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IDENTIFYING AND REFERRING CHILDREN WITH DEVELOPMENTAL DELAYS TO EARLY INTERVENTION SERVICES

- Screen children for developmental delays at each well-child visit.
- Use a combination of clinical judgment, standardized screening tools, and listening to parent concerns to identify children with developmental delays.
- Collaborate with families to refer children to Early Intervention services.

Early diagnosis of developmental delays and disabilities between birth and age 3 is a vital component of well-child care and should be routine practice for pediatric primary care providers (PCPs). Approximately 15% of children in the United States (US) have some form of developmental delay that affects their ability to communicate, learn, interact with others, or regulate their behavior. Yet only 30% of such delays are detected before a child reaches school age.¹⁻³ School-age children with developmental disabilities typically have more doctor visits, more hospital stays, lower school attendance, and are more likely to repeat grades.^{1, 4-6}

Identification of developmental delays and implementation of Early Intervention (EI) services can improve children's lifelong development (**Resources**).⁴⁻⁸ EI services not only help address a range of developmental problems, but can also reduce later associated comorbidities (such as depression and anxiety) and greatly improve quality of life for children and families.⁸⁻¹⁵ Under the federal Individuals with Disabilities Education Act (IDEA), states and public agencies must provide EI services, special education, and related services to eligible US infants, toddlers, children, and youth with disabilities. EI services for eligible children from birth to age 3 include speech, physical, and occupational therapy, special instruction, psychological and social work services, family support groups, and assistive technology. EI providers are committed to working with the family as well as the child to

deliver effective assistance for children with delays or disabilities. Most EI services are provided in the child's home or daycare setting.

Pediatric PCPs and other professionals who have regular contact with young children are in a key position to recognize early problems in physical, social, emotional, and mental development, and to refer families to EI services, such as those offered by the New York City Department of Health and Mental Hygiene (NYC DOHMH) Early Intervention Program. Pediatric health care providers can obtain information for referrals to EI services and interventionists by calling 311 or the office in the borough where the family resides (**below**).



DEFINING DEVELOPMENTAL DELAYS

Developmental delays and disorders have been linked to a wide range of genetic and environmental factors, including early prenatal and postnatal exposure to teratogens and other environmental insults, prematurity, and low birth weight.¹⁶

However, the causes of most neurodevelopmental delays and disorders are not well understood.

Developmental delays mean a child is not exhibiting skills by the expected age. These skills are often grouped into 5 broad categories:

- Communication and language;
- Social-emotional processes;
- Motor abilities;
- Cognitive abilities;
- Adaptive living and self-help skills.

Table 1 lists red flags of possible developmental delays between birth and age 3.

IDENTIFICATION OF DEVELOPMENTAL DELAYS THROUGH SURVEILLANCE AND SCREENING

According to the American Academy of Pediatrics (AAP), a combination of objective screening tools and clinical judgment can increase the detection of developmental delays and lead to more effective treatment than the use of clinical judgment alone.¹⁶ The AAP offers a listing of developmental screening tools, with ratings on their sensitivity and specificity for particular delays. While some screening tools are included in this publication, the full listing can be accessed at <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405/T1>.

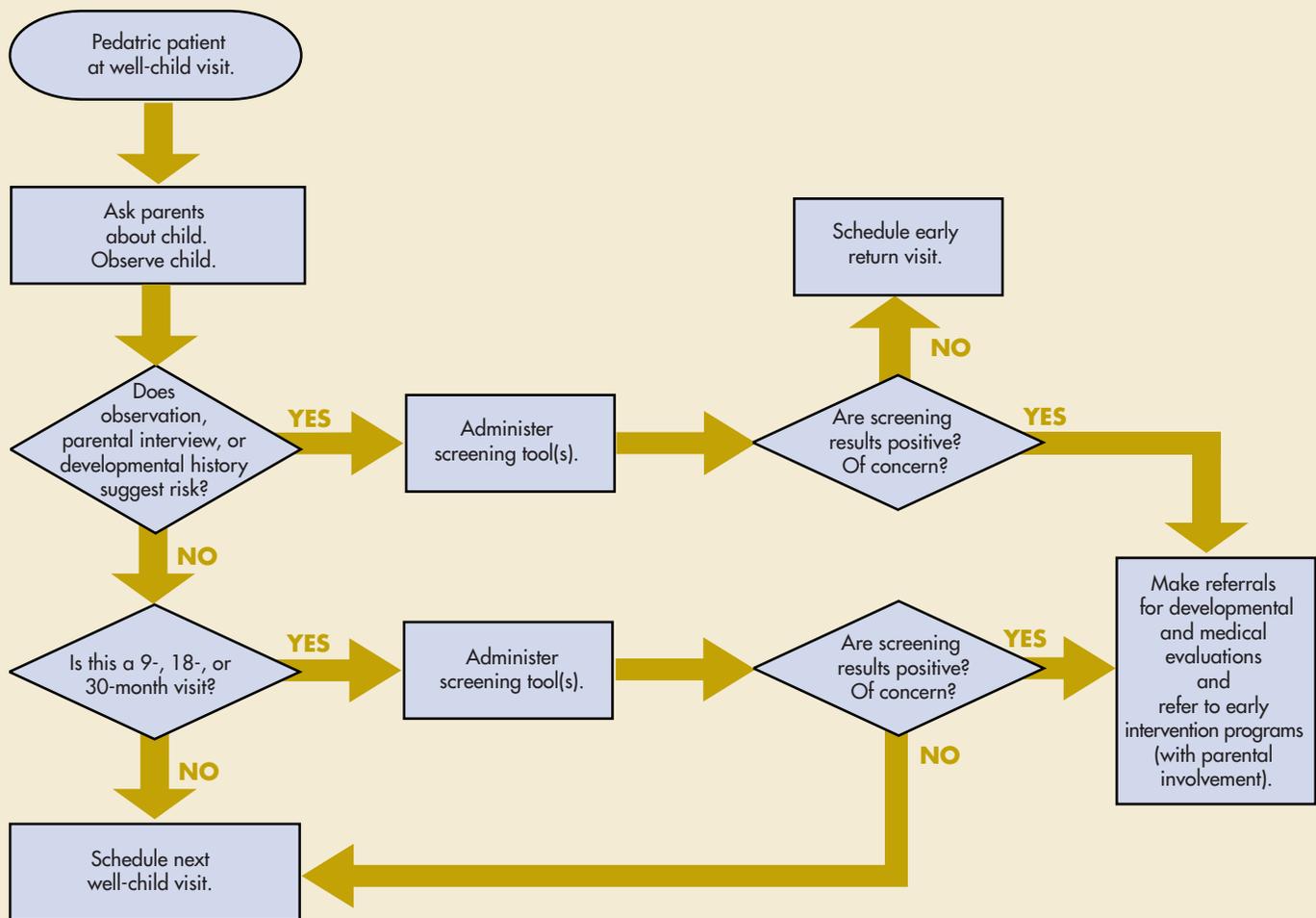
TABLE 1. SIGNS OF POSSIBLE DEVELOPMENTAL DELAYS

A child may be developmentally delayed if he/she cannot achieve the milestones listed below by the ages specified.

Developmental Area	Child Does NOT	By Age	Developmental Area	Child Does NOT	By Age
Gross Motor	Pull up to sit	4½ months	Communication/ Language	Babble	5-6 months
	Roll over	5 months		Say "da" or "ba"	8-9 months
	Sit without support	7-8 months		Say "dada" or "baba"	10-11 months
	Stand while holding on	9-10 months		Use 3 words with meaning	18 months
	Walk	15 months		Use 2-word phrases or repetition of phrases	2 years
	Climb up or down stairs	2 years		Use 1 personal pronoun	2½ years
	Jump with both feet	2½ years		Cognitive	Alert to mother, with special interest
Fine Motor	Have flexible grasp (not consistently closed)	3½ months	Search for dropped object		6-7 months
	Hold rattle	4-5 months	Show interest in peek-a-boo		8-9 months
	Hold an object in each hand	7 months	Search for hidden object		12 months
	Have Pincer grasp	10-11 months	Show interest in cause-and-effect games		15-18 months
	Put objects in or take out of a container	15 months	Categorize similarities (e.g., animals vs. vehicles)		2 years
	Remove socks or gloves by self	20 months	Social-emotional		Smile socially
	Stack blocks	2 years		Laugh in playful situations	6-8 months
	Scribble	2 years		Show ability to be consoled	1 year
	Turn a single page in a book	2½ years		Show consistent eye contact	2 years
				Show engagement with other children or other adults	2 years

Based on: First L, Palfrey P. The Infant or Young Child with Developmental Delay. *N Engl J Med.* 1994;331(56):478-483.

FIG. 1. HOW TO INTEGRATE DEVELOPMENTAL SURVEILLANCE AND SCREENING INTO WELL-CHILD VISITS



Adapted from: Council on Children with Disabilities Section on Developmental Behavioral Pediatrics, et al. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. *Pediatrics*. 2006;118(1):405-420.

Despite clear evidence for the utility of objective screening tools, only about one third of pediatricians currently use formal screening tools during well-child visits.^{5, 17, 18}

Screening tools should be incorporated into certain well-child visits (9-, 18-, and 30-month visits) and used when otherwise indicated, based on routine developmental surveillance. Such surveillance should also be part of every well-child visit. Delays in development are often observed by parents and family members and brought to the attention of a pediatrician. The presence of any concerns or risk factors should prompt developmental screening with a standardized test (**Fig. 1**). Risk factors include environmental, genetic, biological, social, and demographic factors. Routine well-child office visits

are opportunities for physicians to assess and screen children, and to help parents understand their options for referral to various EI services.

Developmental monitoring and screening at well-child visits should include:

- Listening to parental concerns.
- Observing the child carefully.
- Maintaining a developmental history of the child with parental input.
- Assessing the presence of risk and protective factors.
- Using standardized screening tools at the 9-, 18- and 30-month well-child visits (and whenever otherwise indicated).
- Documenting all procedures and findings.

The AAP advises pediatric PCPs to choose screening tools that address all developmental domains, are culturally appropriate, and have good sensitivity (at least 70%) and specificity (at least 80%).¹⁹

The Ages and Stages Questionnaires (ASQ) are one of the most comprehensive and concise tools for screening for developmental delays.²⁰ The ASQ are most effective when used in combination with clinical judgment to screen for possible communicative, gross and fine motor, and cognitive and social-adaptive delays. The questionnaires contain 30 items (accompanied by small illustrations) and take 10-15 minutes to administer. There are 15 age-specific ASQ versions for parents or clinical staff to complete for a child from infancy to age 3 as part of the screening process for EI (**Resources**). ASQ assessment has a 70-90% sensitivity rate and a 76-91% specificity rate for infants. (Specific scoring information is provided with each ASQ checklist purchased.)

TABLE 2. SAMPLE QUESTIONS FROM EACH DOMAIN FOR THE AGES AND STAGES QUESTIONNAIRE FOR AGE 8 MONTHS
A parent is asked to try each activity with their child and respond "Yes," "Sometimes," or "Not Yet."

Communication	If you call to your baby when you are out of sight, does he look in the direction of your voice?
Gross Motor	When sitting on the floor, does your baby sit up straight for several minutes without using her hands for support?
Fine Motor	Does your baby pick up small toys with only one hand?
Problem Solving	Does your baby play by banging a toy up and down on the floor or table?
Personal-Social	When in front of a large mirror does your baby reach out to pat the mirror?

The ASQ checklists are scored using 10 points for a "yes" answer, 5 points for a "sometimes," and 0 points for a "no." Scores are added up by area and compared to a table of norms for each age. See Hix-Small, et al. (*Pediatrics*, 2007;120(2):381-389) for a report on the impact of implementing developmental screening at 12 and 24 months in a pediatric practice among 1,428 caregivers and children.

The ASQ checklists can be used at any well-child visit by having clinical staff complete the assessments with a family member in the waiting room. Families can also be asked to complete the assessment at home and bring it to the next office visit.²¹ Sample ASQ questions for assessing an 8-month-old child that could be brought to the 9-month visit are provided in **Table 2**.

The Modified Checklist for Autism in Toddlers (M-CHAT) is one of several screening tools for autism spectrum disorders (ASD). While the M-CHAT is a proven and effective screening tool for children ages 16-24 months when used in health care settings, the AAP has also suggested that it can be used in children as old as 48 months.²²⁻²⁷ (The M-CHAT is provided in English and Spanish on pages 14 and 15.)

TIMING OF SCREENING

The earlier screening is performed and developmental delays are identified, the earlier treatment can begin; EI is more effective than interventions started later in childhood.^{2, 22-25}

While screening for signs of developmental delays should be part of the routine series of well-child visits, the AAP also recommends that screening tests should be regularly administered at the 9-, 18-, and 30-month visits (or the 24-month visit if the 30-month visit is not covered by family insurance).^{6, 19} Specific screening dates can be important. For example, at 9 months, a targeted screening may reveal early communication, motor, and language skill delays. At 18 (and/or 24) months, indications of autism may become more evident (**Table 3**). A recent policy statement by the AAP recommends that all children be screened for ASDs at 18 and 24 months, regardless of whether there are any concerns. The 30-month well-child visit (when most children can speak in two-word phrases) can be a key opportunity to detect language delays, as well as motor, social-emotional, and cognitive delays.

FAMILIES ARE THE KEY TO SUCCESS IN EARLY INTERVENTION

The NYC DOHMH Early Intervention Program provides comprehensive services for children with developmental delays and their families. These include a multidisciplinary and linguistically appropriate evaluation, a service coordinator to guide families through the intervention process and,

TABLE 3. AUTISM SPECTRUM DISORDERS (ASD)

Diagnosis of Autism and Autism Spectrum Disorders (ASD) has increased in recent years. Recent data from the Centers for Disease Control and Prevention suggest that 1 in 150 children have an ASD.^{26,28}

What are ASDs?

ASDs are neurologically based conditions that range from classic autism, in which children demonstrate severe deficits in reciprocal social interaction and communication, along with highly restricted patterns of interests and behaviors, to Asperger Syndrome (AS). In AS, children have difficulties with social interactions, display patterns of repetitive behaviors, and intensely focused interests.

When do ASDs occur?

Research shows that there may be two different paths to ASDs. Some children may be diagnosed as early as 14 months.²⁶ Other children appear to develop normally and then regress, losing social and language skills between ages 14 to 24 months.

When to screen for ASDs?

The AAP now recommends universal screening at ages 18 and 24 months for ASDs.¹⁶ The Modified Checklist for Autism in Toddlers (M-CHAT) is one of a number of effective screening tools, and studies show it is useful in health care settings for children aged 16-48 months.^{22,25, 29,30} The M-CHAT is available in English, Spanish, Chinese, Japanese, and Turkish (www.firstsigns.org). However, there is a high false positive rate when the M-CHAT is used as the sole screening tool for ASDs.

Red Flags of ASDs (indications for immediate evaluation).

- No babbling or pointing or other gesture by 12 months.
- No single words by 16 months.
- No 2-word spontaneous (nonecholalic) phrases by 24 months.
- Loss of language or social skills at any age.

How to manage child patients with ASDs?

The AAP has developed a practical tool kit, entitled "Autism: Caring for Children with Autism Spectrum Disorders: A Resource Toolkit for Clinicians." The tool kit is designed to help pediatricians and PCPs identify ASDs earlier and guide their management of children with ASDs and their families. The tool kit can be found at: www.aap.org. Parents can benefit from educational materials about ASDs that are available on the Internet (**Resources**).

if the child is found eligible, an Individualized Family Service Plan (IFSP) to identify those services that are needed.

Pediatric PCPs and pediatricians should help families understand that the NYC Early Intervention Program involves families as partners at all stages of intervention with the child, including the initial meeting with the service coordinator, the evaluation, the IFSP meeting, and the delivery of all services. This family-centered approach, called Families as Partners, is based on evidence that EI services are much more effective when the family works closely with service providers and their child.³¹⁻³⁴

All EI services are individualized to the needs of the child and family, and are completely voluntary. Interventionists (such as occupational and speech

therapists), in conjunction with parents, identify activities for families to practice with their children between sessions. Activities are structured to fit into the family's daily routines and are designed to increase the confidence of parents, as well as utilize a child's natural learning opportunities to address specific developmental needs. For example, a speech therapist may suggest simple activities for families to do with a child at the dinner table or at bath time to build on what was done during the intervention session.

Physicians can help the process by stressing to families that their participation is important to the effectiveness and success of EI services. EI services not only enhance functional outcomes and educational achievement for children, but also improve quality of life for children and families.^{7, 9-12}

TABLE 4. MAJOR RISK FACTORS FOR DEVELOPMENTAL DELAYS IN YOUNG CHILDREN ³⁵⁻³⁷

- Low birth weight.
- Prematurity.
- Exposure to drugs or alcohol in utero.
- Being in foster care.
- Living in poverty or chaotic home situations.

ADDRESSING RISK FACTORS THAT MAY AFFECT YOUNG CHILDREN’S DEVELOPMENT

Prematurity, congenital anomalies, and perinatal injuries are leading medical risk factors for developmental delays. A variety of external factors, such as exposure to drugs or alcohol in utero or living in poverty, may also increase a child’s risk (Table 4). The family and home environment can significantly affect a child’s developmental trajectory.

Recent research has shown that living in an impoverished or chaotic home environment with families that face many life stressors can have a negative impact on a child’s developing nervous system⁴ and overall health.³⁸ Healthy brain development requires the involvement of adults who can support young children’s learning. The quality of the home environment has also been linked to early language and cognitive skills, social-emotional development, and success in school.^{15, 39-41}

It is critical to be sensitive to such issues when working with families at risk.^{42, 43} Parenting curricula are available for pediatric PCPs to educate at-risk parents about child health and safety. For example, the Health and Wellness Program parenting curriculum (**Resources**) is designed for pediatricians to assist caregivers who themselves have disabilities, mental illness, or other challenges such as poverty⁴⁴ that may place their children at risk for delays. The curriculum provides simple instructions and guidelines for working with families to increase parenting knowledge and skills, knowledge of child development, and health education targeted to infancy and early child development, along with information on home safety precautions.

MODIFIED CHECKLIST FOR AUTISM IN TODDLERS (M-CHAT) *Reproduced with permission*

Scoring the M-CHAT: Failure is considered to be a “no” answer to the critical items 2, 7, 9, and 13-15, and a “yes” answer to items 11, 18, 20 or 22. If the child fails two or more critical questions or any other 3 items, they should be evaluated in more depth and/or referred to EI. Failing the M-CHAT does *not* equal a diagnosis of autism, but puts a child at risk for an ASD.

M-CHAT

Please answer the following questions about how your child usually acts. Please try to answer every question. If a behavior is rare (e.g., observed once or twice), please answer “no.”

- | | | |
|---|-----|----|
| 1. Does your child enjoy being swung, bounced on your knee? | Yes | No |
| 2. Does your child take an interest in other children? | Yes | No |
| 3. Does your child like climbing on things, such as up stairs? | Yes | No |
| 4. Does your child enjoy playing peek-a-boo/hide and seek? | Yes | No |
| 5. Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things? | Yes | No |
| 6. Does your child ever use his/her index finger to point, to ask for something? | Yes | No |
| 7. Does your child ever use his/her index finger to point, indicate interest in something? | Yes | No |
| 8. Can your child play properly with small toys (e.g., cars or blocks) without just mouthing, fiddling, or dropping them? | Yes | No |
| 9. Does your child ever bring objects over to you (parent) to show you something? | Yes | No |
| 10. Does your child look you in the eye for more than a second or two? | Yes | No |
| 11. Does your child ever seem oversensitive to noise? (e.g., plugging ears) | Yes | No |
| 12. Does your child smile in response to your face or your smile? | Yes | No |
| 13. Does your child imitate you? (e.g. you make a face—will your child imitate it?) | Yes | No |
| 14. Does your child respond to his or her name when you call? | Yes | No |
| 15. If you point at a toy across the room, does your child look at it? | Yes | No |
| 16. Does your child walk? | Yes | No |
| 17. Does your child look at things you are looking at? | Yes | No |
| 18. Does your child make unusual finger movements near his/her face? | Yes | No |
| 19. Does your child try to attract your attention to his/her own activity? | Yes | No |
| 20. Have you ever wondered if your child was deaf? | Yes | No |
| 21. Does your child understand what people say? | Yes | No |
| 22. Does your child sometimes stare at nothing or wander with no purpose? | Yes | No |
| 23. Does your child look at your face to check your reaction when faced with something unfamiliar? | Yes | No |

MODIFIED CHECKLIST FOR AUTISM IN TODDLERS (M-CHAT) IN SPANISH

Reproduced with permission

M-CHAT en Español: Evaluación del desarrollo de niños en edad de caminar

Por favor conteste acerca de como su niño (a) es usualmente. Por favor trata de contestar cada pregunta. Si el comportamiento de su niño no ocurre con frecuencia, conteste como si no lo hiciera.

- | | | |
|---|----|----|
| 1. ¿Disfruta su niño (a) cuando lo balancean o hacen saltar sobre su rodilla? | Sí | No |
| 2. ¿Se interesa su niño (a) en otros niños? | Sí | No |
| 3. ¿Le gusta a su niño (a) subirse a las cosas, por ejemplo subir las escaleras? | Sí | No |
| 4. ¿Disfruta su niño (a) jugando "peek-a-boo" o "hide and seek" (a las escondidas)? | Sí | No |
| 5. ¿Le gusta a su niño (a) jugar a pretender, como por ejemplo, pretende que habla por teléfono, que cuida sus muñecas, o pretende otras cosas? | Sí | No |
| 6. ¿Utiliza su niño (a) su dedo índice para señalar algo, o para preguntar alguna cosa? | Sí | No |
| 7. ¿Usa su niño (a) su dedo índice para señalar o indicar interés en algo? | Sí | No |
| 8. ¿Puede su niño (a) jugar bien con juguetes pequeños (como carros o cubos) sin llevárselos a la boca, manipularlos o dejarlos caer? | Sí | No |
| 9. ¿Le trae su niño (a) a usted (padre o madre) objetos o cosas, con el propósito de mostrarle algo alguna vez? | Sí | No |
| 10. ¿Lo mira su niño (a) directamente a los ojos por mas de uno o dos segundos? | Sí | No |
| 11. ¿Parece su niño (a) ser demasiado sensitivo al ruido? (por ejemplo, se tapa los oídos)? | Sí | No |
| 12. ¿Sonríe su niño (a) en respuesta a su cara o su sonrisa? | Sí | No |
| 13. ¿Lo imita su niño (a)? Por ejemplo, si usted le hace una mueca, su niño (a) trata de imitarlo? | Sí | No |
| 14. ¿Responde su niño (a) a su nombre cuando lo (a) llaman? | Sí | No |
| 15. ¿Si usted señala a un juguete que está al otro lado de la habitación a su niño (a), lo mira? | Sí | No |
| 16. ¿Camina su niño (a)? | Sí | No |
| 17. ¿Presta su niño (a) atención a las cosas que usted está mirando? | Sí | No |
| 18. ¿Hace su niño (a) movimientos raros con los dedos cerca de su cara? | Sí | No |
| 19. ¿Trata su niño (a) de llamar su atención (de sus padras) a las actividades que estada llevando a cabo? | Sí | No |
| 20. ¿Se ha preguntado alguna vez si su niño (a) es sordo (a)? | Sí | No |
| 21. ¿Comprende su niño (a) lo que otras dicen? | Sí | No |
| 22. ¿Fija su niño (a) su mirada en nada o camina sin sentido algunas veces? | Sí | No |
| 23. ¿Su niño (a) le mira a su cara para chequear su reacción cuando esta en una situación diferente? | Sí | No |

In NYC, the EI program maintains a Developmental Monitoring Unit to track those children who are facing multiple risks for developmental delays, but who do not show evidence of delays that would make them eligible for EI services. Providers can refer a child to the program by calling 311 or the appropriate borough office (**Page 1**). The Developmental Monitoring Unit conducts ongoing periodic surveillance using the ASQ checklist. The unit also educates parents on the progression of typical child development and addresses family concerns about delays that might affect their child. If screening suggests a child is developing atypically, he or she may be referred for further diagnostic assessment and EI services, with the parent's permission. Written permission is not required for referrals, but families should ideally be involved in the referral process. While a child may be referred for EI services without a parent's consent, they may not be referred if a parent voices objections. Monitoring the child's development through EI services can continue until the child is 3 years old.

BEYOND EI: DEVELOPMENTAL DELAYS IN OLDER CHILDREN

Older children (aged 3-5) in NYC diagnosed with developmental delays are referred to intervention services provided by the city's Department of Education. To refer a preschool child for an evaluation or services, call 311 or visit the Department Web site: <http://schools.nyc.gov/default.aspx>. Detecting developmental delays as early as possible and referring children to appropriate services can support a family's ability to meet the needs of its children. ♦

THE NURSE-FAMILY PARTNERSHIP

The Nurse-Family Partnership (NFP) is a home visiting program for low-income, first-time mothers, their infants, and families. Research has shown the NFP is effective in improving health-related outcomes. An NFP nurse visits a family every 1-2 weeks until a child is 2 years old, and can make referrals to needed services in the community, including early intervention services. Women can enroll in the program until the 28th week of pregnancy by calling 311, and asking for the NFP.

To find out more about the program, see www.nycnfp.com or visit the national NFP Web site at:

www.nursefamilypartnership.org/index.cfm?fuseaction=home.

RESOURCES

Screening Tools

Ages and Stages Questionnaires (ASQ) – Note: There are different versions appropriate for use in children between the ages of 4 to 60 months. Paul H. Brookes Publishing Co: 1-800-638-3775. Available at: www.brookespublishing.com/store/screening.htm

Modified Checklist for Autism in Toddlers (M-CHAT): www.dbpeds.org/media/mchat.pdf
www.firstsigns.org

Tymchuk, A. Health and Wellness Program: A Parenting Curriculum for Families at Risk. Paul H. Brookes Publishing Co. 2006. www.brookespublishing.com/store/screening.htm

Information on Developmental Assessment Tools from the American Academy of Pediatrics: <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405/T1>.

General Information on Developmental Delays

National Early Childhood Technical Assistance Center (NECTAC) www.nectac.org. NECTAC is funded by the US Department of Education and its goal is to improve services and better implement IDEA part C. See also: www.ed.gov/about/offices/list/osers/osep/index.html for information about the federal EI program.

Centers for Disease Control and Prevention (CDC). Developmental Disabilities Web site. Available at: www.cdc.gov/ncbddd/dd/default.htm

Information on Partnership Between Parents and Doctors

Building Early Intervention Partnerships with Your Child's Doctor: Tips for Parents. Available at: www1.dshs.wa.gov/

National Center of Medical Home Initiatives for Children with Special Needs www.medicalhomeinfo.org

A range of services are provided by this center to improve services and inform parents and providers about tools for screening infants and young children and other health care needs

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Autism: Caring for Children with Autism Spectrum Disorders: A Resource Toolkit for Clinicians. www.pediatrics.org/cgi/content/full/120/5/1162

References Available Online: www.nyc.gov/html/doh/downloads/pdf/chi/chi27-2.pdf

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DOHMH JOB OPENINGS: Nurse Careers: Nurse-Family Partnership Nurses (home-visiting nurses to partner with first-time mothers), School Nurses, and Newborn Home Visiting nurses. View jobs at www.nyc.gov/health/careers.



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Continuing Education Activity

Identifying and Referring Children with Developmental Delays to Early Intervention Services.

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Learners participate in this continuing education activity through self-instruction by reading the text and taking a post-test.

Objectives

At the conclusion of the activity, the participants should be able to:

- 1) Increase awareness that developmental delays should be identified in young children and promote referrals to early intervention programs. Early identification and treatment of developmental delays can have a positive impact on children and families.
- 2) Emphasize that objective screening tools and clinical judgment should be used with children under the age of 3 years to detect developmental delays.
- 3) Provide pediatricians and PCPs with materials regarding the best screening tools to use with children under the age of 3. (www.aap.org)
- 4) Provide specific information about autism and autism spectrum disorders and inform pediatricians and PCPs that the AAP recommends that all children should be screened for ASD at ages 18 and 24 months, and at other times when there is concern by families or physicians.

CME Accreditation Statement

The *New York City Department of Health and Mental Hygiene* (NYC DOHMH) is accredited by the *Medical Society of the State of New York* to sponsor continuing medical education for physicians. The NYC DOHMH designates this continuing medical education activity for a maximum of 1.0 AMA PRA Category 1 Credit(s)[™]. Each physician should only claim credit commensurate with the extent of his/her participation in the activity.

Participants must submit the accompanying exam by **February 28, 2009.**

CME Faculty:

Barbara Burns, PhD
Jeanne Clancy, PhD
Margo Amgott, MPA
Paulette Flores, MA
Prashil Govind, MD, MPH
Linda Stone, PhD

All faculty are affiliated with the NYC DOHMH. The faculty does not have any financial arrangements or affiliations with any commercial entities whose products, research, or services may be discussed in this issue.

CME Activity Identifying and Referring Children with Developmental Delays to Early Intervention Services

1. Which of the following is not true?

- A. Most developmental delays are detected before children reach school age.
- B. EI services can positively impact child and family outcomes.
- C. A child should be holding a rattle at 4-5 months.
- D. When developmental delays are detected earlier, treatment is more effective.

2. A well-child visit should include:

- A. Use of standardized screening tools for children (when indicated).
- B. Listening to family concerns.
- C. Careful observation of the child.
- D. b and c.
- E. a, b, and c.

3. Early Intervention services:

- A. Are only provided for children from low-income families.
- B. Are individualized to meet the needs of children and their families.
- C. Engage families as an integral part of effective treatment.
- D. b and c.
- E. a, b, and c.

4. Which of the following is most effective in the detection of developmental delays?

- A. Parent interviews.
- B. Detailed developmental histories.
- C. Adherence to vaccination schedules.
- D. Use of objective screening tools with clinical judgment.

5. The prevalence of ASDs is now estimated to be 1 per 150 children. The AAP recommends universal screening for ASDs at:

- A. 6 and 12 months.
- B. 6 or 12 months.
- C. 18 and 24 months.
- D. 18 or 24 months.
- E. 6, 12, 18, and 24 months.

6. Risk factors for developmental delays include:

- A. Prematurity.
- B. Exposure to drugs and alcohol in utero.
- C. Congenital abnormalities.
- D. Poverty.
- E. a, b, and c.
- F. All of the above are risk factors.

7. How well did this continuing education activity achieve its educational objectives?

- A. Very well
- B. Adequately
- C. Poorly

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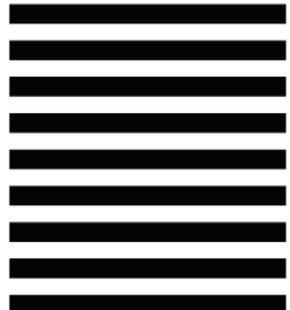
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