

# IDA and the Provence Profile- Efficient Early Assessment

by Thomas A. Hutchinson

The last ECOletter gave a brief overview of the Infant-Toddler Developmental Assessment (IDA). This issue gives a more complete view of the multidisciplinary, family-oriented procedures that make up the IDA and the Provence Birth to Three Developmental Profile. Named for its author, the late Sally Provence, MD (see the story on page 1) the Provence Profile is the assessment protocol integral to the IDA process.

From an administrative perspective, the IDA is a broad-based, interagency approach to developmental assessment and family service planning for at-risk children ages birth to 3 and their families. In the words of Joanna Erikson, MPH, one of the four IDA authors, "The IDA is intended to bridge the gap between simple screenings and complex tertiary evaluations. An integrated process conducted by a team of two or more from complementary disciplines, IDA is designed to assess health, family, social, and developmental dimensions."

From a practitioner's perspective, the IDA is a framework of procedures for collecting, reviewing, and integrating data from multiple sources. These procedures consist of activities in six distinct phases: referral and preinterview data gathering; the initial parent interview; the health review; the developmental observation and assessment, the integration and synthesis of information, and the sharing, completing, and reporting of findings. Each of the phases offers an important piece in the puzzle of information and the complexity of specialized disciplines that serve young children at risk. Amidst this complexity, the IDA process integrates information through

the role of the "developmental generalist." As Erikson writes, the process provides clinicians with a basis for informed clinical judgment. She stresses that assessment is a pivotal point for families and children. The type and scope of assessment often determines the type and scope of intervention. Among the IDA's greatest strengths are its extensive support on health concerns for those not in the health field; its attention to affective domains as well as more traditional developmental domains; its team-based approach to integrating complex information about a child and family; and its built-in assessment tool, the Provence Profile.

Even though the intended use of the Provence Profile is within the larger context of the IDA process, its qualities as an assessment should be judged by the same standards as any other formal assessment. That is, practitioners and prospective users should ask the same questions they would ask of any other assessment instrument not yet familiar to them. The next section offers, in question-and-answer style, a look into the Provence Profile.

## Who Uses the Provence Profile?

The Provence Profile is intended for use by two or more professionals and one or more parents or other caregivers. The professionals who have been involved in the IDA include pediatricians, psychologists, nurses, social workers, speech-language pathologists, audiologists, physical therapists, occupational therapists, and other health care professionals. The specific results of the Provence Profile are always to be interpreted and used within the context of the entire IDA process.

## What Domains Are Assessed?

The assessment examines eight developmental domains, including gross motor, fine motor, cognition (called "Relationship to Inanimate Objects"), language, self-help, relationship to persons, emotion and feelings, and coping. Development in each of these domains is examined by sets of items typically accomplished by normally developing children ranging from 1 to 36 months of age. All eight of the domains sample performance from the levels of 1-2 months of age through 36 months. Items that share characteristics of more than one domain are cross-referenced. Items that cannot be administered successfully during an assessment can also be credited if the parent or caregiver reports the behavior as having been exhibited by the child outside the assessment. The items and domains are also accompanied by a useful checklist of maladaptive and symptomatic behaviors that may warrant further evaluation.

## Is the Provence Profile Standardized?

Many times this question is really several questions, including one or more the following.

*Is the administration and scoring standardized?* The Provence Profile uses a standard set of procedures for determining the most appropriate sets (levels) of items to administer to a child, as well as standard procedures and materials for administering the items. There are also standard methods for scoring the individual items and applying the scoring criteria to sets of items that identify a child's developmental level in each domain. To this extent, the Provence Profile is

*continued on p. 11*

IDA continued from p. 10

standardized. As with any standardized measure, practitioners may exercise clinical judgment by choosing to depart from these standard procedures and describe their modifications in reporting results. This may be especially appropriate when a child has sensory or physical problems that are not adequately accommodated by the standard administration procedures.

*Is the test normed (based on a standardization sample)?* There was no special norming sample obtained for the Provence Profile because the aspects of development that it measures are well-established as milestones of normal development during the first three years of life. Rather than collect additional data on these milestones, Dr. Sally Provence concentrated on establishing criteria for progressive sets of items in each domain that accurately identified a child's developmental level. Thus, the Provence Profile is most accurately described as a measure that uses developmental scoring criteria based on widely accepted normative expectations.

*Are scores such as standard scores or age equivalents reported?* The Provence Profile does not report percentile ranks, standard scores, or the type of age equivalent scores commonly derived from average scores at different age levels in a standardization sample. Instead, the scores are based on applying developmental criteria specific to progressive levels of items within each domain. The result is a score that provides less information about a child's relative standing among age peers and more about the relationship between the child's chronological age and the specific developmental milestones the child has reached. The advantage of these age-based criterion scores is their close relationship to specific changes in development, whereas the advantage of scores from a special norming study is the ease of comparing a child's development to that of the child's chronological age group (or other age groups of interest) in the standardization sample.

Team Member(s) Responsible	Phase One	Phase Two	Phase Three	Phase Four	Phase Five	Phase Six
	Referral and Preinterview Data Gathering	Initial Parent Interview	Health Review	Developmental Observation and Assessment	Integration and Synthesis	Share Findings, Completion, and Report
Assessment Coordinator	<ul style="list-style-type: none"> <li>begin IDA Record</li> <li>monitor and record activity</li> </ul>	<ul style="list-style-type: none"> <li>monitor and record activity including records received</li> </ul>	<ul style="list-style-type: none"> <li>monitor and record activity including records received</li> </ul>	<ul style="list-style-type: none"> <li>monitor and record activity</li> </ul>	<ul style="list-style-type: none"> <li>monitor and record activity</li> </ul>	<ul style="list-style-type: none"> <li>have release signed</li> <li>complete IDA Record</li> <li>prepare and send written report</li> </ul>
Parent Interviewer	<ul style="list-style-type: none"> <li>contact parent(s), explain and send Parent Report, releases, and other forms</li> <li>schedule interview</li> <li>prepare for interview</li> </ul>	<ul style="list-style-type: none"> <li>conduct interview; have parent(s) sign releases</li> <li>record notes</li> <li>schedule child observation and assessment</li> </ul>	<ul style="list-style-type: none"> <li>share health information gathered in parent interview</li> </ul>	<ul style="list-style-type: none"> <li>observe child and assist with recording</li> </ul>	<ul style="list-style-type: none"> <li>complete Family Recording Guide</li> <li>see both/either</li> <li>schedule parent conference</li> </ul>	<ul style="list-style-type: none"> <li>see both/either</li> <li>send Parent Report for review</li> </ul>
Health Reviewer	<ul style="list-style-type: none"> <li>send Request for Health Information</li> <li>request medical records</li> </ul>	<ul style="list-style-type: none"> <li>begin Health Recording Guide</li> </ul>	<ul style="list-style-type: none"> <li>contact primary health care provider</li> <li>complete Health Recording Guide</li> </ul>		<ul style="list-style-type: none"> <li>complete Health Recording Guide</li> </ul>	
Child Evaluator		<ul style="list-style-type: none"> <li>prepare for child observation</li> <li>record B, R, on scoring protocols</li> </ul>		<ul style="list-style-type: none"> <li>conduct child assessment and score protocols</li> </ul>	<ul style="list-style-type: none"> <li>see both/either</li> </ul>	<ul style="list-style-type: none"> <li>see both/either</li> </ul>
Both/Either	<ul style="list-style-type: none"> <li>clarify referral questions</li> <li>assign team roles</li> <li>team discussion—determine need for other records, review information to date</li> </ul>	<ul style="list-style-type: none"> <li>team discussion after interview</li> </ul>	<ul style="list-style-type: none"> <li>team discussion regarding health issues</li> </ul>	<ul style="list-style-type: none"> <li>review domains and record</li> </ul>	<ul style="list-style-type: none"> <li>review findings and need for consultation and referral; integrate findings; identify program options and recommendations</li> <li>prepare for parent conference</li> </ul>	<ul style="list-style-type: none"> <li>participate in parent conference</li> <li>draft and review final report</li> </ul>

### Can Percentage Delay be Calculated?

IDA practitioners may wish to compute a percentage delay based on Provence Profile results in those cases where they are required to do so in order to determine eligibility. However, when reporting a percentage delay, users should also indicate that the method of computing the delay was based on a performance age obtained by applying developmental criteria specific to progressive levels of items within each domain (as described above). This can help others understand the meaning of percentage delay and also help distinguish the IDA method from the frequently criticized use of age equivalent scores in computing delays.

### Is the Provence Profile Reliable?

Several studies indicate that the Provence Profile is highly reliable. For example, internal consistency coefficients computed for domain scores based on number of items passed were generally high to very high, ranging from .90 to .96 for 35 children aged 1-18 months and .78 to .96 for 65 children aged 19-36 months (Provence, et al., 1995). Anastasiow

(1988) reported high interrater percentage agreement, ranging from 91% to 95% for seven of the domains and 81% for the Language domain. Anastasiow (1991) later reported that the accuracy of trained IDA practitioners remained high over a period of several years. Agreement among the recommendations of 35 practitioners trained over a six-year period were 97% (early intervention services), 94% (further observation and assessment of the child's language), 85% (family support services), and 78% (recommendations on family mental health services).

### Is Validity Evidence Reported?

Several studies of IDA support the validity of not only the Provence Profile as a standardized measure of development from birth to three but also the IDA procedures as an assessment and decision-making process. In assessing content validity, Anastasiow (1988) compared the items on the Provence Profile with the items on several other developmental assessments, including the Bayley Scales (Bayley, 1969), the HELP (Furuno, et al. 1979), and the LAP (Sanford & Zelman, 1981). In each case, he found

continued on p. 13

IDA continued from p. 11

high percentages of items in common and high agreement (84% to 96%) on the developmental age levels of those items. Anastasiow also reported that follow-up questionnaires to community agencies receiving referrals from IDA practitioners indicated the referrals were appropriate to their agency. A statistical analysis of the Provence Profile for 100 children (Provence, et al., 1995) lent strong support to its construct validity: substantial age-to-age progression across six-month intervals from 1 to 36 months and expected patterns of intercorrelations among the eight domains assessed.

### Is the IDA an Efficient Process?

Anastasiow (1988) studied the efficiency of the IDA in reducing time between initial referral and disposition (referral for services or determination that no further services are required). Data from two settings were examined to investigate three issues: the time between the child's birth and the conclusion of the evaluation, the time between referral and the conclusion of the evaluation, and the number of professionals involved in the assessment process.

One setting produced case histories of 43 children assessed by the procedures in place at a regional child development resource clinic participating in a state child development program. This clinic had a multidisciplinary staff and was considered by the state health department to meet high standards. The second set of data consisted of 20 children who had been clients of the IDA process. When the data on the timing of decisions in these two groups were compared, the differences were significant. The evaluations that used IDA assessments were concluded earlier in the children's lives (75% before age 3) than were those in the comparison group

(40% before age 3). The shorter duration of the IDA assessment process appears to support the goal of identifying children at-risk as early in life as possible.

The efficiency of the IDA was also supported by the shorter time to complete these evaluations, from initial contact to a case decision (to refer for services, to monitor, or to cease further activity). The longest time for the IDA was six months, and 85% of the cases were decided within four months. The longest time for the comparison clinic was nine months, and decisions were made within four months for only 40% of the cases. Equally noteworthy was the discovery that in nearly all (90%) of the IDA cases, a recommendation was achieved with no more than 10 professional contacts. In contrast, none of the clinic cases produced recommendations with only 10 contacts, and more than a third involved more than 30 professional contacts. Taken together, these results strongly suggest that

*The IDA procedures may considerably shorten the process often experienced by a child and family before a decision is made.*

the IDA procedures may considerably shorten the process often experienced by a child and family before a decision is made.

These and other results indicate that

the IDA process not only makes referrals in less time than the comparison group but requires fewer professional contacts before a recommendation or decision is made. The involvement of professionals in a multidisciplinary team can not only yield more timely decisions but also reduce overall requirements for professionals' time and thereby reduce costs. ■

### References

Anastasiow, N. (1988). Connecticut infant-toddler developmental assessment program (IDA): Report of a four year demonstration project. Unpublished report.

Anastasiow, N. (1991). Long term accuracy of certified IDA practitioners. Unpublished report.

Bayley, N. (1969). Bayley scales of infant development. San Antonio: The Psychological Corporation.

Furuno, S., O'Reilly, K. A., Hosaka, C. M., Inatsuka, T. T., Allman, T. L., & Zeisloft, B. (1979). The Hawaii early learning profile. Palo Alto, CA: VORT.

Provence, S., Erikson, J., Vater, S., & Palmeri, S. (1995). IDA foundations and study guide. Chicago: Riverside.

Sanford, A. R., & Zelman, J. G. (1981). The learning accomplishment profile. Winston-Salem, NC: Kaplan.

Shackelford, J. (1994). States/jurisdictions Part H definitions. NEC\*TAS: National Early Childhood Technical Assistance System.

Sparrow, S.S., Balla, D.A., & Cicchetti, D.V. (1984). Vineland adaptive behavior scales. Circle Pines, MN: AGS.

### Note:

A recent survey of states (Shackelford, 1994) indicated that 37 states had explicit criteria for eligibility based on percentage delay in one or more domains. In addition, a total of 25 states had criteria for eligibility based on standard deviations. Still other states had no explicit quantitative criteria but required informed clinical judgment or other similar criteria.

---

*Tom Hutchinson is Editor-in-Chief, Clinical & Special Needs at Riverside Publishing Company.*