- At the end of the screening, it is appropriate to thank the child for playing the game and tell him or her, "I had fun with you today!"

### The Child Who is Shy or Fearful

It is quite natural for a child this age to be shy or anxious. Screening is a new experience, and you are an unfamiliar adult. Some children have been told beforehand that they will be given "a test," and they have no idea what to expect. Others have been told not to talk to strangers. It is important to keep in mind the following guidelines when this occurs:

Do not try to interact immediately with the child or engage the child in conversation directly. Put some materials such as crayons and paper, puzzles, blocks, etc. in front of the child and say that you have brought some things to play with. Do not ask the child *if* he or she wants to play. It might be a good idea to begin playing with the toys yourself, as children are often intrigued by seeing an adult play. If the child begins to interact with the materials, show interest in what he or she is doing. Begin to interact quietly with the child by making comments such as, "You stacked them really high," or "You're really working hard on that picture." Give the child some time to become acclimated to the situation and to you. By being attuned to the child, you will know when she is comfortable enough to move into more formal screening activities.

If a family member has accompanied the child, focus on them initially. Encourage the family member to have the child sit near them or on their lap. Spend a few minutes interacting with the adult and avoid the tendency that we all have to cajole the child into interacting with us. Instead, put out the paper, crayons, blocks, puzzles, etc. in front of the child and continue talking to the adult until the child has shown interest in the materials. Direct comments to both the child and the adult (e.g., "That puzzle sure went together fast.") and then, gradually, to only the child once she or he is more comfortable.

If screening is taking place at an early care and education center, it might be possible to have a teacher or teacher assistant accompany the child using the above strategy. For some children, the presence of a familiar adult (parent or teacher) can initially help put a child at ease. Once comfortable, the child can often independently continue the screening process. Similarly, some children are much less anxious when initially accompanied by a friend.

If the child does not interact with the materials or the screener after several minutes, tell the family member (or teacher or teacher assistant) what you would like the child to do and ask him or her to do it with the child. Be sure to remind the caregiver that you want to see if the child can do it. If the caregiver cannot get the child to complete the task, stop and explain that this often happens and that many children react in this way. Be sure to record any comments on the record form.

If a child is extremely quiet or apprehensive when entering the screening situation, it may be beneficial to introduce nonverbal activities first (e.g., gross and fine motor, pointing tasks, hearing and vision) before proceeding to activities that require verbal responses.

### The Child Who is Very Active or Has a Short Attention Span

Many young children have short attention spans or become very active in new situations. When assessing a child who is having difficulty attending, it is critical that the screener knows the implementation procedures well so her full attention can be placed on supporting the child. The following guidelines should also be helpful:

Conduct screenings in an environment with minimal distractions. Potential distractions for preschoolers include a computer, toys or materials on a shelf, or even jewelry worn by the screener. Ideally, the physical environment should be comfortable but somewhat bland. This is especially important when screening a child who is very active or has difficulty sustaining attention. Efforts should also be made to minimize auditory distractions such as conversations in a nearby room, ringing telephones, or sounds of children on the playground.

Be sure to keep all screening materials out of sight and out of reach unless they are in use.

Focus the child's attention on the task by using the child's name frequently before giving instructions or presenting items. You may want to touch the child gently on the arm and move closer to help maintain attention, but be in tune with the child's reaction, as some children may be averse to touch.

Be very aware of the amount of time you are expecting the child to wait. A child who is very active or has a short attention span may have a very difficult time waiting for the next area of screening to become available. Assigning one screener who can administer all areas of the screening to the child may be a viable option, as the time spent transitioning to new areas and establishing rapport is greatly reduced.

Ignore inappropriate behavior (e.g., any behavior that is not the desired task) and continue to direct the child's attention to the task.

Tell the child what to do and be sure to "catch" him or her beginning to try. Praise the child only when he does what is asked (e.g., by saying, "Alice, you are really listening!").

Screeners may set contingencies by telling the child that after she has finished the games, she may do something she would like to do (e.g., take a walk, get a drink of water). It is important to follow through with the planned activity if this technique is used.

It is sometimes necessary to plan multiple screening sessions if the child has a very short attention span.

### The Child Who Refuses or Cries

The child who initially does not appear shy or fearful but refuses to do what is asked of him or her or begins to cry during screening often presents a dilemma to even the most experienced screeners. Variations in mood in young children can sometimes occur rapidly and dramatically. A preschooler's demeanor may change from smiling and engaged one minute to tears or refusals the next. The pace of screening and particularly the nature of the tasks presented can be important factors. This behavior may be:

- related to the fact that the child knows he cannot do what he is being asked to do;
- because the child has "had it" with the whole process;
- because he's tired or hungry;
- because he has been away from his familiar classroom or home for too long;
- because he hears his peers on the playground; or,
- because he has to go to the bathroom and is hesitant about speaking up.

It is important that the screener is sensitive to such changes in mood and tries to intervene appropriately. The screening process needs to be one that the child remembers as being a pleasant experience. The following strategies might also prove helpful:

- If the behavior occurs in the middle of the screening procedure, go back to the point or activity where the child was successful and give him an opportunity to do some things that he has enjoyed or done well, being certain to praise his efforts (e.g., "You're really trying hard today!").
- Omit the items the child is refusing and come back to them at the end of the screening.

- Solicit help from the parent, teacher/teacher assistant, or another child. Give the child a choice about whom he wants to sit with to watch him finish the game or "show them how it is done." If the child still refuses, perhaps the parent or caregiver can help administer the items.

It is important to note any deviations from the standardized procedure (e.g., administering items out of order, having a parent help administer the items) and consider these factors in the interpretation of screening results.

## SCREENING DUAL LANGUAGE LEARNERS (DLLs)

The child population in Rhode Island is becoming increasingly diverse. Young children who continue to learn their home language while simultaneously learning English are referred to as Dual Language Learners (DLLs). Research shows that children can learn two or more languages at the same time. Supporting the development of a child's home language not only helps with the acquisition of English, but promotes multiple cognitive and social-emotional benefits that are associated with being multilingual.[39,40,41]

At the same time, there are challenges to conducting accurate assessments for children who are DLLs. A particular dilemma is how to distinguish between typical patterns of language acquisition when learning two languages as opposed to the presentation of a delay due to a disability. As many of the characteristics are the same, it is possible for children who are DLLs to be inadvertently identified as children with language-based disabilities. Screening outcomes may look similar to delays but may instead be a matter of placement along a trajectory of language acquisition milestones, in either or both of a child's languages. Furthermore, a child who is a DLL may not understand the directions to a screening task (even if he can perform the requisite skill or behavior) or he may not have experience with a specific concept, such as counting, in his primary language. Given the trajectory of language development in emergent bilingual children, referrals for special education as the result of screening outcomes must be thoughtful and attentive to nuanced details regarding children's language proficiencies in both of their languages. Although there are many challenges when screening young dual language learners, there are also several ways to increase the accuracy of the screens. These methods will be discussed in the paragraphs below.

### Identifying Language of Screening

Screening is not intended to be an assessment of a child's English language ability, but rather a snapshot of the child's development. Screening results should accurately reflect the child's skills and capabilities as assessed by the screening instrument rather than reflecting the child's linguistic difference. Thus, if a child communicates in a language other than English, Child Outreach makes every effort to screen the child and communicate with the family in their dominant language. Screening in the child's dominant language provides the most accurate picture of how the child is growing and learning. Parents should be encouraged to complete the Preschool Language Survey (see Appendix H) prior to the screening so that a bilingual screener or interpreter can be made available in the primary language. As children are often learning English at the same time, the screening is frequently performed in both languages to ensure the most accurate picture of the child's development.

### Using Culturally and Linguistically Appropriate Tools

Whenever possible, screenings should use linguistically and culturally appropriate tools that meet appropriate standards.[42] The current screening instruments used in Rhode Island have been selected with these technical standards as a point of reference and are standardized in English and Spanish. We recognize, however, that until more technically sound and developmentally, linguistically, and culturally appropriate assessments become available, Child Outreach professionals will need to continue to use their best judgment, wisdom, and practical knowledge to make decisions about screening and use of screening results with the limited means currently available to them.[43] As there are only a few instruments available for administration in Spanish, all other languages will require the use of an interpreter to interpret the English tools. These results will need to be viewed with caution and supplemented with information from other sources, such as families and teachers.

### Best Practices during the Screening

Screeners can also take measures to improve screening conditions for DLLs. Although it is best practice when conducting screening with any child, it is especially important when working with DLLs that screeners be well prepared, organized, and familiar with the screening instruments and that the screening environment is quiet with limited distractions. It is often helpful for screeners (who are bilingual) to spend time talking with the child in their dominant language before beginning the screening. Care should be taken to ensure that children understand directions for test administration. However, to ensure the validity of results, it is important to follow the standardized procedures for administration that are prescribed by the publisher. Although the screener may accept "code-switching" responses from the child (in which they answer in English or their home language), the screener should not code switch throughout a screening, again to preserve the standardization of the screening. When using a screen that allows for administration in two languages, the screener should either give a break in between or complete one language on one day and another language on a subsequent day.

### Using an Interpreter

If the usual Child Outreach screeners are not fluent in a child's primary language, a trained bilingual screener who is a native speaker of the child's home language and familiar with early childhood assessment should implement the screening process whenever possible. A listing of interpretation agencies with trained bilingual screeners is available by visiting the Child Outreach page of the RIDE website (www.ride.ri.gov/ecse).

When a bilingual screener is unavailable, the next best option is to use an interpreter when administering screening measures to a child and/or speaking with families. Because of possible conflicts of interest, it is best that the person selected be a neutral party rather than a family member, family friend, or someone the family knows. The interpreter should be thoroughly familiar with English and with the child's language (and if possible with linguistic variations or dialect). It is important that a standardized plan of action be well established prior to screening so that the screener and interpreter both understand when and how communication will occur between them. The screener should face the child when talking to him or her with the interpreter positioned at the screener's side. The screener should speak as though the child can understand him or her, listening to and looking at the child, not the interpreter. The screener should allow extra time for the screening session, as the back-and-forth translation would extend the time needed to administer the screens. Breaks should be taken as needed. It is important to note that screening results should be interpreted with caution, as the use of an interpreter and any language other than English or Spanish represents a deviation from the standardized protocol under which the test was normed and validated.

As a last resort, if a family member is used as an interpreter, it is important to discuss the role of the interpreter, as noted above, prior to the screening. If it is not possible to screen the child in their primary language with either a bilingual screener or an interpreter, a screening in English should be conducted. This will provide some baseline information to be collected about the child's present levels of performance with the second language, English.

### Accurately Identifying DLLs in Rhode Island

If there is indication that a child speaks a language other than English, which may be identified through the Family History Questionnaire (see Appendix E), the Preschool Language Survey (see Appendix H) will need to be completed by the parent or guardian. In many districts, the Preschool Language Survey is completed by all families.

The Preschool Language Survey (see Appendix H) allows the parent or guardian an opportunity to answer multiple questions relative to language exposure and usage. The first three questions are most informative and ask what language the child first learned to speak, the language the child speaks most often, and the language that is spoken to the child most often. If the response to any of these questions includes a language other than English, the child would be considered a DLL and receive a screening according to Rhode Island's DLL protocol. Children without any exposure to English need to be screened only in their home language.

## Rhode Island's DLL Screening Process

Once a child is identified as a DLL through the Preschool Language Survey (see Appendix H), the screening follows Rhode Island's DLL screening process (see Appendix K for a visual depiction of the process). This process can also be used when children fail an English screen and there is reason to suspect that the child knows another language.

***The Initial Screen:***

1) The initial screening should occur in both the child's home language and English, if the child speaks any English. The Child Outreach Coordinator should make every effort to start by screening in the child's home language. If the child does not pass the screen in the identified language, the child should be screened again in English. Screeners will need to be aware of the implementation procedures for different instruments, especially those that allow the screener to assess the child using both English and Spanish. As will be discussed in detail below, there are only a few instruments available for administration in Spanish, with all other languages requiring the use of interpreters using English tools.

   There are times when it might make sense to complete the screening in English first.

***Children without any exposure to English only need to be screened in their home language.***

2) When the results of the screening indicate a *pass* in either language, no further screening will be needed, and the child's results will be processed according to the standard procedure.
3) When the results of the initial screening indicate a *rescreen* or *referral*, all options must be thoughtfully considered. There are times when the Child Outreach screener is concerned that the child may not have performed at a level commensurate with his or her ability due to reasons beyond those explicitly related to DLLs. These would be conditions that would affect any child, such as an overly loud or disruptive screening site, illness, sleepiness, shyness, or discomfort in the new testing situation. In these cases, a ***typical rescreen*** could be conducted within a month of the initial screening. This type of rescreen is not indicated for most DLLs, as it does not allow for a long enough opportunity for growth and should be used with caution.
4) Many times, however, when a DLL's results from the initial screen indicate a *rescreen* or *referral*, the child should receive a ***secondary DLL rescreen***. Secondary DLL rescreens take place no more than eight weeks after the initial screen, allowing the child an opportunity for growth. The Child Outreach Coordinator may use the eight weeks to consult with the English Language Coordinator, a representative from early childhood special education, the family, and/or the early childhood program regarding how best to support the child's growth and development.
5) There are also times when the results of the initial screen indicate a *fail* or a *rescreen* that the child should be considered for an ***immediate referral*** to special education. Child Outreach Coordinators should consider direct referrals when the child demonstrates an apparent lack of skill or behavior that indicates a suspicion of a disability or the parent or teacher is sufficiently concerned.

***The Secondary DLL Screen:***

6) For many DLLs, the secondary rescreen is necessary and, as stated above, occurs no longer than eight weeks after the initial screen. This screening should be a repeat of the initial screening as outlined in number one above.
7) As indicated in number two above, if the results of the secondary DLL screening demonstrate a pass in either language, no further screening is needed, and the child's results are processed according to the standard procedure.
8) When the results of the secondary DLL screen continue to indicate a rescreen or referral, due to the non-standardized administration of the instrument, the Child Outreach Coordinator will have to reflect on all of the available information, including but not limited to the following:
   a. Were the instruments normed appropriately based on the child's culture and language?
   b. Were the components of language assessed compatible with the child's primary language? For instance, does the screen assess use of pronouns when pronouns do not exist in the child's primary language?

c. What is the extent of the child's exposure to the primary and secondary culture/language?

d. Is the family/teacher reporting that the child is progressing similarly to peers or other family members?

e. How much progress is the family/teacher reporting since the initial screening? If the child is in school, is there formative assessment data available that shows growth?

It is important to remember that the Child Outreach screening process is not intended to identify children with disabilities but rather to identify those that require further evaluation to make that determination. Child Outreach Coordinators should carefully consider all available information before making the important decision to pass or refer each child.

## CHILD OUTREACH TARGETS, GOALS, & IMPROVEMENT ACTIVITIES

Although the overarching goal of Child Outreach is to screen every 3-, 4-, and 5-year-old each year prior to kindergarten, the state sets annual targets relative to the percentages of children to be screened. If state targets are not met, Child Outreach Coordinators must provide a description of their district's Child Outreach system and create an improvement plan. Components of this description include personnel and roles, screening schedules, availability, sites, training procedures, and referral procedures. Components of the plan include district screening targets, goals, and strategies for improvement for the upcoming year. In addition, if districts do not demonstrate growth in achieving targets for two years in a row, they are assisted by RIDE Child Outreach technical assistance providers.

## DATA COLLECTION, USAGE, AND SECURITY—KIDSNET DATA SYSTEM

### Data Collection and Child Outreach Staff Responsibilities

In August 2013, in collaboration with the Rhode Island Department of Health, RIDE developed a new Child Outreach data collection system. This secure data system resides within KIDSNET, Rhode Island's confidential, computerized child health information system.

Integration into KIDSNET allows school districts to accurately locate, screen, and monitor Rhode Island's young children, resulting in the ability to effectively and efficiently provide the necessary supports and interventions. It provides the state centralized access to consistent data from all districts to summarize for the purposes of state and federal reporting. Finally, as part of Child Outreach's continuous quality improvement efforts, it also allows for in-depth data analysis that informs policy decisions at the district and state level.

The Child Outreach data collection system within KIDSNET provides:

- a web-based user experience for Child Outreach programs to identify and locate children who are eligible to be screened;
- secure access to view and/or enter child-level Child Outreach screening results;
- the ability to monitor screenings and re-screenings;
- a vehicle through which Child Outreach can share data with primary care providers, early care and education programs, and/or other school districts (if the child moves);
- a summary view of screening results that also includes identification of special education referrals and referral outcomes;
- a variety of reports designed for in-depth data analysis; and
- a "forms and resources" section for users to quickly locate the necessary documents and resources needed for screening.

Child Outreach Coordinators and identified data entry personnel are the primary users of the system. Their responsibilities relative to KIDSNET include:

***Locating Children***

- completing child searches within the statewide KIDSNET child database;
- adding new children if a child is not currently in KIDSNET;
- verifying and updating child addresses (including mailing address) and phone numbers listed in KIDSNET;

- identifying families whose residence address and/or mailing address are no longer accurate, including identifying when a child has moved out of state; and
- generating mailing labels for Child Outreach letters for children residing in district according to the KIDSNET database.

***Data Entry***

- ensuring complete and accurate screening packets prior to data entry;
- ensuring signed parent consent forms before entering any data; and
- entering and submitting Child Outreach results and recommendations as indicated in the screening packet.

In addition, Child Outreach Coordinators are responsible for:

***User Management***

- ensuring every KIDSNET user has been trained according to the guidelines set by RIDE and the Department of Health;
- disseminating updated Child Outreach/KIDSNET requirements and information to all Child Outreach personnel;
- maintaining annual signed KIDSNET confidentiality agreements from all users (see Appendix L); and
- adding/removing users, creating profiles, and changing passwords.

***Running Reports***

- running reports to be used as part of a process of continuous quality improvement.

***Child Outreach Child Demographic Information***

The demographic pages require entering data from relevant Child Outreach forms such as the Child Outreach Personnel Screening Form (Appendix F), Family History Questionnaire (Appendix E), Child Outreach Parent Consent Form (Appendix C), and Preschool Language Survey (Appendix H). The information in the forms includes, but is not limited to, parent consents to screen, share with the primary care provider, and share with the early childhood program; screening location; district administering screen; enrollment in an early childhood program; screening requested by and date of request; and home language. All demographic information entered into KIDSNET must be provided prior to data entry of screening results.

***Screening Data***

All information from Child Outreach screenings, rescreens, and DLL secondary screenings in each of the five Child Outreach domains must be entered. Information inputted in this section includes screening date, screening language, screening type, screener name, interpreter name (if applicable), reason a screening was unnecessary, and the results from each of the screenings. All screening information entered into KIDSNET must be provided prior to data entry of screening outcomes.

***Screening Outcomes***

Once all screens, rescreens, and DLL secondary screens have been completed, the outcomes page is reviewed. Most of the final screening results entered on the five domain pages will automatically populate on the outcomes page. The final screening results include: *pass, referral to special education, referral to primary care provider, referral to community agency, communication of concern to Individualized Education Program team* (if the child is currently receiving special education services), *screening unnecessary* with the reason, and *screening necessary but incomplete* with the reason.

This data is reviewed for accuracy and any missing, inaccurate, or incomplete information is entered.

Prior to submitting the child's screening data package, the outcomes should be reviewed for accuracy. If a user requires a change in data after submission, a request must be sent to RIDE, along with a brief description of the reason for the request.

Parents are always notified of their child's screening results through a KIDSNET-generated screening results report. However, districts are responsible for attaching a letter that explains the child's screening results and includes the procedures for any necessary follow-up and the contact information in case of questions.

***Special Education Referral Follow-up (SERF)***

Once Child Outreach makes a referral to special education, Child Outreach must obtain the Special Education Referral Follow-Up (SERF) results when they become available. SERF results include the date of the eligibility meeting and the eligibility result. Eligibility results include: *multiple appointments not kept, parent refusal, evaluation team determined evaluation was unnecessary—no suspicion of disability, child eligible for special education services, child ineligible for special education services,* or *child moved prior to the eligibility meeting.* This information closes the loop in the process of locating, screening, and referring children and ensures that children are receiving the services that they require.

***Out-of-District Screening Results***

When a Child Outreach program screens a child who resides in a different district, there are specific protocols around screening, data entry, and sharing of results. For example, for children who pass the screening, the screening district will enter and submit the complete package into KIDSNET and send out a results letter to the family. When children do not pass, the screening district will contact the district of residence to determine next steps. For complete information about these protocols, please see the Child Outreach–Out-of-District Screening Protocol document in Appendix G.

## Child Outreach KIDSNET Reports

Child Outreach programs can access a number of reports that are built into the KIDSNET Child Outreach system. These reports enable both the districts and the state to identify strengths and needs relevant to program improvement and to interpret, report, and communicate the Child Outreach data publicly. Ongoing data analysis and the implementation of data-driven decisions are part of the system of continuous quality improvement within Child Outreach.

The district data reports include:

- **Parent Report:** A Parent Report is generated and printed to inform families about the results of their child's screening within each of the five domains. The Parent Report identifies areas of age-expected performance and those that require follow-up. Districts are responsible for attaching a letter that explains the child's screening results in detail, includes the procedures for any necessary follow-up, and provides contact information in case of questions.
- **Early Childhood Environments Report:** An Early Childhood Environments Report provides early care and education programs/providers with screening results for all students for whom parents have provided consent for release.
- **State-Funded PreK Report:** A comprehensive early childhood environments report is provided to state-funded PreK programs and includes screening results and recommendations, and any necessary special education referral and eligibility determination for all students for whom parents have provided consent for release.
- **Primary Care Provider Report:** A Primary Care Provider Report contains results for all children in their practice for whom parents have indicated permission on the consent form.
- **Needs Screening Report:** The Needs Screening Report provides all demographic information on children who have not yet been screened as of the date that the report was generated. This enables districts to use demographic information to contact families to schedule screenings.
- **Demographics Report:** The Demographics Report contains comprehensive information on children who have already been screened, including the dates of screening, parental consent details, and who requested the screening.
- **Outcome Report—All Domains Combined:** The Outcome Report—All Domains Combined displays the specific screening results in each domain for every child, including whether screening was unnecessary or necessary but incomplete.

- **Referral Report:** The Referral Report collects the information on children who have been screened by Child Outreach and referred to Early Childhood Special Education. It allows districts and the state to not only look at the number and percentage of children screened who were referred to special education, but also the number and percentage of children who were determined by the evaluation team not to need evaluations, children whose parents refused the referral, and those who were ultimately determined eligible or ineligible.
- **Moved In/Moved Out of District Report:** The Moved In/Moved Out of District Report contains the information on children who have moved in or out of the district of residence along with contact information and status of the screening.

At the state level, there are additional reports that include the Child Outreach Performance Report, Screening Rates and Referral Rates Reports, and Reports on Archived Screening Data. Analysis of the Child Outreach data provides both the LEAs and the state opportunities to organize, evaluate, and interpret Child Outreach screening information to implement a system of continuous quality improvement that ensures that all children receive the supports they need to be successful in kindergarten and beyond.

### KIDSNET Confidentiality and Security

All Child Outreach users entering data into KIDSNET must have completed a RIDE-sponsored training before receiving a login and password and entering KIDSNET. In addition, each user must annually sign a KIDSNET confidentiality agreement (see Appendix L), which is kept on file by the Child Outreach Coordinator.

By entering KIDSNET, users agree that they are utilizing a personal user ID and password that has been issued to themby the Department of Health or an authorized KIDSNET administrator and agree not to share their user ID and password with others. They further agree to access only information on children screened or needing screening and agree to comply with all relevant state and federal laws pertaining to confidentiality, and the KIDSNET User Agreement.

A "read-only" KIDSNET confidentiality form (see Appendix M) is available for district administrators who would like to access KIDSNET to view reports for purposes of data analysis and continuous quality improvement.

## CHILD OUTREACH RECORDS

Information collected through the Child Outreach process must be held in strictest confidence. Screening packets, which include a signed parent consent form (Appendix C); a completed Preschool Language Survey (Appendix H); and scored test protocols in the areas of vision, hearing, speech/language, general development, and social/emotional skills, are stored in locked files at a central site.

Child Outreach results can be shared with personnel in the public school district in which the child resides. The Child Outreach screening results can be part of the child's cumulative folder and can travel from teacher to teacher. The entire screening packet, however, should remain in the central site under the responsibility of the Child Outreach Coordinator. The Rhode Island public school records retention schedule requires Child Outreach records to be kept until the child is in third grade or until information becomes obsolete due to new testing (e.g., if the child is evaluated for special education services). At this time, Child Outreach records must be disposed of according to district protocol for disposing of confidential records.

Families are encouraged to provide consent to share Child Outreach results with their child's early care and education program and primary care provider (see Appendix C). If the consent has been obtained to share with the early care and education program, Child Outreach Coordinators are required to forward results. Likewise, coordinators must also forward all screening results to the child's pediatrician if the child failed vision or hearing screens or if the pediatrician requested the screen. Given parent consent, primary care providers can also directly view screening results in KIDSNET.

Parents are also encouraged to share Child Outreach results with other doctors or specialists, besides the primary care provider, whom the child may be seeing, such as neurologists or developmental psychologists. These doctors can view results in KIDSNET given parent consent on the appropriate form (see Appendix D).

## SUMMARY STATEMENT

The Rhode Island Child Outreach Screening Procedures and Protocols underscore the importance of the implementation of best practice in providing high-quality screening programs for children ages 3 through 5 prior to kindergarten entry. Child Outreach screening not only meets federal and state mandates, but also provides significant benefits to children, their families, and to the communities in which they live. Screening provides the first step in identifying children who may require special education services. It is well documented that early identification and intervention result in improved child outcomes as well as reductions in the amount of time special education services are required and the need for costlier remedial services. A high-quality screening program includes qualified staff who are well trained in administering screens to a diverse population of children; are responsive to the needs of each child and family; and communicate with families in a thoughtful, sensitive manner. High-quality screening programs also use data to efficiently and effectively locate, screen, and monitor young children as well as inform policy decisions and quality improvement efforts. The goal of RIDE is the realization of comprehensive screening programs that reach all young children. Toward this goal, RIDE has developed these guidelines and will monitor and support their implementation through annual reporting and technical assistance.

# APPENDIX A

# SCREENING INSTRUMENTS AND PROCEDURES

## VISION SCREENING INSTRUMENTS

**EyE Check Screener with LEA SYMBOLS®**

**Good-Lite Company**

1155 Jansen Farm Dr., Elgin, IL 60123

Phone: 800-362-3860 http://orders@good-lite.com Fax: 888-362-2576

**Screening Tool:**

EyE Check Screener is an optotype-based screening test that uses LEA Symbols to screen visual acuity using evidence-based screening principles.

**Authors:** Wendy Marsh-Tootle, OD, Bruce Moore, OD, Kira Baldonado, BS, P. Kay Nottingham Chaplin, EdD

**Description of the Tool:** The EyE Check Screener is available in two versions: one for children ages 3 and one for children ages 4 and 5. They are sold as a package or can be purchased separately. Each card contains a single LEA Symbol octotype surrounded with 50%-spaced crowding bars in a flip book that contains offset pages for easy flipping. The attached measuring cord ensures that the 5-foot screening distance between the flipbook and the child's eyes is accurate and maintained. In addition to the booklet, the kits include occluders, instructions, recording forms, a response key, and training cards. It is available in English and Spanish.

**What does it screen?** Visual acuity

**What is the age range?** Ages 3-5

**Format for Administration:** Individually administered

**Who can administer?** Designed for use by trained lay screeners, nurses, or others who screen children in educational, community, or public health care settings

**How long does it take to complete?** 5 to 10 minutes

**Validity and reliablity:**

In the Vision in Preschoolers Study (VIP)11-12, nurses and lay screeners detected more children with strabismus and amblyopia using the VIP Study 5-foot test of visual acuity with single, surrounded LEA Symbols optotypes than they did with a test showing a line of optotypes surrounded by a rectangular box at a 10-foot screening distance. Lay screeners in the VIP Study11-12 found 79% of children with strabismus and 87% of children with amblyopia with the VIP 5-foot test.

**Procedure:**

- Identify the correct flipbook to use according to the child's age: 20/50 for 3-year-old children and 20/40 for 4- or 5-year-old children.
- Begin by familiarizing the child with the screening task. Hold the flipbook close to the child with the child's eyes uncovered and ask the child to name the symbols (pictures) on cards 1 through 4.
- Accept whatever name the child calls each symbol.
- Occlude child's left eye, ensuring that the child does not peek.
- Measure a 5-foot (1.5 meter) screening distance between the flipbook and the child's eyes using the attached cord.
- At 5 feet (1.5 meters), present the flipbook at the child's eye level with adequate non-glare lighting.
- Beginning with flipbook card 5, ask the child to identify (by verbally naming or matching on the provided lap card) each symbol on flipbook cards 5 through 8.

- Occlude the right eye.
- Repeat screening and recording steps for the left eye, using flipbook cards 9 through 12.
- Record results on recording form.

**Follow-up:**

The criteria recommended by the National Center for Children's Vision and Eye Health at Prevent Blindness (NCCVEH) and the American Academy of Pediatrics for adequate screening results are that a child at age 3 will correctly identify three or four of the required symbols at the critical 20/50 line with each eye. For children ages 4 and 5, the three or four symbols at the critical 20/40 line are correctly identified with each eye. If the child cannot identify at least three symbols with each eye, the authors recommend rescreening on the same day, or as soon as possible. The child's physician is to be notified if the child fails the eye screening. In addition to notifying the child's doctor, a referral to an eye care provider is recommended if the child fails the rescreen, or if a rescreeen is not conducted and the child failed the initial screening. In either case, referral is recommended.

Child Outreach vision screening is recommended for all children each year. However, if a child is found to be unable to complete the screening (or rescreening), they should be referred for an eye exam and the child's doctor should be notified of these results. The NCCVEH recommends that some children with particular medical conditions or concerns should be referred for a comprehensive eye exam as a follow up to screening, *even if they obtained adequate results on the day of the screening*. This would include children with observable ocular abnormalities (ptosis or strabismus), neuro-developmental disorders, systemic conditions with ocular abnormalities, a history of prematurity (< 32 weeks), a family history of ocular abnormalities, or those whose parents express concerns about vision.

**Who has recommended this instrument and why?** Meets preferred practice recommendations from the National Expert Panel to the NCCVEH.

# APPENDIX A

## HEARING SCREENING INSTRUMENTS

**Otoacoustic Emissions Device** is an instrument that directly measures the outer hair cell and cochlear function of the ear in response to acoustic stimulation. It is available from multiple distributors and manufacturers.

**Purpose of the Screening Tool:** The Otoacoustic Emissions Device gives an indirect estimate of peripheral hearing sensitivity. This is useful in the diagnosis of hearing loss, middle ear problems, otitis media, and eustachian tube dysfunction.

**Description of the Tool:** The OAE Device does not technically test an individual's hearing; rather, the results reflect the performance of the inner ear mechanics. The device measures the sounds (otoacoustic emissions) given off by the inner ear when the cochlea is stimulated by sound. The vibration produces a nearly inaudible sound that echoes back into the middle ear. The sound is measured with a small probe that has been inserted in the ear canal.

**What does it screen?** The Otoacoustic Emissions Device provides an objective physiological measure that provides information on the functioning of the pathway from the outer to inner ear.

**What is the age range?** All ages

**Format for Administration:** Individually administered

**Who can administer?** Training is needed on probe selection, probe insertion, child management, and recording the outcome. The American Speech-Language-Hearing Association (ASHA) recommends that all screeners receive thorough initial training and refresher training as needed to maintain screening skills and knowledge. It may be beneficial for the results of new screeners to be validated by experienced screeners until novices become more comfortable with the equipment and screening process.

**How long does it take to complete?** In most cases, less than 5 minutes

**Validity and reliability:**

The Otoacoustic Emissions Device must be professionally calibrated on an annual basis to insure its continued validity and reliability. It should not be subjected to extreme variations in temperature.

**Procedure:**

- Perform a visual inspection of the external ear and note any observations.
- The device calibrates prior to each test and will indicate if the environment is too noisy, batteries are low, etc.
- It does require that the child and testing environment are relatively quiet.
- It is sometimes helpful to have the child sit on the parent's lap and/or help the screener perform the procedure on a stuffed animal to show how the screening works.
- It is beneficial to acclimate the child by allowing the child to touch the probe and then touching him or her playfully with the probe. If the screener can touch the ear without problems, the child will typically accept the probe being inserted.
- Young children are told beforehand that "It's like having your temperature taken. I'm just going to put this little tip in your ear. It won't hurt. You will hear a little music."
- Tips come in various sizes and can be purchased in bulk.
- The screener selects "left" or "right" ear. Once a seal is obtained, the device automatically records the results. Screening is then conducted in the other ear.
- Results are recorded in the child's file.

# APPENDIX A

**Universal Precautions:**

It is important to ensure that adherence to universal precautions and appropriate infection control procedures are in place during screenings. Probes and instrumentation that come into physical contact with the patient must be cleaned and disinfected after each use (and per manufacturer's instructions), and clinician hand washing between patients should be routine.

**Follow-up:**

A PASS/REFER criteria is calculated automatically by the instrument. PASS suggests normal cochlear function or sensitivity for that frequency range. REFER means that the OAEs did not pass the required number of frequencies. For children who cannot complete screening due to lack of cooperation, internal or external noise, or other reasons, the findings are recorded as "could not screen." For children who cannot be screened, a referral for further assessment utilizing play audiometry is recommended. This assessment is administered by a screener trained in conditioned play audiometry techniques. The Rhode Island Department of Health recommends that the "parent of a student who does not meet the 'passing' criteria of the hearing screening shall be notified and recommended to obtain a comprehensive audiological evaluation and/or medical follow-up with the child's primary care doctor."

Children given a "refer" result should be rescreened within a month. This period of time allows for any mild middle ear involvement due to a cold or congestion to resolve. All those who fail the rescreening, however, should be referred to an ENT or to the family's pediatrician or primary health care provider. According to ASHA guidelines, a rescreen is acceptable on the same day of the screening. If there is a high likelihood that the child may not return for a rescreen or the rescreen may not take place within one month, this may be the preferable course of action. If a family expresses concern about their child's ability to hear or if there is a history of middle ear complications and/or signs of hearing problems, rescreening may be bypassed and a direct referral for a more diagnostic medical evaluation may be made. Parent referrals for hearing assessments should be accompanied by a copy of the hearing screening results whenever possible. Physicians should be alerted to the recommendation for further assessment.

Some school districts choose to use a shorter 2- to 4-week timeline, which has the benefit of earlier assessment and management of those children with undiagnosed permanent hearing loss. A drawback of a shorter timeline is possible over-referral of children who may have a middle ear effusion that is in the process of resolution. Otitis media is among the most common health care concerns prompting childhood visits to a doctor.

**Who has recommended the instrument?** The Rhode Island Department of Health recommends that "Screening shall consist of an initial Otoacoustic Emission hearing test."

# APPENDIX A

## SOCIAL & EMOTIONAL SCREENING INSTRUMENTS

**ASQ:SE-2 — Ages and Stages Questionnaires: Social/Emotional**

Second Edition (2015)

Paul H. Brookes Publishing Co., P.O. Box 10624, Baltimore, MD 21285

Phone: 800-638-3775 www.agesandstages.com Fax: 410-337-8539

**Screening Tool:**

The ASQ:SE questionnaire is used to quickly recognize young children at risk for social or emotional difficulties and who may need further assessment and/or intervention. It can be used as a one-time screening or used repeatedly to monitor children's social/emotional development.

**Authors:** Jane Squires, Ph.D., Diane Bricker, Ph.D., and Elizabeth Twombly, M.S., with assistance from Robert Hoselton, Kimberly Murphy, Jill Dolata, M.A., CCC-SLP, Suzanne Yockelson, Ph.D., Maura Schoen Davis, Ph.D., and Younghee Kim, Ph.D.

**Description of the Tool:**

Ages & Stages Questionnaires®: Social-Emotional, Second Edition (ASQ:SE-2™) is a highly reliable tool with a deep, exclusive focus on children's social and emotional development. Behaviors of concern can be targeted for further assessment or ongoing monitoring. It utilizes parent-completed questionnaires that reliably identify young children at risk for social or emotional difficulties. It includes Learning Activity Tip Sheets, which provide families with simple developmentally appropriate activities organized by age. In addition, a one-page summary is provided for parents that briefly highlights what to expect in terms of their child's social-emotional development. The user's manual includes guidance on cultural sensitivity. It is available in English and Spanish.

**What does it screen?**

Self-regulation, compliance, communication, adaptive behaviors, autonomy, affect, and interaction with people. The ASQ:SE-2 contains items that target "red flags" for autism spectrum disorder.

**What age range does it cover?**

1–72 months

**Format for Administration:** Parent Questionnaire. There are nine age-appropriate questionnaires for use at 2, 6, 12, 18, 24, 30, 36, 48, and 60 months of age.

**Who can administer?** Professionals, paraprofessionals, and program staff with training

**How long does it take to complete?**

Each questionnaire takes 10–15 minutes for parents to complete and 2–3 minutes for professionals to score.

**Validity and reliability:**

Validity, reliability, and utility studies were conducted on ASQ:SE-2 between 2009 and 2011 to accurately determine the psychometric properties of the screening instrument. Normative studies included 14,074 children, ages 1 month up to 72 months, mirroring the U.S. population in terms of race/ethnicity and socio-economic groups. The results support the ability of ASQ:SE-2 to discriminate between children with social-emotional delays and those who appear to be developing typically in social-emotional areas.

- Test-retest reliability, measured as the agreement between two ASQ:SE-2 questionnaires completed by parents at 1- to 3-week intervals, was 89%. These results suggest that ASQ:SE-2 scores were stable across time intervals. Internal consistency was reported as 84%.

- Concurrent validity, as reported in percentage agreement between ASQ:SE-2 and concurrent measures, resulted in overall agreement of 84%.
- Sensitivity, or the ability of the screening tool to identify those children with social-emotional disabilities, was reported to be 81% overall.
- Specificity, or the ability of the screening tool to correctly identify those children without social-emotional delays, ranged from 76% at 18 months to 98% at 60 months, with 83% overall.

**Procedure:**

This instrument is designed to be independently completed by the child's parent or caregiver. Caregivers and teachers should spend a minimum of 15 hours per week with the child if completing the questionnaire. Parents or caregivers are asked to choose the response that reflects what they know about their child: "often or always," "sometimes," or "rarely or never." Further, they are asked to indicate any behaviors that are of concern to them. If parents cannot read English or Spanish at a fourth-grade reading level, then parents will require assistance to complete the questionnaire.

**Follow-up:**

A professional completes the scoring and provides interpretation. While comments made by the family or caregiver are not factored into the score, referrals may be made on the basis of comments alone, even if the child scores in a typical range. Reproducible scoring sheets include referral considerations that help determine if the child needs further evaluation. Cut-off scores are provided and a monitor zone clearly identifies children close to the cutoff. The information summary sheet guides the recording and interpretation by providing checklists of factors to consider when making referral decisions and follow-up actions. If the child's score is above the empirically derived cut-off point, the child should be referred for further assessment. If the score falls in the area labeled monitor, the summary sheet provides suggestions for follow-up and rescreening. If the child's score falls below the cutoff score, the child's teacher and/or other adults close to the child should be asked to fill out an ASQ:SE to provide additional rescreen information with the parent's consent. ASQ:SE-2 includes family engagement materials for parents and activities to promote family involvement for each age group.

Special considerations for girls in the monitor zone: It is noted that the validity sample did not include enough girls with social/emotional problems, therefore, the authors recommend that programs carefully review with parents/caregivers the results of girls with scores in the monitoring zone. Girls may need to be considered for referral for further assessment and/or community services when their scores are near or above the screening cutoff points.

# APPENDIX A

## GENERAL DEVELOPMENT SCREENING INSTRUMENTS & PROCEDURES

**Early Screening Inventory Revised, 2008 Edition (ESI-R)**

Pearson Education, Inc.

Pearson Inbound Sales and Customer Support

P.O. Box 599700, San Antonio, TX 78259

Phone: 800-627-7271 www.pearsonclinical.com Fax: 800-232-1223

**Screening Tool:**

The ESI-R is a brief developmental screening instrument that samples performance in the areas of speech, language and cognition, perception and motor coordination. It is designed to identify children who may need further evaluation or services in order to perform successfully in school. It is available in English and Spanish.

**Authors:** Samuel J. Meisels, EdD, Dorothea B. Marsden, MEd, Martha Stone Wiske, EdD, and Laura W. Henderson, EdD

**Description of the Tool:**

The ESI-R is built on a well-articulated model of child development in the visual-motor/adaptive, language and cognition, and gross motor areas, with the item types clearly linked to these developmental areas. It is designed to survey a child's ability to acquire skills utilizing developmental tasks. The ESI-R is very easy to administer, and contains detailed directions for administering and scoring included in the examiner's manual. The ESI-R represents one of the most accurate and stable preschool screening instruments available today. It is a norm-referenced measure that provides criterion scores for each age group. Separate color-coded recording forms for each age group are provided with the kit. Additional forms can be purchased each year to meet the needs of the district.

**What does it screen?**

The instrument consists of performance-based items that assess the child's capabilities in the areas of visual motor/adaptive, gross motor skills, language and cognition.

**What age range does it cover?** ESI-P (preschool for ages 3:0 through 4:5) and ESI-K (kindergarten for ages 4:6 through 5:11)

**Format for Administration:** Individual administration

**Who can administer?** The tool can administered by those with a degree or professional certification that included training in early childhood assessment and development. It can be administered by supervised paraprofessionals who have attended training, studied the manual, observed an experienced examiner giving the screening, and/or observed the training video (offered online as a webinar) and received supervised practice.

**How long does it take to administer?**

15–20 minutes per child

**Validity and reliability:**

The ESI-R was initially standardized on a total of 6,031 children. The results were corroborated with a standardization sample of 1,200 cases that was carefully matched to 2006 U.S. Census data. The findings for local reliability, inter-rater reliability, and test-retest reliability show that scores on both forms of the ESI-R are accurate, stable, and consistent. Both ESI-P and ESI-K have sensitivity at or above .92 and specificity of .80. Nine of 10 children who were at risk were correctly identified. Conversely, 4 out of 5 who were not at risk were correctly identified as not needing further evaluation. Thus, the majority of children who are screened with the ESI-R are correctly identified.

# APPENDIX A

**ESI-K**

- Reliability: Interobserver = .97 (based on 586 tester-observer pairs)

  Test —retest = .87 (7–10 days apart; two different screeners)

- Validity: Concurrent = N/A

  Predictive = .73

- Sensitivity = .93
- Specificity = .80

**ESI-P**

- Reliability: Interobserver = .99 (based on 35 tester-observer pairs)

  Test —retest = .98 (7–10 days apart; two different screeners)

- Validity: Concurrent = N/A

  Predictive = .73 (4–6 months later with McCarthy Scales of Children's Abilities)

- Sensitivity = .92
- Specificity = .80

**Procedure:**

The visual-motor adaptive section uses block building, drawing tasks, and a visual memory game to assess fine motor skills, eye-hand coordination, the ability to reproduce two- and three- dimensional forms and structures, and short-term memory skills. The language and cognition section focuses on language comprehension, verbal expression, the ability to reason and count and to remember and repeat auditory sequences. The gross motor section evaluates the child's ability to balance, hop, and skip; gross motor coordination; and the ability to imitate body positions from visual cues. Screeners are to complete a checklist regarding the child's speech articulation as well as make comments regarding any concerns with speech/language and provide overall impressions of the screening experience.

**Follow-up:**

Screening recommendations are based on the total score across these three areas. Three classifications are provided: OK, Rescreen, and Refer.

OK: Score is in the acceptable range for the child's chronological age. Children who score in this range are presumed to be developing normally and are not in need of further assessment.

Rescreen: Score is marginal and a rescreen is indicated. The following factors should be considered when interpreting the score: Were most points lost in one section or domain? Do the points lost across sections fall into any pattern? Did the child just move from one age group to another? Does the information, including from parent and teacher, suggest a consistent interpretation and recommendation?

The indicated rescreen should be scheduled to occur within a month of the initial screening.

Children who score in the Rescreen range, both on the initial and second screening, "may also benefit from specialized or individualized classroom instruction, but their problems should not be considered as potentially serious as those on the Refer range" (Examiner's Manual, p. 3). In this case, Child Outreach should arrange to monitor and follow up in 8-10 weeks.

Refer: Score is below the acceptable range and student should be referred to the assessment team for further evaluation.

# APPENDIX A

## SPEECH LANGUAGE SCREENING INSTRUMENTS & PROCEDURES

**Preschool Language Scales-5 Screening Test (PLS-5 Screening Test)**

5th edition (2012)

Pearson Education, Inc.

Pearson Inbound Sales and Customer Support

P.O. Box 599700, San Antonio, TX 78259

Phone: 800-627-7271 www.pearsonclinical.com Fax: 800-232-1223

**Screening Tool:**

The PLS-5 Screening Test is designed to assist in the identification of children who may need to be referred for further assessment of their speech and/or language abilities. It is available in English and Spanish.

**Authors:** Iria Lee Zimmerman, PhD, Violette G. Steiner, BS, and Roberta Evatt Pond, MA

**Description of the Tool:**

The PLS-5 Screening Test is specifically designed to assist in the identification of children who may need in-depth assessment of their speech and/or language abilities. It offers a broad-based speech and language screening that is comprehensive and based on sound research but is also quick to administer, in a child-friendly format. The development of the PLS-5 Screening Test involved the use of the most discriminating items from the Preschool Language Scale—Fifth Edition (PLS-5; Zimmerman, Steiner & Pond, 2011). It is a norm-referenced measure that provides criterion scores for each age group. Separate color-coded recording forms for each age group are provided with the kit. Additional forms can be purchased each year to meet the needs of the district.

**What does it screen?** The PLS-5 screens the following domains: language, articulation, connected speech, social interpersonal communication, fluency, and voice.

**What is the age range?** It is appropriate for children birth through 7 years 11 months of age.

**Format for Administration:** Individual administration

**Who can administer?** The tool can be administered by those with a degree or professional certification that included training in early childhood assessment and development. It can be administered by supervised paraprofessionals who have attended training, studied the manual, observed an experienced examiner giving the screening, and/or observed the training video (offered online as a webinar) and received supervised practice.

**How long does it take to complete?** Administered in about 10 minutes, scored in 10 to 15 minutes

**Validity and reliability:**

"The data obtained from the reliability studies conducted during the PLS-5 standardization research demonstrated that the PLS-5 scores are stable and exhibit good classification agreement from test to retest for all age groups. The PLS-5 Screening Test was developed using the most predictive items from the PLS-5 and the data collected during the PLS-5 standardization conducted in 2010. Also, validity studies conducted during the PLS-5 standardization research demonstrated that PLS-5 Screening Test exhibits good sensitivity when identifying children who may need in-depth assessment of their speech and language abilities. The results support the use of PLS-5 as a reliable and valid tool that could be administered during the first level of the assessment process" (Manual, p. 40).

# APPENDIX A

Psychometric Information:

- The PLS-5 normative sample contained 1,400 children between the ages of 0:0–7:11. There were additional samples for reliability and validity studies. The sample included African-American, Asian, Hispanic, White and other ethnic categories. The sample drew from all four regions of the United States.
- PLS-5 Screening Test Sensitivity = .80–.83
- PLS-5 Screening Test Specificity = .84
- Test-Retest Stability was estimated using data obtained by administering the PLS-5 Screening Test and the PLS-5 test to 189 children aged 0:0–7:11. The data suggests sufficient stability of scores from test to retest with percentage of agreement ranging from 89% to 100% for all age groups.
- "Inter-examiner reliability coefficients ranged from .96 -.99 across 9 subtests for both age groups, indicating acceptable inter-examiner reliability" (Salvia, Ysseldyke, & Bolt, 2010, as cited in Betz, Eickhoff, & Sullivan, 2013).
- The PLS-5 Screening Test correctly classified 91% of the children who were identified as clinical or nonclinical on the Clinical Evaluation of Language Fundamentals Preschool—2nd Edition (CELF P-2; Wiig, Secord & Semel, 2004) Core Language Scores. Forty-five children between the ages of 3:0 and 6:6 participated in this study.

**Procedure:**

The PLS-5 is presented in an easel-style manual with pictures on one side and screener directions on the other. The easel is placed directly in front of the child. The screener turns to the tab that is appropriate for the child's age and administers only the items that are appropriate for the child's age. One item at a time is presented with adequate time for response. The screener is provided with the exact verbal stimuli for each item. Items can be administered out of sequence to maximize the child's performance and maintain their attention. The test may also be resumed at a later time if fatigue or frustration is a factor. It is important that the screener include observations about the child's behavior and participation during the screening session, as these notes about performance may be an important supplement to the recorded scores when making individual decisions about the child's level of engagement and performance.

**Follow-up:**

The screening summary indicates "Pass" and "Obtain Additional Information" categories for each of the six domains. Pass criterion are provided separately for each domain within each age group. A child should be referred for additional assessment if the "Obtain Additional Information" category is checked for any of the six domains on the summary. Appropriate next steps include rescreening in two to four weeks and interviewing the child's caregiver, teacher, and/or parent to gather more information about their concerns. If the child's rescreen result is also "obtain more information," a referral is indicated.

The articulation section includes developmentally appropriate speech sounds in the initial, medial, and final positions. Selected items represent the target sounds by age and it is significant that each of the targeted phonemes were passed by 90% of the children in the normative sample group. In fact, some children may produce all of the targeted sounds for articulation, but it may be observed that they have poor speech intelligibility. This should be reflected in the score for the connected speech section. There is only one pass criterion for the connected speech section, which is, "You understand most of what the child says." All others require that additional information be obtained. The connected speech section includes items for children ages 3:0–6:11. The statement "You understand most of what the child says" is guided by research that indicates that the speech of children who are 36 months of age should be 80% intelligible to unfamiliar listeners. Additionally, if any atypical characteristics for fluency or voice are noted, the manual states that additional information should be obtained. When a child's poor performance is thought to be due to inexperience, lack of attention, distractibility, lack of response, or not following directions, additional information should be obtained by interviewing caregivers, observing the child's interactions with peers, and administering the screening at a later time.

# APPENDIX B

*The following materials are samples. The most up-to-date versions available in English, Spanish & Portuguese are on the Child Outreach page of the RIDE website- www.ride.ri.gov.*

## SCREENING LETTER TO FAMILIES

# CHILD OUTREACH SCREENING

**Dear Families,**

It is time to schedule your child's annual Child Outreach Screening. This screening is free and recommended for every child, every year at the ages of three, four, and five years. Screening can usually be completed within 45 minutes.

Child Outreach Screening provides important information about your child's growth and development. It can help you understand how your child is progressing in the areas of vision, hearing, speech/language, social/emotional, and general development. Screening can also assist in identifying children who may need further assessment and intervention at an early age in order to prevent the occurrence of more significant problems later.

The Rhode Island Department of Education and your local school district are your partners in ensuring the success of your child. We want to make sure all children are off to a great start before they enter kindergarten! Please contact your local Child Outreach Office to make an appointment.

You may also learn more about Child Outreach and request a screening by completing a contact form found at: http://www.earlydevelopmentri.com/about#info.

If you no longer reside in _____ or the State of Rhode Island, please contact us so that we can update our records.

Sincerely,

_____

**Child Outreach Coordinator**

Child Outreach Address: _____

_____

_____

Child Outreach Phone: _____

Child Outreach Email: _____

# APPENDIX C

# PARENT CONSENT FORM

Child's Name _____ D.O.B._____

**Child Outreach Screening- Parental Consent**

Child Outreach is a developmental screening system designed to screen all 3-5 year olds annually prior to kindergarten entry. Children are screened in the areas of vision, hearing, general development, speech/language, and social/emotional development. Child Outreach is an important first step in the identification of children who may require further evaluation or intervention. Accordingly, _____ _ Public Schools conducts a Child Outreach screening program. Parents will receive a summary of Child Outreach screening results by mail. All personal information and screening results collected during the screening process are treated in strictest confidence.

The Department of Education is responsible for the general supervision of the Child Outreach Screening Program. The Department of Health maintains the KIDSNET data system, which hosts Child Outreach data on behalf of Rhode Island public school systems. KIDSNET, a secure database, also includes children's vaccinations, lead screenings, preventive health services, and other developmental screenings. The information in KIDSNET can be used to coordinate care, assure that preventive health services are provided, and identify children who may need medical and/or developmental support. No personal information or screening results however will be released without your written consent to anyone other than personnel in the public school district in which you reside and the Rhode Island Department of Elementary and Secondary Education and the Rhode Island Department of Health for regulatory purposes.

_ _ _ _

# APPENDIX D

## CONSENT FORM FOR ADDITIONAL PHYSICIANS
# CHILD OUTREACH SCREENING

Child's Name _____ D.O.B._____

### Child Outreach Screening- Parental Consent

Child Outreach is a developmental screening system designed to screen all 3-5 year olds annually prior to kindergarten entry. Children are screened in the areas of vision, hearing, general development, speech/language, and social/emotional development. Child Outreach is an important first step in the identification of children who may require further evaluation or intervention. All personal information and screening results collected during the screening process are treated in strictest confidence.

The Department of Education is responsible for the general supervision of the Child Outreach Screening Program. The Department of Health maintains the KIDSNET data system, which hosts Child Outreach data on behalf of Rhode Island public school systems. KIDSNET, a secure database, also includes children's vaccinations, lead screenings, preventive health services, and other developmental screenings. The information in KIDSNET can be used to coordinate care, assure that preventive health services are provided, and identify children who may need medical and/or developmental support. No personal information or screening results however will be released without your written consent to anyone other than early childhood personnel in the public school district in which you reside and the Rhode Island Department of Elementary and Secondary Education and the Rhode Island Department of Health for regulatory purposes.

_ _ _ _

# APPENDIX E

RI CHILD OUTREACH SCREENING

## FAMILY HISTORY QUESTIONNAIRE

| Child's Last Name: | Middle Initial: | First Name: | Date of Birth: |
|---|---|---|---|
| | | | |

| #1- Parent / Guardian/ Foster Parent (Please circle)<br>Name: | #2- Parent / Guardian/ Foster Parent (Please circle)<br>Name:<br>____ Check here if you'd like additional results sent to this parent/guardian. |
|---|---|
| Address: | Address: |
| Mailing Address (if different): | Mailing Address (if different): |
| Primary Phone Number: | Primary Phone Number: |
| Alternate Phone Number: | Alternate Phone Number: |
| Email Address: | Email Address: |
| Best way to contact family: *phone/ email* (circle one) | Best way to contact family: *phone/ email* (circle one) |
| Other children living in household:<br>Name: _____ D.O.B.: _____<br>Name: _____ D.O.B.: _____<br>Name: _____ D.O.B.: _____ | Other children living in household:<br>Name: _____ D.O.B.: _____<br>Name: _____ D.O.B.: _____<br>Name: _____ D.O.B.: _____ |
| Who does the child live with? | Child's Primary Language: |

| |
|---|
| Has your child's hearing been tested? Yes ___ N o ___ When/by whom: _____ |
| Has your child had 3 or more ear infections? Yes _____ No _____ Does your child have tubes? Yes _____ No _____ |
| Do you have concerns about your child's hearing? Yes _____ No _____ List concerns: _____ |
| Has your child's vision been tested? Yes _____ No _____ When/by whom: _____ |
| Do you have concerns about your child's vision? Yes _____ No _____ List concerns: _____ |
| Does your child wear glasses? Yes _____ No _____ |
| Additional Relevant Health Information: |

RI CHILD OUTREACH SCREENING

# FAMILY HISTORY QUESTIONNAIRE • PAGE 2

| |
|---|
| Does your child currently receive Special Education services ? Yes _____ No _____ |
| Did your child receive Early Intervention services? Yes _____ No _____ |
| Do you have any concerns with your child's development? (Please explain) |
| What things are difficult for your child? |
| Does your child currently attend preschool? Yes _____ No _____ Name of Preschool: _____<br>Times attending: Monday _____ AM _____ PM *(please check all that apply)*<br>Tuesday _____ AM _____ PM<br>Wednesday _____ AM _____ PM<br>Thursday _____ AM _____ PM |
| Please list anything else you would like us to know about your child's developmental history or family. |
| Name of person completing this form: _____<br>Relationship to child: _____ |
| THANK YOU |

**RI Child Outreach Screening does not discriminate on the basis of age, sex, sexual orientation, race, religion, national origin, color or disability in accordance with applicable state laws and regulations.**

# APPENDIX F

## CHILD OUTREACH PERSONNEL SCREENING FORM

# RI CHILD OUTREACH SCREENING

**Child's Name:** _____ **DOB:** _____

**Screening Date:** _____

**District Administering Screen:** _____ **Screening Location:** _____

**Kindergarten Placement (if applies) K KPS Planned Kindergarten School:** _____

**Parent consent for screening – consent #1 signed:** _____YES **Date parental consent signed:** _____

_____ **No**-Parent Refusal _____ **No**-Parent did not return consent _____ **No**-Unable to locate child/No response to CO contact

_____ N**A**- Child receiving Sp Ed at time of screen _____ **No**-Other _____

**Parent consent to share with authorized PCP-consent #2 signed** _____Yes _____No

**Name of PCP Practice:** _____

**Parent consent to share with ECE-consent #3 signed** _____Yes _____No

**Enrollment in Early Childhood Setting:** _____General EC setting _____Family child care setting

_____ Self-contained setting (separate class) ____ Kindergarten ____ Public School integrated preschool

____ State Funded Pre-K _____ None-home or care by relative

**Name of EC Environment:** _____ **NA**

**Consent for Medicaid:** _____Yes _____No _____NA **Date Medicaid consent given:** _____

**Screening Requested By:** _____Family request _____Pediatrician request* _____EC teacher request

_____No request-General EC program screen _____No request-Open screen

_____No request-Found in KIDSNET _____No request-K screen _____ Other: _____

**Date Screening Requested:** _____

*date must be entered if PCP request and date of PCPfollow-up must be completed on outcomes screen. Appendix F: Child Outreach Personnel Screening Form

---

### Vision Screening Details

Screening Date: _____ Screening Language (if other than English): _____

Screener's Name: _____ Interpreter Name (if applicable): _____

Screening Type: _____Initial _____Rescreen _____Secondary DLL Screen

If Screen Unnecessary, reason: _____Receiving SpEd at time of screen

_____Evaluated by other source: _____Other: _____

Recommendation for additional screen: _____None _____Needs Rescreen _____Needs Secondary DLL Rescreen

Comments: _____

---

# APPENDIX F

### Hearing Screening Details

Screening Date: _____ Screening Language (if other than English): _____

Screener's Name: _____ Interpreter Name (if applicable): _____

Screening Type: _____Initial _____Rescreen _____Secondary DLL Screen

If Screen Unnecessary, reason: _____Receiving SpEd at time of screen

_____Evaluated by other source: _____Other: _____

Recommendation for additional screen: _____None _____Needs Rescreen _____Needs Secondary DLL Rescreen

Comments: _____

_____

### Speech/Language Screening Details

Screening Date: _____ Screening Language (if other than English): _____

Screener's Name: _____ Interpreter Name (if applicable): _____

Screening Type: _____Initial _____Rescreen _____Secondary DLL Screen

If Screen Unnecessary, reason: _____Receiving SpEd at time of screen

_____Evaluated by other source: _____Other: _____

Recommendation for additional screen: _____None _____Needs Rescreen _____Needs Secondary DLL Rescreen

Comments: _____

_____

### General Development Screening Details

Screening Date: _____ Screening Language (if other than English): _____

Screener's Name: _____ Interpreter Name (if applicable): _____

Screening Type: _____Initial _____Rescreen _____Secondary DLL Screen

If Screen Unnecessary, reason: _____Receiving SpEd at time of screen

_____Evaluated by other source: _____Other: _____

Recommendation for additional screen: _____None _____Needs Rescreen _____Needs Secondary DLL Rescreen

Comments: _____

_____

### Social/Emotional Screening Details

Screening Date: _____ Screening Language (if other than English): _____

Screener's Name: _____ Interpreter Name (if applicable): _____

Screening Type: _____Initial _____Rescreen _____Secondary DLL Screen

If Screen Unnecessary, reason: _____Receiving SpEd at time of screen

_____Evaluated by other source: _____Other: _____

Recommendation for additional screen: _____None _____Needs Rescreen _____Needs Secondary DLL Rescreen

Comments: _____

# APPENDIX F

**Screening Outcome** **If PCP Referral, Date PCP Notified: _____**

| | Pass | Referral to Spec Ed | Refer to Physician | Referral to Community Agency | Commun of Concern to IEP Team | Screening Unnecessary | Screening Necessary but Incomplete |
|---|---|---|---|---|---|---|---|
| Vision | | | | | | | Child refused/unable to train<br>Multiple appointments not kept<br>Moved out of state with incomplete package<br>Other: _____ |
| Hearing | | | | | | | Child refused/unable to train<br>Multiple appointments not kept<br>Moved out of state with incomplete package<br>Other: _____ |
| Sp/Language | | | | | | | Child refused/unable to train<br>Multiple appointments not kept<br>Moved out of state with incomplete package<br>Other: _____ |
| General Dev | | | | | | | Child refused/unable to train<br>Multiple appointments not kept<br>Moved out of state with incomplete package<br>Other: _____ |
| Soc/Emot | | | | | | | Child refused/unable to train<br>Multiple appointments not kept<br>Moved out of state with incomplete package<br>Other: _____ |

**Referral to Special Education Follow-up:**

_____ **Multiple appointments not kept**

_____ **Parent refusal**

_____ **ET eval unnecessary-no suspicion of disability**

_____**Eligible for special education**

_____**Ineligible for special education**

_____**Child moved prior to eligibility**

**Date of final outcomes: _____**

# APPENDIX G

### OUT-OF-DISTRICT SCREENING PROTOCOL

## CHILD OUTREACH- OUT OF DISTRICT SCREENING PROTOCOL- BEST PRACTICE

Districts will provide initial screenings for all out of district children participating in local early childhood programs

1. For children who **pass** the screening, the screening district will enter and submit the complete package intoKIDSNET and send out a results letter to the family.
2. For children who fail only the **Vision and/or Hearing**, the screening district will either provide a rescreen, a DLLsecondary screen, or a referral to the PCP. The screening district will be responsible for completing andsubmitting the package into KIDSNET, sending the result letter to the family and sending the referral to the PCPas required.
3. For children who need a rescreen, a DLL secondary screen or a referral to special education in **Speech, GeneralDevelopment or Social-Emotional**, the screening district will contact the child's district of residence todetermine which district will complete the rescreen or DLL secondary screen or to make the decision to go rightto referral.
4. If the decision is that the non-resident district completes the rescreen and the child fails Speech, GeneralDevelopment, or Social-Emotional again, the district of residence must be notified again.
5. The demographics page and domain pages must be entered into KIDSNET by the district that provided thescreening.
6. The screening district is responsible for sending the parent letters for the screenings that they have completed.
7. The *Outcomes Screen* and the *submission* in KIDSNET must be completed by the district of residence if the childhas failed Speech, General Development, or Social-Emotional. This will ensure that the district of residence isaware of all necessary referrals to Special Education.
8. Regardless of the outcome of the screening, the screening district must ensure that the hard copies of thecomplete screening packages (forms & protocols) are sent to the district of residence as soon as possible aftercompletion.
9. Districts of residences should ensure that they are monitoring both the KIDSNET columns that indicate "non-residents-started not yet submitted" and "submitted awaiting special education referral."

# APPENDIX H

# PRESCHOOL LANGUAGE SURVEY

Child's Name: _____ Child's Birthplace: _____

Child's Age: _____ Child's Age When First Exposed to English: _____

Does the child talk? ☐ No ☐ Yes, Single Words ☐ Yes, Puts 2-3 Words Together ☐ Yes, Sentences

Family's Country of Origin: _____ Number of Years Family Has Lived in the USA _____

If English is not the family's first language, do they prefer verbal or written communication?

☐ No preference ☐ Verbal (phone/in person) ☐ Written (letters/forms)

Form Completed By: _____ Relationship to Child: _____

## HOME LANGUAGE INFORMATION:

**1. What language did the child first learn to speak?** ☐ English ☐ Spanish ☐ Both ☐ Other: _____

**2. What language does the child speak most often?** ☐ English ☐ Spanish ☐ Other: _____

**3. What language is spoken to the child most often?** ☐ English ☐ Spanish ☐ Other: _____

4. Does anyone else care for the child during the week (*ex. grandparents, babysitter, etc.*)? ☐ No ☐ Yes

If so, what language does he/she speak most often? ☐ English ☐ Spanish ☐ Both ☐ Other: _____

5. What language is used most often when parents speak to each other? ☐ English ☐ Spanish ☐ Both ☐ Other: _____

6. What language(s) does the child use most often when speaking with the following people?

Parents: ☐ English ☐ Spanish ☐ Both ☐ does not talk yet ☐ other: _____

Siblings: ☐ English ☐ Spanish ☐ Both ☐ does not talk yet ☐ other: _____

Relatives: ☐ English ☐ Spanish ☐ Both ☐ does not talk yet ☐ other: _____

Friends ☐ English ☐ Spanish ☐ Both ☐ does not talk yet ☐ other: _____

## LANGUAGE EXPOSURE

7. Does/Did the child attend school or receive Early Intervention?

☐ No ☐ Yes- Head Start ☐ Yes- Preschool ☐ Yes- EI

Name of school or EI: _____

What language is/was used? ☐ English ☐ Spanish ☐ Both ☐ Other: _____

8. What language is the child exposed to or uses most often during the following activities?

Books/Storytelling: ☐ English ☐ Spanish ☐ Both ☐ Other: _____

TV/Radio: ☐ English ☐ Spanish ☐ Both ☐ Other: _____

Computer/Video games: ☐ English ☐ Spanish ☐ Both ☐ Other: _____

Play: ☐ English ☐ Spanish ☐ Both ☐ Other: _____

# APPENDIX I: CHILD OUTREACH SCREENING BROCHURE

## Child Outreach Screening

is a **FREE** service offered to ALL children 3 to 5 years old by your local school district in partnership with the Rhode Island Department of Education.

## What are the goals of Child Outreach?

### INFORMATION

Child Outreach provides information about your child's development and resources that are available within your community.

### POSITIVE OUTCOMES

Child Outreach can help identify children who may need further assessment, intervention and/or services at an early age to promote positive outcomes in kindergarten and beyond.

Provided By:

exceed Rhode Island's Early Childhood Commitment

RIDE Rhode Island Department of Education

Child Outreach


Office of Student, Community and Academic Supports
RI Department of Elementary and Secondary Education

**255 Westminster Street**
**Providence, RI 02903**

Tel (401) 222-4600 Fax (401) 222-3605
TTY (800) 745-5555 Voice (800) 745-6575


# CHILD OUTREACH SCREENING

## Every Child | Every Year

## FREE SCREENING

For Rhode Island Children
3, 4 and 5 Years Old
Prior to Kindergarten

**https://exceed.ri.gov/earlydevelopment**

**The information** about your child's development is gathered in two ways:

### FIRST

Your child will participate for about 45 minutes in game-like activities conducted by trained personnel from the public school system. You are always welcome to join your child as he/she participates in the screening activities.

### SECOND

You will complete brief family questionnaires about your child's health history and his/her development as observed at home in everyday activities.

## What does screening involve?

Child Outreach provides a brief assessment in five areas of development:

- Vision
- Hearing
- Speech and Language Skills
- Social/Emotional Development
- General Development, such as gross and fine motor skills, memory, etc.

## What if my child speaks and understands a language other than English?

If your child communicates in a language other than English, Child Outreach (CO) makes every effort to screen your child and communicate with you in your dominant language.

Screening is not an assessment of your child's English language ability, but rather a snapshot of your child's development. Screening in your child's dominant language provides the most accurate picture of how your child is growing and learning. Please notify CO prior to the screening so that a bilingual screener or interpreter can be made available in your primary language.

## Why should I participate?

Often, families have questions about their child's growth and development.

Child Outreach can help you understand how your child is progressing and learn ways to continue to support his/her development.

## When should my child participate in screening?

Much like your well child visit with the pediatrician, children should participate in screening annually at 3, 4 and 5 years old. Because children learn rapidly during these early years, each screening provides families with an up-to-date check on their child's development.

## How do I arrange screening for my child?

Screening is offered in a variety of locations such as early care and education settings, Head Start programs, public schools, libraries, etc. All school districts provide ongoing screening throughout the school year.

Families can schedule a screening appointment at any time during the school year by going to: **https://exceed.ri.gov/earlydevelopment** and clicking on "How to Access Screening" and then "Listing of Child Outreach Coordinators" or by calling the RI Department of Education at **(401) 222-4600** and requesting the contact information for the Child Outreach Program in your local community.

## What happens after screening?

Screening results are reviewed and a summary sent to you within a few weeks. The summary will include the areas of development that indicate age-appropriate results as well as those that may require a rescreen or follow-up.

Child Outreach wants to ensure that ALL children are off to a good start before entering kindergarten.

## What happens to screening results?

While sharing screening results with your child's pediatrician and early care and education program is beneficial, no results will be shared without your permission. Confidentiality is always a priority.

# CHILD OUTREACH SCREENING

## Every Child | Every Year

## FREE SCREENING

For Rhode Island Children 3, 4 and 5 Years Old,
Prior to Kindergarten

Screening in vision, hearing, speech/language, social/emotional and general development

To schedule a screening appointment at any time during the school year, go to **https://exceed.ri.gov/earlydevelopment** and click on "How to Access Screening" and then "Listing of Child Outreach Coordinators" or call the **RI Department of Education at (401) 222-4600**.

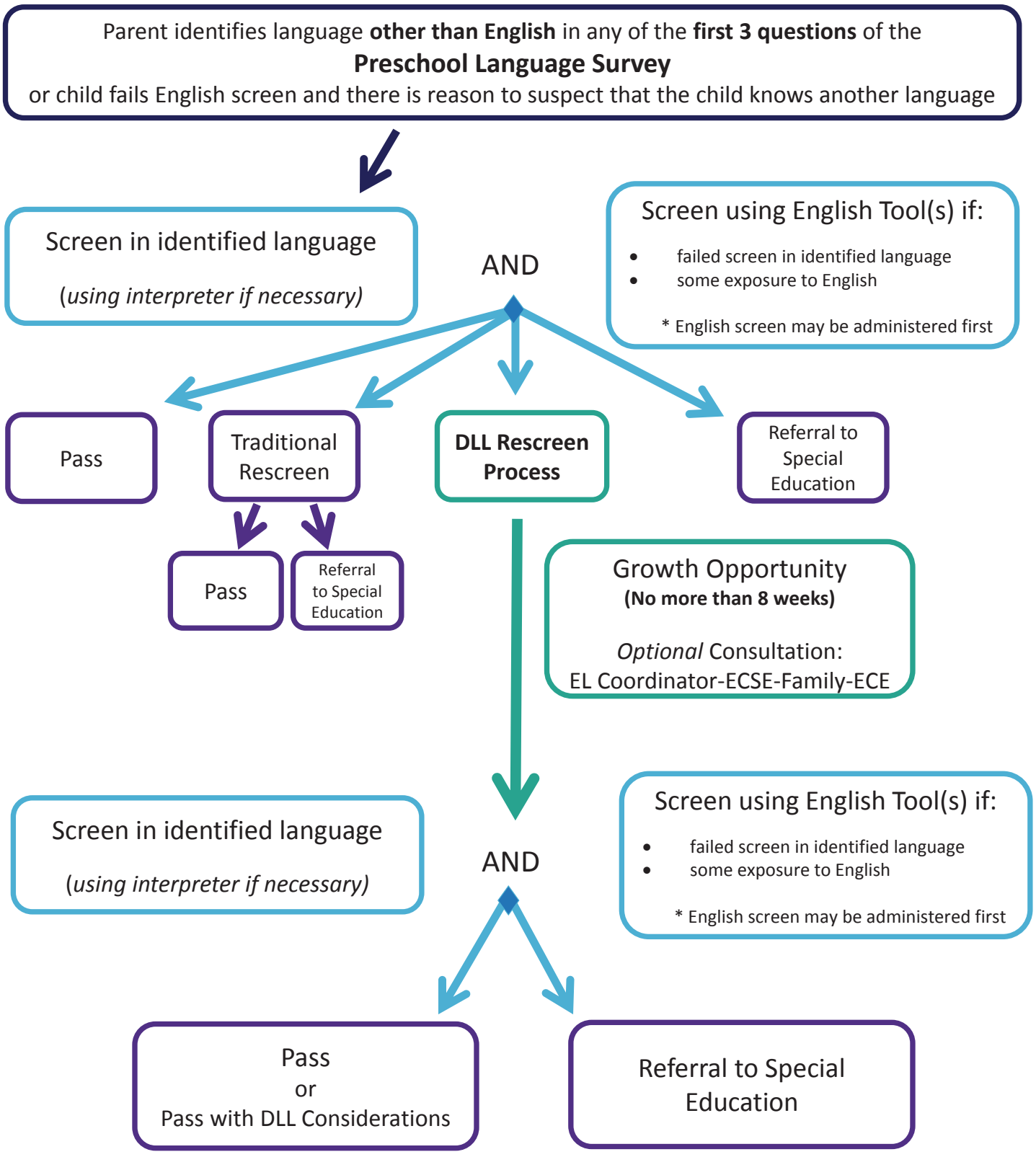
Provided By:

exceed Rhode Island's Early Childhood Commitment

RIDE Rhode Island Department of Education

Child Outreach

# DLL SCREENING FLOWCHART




RIDE Rhode Island Department of Education

RI Department of Education Early Childhood Special Education
Celebrating and supporting all young children

# APPENDIX K

## DLL CONSIDERATIONSS

- Were the instruments normed appropriately, based on the child's culture and language?
- Were the components of language assessed compatible with the child's primary language? *For instance, does the screen assess use of pronouns when pronouns do not exist in the child's primary language?*
- What is the extent of the child's exposure to the primary and secondary culture/language?
- Is the family/teacher reporting that the child is progressing similarly to peers and other family members?
- How much progress is the family/teacher reporting since the initial screening?
- If the child is in school, is there formative assessment data that shows growth?

# APPENDIX L

## KIDSNET CONFIDENTIALITY AGREEMENT

# RHODE ISLAND DEPARTMENT OF HEALTH

KIDSNET

I recognize a person's basic right to privacy and confidentiality of personal information, and the extension of that right to recorded information in which a person is identified individually.

I understand that "confidential records" are the records as defined in Section §38-2-2 (4) of the Rhode Island General Laws, entitled "Access to Public Records."

I agree to utilize KIDSNET only for the purpose of obtaining information needed for coordinating care of children seen in this office/program.

I agree not to disclose information from confidential records to any unauthorized person or persons.

I understand that unauthorized disclosure of information from confidential records may be punishable, upon conviction, by a fine and/or imprisonment or both, and/or civil penalties as prescribed by law as well as sanctions and/or disciplinary action.

I understand that I am authorized to have access to the KIDSNET Automated Data System records which are confidential only as part of my required employment responsibilities.

I further state that I have been provided with a personal copy of this agreement.

_____ _____

Employee Signature Date

_____

Employee Name (PRINT)

_____

Program Name – City/Town Location

S:\operations\KIDSNET\providerrelations\confagree

# APPENDIX M

## KIDSNET CONFIDENTIALITY AGREEMENT-READ-ONLY ACCESS

# RHODE ISLAND DEPARTMENT OF HEALTH

KIDSNET

I recognize a person's basic right to privacy and confidentiality of personal information, and the extension of that right to recorded information in which a person is identified individually.

I understand that "confidential records" are the records as defined in Section §38-2-2 (4) of the Rhode Island General Laws, entitled "Access to Public Records."

I agree to utilize KIDSNET only for the purpose of obtaining information needed for coordinating care of children seen in this office/program.

I understand that I am authorized to have access to the confidential KIDSNET Automated Data System records, only as part of my required employment responsibilities.

I agree to utilize a personal User ID and Password that has been issued to me by the Department of Health or an authorized KIDSNET Administrator in my office. I agree not to share my User Id and Password with others.

I agree not to disclose information from confidential records to any unauthorized person or persons.

I understand that unauthorized disclosure of information from confidential records may be punishable, upon conviction, by a fine and/or imprisonment or both, and/or civil penalties as prescribed by law as well as sanctions and/or disciplinary action.

I agree to review the procedures necessary to access and utilize Child Outreach reports in KIDSNET with my state or district Child Outreach KIDSNET Administrator. I understand that I am authorized to have read-only access to KIDSNET and agree not to enter any data.

I further state that I have been provided with a personal copy of this agreement

_____ _____

Employee Signature Date

_____

Employee Name (PRINT)

_____

Program Name – City/Town Location

# REFERENCES


1 Nelson, C. (2000). "The neurobiological bases of early intervention" in J. Shonkoff & S. Meisels, eds., *Handbook of Early Childhood Intervention* (2nd ed.) (New York: Cambridge University Press).

2 Center on the Developing Child at Harvard University (2007). "A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children." Retrieved from: http://www.developingchild.harvard.edu

3 See, for example, Lange, S. M., & Thompson, B. (2006). "Early identification and intervention for children at risk for learning difficulties," *International Journal of Special Education*, 21(3), 108–119.

4 Center on the Developing Child at Harvard University (2007). "A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children." Retrieved from: http://www.developingchild.harvard.edu

5 Heckman, J. J., (2008). "Schools, skills, and synapses," *NBER Working Paper*, 14064 (Cambridge, MA: National Bureau of Economic Research).

6 Bitsko, R. H., Holbrook, J. R., Kaminski, J., Robinson, L. R., Ghandour, R., Smith, C., & Peacock, G. (2016). "Health-care, family and community factors associated with mental, behavioral and developmental disorders in early childhood - United States, 2011-2012," *Morbidity and Mortality Weekly Report*, 65(9), 221–226.

7 Office of Special Education Programs (2015). "Identification of Children with Disabilities." Retrieved from: https://osep.grads360.org/services/PDCService.svc/GetPDCDocumentFile?fileId=11214

8 See, for example, Lange, S. M., & Thompson, B. (2006). "Early identification and intervention for children at risk for learning difficulties," *International Journal of Special Education*, 21(3), 108–119.

9 Hebbeler, K., Spiker, D., Bailey, D., Scarborough, A., Mallik, S., Simeonsson, R., & Singer, M. (2007). "Early intervention for infants & toddlers with disabilities and their families: participants, services, and outcomes." Final report of the National Early Intervention Longitudinal Study (NEILS) and National Research Council and Institute ofMedicine (2000). "From Neurons to Neighborhoods: The Science of Early Childhood Development." Committee on Integrating the Science of Early Childhood Development. Jack P. Shonkoff and Deborah A. Phillips, eds. Board on Children, Youth, and Families, Commission on Behavioral and Social Sciences and Education (Washington, D.C.: National Academy Press).

10 Chou, R., Dana, T., & Bougatsos, C. (2011). "Screening for visual impairment in children ages 1-5: Update for the USPSTF," *Pediatrics*, 127(2), e442-479. doi:10.1542/peds.2010-0462

11 Ying, G. S., Maguire, M. G., Cyert, L. A., Ciner, E., Quinn, G. E., Kulp, M. T., Moore, B. (2014). "Prevalence of vision disorders by racial and ethnic group among children participating in Head Start," *Ophthalmology*, 121(3), 630-636. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4128179/pdf/nihms603561.pdf

12 Wen, G., McKean-Cowdin, R., Varma, R., Tarczy-Hornoch, K., Cotter, S. A., Borchert, M., & Azen, S. (2011). "General health-related quality of life in preschool children with strabismus or amblyopia," *Ophthalmology*, 118(3), 574-580. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3017225/pdf/nihms222801.pdf

13 Roch-Levecq, A. C., Brody, B. L., Thomas, R. G., & Brown, S. I. (2008). "Ametropia, preschoolers' cognitive abilities, and effects of spectacle correction," *Archives of Ophthalmology*, 126(2), 252-258. Retrieved from http://jamanetwork.com/jounals/jamaophthalmology/fullarticle/420351

14 Atkinson, J., Anker, S., Nardini, M., Braddick, O., Hughes, C., Rae, S., Atkinson, S. (2002). "Infant vision screening predicts failures on motor and cognitive tests up to school age," *Strabismus*, 10(3), 187-198.

15 Ibironke, J. O., Friedman, D. S., Repka, M. X., Katz, J., Giordano, L., Hawse, P., & Tielsch, J. M. (2011). "Child development and refractive errors in preschool children," *Optometry and Vision Science*, 88(2), 252-258. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3079532/pdf/nihms259842.pdf

16 U.S. Preventive Services Task Force (2011). "Vision screening for children 1 to 5 years of age: U.S. Preventive Services Task Force recommendation statement." *Pediatrics*, 127(2), 340-346. doi:10.1542/peds.2010-3177

17 Maples, W. C. (2003). "Visual factors that significantly impact academic performance," *Optometry*, 74(1), 35-49.

18 Basch, C. E. (2011). "Vision and the achievement gap among urban minority youth," *Journal of School Health*, 81(10), 599-605. doi:10.1111/j.1746-1561.2011.00633.x

19 Kulp, M. T., Ciner, E., Maguire, M., Moore, B., Pentimonti, J., Pistilli, M., Cyert, L., Candy, R., Quinn, G., & Ying, G. (2016). "Uncorrected hyperopia and preschool early literacy: Results of the Vision in Preschoolers-Hyperopia in Preschoolers (VIP-HIP) Study," *Ophthalmology*, 123(4), 681-689. doi:10.1016/j.ophtha.2015.11.023

20 Davidson, S., & Quinn, G. E. (2011). "The impact of pediatric vision disorders in adulthood," *Pediatrics*, 127(2), 334-339. doi:10.1542/peds.2010-1911

21 American Speech-Language-Hearing Association. "Effects of Hearing Loss on Development." Retrieved from: http://www.asha.org/public/hearing/Effects-of-Hearing-Loss-on-Development/

22 American Academy of Audiology (2011). "Childhood Hearing Screening Guidelines September 2011." Retrieved from: https://www.cdc.gov/ncbddd/hearingloss/documents/AAA_Childhood%20Hearing%20Guidelines_2011.pdf

23 Cunningham, M., & Cox, E. O. (2003). "Hearing assessment in infants and children: Recommendations beyond neonatal screening," *Pediatrics*, 111(2), 436–440.

24 American Academy of Pediatrics (1999). "Newborn and infant hearing loss: Detection and intervention." Task Force on Newborn and Infant Hearing. *Pediatrics*, 103, 527-530.

25 American Academy of Audiology (2011). "Childhood Hearing Screening Guidelines September 2011." Retrieved from: https://www.cdc.gov/ncbddd/hearingloss/documents/AAA_Childhood%20Hearing%20Guidelines_2011.pdf

26 Justice, L. (2006). "Evidence-Based Practice, Response to Intervention, and the Prevention of Reading Difficulties." *Language, Speech, and Hearing Services in Schools*, 37(4), 284–97.

27 Whitehouse, A. J. O., Robinson, M., & Zubrick, S. R. (2011). "Late talking and the risk for psychosocial problems during childhood and adolescence," *Pediatrics*, 128(2) e324-e332; doi: 10.1542/peds.2010-2782

28 Schoon, I., Parsons, S., Rush, R. & Law, J. (2010). "Children's language ability and psychosocial development: A 29-year follow-up study," *Pediatrics*, 126(1) e73-e80; doi: 10.1542/peds.2009-3282

29 Hart, B., & Risley, T. R. (2003). "The Early Catastrophe: The 30 Million Word Gap by Age 3," *American Educator* 27(1), 4-9.

30 Black, L. I., Vahratian, A., & Hoffman, H. J. (2015). "Communication disorders and use of intervention services among children aged 3–17 years: United States, 2012," NCHS data brief, no. 205 (Hyattsville, MD: National Center for Health Statistics).

31 Perkins, S. C., Finegood, E. D., & Swain, J. E. (2013). "Poverty and Language Development: Roles of Parenting and Stress," *Innovations in Clinical Neuroscience*, 10(4), 10–19.

32 Rhoades, B., Warren, H., Domitrovich, C. and Greenberg, M. (2011). "Examining the link between preschool social-emotional competence and first grade academic achievement: The role of attention skills," *Early Childhood Research Quarterly*, 26(2), 182-191.

33 Shonkoff, J. P., Garner, A. S., The Committee on Psychosocial Aspects of Child and Family Health, The Committee on Early Childhood, Adoption, and Dependent Care, and The Section on Developmental and Behavioral Pediatrics (2011). "The Lifelong Effects of Early Childhood Adversity and Toxic Stress," *Pediatrics*, 129, 232–246. doi: 10.1542/peds.2011-2663

34 Weitzman, C., Wegner, L., The Section on Developmental and Behavioral Pediatrics, Committee on Psychosocial Aspects of Child and Family Health, Council on Early Childhood, and Society for Developmental and Behavioral Pediatrics (2015). "Promoting optimal development: Screening for behavioral and emotional problems," *Pediatrics*, 135(2), 384–395. doi: 10.1542/peds.2014-3716

35 Ibid.

36 The comments to the final regulations issued by the United States Department of Education state that "the child find requirements permit referrals from any source that suspects a child may be eligible for special education and related services." *Federal Register*, 71(156), August 14, 2006, p. 46636.

37 Karoly, L. A., Kilburn, M. R., & Cannon, J. S. (2005). *Early childhood interventions: Proven results, future promise* (Arlington, VA: RAND Corporation).

38 Burchinal, M., Kainz, K., & Cai, Y. (2011). "How well do our measures of quality predict child outcomes? A meta-analysis and coordinated analysis of data from large-scale studies of early childhood settings." In M. Zaslow, I. Martinez-Beck, K. Tout & T. Halle, eds., *Quality measurement in early childhood settings*, 11-31.

39 Lindsey, K. A., Manis, F. R., & Bailey, C. E. (2003). "Prediction of first-grade reading in Spanish-speaking English-language learners," *Journal of Educational Psychology*, 95(3), 482–494.

40 Roberts, T. A. (2008). "Home storybook reading in primary or second language with preschool children: Evidence of equal effectiveness for second-language vocabulary acquisition." *Reading Research Quarterly*, 43(2), 103–130.

41 Administration for Children and Families: Office of Head Start. U.S. Department of Health and Human Services (2015). "Benefits of being bilingual." Retrieved from: https://eclkc.ohs.acf.hhs.gov/hslc/tta-system/cultural-linguistic/docs/benefits-of-being-bilingual.pdf

42 Schilder, D. (2013). "Training to Screen Young English Language Learners and Dual Language Learners for Disabilities," *CEELO FASTfacts* (New Brunswick, NJ: Center on Enhancing Early Learning Outcomes).

43 Ibid.