

II Critical Elements of Care by Age of Child

Age 1 to 5 Years - Early Childhood

Area Of Focus	Assessment	Interventions Referral Resources	Anticipatory Guidance
Medical Evaluation	<ul style="list-style-type: none"> - Routine assessment 		<ul style="list-style-type: none"> - Most LBW NICU graduates do not develop adverse outcomes for which they are at higher risk (avoid "vulnerable child" syndrome)
Interim History			
Growth	<ul style="list-style-type: none"> - Measure height, weight, and head circumference at each visit and record until at least 2 years corrected age 	<ul style="list-style-type: none"> - If growth decelerates and child drops across a channel line on the growth chart: <ul style="list-style-type: none"> • Review for potential onset of illness causing growth deceleration and treat as indicated 	<ul style="list-style-type: none"> - Several patterns of catch up growth may be seen with some former NICU graduates, showing continued catch up in early elementary years
Nutrition/ Feeding	<ul style="list-style-type: none"> - Obtain feeding and nutrition history, assess for deviations from normal feeding pattern - Assess oromotor function and swallowing skills - Review calorie adequacy for catch up growth Review drug - nutrient interaction 	<ul style="list-style-type: none"> • Have parent take a 3 day food history • Consider referral to a pediatric nutritionist to review calorie adequacy and suggest methods of increasing caloric intake if needed - Referral as indicated to: <ul style="list-style-type: none"> • Feeding specialist (SLP, OT) • GI specialist • WIC/Health Department 	<ul style="list-style-type: none"> - Avoid lowfat milk before 2 years of age
Vision	<ul style="list-style-type: none"> - Assess per well child practice guidelines - Monitor eye alignment, red reflex, and acuity at each visit 	<ul style="list-style-type: none"> - Referral to ophthalmologist for strabismus, tearing, or acuity concern by exam or parent report - Referral to programs for visually impaired where indicated 	<ul style="list-style-type: none"> - If there was any evidence of ROP in the nursery, ophthalmology exams are recommended at one year corrected age and at school entry, or as requested by ophthalmologist (Due to increased risk of visual acuity abnormality or strabismus with any ROP history) - Virtually no retinal detachment & little retinal scarring is described in preterm infants >1500 gm BW
Hearing	<ul style="list-style-type: none"> - Monitor for conductive and/or sensorineural hearing loss at each visit - At ages 3 and 4 years perform audiology screen in office (assess per well-child practice guidelines) - Observe for delayed onset hearing loss (see Appendix 3) 	<ul style="list-style-type: none"> - Refer to Audiologist as indicated by exam, parent concerns or poor language development - ENT referral for documented hearing impairment - Amplification as indicated - Augmentative communication as indicated 	<ul style="list-style-type: none"> - Articulation difficulties may be the only presentation of a partial hearing loss - Children with hearing loss are very visually alert. One can mistake visual orienting for orienting to a sound stimulus if not careful in the stimulus presentation
Special Health Concerns	<ul style="list-style-type: none"> - Assess: <ul style="list-style-type: none"> • Dentition and reinforce good dental hygiene. • Monitor dental enamel hypoplasia • if S/P NEC - review for fat soluble vitamin & mineral adequacy & vitamin B12 • Reactive airway disease & abnormal pulmonary function • GERD - Monitor for late occurrence of feeding refusal secondary to occult reflux. Pay close attention to nutritional status • Hernias • Hydrocephalus, seizure disorder • Cerebral Palsy - hemiplegia, milder spastic diplegia, extrapyramidal CP, transient dystonia resolution may become apparent in the 1-2 yr. child 	<ul style="list-style-type: none"> - Dental referral as indicated - Medical consultation with pediatric subspecialist as indicated 	<ul style="list-style-type: none"> - Recommend pediatric dentist appointment in 3rd year of life or sooner for concerns - Continue to avoid exposure to airway irritants such as cigarette smoke

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AREA OF FOCUS	ASSESSMENT	INTERVENTIONS REFERRAL RESOURCES	ANTICIPATORY GUIDANCE
Developmental Behavioral Assessment	<ul style="list-style-type: none"> - Subjective assessment at each visit. Ask about parental perception & concerns 	<ul style="list-style-type: none"> - Parenting information and behavior management skills - Refer to parenting classes as needed 	<ul style="list-style-type: none"> - May see impulsivity, overactivity, irritability etc. that may be early signs of ADHD. Note: Majority of LBW graduates do not have ADHD
Temperament/ Rhythmicity			
Sensory/ Motor	<ul style="list-style-type: none"> - Ask about parental perception of development at each visit, survey critical developmental milestones - Administer appropriate developmental screening tests at regular intervals (in office or refer) - Assess late sensorimotor development between 12 and 18 months of age (corrected) with standardized assessment test 	<ul style="list-style-type: none"> - Refer to a pediatric physical or occupational therapist or multidisciplinary team if concerned about atypical movement patters or delayed milestones 	<ul style="list-style-type: none"> - 20% of LBW infants have visual motor perceptual dysfunction - Increased incidence of difficulties with postural control, balance & motor coordination (e.g. tremulous involuntary hand movements) - Increased incidence of CP <ul style="list-style-type: none"> • 20% in smallest infants • 6-8% in the 1500-2500 gm BW infants
Language	<ul style="list-style-type: none"> - Ask about parental perception of development at each visit, survey critical developmental milestones. - Administer appropriate developmental screening tests at regular intervals (in office or refer) - Assess early language development between 18 and 30 months of age with standardized assessment tool - Monitor articulation and fluency 	<ul style="list-style-type: none"> - Hearing assessment if language is delayed - Consider referral to a pediatric communication disorders specialist if speech and/or language development appear delayed or atypical - For therapeutic intervention in any of the above areas of development: <ul style="list-style-type: none"> • 12-36 months of age - refer to an early intervention program or birth to three program with the desired therapies available • 33-60 months of age - refer to the local school district for a developmental preschool. (Children may not be eligible for enrollment in a school program until 36 months of age, but the enrollment process may take months, learn the requirements of your local school districts and the recommended timeline for beginning the enrollment process.) 	<ul style="list-style-type: none"> - Approximately 12% of VBLW children with normal intelligence have a language disability: <ul style="list-style-type: none"> • Decreased language comprehension • Decreased expressive language skills vocabulary & word finding • Articulation & fluency disorders
Cognitive	<ul style="list-style-type: none"> - Assess early verbal and nonverbal cognitive skills between 30 and 48 months of age with standardized assessment test 	<ul style="list-style-type: none"> - Refer to multidisciplinary neurodevelopmental assessment if atypical development is suspected - Consider referral to pediatric psychologist if development appears delayed or atypical - For therapeutic intervention in any of the above areas of development: <ul style="list-style-type: none"> • 12-36 months of age - same as above • 33-60 months of age -same as above 	<ul style="list-style-type: none"> - May see difficulties with memory, attentive, perceptual motor skills, non-verbal reasoning & problem solving - Mental retardation occurs in 4-5% of LBW infants
Social Adaptive	<ul style="list-style-type: none"> - Subjective assessment at each visit - Standardized assessment at 36-48 months 	<ul style="list-style-type: none"> - Encourage age/developmental level appropriate skills - Facilitate opportunities for appropriate peer interaction 	<ul style="list-style-type: none"> - Review developmentally appropriate behavioral expectations - Increased risk for conduct disorder, hyperactivity & inattention - Some children exhibit shyness, unassertiveness & withdrawn behavior
School Performance	<ul style="list-style-type: none"> - Review any daycare or preschool experiences & performance - Monitor attention skills 	<ul style="list-style-type: none"> - B-3 or 3-5 year programming as indicated - Consider assessment of motor skill prior to school entry 	<ul style="list-style-type: none"> - Review birthdate vs due date as an important consideration relative to Kindergarten entry - Visual motor & fine motor difficulties are more common in LBW children and can adversely impact early school performance
Family Support	<ul style="list-style-type: none"> - Assess parenting skills and understanding of appropriate child development and behavior for their child. If prescribing therapeutic programs, when necessary, assist parents in follow through with assessment and enrollment processes for any referrals. Parents at highest risk for difficulty following through are adolescent parents, those with less than high school education, those in extreme poverty, and any parent with multiple stressors. - Establish goals with the family's input, support siblings & other family members 	<ul style="list-style-type: none"> - Consider referral to Family Resources Coordinator (available in most early intervention programs and through the public health department) to help parents understand and access evaluations and services for their child - Provide requested medical and developmental reports to support parent's application to the intervention program and to social and financial support agencies - Refer to literature resources and organizations for specific disorders (e.g. ARC, POP...) - Refer to community resources, respite care, parent support groups, etc. 	