

Practical Tips for Implementing the ASQ-3™ in a Pediatric Office Setting

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The following information is designed to help pediatric practices effectively and efficiently implement a **paper-based** screening and surveillance system using the **Ages & Stages Questionnaires®, Third Edition** (ASQ-3™). Recommended tasks for various staff members are provided. Information about optional supplemental social-emotional, autism-specific, and family psychosocial screening is also included.

1. **SCHEDULER:** The scheduler (and an automated phone appointment reminder system) instructs the caregiver(s) to come in 15 minutes early for the well-child visit (WCV) so he or she can thoughtfully complete the ASQ-3™ in a quiet corner of the reception area with available ASQ-3 toys. If a practice has a lower percentage of Medicaid-eligible patients, the ASQ-3 can be mailed to the home 2-4 weeks prior to the targeted WCV so it can be thoughtfully completed at home. Scheduler's message is: "The AAP and your doctor strongly recommend a standardized developmental screening at 9, 18 and 30 [or alternately, 24] months."

Note: single-point screening (i.e., screening a child at only one well-child visit) is an inadequate approach to detecting developmental delays and makes it difficult for clinicians to recognize problem patterns (i.e., developmental delay, dissociation, deviancy, regression, or disorder). Over time, consider expanding universal ASQ-3 screening to 9 (if missed, then 12), 18, 24, and 36 months.

2. **RECEPTIONIST:** For AAP-recommended universal screening visits, the receptionist gives the caregiver the correct age-interval ASQ-3 as soon as he or she enters the waiting room. The receptionist has several recommended tasks:

- 1) Ask caregiver "How many months old is your child currently?"
- 2) Ask caregiver "Was your child a preemie?" If yes, ask "How many weeks premature was he/she?" so the correct, age-adjusted ASQ-3 can be given.
- 3) Then, the receptionist says, "The ASQ-3 is a fun and important part of your child's well-child visit. Please fill it out thoughtfully."
- 4) The caregiver should be given a pen and clipboard. (This detail may sound trivial but it makes a difference with ASQ-3 completion rates.)
- 5) If possible, a receptionist or another designated clinic staff member should score the ASQ-3 before the clinician walks into the exam room. With repetition, ASQ-3 scoring takes less than a minute.

Note: pre-visit screening increases the quality of a clinician's less structured surveillance, increases parental satisfaction, and allows practices to reliably obtain 96110 reimbursement, which allows periodic screening to be sustainable.

3. **NURSE:** The nurse double-checks to make certain the caregiver received the correct age-interval ASQ-3 and that the caregiver has a pen. Then, the nurse repeats, "The ASQ is a fun and important part of the well-visit. Please fill it out thoughtfully." Nurses are typically overloaded with tasks prior to any WCV. This is why the receptionist or another designated staff member typically is responsible for scoring the ASQ-3.

4. **CLINICIAN:**

Routine practice—at every WCV: the clinician states "Please tell me any concerns about your child's behavior, learning and development." The wording of this open-ended statement and consideration of cultural/language issues is critically important. Do not ask caregivers if they have any *worries* about their

child's development. The word *worries* has a negative context that may skew their response. Be aware that many parents interpret the word *development* to merely reflect physical growth.

If the caregiver indicates the presence of concerns or other components of a clinician's surveillance indicate *developmental-behavioral risk*, then administer the correct age-interval ASQ-3, if it has not already been completed. For some practices, *screening as needed* when surveillance demonstrates *developmental-behavioral risk* may be less feasible and more disruptive to office flow than regular screening at established intervals.

AAP-recommended universal screening visits: the clinician should review and "interpret" the completed (and preferably scored) ASQ-3. The clinician checks to see that no question(s) were missed. If item(s) were not answered, it's sometimes possible to complete them during the exam. For items marked "not yet," the clinician asks the caregiver if the child has ever tried that developmental task.

After thoughtfully reviewing the scored ASQ-3 results in the context of a clinician's ongoing, less structured surveillance, standardized patient management options include:

- Caregiver to schedule next routine WCV (observation only)
- Add problematic ASQ-3 result to patient's problem list
- Provide caregivers with age-appropriate ASQ-3 activity sheets to encourage development (or mail them to the family's home)
- Refer to local EI or ECSE agency
- Refer to early childhood community resource (e.g., parenting education/support group, domestic violence program, high-quality daycare or preschool program such as Head Start, etc.)
- Early return (< 2 months) office visit for a repeat assessment, which might include a secondary social-emotional (ASQ:SE) or autism-specific (M-CHAT +/- M-CHAT Follow-up Interview) screening
- Refer to a developmental-behavioral and/or medical sub-specialty team, in addition to an EI or ECSE agency referral (e.g., developmental-behavioral pediatrician, neuro-developmental pediatrician, speech-language pathologist, audiologist with or without an ENT surgeon, occupational or physical therapist, mental health provider, pediatric neurologist, genetic or metabolic clinic, etc.)

Sometimes, the ASQ-3 is not completed by the time the clinician enters the exam room. For Medicaid patients and children with younger (< 21 years old) or Spanish-speaking parents, it is imperative to have caregivers complete the ASQ-3 at the WCV. For other caregivers, it is acceptable to have them thoughtfully complete the ASQ-3 at home and mail it back in an envelope addressed to the clinic.

Note: 96110 reimbursements will be problematic with the mail-back data collection protocol. Most all payers require that the 96110 CPT code be paired with the WCV code.

5. RESOURCE STAFF: After the clinician has taken action upon ASQ-3 results and discussed "next steps" with the caregiver(s), clinic resource staff should then generate the necessary referrals and act upon other clinician recommendations. System-wide programs like the Help Me Grow (HMG) program can provide more reliable referral care coordination assistance for practices with limited resources.

Note: multiple studies indicate that referral care coordination is the weak link in the chain of ongoing developmental and behavioral surveillance.

For some practices, pre-visit ASQ-3 scoring and interpretation is less feasible. In this situation, the ASQ-3 should ideally be completed before the caregiver leaves the clinic and then promptly scored (the same day as the WCV so 96110 can be paired with the WCV code) by resource staff. ASQ-3 results are sent back to the clinician (the same day) for interpretation so evidence-based management decisions (see #4) can be promptly made.

Supplemental Social-Emotional, Autism-specific, and Family Psychosocial Screening

Initial office visit or 2-week WCV: AAP/Bright Futures Pediatric Intake Form

If psychosocial risk factors are identified, this increases the need for supplemental social-emotional screening, community-based interventions (e.g., parenting support groups, post-partum mood disorder referral sources, domestic violence program, drug and/or alcohol treatment centers, etc.) and clinic-based interventions (e.g., Reach Out and Read, promotion of developmental and behavioral wellness, etc.). If (+) parental or provider behavioral concerns, (+) developmental-behavioral risk factors, or problematic ASQ-3 results, then consider supplemental ASQ:SE screening at future WCVs.

2-month WCV: Edinburgh Postnatal Depression Screen (EPDS)

If the score is 10 or above, post-partum mood disorder counseling (reinforced by a trusted patient handout) and a community resource phone number should be provided. A courtesy copy of the clinic note should be sent to the mother's primary care physician (PCP) (e.g., family practitioner, obstetrician, nurse midwife). If the EPDS or the clinician's less structured surveillance indicates a post-partum psychosis or severe mood disorder, then a personal phone call should be made to the mother's PCP.

4- and 6-month WCV and "as needed": EPDS

Administer the EPDS at 4 and 6 months if the EPDS score was 10 or above at 2 months or if a clinician's less structured surveillance demonstrates risk for a maternal mood disorder. Whenever the EPDS score is 10 or above, please see above procedures for suggested next steps.

18- & 24-month WCV and "as needed": M-CHAT +/- M-CHAT Follow-up Interview

Autism-specific (M-CHAT) screening is recommended at 18 and 24 months. The M-CHAT can be scored with a transparent scoring sheet that highlights the 6 critical items. This allows the M-CHAT to be scored in < 15 seconds. Autism-specific screening is especially important when there is a (+) family history of ASD or if there are (+) parental, other caregiver, or clinician concerns about ASD. If (+)/concerning M-CHAT, then child should be referred to EI and an early return visit (<2 months) is typically needed for a more in-depth assessment. The authors of the M-CHAT now recommend the M-CHAT Follow-up Interview for any failed M-CHAT (which could also be completed by the EI agency).

Note: a preliminary retrospective study indicates that 97.8% of ASD cases (non-ASD cases not examined) previously had a suspected delay on their ASQ in 1 or more domains; therefore, the ASQ is likely highly sensitive to ASD. However, supplemental use of the M-CHAT and M-CHAT Follow-up Interview helps providers to more accurately determine which children truly are in need of a comprehensive ASD-specific EI plan and sub-specialty team evaluation.

4- or 5-year WCV and "as needed": ASQ:SE

The AAP recommends a school readiness screening at 4 years. Social-emotional problems are oftentimes predictive of future academic problems and school failure; therefore, practices should consider universal social-emotional screening at the 4-year (and if missed, then 5-year) WCV. Social-emotional screening should also occur whenever there is: 1) (+) caregiver or provider concerns about a child's behavior (self-regulation, compliance, communication, adaptive functioning, autonomy, affect, interpersonal interactions, etc.), 2) a history of a failed general developmental (ASQ-3) or autism-specific (M-CHAT) screen (per the AAP), 3) (+) history of a medical condition (e.g., prematurity) that increases the probability of a future mental health disorder, 4) (+) family history of a mental health disorder, or 5) notable psychosocial risk factors that increase the probability of an impairing mental health problem. For "as needed" social-emotional screening to be feasible in a primary care setting, supplemental ASQ:SE screening commonly needs to be done at an early return (< 2 months) office visit.

Note: The ASQ:SE tends to be more quickly completed by parents because its questions are based on parental experience/recall and not on their child's ability to perform a specific developmental task (like the ASQ-3). For this reason, universal pre-visit ASQ:SE screening at 4-5 years is not as difficult as many practitioners might assume. As with the ASQ-3, cultural and language issues should be considered when interpreting the results of the ASQ:SE.