**Judging the Effectiveness of Training: Pre- and Post-tests**

**Website support for Appendix B**

When training others, you’ll need information on what trainees want and need to learn, how well content has been mastered, what participants will do with the information you’ve provided and any suggestions they have for improving your presentation. Provided on this web page are pre- and post-test questions designed to be a learning experience that requires trainees to think in a variety of ways, affirm what they’ve learned, and allow trainers to discern what content has been mastered or not. Included are items focused on: a) pre-testing, i.e., questions designed to identify in advance what trainees need and want to know; b) post-testing to determine whether trainees demonstrate sufficient knowledge and functional skills in understanding development, policy, services, and screening test administration, and potentially train others; and c) presentation feedback and questions to help trainees implement what they have learned. A scoring guide is shown at the end.

**The topics covered are:**

* Knowledge of child development and its domains
* Meaning and prevalence of delays and disabilities
* Policy, service mandates, and the rationale for these
* The value of early intervention and developmental promotion
* Psychosocial risk, resilience, and parenting issues including best methods for explaining results
* Knowledge of referral options
* Specifics about measurement including administration, scoring and interpretation of various screens
* Implementation and collaboration issues
* Questions for program evaluation including pre- and post-course feedback

The entire set of items requires about 30 – 45 minutes to complete but all may not be needed. So, you can download the questionnaire (in Word) and delete items not covered in your presentation. We ask that you keep the copyright and permissions notice on each page of your questionnaire. If you create new questions you wish we’d included, [please send them to us](http://www.pedstest.com/ContactUs) so we can add them to the website to share with others*.* Finally, if you are applying for continuing education credits for your course, you will undoubtedly need to share (your adapted version of) this questionnaire with the sponsoring university or agency.

*Note:* Performance criterion (e.g., 80%, 95%) is a decision you will need to make based on whether you expect participants to demonstrate mastery of skills (e.g., in test administration) or also have the background skills to train others. Please see Chapter 15 for additional ideas (such as requiring independent practice with test scoring before offering certification). Included on the website is a downloadable sample certificate (in PowerPoint) that can modified to show course completion, mastery, etc.

Trainees appreciate certificates of attendance or mastery. Included here is a downloadable certificate (in Powerpoint) you can personalize and print out as needed.

**PRE-PRESENTATION QUESTIONS**

#### What do you hope to learn from today’s presentation?

#### What methods of early detection are you currently using?

#### What challenges, successes, and worries do you have about your current approaches?

#### Any other comments about what you’d like to learn today?

#### Services

#### 1. What does IDEA stand for? (circle all that apply)

#### Irksome Developmental Efforts and Annoyances

#### International Development and Education Association

#### Individuals with Disabilities Education Act

#### Intervening in Development is Effective Act of 1976

#### 2. IDEA services: (circle all that apply)

#### are rarely available

#### are expensive and involve lengthy waiting lists

#### exist in every county and State

#### must be provided within approximately 40 days of referral

3. **How is early intervention beneficial?** (circle all that apply)

a) reduces the impact of psychosocial risk factors

b) reduces drop-out rates

c) increases chance of employment and school success

d) decreases teen pregnancy and violent crime

e) saves society money

f) increases likelihood of owning a home

g) increases chance of graduating from high school

4. **List three services for children with delays who do not qualify for IDEA programs:**

1. **AAP Policy and Billing/Coding**

**1. What are the components of the American Academy of Pediatrics policy statements on screening and surveillance for mental health, developmental-behavioral problems, and autism spectrum disorder?** Circle all that apply:

* 1. encourages providers to detect and address psychosocial risk factors
	2. discourages use of screening tests
	3. confirms clinical judgment as the primary detection method
	4. encourages watchful waiting rather than prompt referral
	5. emphasizes prompt referrals to early intervention
	6. encourages frequent use of screening tests
	7. confirms the value of informal milestones checklists

**2. Why does American Academy of Pediatrics policy state, in effect, “*We hope the combination of surveillance and screening sets up a pattern of practice that extends to well-visits beyond the 24 – 30 month age range”*?**  Circle all that apply:

* 1. developmental-behavioral problems are still developing
	2. language impairments and other disabilities or delays aren’t always visible before 24 – 30 months
	3. clinical observation, judgment, and informal milestones checklists are not an effective early detection method
	4. psychosocial risk factors have not yet impacted adversely children’s development
	5. early intervention continues to be effective after 24 – 30 months of age
	6. This is overkill because detection at 24 – 30 months will pick up most children with problems and so additional screening/surveillance is not needed.

**3. Should we stop screening after 24 – 30 months of age: Why or why not?** (in your own words):

**4. What is meant by developmental surveillance?** (circle all that apply):

1. eliciting and addressing parents’ concerns at each visit
2. measuring milestones at each visit
3. identifying and intervening with psychosocial risk factors
4. promoting development and educating parents
5. exclusive reliance on provider judgment to identify children with problems
6. determining families’ needs for various types of services
7. maintaining child and family medical history
8. conducting a thorough physical exam
9. monitoring parental well-being
10. frequent use of accurate screening tools

**5. AAP policy recommendations for screening and surveillance:**

a) **Require different tools for surveillance than for screening**

\_\_\_True \_\_\_\_False

b) **Can be accomplished by using the same tools for both surveillance and screening**

\_\_\_True \_\_\_\_False

c) **Can be accomplished by clinical judgment and informal age specific milestones**

\_\_\_True \_\_\_\_False

**6. When coding for developmental screens in primary care** **and public health, you should, depending on payer requirements/denials:** (circle all that apply)

1. attach the -25 modifier to the preventive service code and then add 96110
2. show next to 96110, the number of screens administered (e.g., X 3)
3. expect to receive about $8.00 per screen
4. need to help families appeal claims denied by private payers
5. use the -59 modifier typically with denied claims
6. expect separate payments for 96110 in States with enhanced reimbursement for well visits
7. ask for help from the American Academy of Pediatrics
8. have each clinic’s coordinator check with each payer for specific coding details

**7. If you are (wisely) screening at well visits beyond 24 – 30 months and your payer denies claims, you should:** (circle all that apply)

1. sigh deeply and let it go
2. appeal the claim to the payer
3. point out to the payer that the AAP encourages screening at all well-visits
4. appeal to the AAP

**III. Child Development, Disabilities, Delays, and Prevalence**

1. **Of the various domains of development, which are the best predictors, during the preschool years, of future school success?**

2. **Identify each of these statements as true or false**:

 a**)Developmental-behavioral problems are usually innate, genetic, or congenital and present at birth.**

 \_\_\_\_True \_\_\_\_False

 b) **Most children with developmental-behavioral problems have dysmorphic features (e.g., unusual eye shape or hairlines) or observable deficits (e.g., gait problems, floppy tone, etc.)**

 \_\_\_\_True \_\_\_\_False

3. **What is the prevalence of developmental disabilities in the 0 through 18 year age range?** Circle one:

a) 6% – 8%

b) 16% - 18%

c) 8% - 12%

d) 23% – 27%

e) 28%

4. Identify this statement as true or false: **If working with low-income families, professionals should expect incidence rates to be higher than national averages.**

 \_\_\_True \_\_\_ False

5. **The national prevalence rates (in the middle column) do not match the age groups (shown in the left column).** Please write in the left hand column the letter assigned to the correct prevalence for each age group.

|  |  |  |
| --- | --- | --- |
| **Age Group (in years)** | **Prevalence** | **Letter for correct Prevalence by Age Group** |
| 0 - 2 | A. 6% |  |
| 0 - 3 | B. 12% |  |
| 0 - 4 | C. 8% |  |
| 0 - 6 | D. 16% |  |
| 0 - 8 | E. 4% |  |
| 0 - 18 | F. 16 - 18% |  |

6. **Which new (or previously undiagnosed) developmental-behavioral problems might we expect to discover in children 8 years and older**: (circle all that apply)

* + 1. speech-language impairment
		2. learning disabilities
		3. cerebral palsy
		4. mild autism spectrum disorder
		5. slow learning (e.g., IQ < 85)
		6. mental health problems
		7. none of the above

7. **Indicate True or False to the following statements regarding differences in developmental delays versus disabilities:**

a) **Developmental delay is diagnosis typically used in IDEA 0 – 3 programs.**

 \_\_\_True \_\_\_\_False

b) **Developmental delay is uniformly defined across US States’ IDEA programs.**

 \_\_\_True \_\_\_\_False

c) **Beyond the 0 – 3 age range and outside of IDEA programs, developmental delay refers to children who are behind age-mates and are likely to fail once they reach kindergarten.**

 \_\_\_True \_\_\_\_False

d) **Developmental disabilities refers to a range of conditions which, if diagnosed, indicate eligibility for IDEA programs serving children 3 years of age and older.**

 \_\_\_True \_\_\_\_False

e) **ADHD is a disability that consistently qualifies children for IDEA programs.**

 \_\_\_True \_\_\_\_False

f) **Family psychosocial risk factors often contribute to developmental delay.**

 \_\_\_True \_\_\_\_False

g) **Children with delays always qualify for IDEA programs.**

 \_\_\_True \_\_\_\_False

h) **Developmental delay means that children will catch up with time.**

 \_\_\_True \_\_\_\_False

i) **Developmental disorders are disabilities characterized by age-appropriate skills but problematic application (e.g., four-word utterances months with excessive repetition, lack of communicative intent, odd syntax, difficulty with pronouns).**

 \_\_\_\_True \_\_\_\_False

8. **Children with disordered development may talk, walk, even read on time. They may not always exhibit delays on milestones type screening tests. This means that providers should:** (check all that apply)

a) \_\_\_ consider the quality of performance on milestones tasks

b)\_\_\_ listen carefully to parents’ observations and concerns

c)\_\_\_ wait and see

d)\_\_\_ refer only children with obvious delays

**9. Assign a number to the common disabilities of early childhood in order of prevalence (with “1” being most frequent):**

 \_\_\_intellectual disabilities

 \_\_\_ attention deficit hyperactivity disorder

 \_\_\_ specific learning disabilities

 \_\_\_ speech-language impairment/delays

 \_\_\_ autism

 \_\_\_ cerebral palsy and other physical impairments

**10. Disabilities and delays are difficult to detect by clinical judgment. Reasons include** (circle all that apply):

a) most children seem typically developing in the first two years of life

b) psychosocial risk factors take a slow toll on developmental outcomes that may not be visible until 3 to 4 years of age

c) the limits of the “broad range of normal” are too broad in the absence of criteria/cutoffs

d) all of the above

e) a and c above

**IV. Parenting, Psychosocial Risk, Explaining Results**

1. **When explaining screening results to families, it is wise to:** (circle all that apply)

1. describe the more potentially adverse future outcomes
2. explore what families already know
3. affirm the potential value of their concerns
4. allow time for questions and expression of emotions
5. discuss the negative impact on siblings
6. suggest out of the home placements
7. explain risk/prevalence in several ways
8. give news over the telephone
9. offer a follow-up meeting with other family members
10. offer global reassurance (e.g., likelihood that a problem may not exist)
11. present early intervention in a positive light
12. provide a diagnostic label (if you have not administered diagnostic measures of development and behavior)
13. use everyday language (e.g., “seems behind”)
14. provide a take home summary of results/recommendations
15. sit behind a desk or stand to deliver information to families
16. avoid giving difficult news because it is uncomfortable for parents and providers

2. **List some appropriate activities for parent-child interactions when children are 6 – 12 months of age**.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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3. **Match parenting styles with their definitions by placing the definition number in the space next to parenting style:**

**Parenting Style Definition**

|  |  |
| --- | --- |
| Permissive\_\_\_\_ | 1. Both demanding and responsive. Disciplinary methods are supportive, rather than punitive.
 |
| Authoritarian \_\_\_\_ | 1. indulgent, avoiding confrontation, more responsive than demanding
 |
| Authoritative \_\_\_\_ | 1. low in both responsiveness and demanding-ness. Often uninvolved and depressed
 |
| Neglectful \_\_\_\_\_ | 1. highly demanding and directive, but not responsive. Often intrusive and punitive
 |

4. **Psychosocial risk factors include:** (circle all that apply)

1. a permissive parenting style
2. authoritarian or uninvolved parenting style
3. two parents with stressful full-time jobs
4. single parent
5. parents with less than a high school education
6. frequent household moves
7. first born/only child
8. 4 or more children in the home
9. limited social support
10. parental mental health problems such as depression
11. minority status
12. limited parental literacy
13. teen motherhood
14. limited two-way communication between parent and child

5. **Psychosocial risk factors:** (check all that apply)

1. usually cause declines in intelligence, language and academic skills
2. are associated with being held back in school
3. increase the likelihood of dropping out of high school
4. are associated with teen pregnancy, criminality, and unemployment
5. are rarely changeable and thus not an effective target for intervention
6. often have a greater adverse impact on child development than prematurity

6. **Children with psychosocial risk factors for developmental problems:** (circle all that apply)

a) are unlikely to have emerging disabilities

b) may need to be enrolled in Head Start

c) often have numerous psychosocial risk factors

d) are likely to be over-referred by screening tests

e) may not qualify for early intervention

f) benefit from quality preschool or Head Start

g) have parents who may need to be taught parenting skills

h) have parents who may need social work services for assistance with housing, food, job training, etc.

i) have parents who may have depression, anxiety or other mental health problems needing treatment

7. **Parents sometimes ask for parenting advice and suggestions for age-appropriate parent-child activities. Please name two or more sources for information you can share with parents:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**V. Measurement Principles in Early Detection**

1. **Accurate screening tests typically identify what percent of children with disabilities prior to kindergarten enrollment?** (circle one)

a) 5%

b) 15%

c) 30%

d) 60%

e) 70% to 90%

2. **Primary care providers using clinical judgment and informal milestones typically identify what percent of children with disabilities prior to kindergarten enrollment?** (circle one)

a) 5%

b) 15%

c) 30%

d) 60%

e) 70% to 90%

3. **What is meant by “developmental screening”?** (Circle all that apply)

* 1. use of informal milestones checklists
	2. use of selected items from lengthier screens such as the Denver
	3. use of measures that are standardized and reliable
	4. use of measures that are validated, sensitive and specific
	5. trigger or informal questions to parents

4. **Specificity is the**: (circle all that apply)

a) percentage of children without disabilities correctly detected by a screen

b) percentage of children with disabilities correctly detected by a screen

c) the percentage of children with failing screening test scores who actually receive a diagnosis

5. **Sensitivity is the**: (circle all that apply)

a) percentage of children without disabilities correctly detected by a screen

b) percentage of children with disabilities correctly detected by a screen

c) the percentage of children with failing screening test scores who actually receive a diagnosis

6. **Minimal but acceptable standards for screening test accuracy are**: (circle all that apply)

(a) sensitivity and specificity of 70% to 80%

(b) sensitivity and specificity of 60% to 70%

(c) sensitivity and specificity of 50% to 60%

(d) sensitivity and specificity of 80% to 90%

7. **Over-referrals on screening tests**: (circle all that apply)

1. are discovered when children do not qualify for IDEA
2. can be minimized by using more than one screen

c) are best met with “watchful waiting” to see if problems persist

d) require monitoring but should not result in recommendations for additional services

e) are children who tend to perform below average and have risk factors for school failure

f) should lead to referrals such as Head Start, quality preschool programs, parenting training etc.

8. **The Denver-II:** (Circle all that apply)

a) takes longer to administer than the average well visit/parent-teacher conference

b) was never validated by the authors

c) is inaccurate and misses children with developmental-behavioral problems

d) leads to use of selected items that lack scoring criteria

e) does a good job detecting academic problems in older children

f) does a good job detecting developmental problems in young children

9. **Milestones checklists, even if items are drawn from validated tools, are problematic because:** (circle all that apply)

1. items are often ambiguously worded (e.g., “Knows Colors?” What does that mean exactly: How many colors?; Which colors; Should colors be named or is pointing to colors an acceptable response?)
2. items are usually set at the 50%tile and so about half of all children will fail
3. milestones do not provide referral criteria
4. informal milestones checklists lead providers to refer only about 30% of children with delays, and so they miss 70% of children with problems
5. neither lend credibility to a referral recommendation nor generate reimbursement for billable services
6. (a) and (d) above

#### 10. Why is it better to use a quality screening test than a milestones checklist or selected items from longer measures?

#### \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. **Validated screening tools relying on parents’ concerns or report about specific skills are**: (circle all that apply)

a) as accurate than other tools

b) enhance provider-parent collaboration

c) save providers time and money

d) may require interview for some parents

e) take more time than my usual approach to early detection

f) less accurate than commonly used milestones checklists

#### V. (A) Specific questions About Using Parents’ Evaluation of Developmental Status (PEDS)

#### 1. PEDS measures which of the following domains: (Circle all that apply)

#### social-emotional/behavioral/mental health

#### expressive language

#### fine motor

#### self-help

#### academic skills

#### receptive language

#### gross motor

#### cognitive

#### health/family issues

#### academic skills

#### b, c, d, f, g

#### 2. PEDS is for children: (Circle one answer)

#### 4 months to 6 years of age

#### birth to age 17

#### birth to age 8

#### birth through age 8

#### 3. If parents complete the PEDS Response Form on their own you must: (check all that apply)

#### Make sure they have written something on the Response Form

#### Administer by interview if only “yes”, “no” or “a little” boxes are circled

#### Follow up their answers with additional questions about developmental milestones

#### Make sure they’ve been asked first, “Would you like to go through this on your own or would you like someone to go through it with you?”

#### Make sure you’ve given them the correct foreign language translation if they do not speak English at home.

#### Give them the Score Form so they can mark the categories of their concerns

#### 4. When scoring PEDS: (circle all that apply)

1. Correct for prematurity for children 2 years and younger born 3 or more weeks early.
2. Categorize comments in response to the domain/intent of the question asked.
3. Read all responses, view the Brief Guide showing the types of concerns, and then mark the appropriate box on the Score Form
4. Score the global/cognitive category for any response to Question 1 on the PEDS Response Form

#### 5. Match the category of concern in the left column with the number assigned to the examples in the right-hand column:

|  |  |
| --- | --- |
| Category | Examples |
| \_\_\_­\_\_ global/cognitive | *1. He can’t sit still….won’t concentrate…disobeys… may have ADHD…bites*  |
| \_\_\_\_\_ Receptive Language | *2. She won’t listen… acts like he doesn’t understand even though I think he really does… gives me blank looks when I ask him to do something… Can’t follow a two step command* |
| \_\_\_\_\_ Self-help | *3. She can’t say her “r’s”… Most people other than me can’t understand her… He can’t ask for what he wants… She doesn’t point to things she wants—just takes my hand and puts it on things.*  |
| \_\_\_\_\_ Behavior | *4. He just ignores other people and acts like they aren’t there…. She’s very shy and won’t talk around others…. He likes to watch other kids but won’t join in…. He’s easily frustrated and gets angry fast.* |
| \_\_\_\_\_ School | *5. I don’t think he hears….She is a picky eater…. He doesn’t sleep well at night…. I wonder if she has asthma* |
| \_\_\_\_\_ Gross motor | *6. She’s slow… I think he has autism…She’s regressing and losing skills…. He can’t do what other kids can do…. She is learning but it takes her lots longer and she needs lots of extra practice.*  |
| \_\_\_\_\_ Expressive Language | *7. We’re having trouble even getting him interested in toilet…. He won’t even try to get dressed* |
| \_\_\_\_\_Fine Motor | *8. He can’t read as well as other children…. His behavior interferes with learning at school…. She hates math…. He can’t write clearly.*  |
| \_\_\_\_ Other/Health | *9. He falls a lot. …She’s really clumsy…. Can’t run well. …She’s only four months old and can stand for hours* |
| \_\_\_\_\_ Social-Emotional | *10. She does funny flapping things with her hands…. He holds his fork oddly…. Just scribbles. Can’t write her name.*  |

6. **If a parent marks “No” to all PEDS questions, but writes the following, in what category of concerns would you place such comments:** *“ She’s doing about as well as any other child. …Occasional meltdowns but that’s typical for his age and we can deal with it.”* (Circle one)

a) behavior

b) other/health

c) social-emotional

d) all of the above

e) none of the above

#### 7. How would you categorize comments such as: *“My other kids could do lots more at the same age…. His friends are much better at learning, talking, and taking care of themselves”… “She’s struggling with everything”* (circle one)

a) Global/Cognitive

b) Other/Health

c) School skills

d) Self-help

e) Expressive Language

8. **When parents have concerns have about self-help skills such as using utensils to eat, trouble with fasteners, what other domain should be marked on the PEDS Score Form:** (circle one)

1. other/health
2. gross motor
3. global/cognitive
4. fine motor

#### 9. If a parent says, “*she won’t listen to me*”, this should be scored as: (circle all that apply)

#### receptive language

#### behavior

#### social-emotional

#### other/health

#### 10. When parents mark they are “a little” concerned, this should be considered: (circle one)

#### ignored as not a real issue for the family

#### an area of concern

#### not marked as a concern on the PEDS Score Form

#### 11. When parents make statements such as *“I used to be worried about his speech but now I think he’s doing better….”I don’t know what a 6 month old should be saying”*, the Score Form box for expressive language: (Circle all that apply)

#### does not need to be marked as a concern for the parent

#### should be marked as an area of concern

#### should be explored further with an additional screen before making a decision about what to do next.

#### 12. Sometimes parents describe concerns that do not appear to professionals to be especially problematic or predictive of problems. In such cases professionals should check the PEDS Score Form for the type of concern raised.

####  \_\_\_True \_\_\_False

#### 13. Sometimes professionals notice delays or are troubled by a child’s development but the parent does not express concerns. In these cases you could: (circle all that apply)

#### use an informal milestones checklist to consider developmental status

#### add your concerns to the PEDS Response Form

#### explain your concerns to the family and the need for additional screening

#### check the box on the Score Form to note your own concern and/or place the child on Path A or Path B

#### assume the parent is correct and ignore your clinical observations

#### administer an additional screen such as PEDS: Developmental Milestones or the ASQ

#### 14. PEDS screens for the following possible conditions: (circle all that apply)

#### Learning Disabilities

#### Speech-language Impairments

#### Autism Spectrum Disorders

#### Orthopedic Impairments for which special education eligibility is likely

#### Developmental delay/intellectual disabilities

#### Giftedness/Academic Talent

#### Typical/Normal Development

#### Behavioral/Social-Emotional/Mental Health problems

#### 15. Assign the numbers for each Risk Level in the right-hand column to PEDS Paths:

|  |  |
| --- | --- |
| PEDS Path | Risk Level |
| Path B (health-focus)­\_\_\_\_\_ | 1. High Risk: needs referral for diagnostic testing (e.g., speech-language, psychoeducational, etc.) |
| Path A \_\_\_\_ | 2. Moderate: needs additional screening to determine whether there is a likely problem |
| Path C \_\_\_\_ | 3. Moderate: needs health screens, (e.g., growth chart, re-explanation of prior medical problems now resolved, hearing, vision, lead screening, etc.) |
| Path B (developmental-focus)\_\_\_\_ | 4. Concerned but Low Risk for developmental problems, with elevated risk for emotional/behavioral/mental health problems |
| Path E \_\_\_\_ | 5. Moderate Risk: difficulty communicating with families due to language barriers or other issues  |
| Path D \_\_\_\_ | 6. Low Risk: needs reassurance and routine monitoring.  |

#### 16. PEDS is known to: (circle all that apply)

#### help parents learn to think about development like professionals do-- as a range of domains

####  encourage parents to observe their children closely

####  increase parents’ worries about their children’s development

####  teach parents that development and behavior are a part of health care

####  increase parents’ willingness to come back for well-child visits and other appointments.

####  increase positive parenting practices such as time out, instead of spanking

####  open the door to parent-teacher/provider discussions about child-rearing

####  make parents less willing to follow through with referrals to other services

####  lengthen well-visit time frames

#### 17. When children receive a Path C result: (circle all that apply)

#### they should be promptly referred for mental health services

#### providers should give parents’ advice about child-rearing and follow-up in a few weeks

#### if concerns persist, mental health screening is needed and if failed, children should be referred for mental health/behavioral interventions

#### professional advice should be tailored to the challenges parents’ describe

#### the effectiveness of professional advice should be monitored in a few weeks to determine if other services are needed

#### providers can rescreen at the next visit and assume child and family are doing well

#### 18. Some parents don’t raise concerns on PEDS when they should. Reasons often include: (circle all that apply)

####

####  a belief that providers will notice problems and shouldn’t be influenced by parents’ concerns

####  parental anxiety and lack of confidence in their observations

####  lack of awareness that providers are interested in developmental-behavioral issues

####  lack of education, poverty, stresses at home

####  limited ability to read

####  limited understanding of the language in which PEDS was administered (in writing or by interview)

####  informal translations of PEDS

####  asking only a few of the PEDS questions

#### 19. Why do parents of infants and toddlers need to be asked the PEDS’ question about school skills: (Circle all that apply)

#### parents don’t need to be asked that and frankly, shouldn’t be asked that question

#### because it informs providers about parents’ understanding of what is developmentally appropriate

#### it helps providers get an idea of what parents are doing with children at home in terms of teaching children new things

#### it alerts providers that parents may not be aware of what to teach young children

####

20. **Parents’ concerns are sometimes vague or developmentally off-target (e.g., “*I don’t know what a 6 month old should be doing?”; “She’s 9 months old but not talking yet”*)**. **Please explain why such comments may be useful to providers in terms deciding on an optimal response.**

21. **Parents’ concerns**: (circle all that apply)

a) always reflect the domains in which children have developmental delays

b) can be significant predictors of disabilities

c) should consistently be met with reassurance and watchful waiting

d) may suggest the need for in-office counseling and monitoring

e) all of the above

 22. **Parents with limited education are**: (circle all that apply):

* + - 1. as likely to have concerns about their children’s development as more educated parents
			2. less likely to raise concerns spontaneously
			3. less likely to notice problems in their children
			4. less likely to know that health care providers are interested in child development
			5. all of the above

#### 23. The value of using PEDS to elicit parents’ concerns in their own words is: (circle all that apply)

#### reduces “oh by the way” concerns at the end of visits

#### saves time during visits

#### enables providers to figure out in advance exactly what families need to know

#### creates a collaborative relationship between professionals and parents

#### helps parents know that providers are interested in development and behavior

#### helps providers know when to look further at children’s skills

#### helps providers view disordered development (e.g., age-appropriate two-word utterances that are excessively repetitive and non-communicative)

#### enhances reimbursement for services

#### 24. In your own words, why is it critical to refer frequently to the PEDS Brief Guide or to use PEDS Online when scoring PEDS?

#### 25. PEDS Online offers: (circle all that apply)

####

#### Modified Checklist of Autism in Toddlers

#### PEDS

#### PEDS:Developmental Milestones

#### automated scoring

#### a diagnosis for various kinds of disabilities

#### referral letters when needed

#### a summary report for parents

#### academic screens for children 8 years and older

#### screens of parental mental health

#### procedure codes for billing/coding

26**. In your own words why should we routinely elicit parents’ concerns?**

#### V. (B) Specific questions About Using PEDS: Developmental Milestones (PEDS:DM)

#### 1. PEDS:DM items are tied to which performance cutoff: (circle one)

#### a) 10th percentile

#### b) 16th percentile

#### c) 25th percentile

#### d) 50th percentile

#### e) 75th percentile

#### f) 90th percentile

#### 2. Performance below the 16th  (or even the 20th to 25th) percentile is worrisome because: (please state in your own words)

#### 3. If a child does not meet a milestone on the PEDS:DM it means that he or she: (circle all that apply)

#### simply needs watchful waiting and rescreening

#### is probably well behind same-age peers in that domain of development

#### needs further evaluation

#### has a diagnosable problem that can be identified by the PEDS:DM

#### 4. Scores on the PEDS:DM are defined as: (circle all that apply)

#### milestones met or unmet

#### pass or fail

#### optimal or suboptimal

#### disabled or not disabled

#### 5. PEDS:DM measures development in which areas: (circle all that apply)

#### expressive language

#### self-help

#### social-emotional

#### fine motor

#### receptive language

#### health, vision, hearing

#### gross motor

#### behavior

#### academics in math and reading

#### 6. The PEDS:DM detects probable delayed development as well as disabilities.

####  \_\_\_ True \_\_\_ False

#### 7. Please explain why measures such as the PEDS:DM or the ASQ even though they detect developmental delays, may not identify children with disordered development:

####

#### 8. When making referrals on the basis of PEDS or the PEDS:DM: (circle all that apply)

#### Early intervention/public school services should be the first consideration

#### A diagnosis is needed before early intervention services can be initiated

#### It is not necessary to refer if a child fails to meet milestones on the PEDS:DM. Instead, watchful waiting is the optimal response

#### Professionals should consider, based on observations of family functioning, medical history, etc. whether social work, mental health, parent training or other services are needed in addition to IDEA

#### A teaching hospital or private diagnostic evaluation clinic should be consulted prior to referring to IDEA

#### Providers should be prepared to make referrals to Head Start or other services.

#### 9. The PEDS:DM can be administered in various ways. Circle the administration methods that apply:

#### interviewing parents

#### administration by parents

#### professional hands-on administration with children

#### observation only (for younger children)

#### professional opinion about the presence or absence of skills

#### 10. Please rate these statements as true or false:

#### a) It is acceptable to probe unmet milestones on the PEDS:DM by administering lower level items

#### \_\_\_\_ True \_\_\_\_ False

#### b) If a child is suspected of advanced development it is NOT acceptable to administer higher level items and note these on the PEDS:DM Recording Form.

#### \_\_\_\_ True \_\_\_\_ False

#### V. (C) Specific questions About Using the Ages and Stages Questionnaires-Third Edition (ASQ-3)

1. **The ASQ-3 can be administered repeatedly for developmental surveillance, monitoring.** \_\_\_\_True \_\_\_\_False

2. **If a child receives a perfect score on the ASQ-3 they are considered above average.**

\_\_\_\_True \_\_\_\_False

3. **Answers on the ASQ-3 should be provided by parents either in writing or by interview.** \_\_\_\_True \_\_\_\_False

4. **The ASQ-3 tells you if a child has a delay or a disability**.

\_\_\_\_True \_\_\_\_False

5. **All items must be answered on the ASQ-3 for it to be valid.**

\_\_\_\_True \_\_\_\_False

6. **Alternative materials and phrasing may be used when completing the ASQ-3**

 \_\_\_\_True \_\_\_\_False

7. **It is acceptable for providers to complete the ASQ without parent-report**

 \_\_\_\_True \_\_\_\_False

*Please circle the best answer/s for questions 8-12*

8. **The beginning of the dark shaded “cutoff” area on the ASQ-3 summary sheet represents:**

1. the mean/average score
2. 1 standard deviation below the mean
3. 1.5 standard deviations below the mean.
4. 2 standard deviations below the mean.

9. **The beginning of the light shaded “monitoring” area on the ASQ-3 summary sheet represents:**

1. the mean score
2. 1 standard deviation below the mean
3. 1.5 standard deviations below the mean.
4. 2 standard deviations below the mean.

10. **The ASQ-3 series of questionnaires covers the following age range?**

a) 4 - 36 months

b) 2 - 66 months

c) 0 - 60 months

d) 2 - 48 months

11. **How many developmental domains and items in each are included on the ASQ-3?**

a) 4 domains with 5 items each

b) 6 domains with 6 items each

c) 1 domain with 30 items

d) 5 domains with 6 items each

e) 10 domains with 2 items each

12. **Which domains are measured by the ASQ-3?**

a) fine motor

b) gross motor

c) communication

d) social-emotional

e) problem-solving

f) personal-social

13.  **A child should be referred to further evaluation if they have the following ASQ-3 score?**  (Circle all that apply.)

a) Child’s score is below the 2 SD cutoff score in all domains.

b) Parent or pediatric practitioner has significant concerns about the child’s development but scores are only in monitoring zone (-1SD).

c) Child’s score is below the 2 SD cutoff score in 1 domain.

d) Child’s score is below the 2 SD cutoff score in communication only.

#### 14. Please explain why measures such as the PEDS:DM or the ASQ even though they detect developmental delays and most disabilities, may not identify children with disordered development:

####

#### 15. ASQ Online offers: (check all that apply)

#### Ages and Stages Questionnaire

#### automated scoring

#### a diagnosis for various kinds of disabilities

#### referral letters when needed

#### a summary report for parents

#### academic screens for children 8 years and older

#### mental health screens for parents

#### procedure codes for billing/coding

#### ASQ:SE

#### V. (D) Specific questions About Using Ages and Stages : Social Emotional (ASQ:SE)

1. **ASQ-3:SE items answered as “Most of the Time” always receive 10 points.**

\_\_\_\_True \_\_\_\_False

2. **If a child’s score is above the cut-off on the ASQ:SE, he is considered typically developing.**

\_\_\_\_True \_\_\_\_False

3. **The ASQ:SE may be completed by multiple caregivers.**

\_\_\_\_True \_\_\_\_False

4. **The sensitivity and specificity of the ASQ:SE (i.e. agreement with professional evaluation) are above 78% and 94% respectively.**

\_\_\_\_True \_\_\_\_False

5. **Children who score above the cut-off should always be referred for a mental health evaluation.** \_\_\_\_True \_\_\_\_False

6. **Cultural considerations should be considered when interpreting ASQ:SE scores.**

\_\_\_\_True \_\_\_\_False

7. **Inter-rater reliability may not be high when looking at social-emotional behaviors.** \_\_\_\_True \_\_\_\_False

*Please circle the best answer/s for questions 8-10*

8.  **The graphed distribution of scores on the ASQ:SE looks like:**

a) A bell curve

b) Scatter

c) A negative skew

d) A positive skew

9. **Cut-off scores on the ASQ:SE represent:**

a) 2 standard deviations above the mean.

b) The median for all scores

c) The mode for the scores

d) The best balance of sensitivity and specificity.

10. **Which of the following are considerations for making referrals even if scores are higher than the cut-off?** (Circle all that apply)

a) Setting/time factors

b) Developmental factors

c) Health factors

d) Family/cultural factors

**11. Identify the areas screened by the ASQ:SE:**

a) self-regulation

b) communication

c) adaptive behavior

d) autonomy

e) affect

f) interaction with people

g) parenting skills

#### V. (E) Specific questions About Using the Bayley Infant Neurodevelopmental Screener (BINS)

1. **The BINS is for infants:** (circle all that apply)

a) birth - 48 months

b) 3 - 24 months

c) birth - 2 years

d) 12 - 48 months

2. **The BINS is scored using:** (circle all that apply)

a) a complications approach

b) a critical items summary

c) an optimality approach

d) developmental milestones

3. **The same BINS items are given for all age groups.**

\_\_\_\_True \_\_\_\_False

4. **In the case of infants born prematurely, the BINS item set administration is based on chronological age.**

\_\_\_\_True \_\_\_\_False

5. **The BINS scoring yields:** (circle all that apply)

a) established, biologic, and environmental risk estimates

b) number of failed items

c) a neurodevelopmental index score

d) low, moderate, and high risk groupings

6. **BINS neuromotor item administration and scoring  are sometimes more difficult for psychologists and other professionals who lack training in neuromotor disabilities. When in need of training, examiners should:** (circle all that apply)

a) rely on clinical judgment

b) practice with infants from a variety of age groups to develop a point of reference.

c) collaborate with occupational or physical therapists

#### V. (F) Specific questions About Using the Modified Checklist of Autism in Toddlers (M-CHAT)

1. **The M-CHAT identifies:** (circle all that apply)

a) mild developmental delays and disabilities

b) possible autism spectrum disorders

c) mental health problems

2. **When parents complete the Modified Checklist of Autism in Toddlers (M-CHAT) and their children receiving a failing score**: (circle all that apply)

1. a referral to ASD specialists/developmental-behavioral clinics is the first best step.
2. failed items should be readministered via the M-CHAT Follow-up Interview
3. IDEA personnel can be asked to administer the M-CHAT Follow-up Interview
4. If the interview is failed, referrals to both Early Intervention and an ASD specialist may be needed
5. a diagnosis of autism spectrum disorders (ASD) can be made
6. a failed M-CHAT means that a child may have ASD and/or other conditions such as intellectual disabilities or a significant language impairment
7. If the broad-band screens are failed but the M-CHAT is passed, no referrals are needed.

3. **The M-CHAT should not be used as a stand-alone parent-report screen because**: (circle all that apply):

1. the most common disabilities such as moderate language impairment, learning or intellectual disabilities are likely to be missed.
2. The M-CHAT does not detect developmental delays (e.g., children who are behind, don’t qualify for IDEA services, but who need services such as Head Start or quality preschool/day care programs will be missed)
3. I disagree with the premise of this question: The American Academy of Pediatrics says the M-CHAT should be used at 18 and 24 months. The M-CHAT alone is sufficient for those visits.

#### V. (G) Specific questions About Using the

#### Safety Word Inventory and Literacy Screener (SWILS)

1. **The SWILS is standardized on children who are:** (circle all that apply)

a) 4 ½ – 16 years

b) 5 ½ - 10 years

c) 6 ½ - 14 years

d) 3 – 8 years

2. **The SWILS can be used to identify literacy and health literacy problems in older students and parents:**

 \_\_\_\_True \_\_\_\_False

3. **The SWILS identifies probable:** (circle all that apply)

a) depression

b) possible autism spectrum disorders

c) learning disabilities

d) mental health problems

e) health literacy challenges

f) academic problems

4. **If the examinee segments a word (e.g., “Volt-age” but does not self correct and say “Voltage”), this answer is marked as correct.**

\_\_\_\_True \_\_\_\_False

#### V. (H) Specific questions About Using the

#### Pediatric Symptom Checklist (PSC)

1. **The PSC identifies probable:** (circle all that apply)

a) depression

b) possible autism spectrum disorders

c) conduct problems

d) attention difficulties

e) developmental deficits

f) mental health problems

2. **In your own words, why should** **the PSC be administered before deciding to use a measure like the Vanderbilt ADHD scale that focuses mainly on attention deficit hyperactivity disorder:**

3. **The Pictorial PSC is helpful for:** (circle all that apply)

a) families who don’t speak English

b) families with limited literacy

c) adolescents who may not read well

d) all youth and their parents

e) improving identification of mental health problems in families with low socioeconomic status

#### VI. Implementation Questions

1. **The following statements describe the process of preparing for use of quality screening tools in health care. Place them in logical order:**

\_\_\_\_ Choose a quality instrument

\_\_\_\_ Conduct training

\_\_\_\_ Organize parent education materials

\_\_\_\_ Provide a rationale for office staff

\_\_\_\_ Consider the details and order of the existing work flow

\_\_\_\_ Plan training, gather training materials

\_\_\_\_ Identify physicians or other staff heavily interested in the issue

\_\_\_\_ Monitor implementation of screening

\_\_\_\_ Allow staff to determine how the workflow steps will be executed

\_\_\_\_ Gather a list of referral resources

\_\_\_\_ Set a timeline

\_\_\_\_ Review implementation and decide on needed adjustments to the process

\_\_\_\_ Encourage staff to evenly allocate steps in the new work process

\_\_\_\_ Work with the Early Intervention community to establish referral mechanisms, the kinds of reports you’d like to receive, times to communicate, preferred mechanisms for communication (e.g., email, fax, phone, surface mail).

2. Please identify your opinion about the following statements. **Collaboration with community services on referral processes:**

|  |  |  |
| --- | --- | --- |
| a) | Takes excessive amounts of time from primary care | \_\_\_True \_\_\_Maybe \_\_\_False |
| b) | Helps identify community wide needs | \_\_\_True \_\_\_Maybe \_\_\_False |
| c) | Is problematic because services are rare or non-communicative | \_\_\_True \_\_\_Maybe \_\_\_False |
| d) | Facilitates providers’ awareness of service options | \_\_\_True \_\_\_Maybe \_\_\_False |
| e) | Enables medical and non-medical providers to communicate and refer to/from each other  | \_\_\_True \_\_\_Maybe \_\_\_False |
| f) | Is usually confusing for families due to conflicting advice  | \_\_\_True \_\_\_Maybe \_\_\_False |
| g) | Enables further evaluation and reduces the need for health care providers to administer multiple screens  | \_\_\_True \_\_\_Maybe \_\_\_False |
| h) | Increases opportunities for care coordination | \_\_\_True \_\_\_Maybe \_\_\_False |
| i) | Leads to turf battles and animosity among various types of providers | \_\_\_True \_\_\_Maybe \_\_\_False |
| j) | Leads to community-wide advocacy for the needs of children and families | \_\_\_True \_\_\_Maybe \_\_\_False |
| k) | Is worth exploring to see whether it aids my work | \_\_\_True \_\_\_Maybe \_\_\_False |

**Post-Training Course Evaluation Questions**

#### How will you use the information you acquired during training?

#### What did you like most about your training experience:

#### What did you like least about your training experience:

#### What additional information did you wish had been covered?

#### What suggestions do you have for improving this presentation?

#### Which measures do you intend to use in your setting and why?

#### Are there existing forms or questions that provide a workflow template for your setting?

Please list your thoughts about use of online screening services in your setting?

#### Scoring Guide to Questions

|  |  |
| --- | --- |
| I. Services | V. (B) PEDS:DM |
| 1. c | 1. b |
| 2. d | 2. acceptable answers mention: hazards of entering school already behind, having future difficulties in school, higher chance of being held back in grade, increased risk of dropping out, etc.  |
| 3. all | 3. b, c |
| 4. (3 of e.g., Head Start, Early Head Start, quality day care, parent training, after school tutoring, parent counseling, monitoring effectiveness of advice) | 4. a, b |
| II. AAP Policy and Billing/Coding | 5. a – e, g, h, i  |
| 1. a, e, f | 6. True |
| 2. a - e | 7. answers should focus on age-appropriate skills but executed in problematic ways (e.g., expressive language that is repetitive and non-communicative; fine motor skills in which tremors or other neuromotor problems are present) |
| 3. desirable answers are any reasons to keep screening after 24-30 months | 8. a, d, f |
| 4. a – d, f - j | 9. a – d |
| 5. a) False; b) True; c) False | 10. a) True b) False |
| 6. a – e, g, h,  | V. (C) ASQ-3  |
| 7. b - d | 1. True |
| III. Child Development, Disabilities, etc. | 2. False |
| 1. language, preacademic skills, cognition | 3. True |
| 2. a) false; b) false | 4. False |
| 3. b | 5. False |
| 4. true | 6. True |
| 5. the order should be: E, A, C, B, D, F | 7. False |
| 6. a, b, d, e, f | 8. d |
| 7. a) True, b) False, c) True, d) True, e) False, f) True, g) False, h) False, i) True | 9. b |
| 8. a, b, | 10. b |
| 9. the order should be: 3,2,4,1,5,6 | 11. d |
| 10. a-c or d | 12. a – c, e, f |
| IV. Parenting, Psychosocial Risk, Explaining Results | 13. a – d |
| 1. b-d, g, i, k, m | 14. answers should focus on age-appropriate skills but executed in problematic ways (e.g., expressive language that is repetitive and non-communicative; fine motor skills in which tremors or other neuromotor problems are present) |
| 2. Desirable answers include four or more among: book-sharing, talking about things the child is noticing, imitating the child’s sounds/word attempts back to him/her, engaging in the child’s self-initiated play, taking the child places and talking about what he/she sees, encouraging creative play such as block stacking, leggos, scribbling, showing the child new things including sounds, objects, etc.) | 15. a, b, d, i |
| 3. The order should be 2,4,1,3 | V. (D) ASQ: SE |
| 4. b, d - f, h - n | 1. False |
| 5. a – d, f | 2. False |
| 6. b - i | 3. True |
| 7. Desirable answers should two or more among: parenting books, websites such as kishealth.com, parenting information handouts plus orally delivered advice, parent training programs, parenting video series, etc. | 4. True |
| V. Measurement Principles | 5. False |
| 1. e | 6. True |
| 2. c | 7. True |
| 3. c, d | 8. d |
| 4. a | 9. d |
| 5. b | 10. a – d |
| 6. a | 11. a – f |
| 7. a, b, e, f | V. (E) BINS |
| 8. a - d | 1. b |
| 9. a - e | 2. c |
| 10. correct answers include: proven accuracy in early detection, clear scoring criteria, higher levels of sensitivity and specificity, ability to detect more children with problems | 3. False |
| 11. a - d | 4. False |
| V. (A) PEDS | 5. d |
| 1. a - j | 6. b, c |
| 2. c | V. (F) M-CHAT |
| 3. a, b, d, e | 1. b |
| 4. a, b, c | 2. b, c, d, f |
| 5. Categories of concerns should be numbered in this order: 6, 2, 7, 1, 8, 9, 3, 10, 5, 4 | 3. a, b |
| 6. a | V. (G) SWILS |
| 7. a | 1. c |
| 8. d | 2. True |
| 9. a (and optionally b but b alone is incorrect) | 3. c, e, f  |
| 10. b | 4. False |
| 11. b, c | V. (H) PSC |
| 12. True | 1. a, c, d, f |
| 13. b – d, f | 2. optimal responses focus on the need to determine whether symptoms of ADHD are instead, due to learning disabilities, language impairment, mental health problems |
| 14. a – e, g, h | 3. a - e |
| 15. PEDS Paths should be numbered in this order: 3, 1, 4, 2, 6, 5 | VI. Implementation |
| 16. a, b, d, f, g | 1. There is not right or wrong sequence here—this question is designed to help trainees consider a workable process although we’d prefer to see the process begin with engendering support among colleagues and recruiting their help in planning the work flow |
| 17. b, c, d, e  | 2. These items elicit opinion and provide presenters information on perceived obstacles to implementation—obstacles for which trainees may need further support and training to overcome. Ideally, you’ll see these answers: a) false b) true, c) false; d) true, e) true, f) false, g) true, h) true, i) false, j) true, k) true  |
| 18. a – c, e - h | Post-Training Evaluation and Take-Home Planning |
| 19. b – d | These questions are designed to solidify learning and give presenters helpful feedback about topics requiring more emphasis, which trainees need further assistance, etc.  |
| 20. appropriate comments are: Alerts us to the need for careful monitoring, developmental promotion, parent education, possible psychosocial risk |  |
| 21. b, d  |  |
| 22. a, b, d  |  |
| 23. a - h |  |
| 24. desirable answers are fidelity to scoring, accuracy of results, reduction of cognitive drift, important administration, etc.  |  |
| 25. a – d, f, g, j |  |
| 26. desirable answers are: eases delivery of difficult news, enhances collaboration, focuses parenting advice on specific topics of interest, creates a teachable moment, reduces “oh by the way concerns” |  |