

CPQCC CCS HRIF GUIDANCE FOR TELEHEALTH VISITS



I. BACKGROUND AND PURPOSE

The COVID-19 pandemic has substantively impacted how many HRIF clinics approach follow up care for children and families. Results from the recent CPQCC CCS HRIF Clinic Virtual Visits survey demonstrates great variation among HRIF clinics in terms of

- Use of “telepractice” or “telehealth” (which include both audio and video capabilities together in a virtual visit) vs. only telephone.
- Types of standardized assessments and questionnaires utilized for telehealth, if any.
- Whether those assessments are appropriate for non in-person visits.

It is clear that most HRIF clinics and other outpatient specialty groups expect to continue to utilize telehealth visits for at least the moderate-term future, and that HRIF teams desire guidance on developmental assessment options and prioritization for telehealth visits. Therefore, stakeholders from across the state were assembled to form the **CPQCC CCS HRIF Telehealth Guidance Work Group**. The goals of the Work Group were to share insights and expertise, provide input on considerations for in-person and telehealth visit benefits and challenges as well as prioritization, and develop high level guidance to inform changes/ additions to the Standard Visit options.

II. GENERAL CONCEPTS AND CONSIDERATIONS: TELEHEALTH VISITS

- A. Telephone** “visits” alone allows for continued family contact, as well as follow up on referred patient services, and touchpoints on family needs. However, there is *limited value* of telephone only for developmental or motor assessment.
- B. Telehealth (audio + visual)** “virtual visits” utilizing appropriate assessments, and with patient/ parent as well as clinic/ provider preparation, can allow for evaluation and observation in the familiar setting of the family home.
 - However, it is recognized that not all HRIF clinics have access to telehealth options.
 - Importantly, not all families can participate in telehealth, in some cases due to resource, access, and economic disparities.
 - Therefore, it is not yet clear whether telehealth may level or widen disparities associated with successful HRIF engagement.
- C. In-person visits are ideal for comprehensive patient assessments and evaluation.** But consistent in-person visits may be considered challenging at present due to the COVID pandemic. The current public health crisis coupled with linked difficulties for parents and primary care providers have made it more difficult for patients and families to travel to clinic locations.
 - In-person access and allowable patient volume have been limited for many HRIF clinics during this period, thus telehealth may be considered the best or only option for some visits and assessments.
 - It is also recognized that some parents and families are appropriately concerned about exposures and contacts, particularly in high or increasing COVID risk areas.
- D. For sites offering both telehealth and in-person options**, and during periods when in-person visits are possible, issues to consider that may prioritize in-person visits include but are not limited to:
 - Families with resource challenges including computer or digital access limitations that may preclude telehealth or make it more difficult.
 - Families who express preference for in-person visits.
 - Patients considered at especially high risk due to previous evaluations or risk factors.

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- During periods with expected escalating motor and developmental trajectory (e.g., Standard Visit 2 and 3), particularly if family/ team concerns or risk factors.
 - Patients scheduled for research evaluations.
- E. **The Department of Health Care Services (DHCS)** has provided guidance pertinent to Medi-Cal billing and codes for telehealth communications relative to the COVID pandemic - https://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_30339_02.aspx
- F. **Telehealth visits may be optimized by parent discussions and preparations in advance**, integrating concepts including but not limited to:
- Assuring that parents/ families have appropriate technology to allow for telehealth visit and providing “trial runs” in advance as desired.
 - Explaining to families in advance what should be available (i.e., toys, play mat/ blanket, etc.) and how the home area should be set up to allow for optimal observation in relation to the computer/ tablet/ phone camera.
 - Making sure to have a phone contact for the parent/ family prior to the telehealth visit in case connection is lost, and reassuring parent/ family that HRIF team will call parent/family if that occurs.
 - Attempting to develop a telehealth approach that supports “**Team Visits**”, allowing for integration of all members of the HRIF team (i.e., provider, coordinator, social worker, OT/PT, nutrition, etc.) as required for the needs of the patient and family.
 - *Click here to see attached “**Telehealth Ideas for Families**” developed by Centre of Research Excellence in Newborn Medicine, Murdoch Children’s Research Institute & The University of Melbourne*

III. CONSIDERATIONS AND ADDITIONS: DEVELOPMENTAL ASSESSMENT TOOLS

A. Telepractice and the Bayley-4

- Per Pearson Assessments guidance, The Cognitive, Language and Motor subtests **cannot be administered in a standardized format via telepractice**. The Social-Emotional & Adaptive-Behavior Questionnaires can be administered in telepractice using Q-global for Remote On-Screen Administration (ROSA) which does not require video contact, using Q-global for On-Screen Administration (OSA) via video-conferencing.
- *Click here to see attached “**Telepractice and the Bayley 4**”, also found at <https://www.pearsonassessments.com/professional-assessments/digital-solutions/telepractice/telepractice-and-the-bayley-4.html>*

B. Additional assessment options included in the 2021 Standard Visit (SV) form:

“Developmental Assessment Test” section of the SV Form:

1. Developmental Assessment of Young Children 2nd Edition (DAYC-2)

- Birth to 5 years 11 months
- Domains available: Cognition, Communication, Physical Development, Social-Emotional, and Adaptive Behavior.
 - Reflects areas mandated for assessment and intervention for young children in IDEA.
- ~ 10-20 minutes per domain; Spanish available; “Level B” required qualifications
- Data to be collected for 2021 SV form:

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DAYC-2		
Domain/Subdomain	Standard Score	Age equivalent
Cognitive		
Communication		
Physical Development		
Social-Emotional		
Adaptive Behavior		

2. Developmental Profile -3 and -4 (DP-3 and DP-4)

- Birth to (12 yrs 11 mo: DP3, 21 yrs 11 mo: DP4)
- Physical, Adaptive Behavior, Social-Emotional, Cognitive, Communication.
 - Reflects areas mandated for assessment and intervention for young children in IDEA.
- ~ 20-40 minutes, Spanish available, “Level B” required qualifications
- Of note: One potential drawback with this instrument is that the range of items in the infant- toddler range is limited.
- Data to be collected for SV 2021 form:

DP-3 or DP-4		
Scale	Raw Score	Standard Score
Physical		
Adaptive Behavior		
Social-Emotional		
Cognitive		
Communication		

“Developmental Assessment Screener” section of the SV form:

3. Warner Initial Developmental Evaluation of Adaptive and Functional Skills (WIDEA-FS)

- Birth to 36 months
- Multidisciplinary observation criterion scale designed to examine emerging functional skills in the following domains: 1) self-care in feeding, dressing, and diaper awareness, 2) mobility, 3) communication, and 4) social cognition
- 50-item checklist, 1-4 point scale for each query, ~ 10 -15 minutes, Spanish available
- Data to be collected for SV 2021 form:

WIDEA-FS	
Domain	Score
Self-Care	
Mobility	
Communication	
Social Cognition	
TOTAL	

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IV. CONCLUSION

In-person HRIF visits are ideal, but the COVID-19 pandemic has created barriers to consistently meeting that goal for some HRIF clinics and families. Despite potential hurdles and provisos, telehealth visits may be an opportunity for quality improvement in HRIF, allowing for some evaluation for high-risk children who may not be able to attend in-person visits, particularly during the period of the COVID-19 pandemic. With additional assessment options for telehealth visits, the goal is that HRIF clinic teams will be better able to appropriately evaluate children even in the current challenging circumstances.

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Attending your child's video appointment

A telehealth guide for families



Step 1: What you will need

Computer, laptop, tablet or smartphone with web-camera, speakers and microphone (these are often built into devices)

Internet connection and web browser

Plain coloured mat or blanket and your child's favourite toys

Paper and pen to take notes if needed

Telehealth instructions provided by your health professional.

List of any questions or concerns to discuss



Your contact phone number

We recommend having 2 adults present if possible

Step 2: Getting ready

Set up in a warm, quiet, private & well lit room

Set up camera with any natural light (e.g. window) behind it



Lay the mat or blanket on the floor

Check you and your child are both in camera view

Place toys within easy reach

Undress your child. Keep their nappy/diaper on



Step 3: Connecting

Follow the telehealth instructions to connect a few minutes before your appointment time

Check the connection with your health professional

"Can you hear me?"
"Can you see me?"



Provide your phone number in case the connection fails

Confirm your child's name and date of birth

If you get cut off and can't reconnect, wait for a phone call from your health professional



Please note that to protect the confidentiality and privacy of all those involved in your telehealth appointment, you or your health professional are not permitted to record the session



Setting up your camera and checking you and your child are both in view takes time. If you don't have a tripod, you can create these phone holders using a bag of rice or a paper cup with the top cut out. For other ideas on how to create your own camera holder google 'DIY phone holders'.

For questions regarding your child's video appointment contact:



For information on our COVID-19 response including any potential business impacts [visit our webpage](#). For telepractice support [see our resources](#).

[Home](#) [Professional Assessments](#) [Digital Solutions](#) [Telepractice](#) [Telepractice and the Bayley-4](#)

Telepractice and the Bayley-4

The telepractice information in this document is intended to support professionals in making informed, well-reasoned decisions regarding remote assessment. This information is not intended to be comprehensive regarding all considerations for assessment via telepractice. It should not be interpreted as a requirement or recommendation to conduct assessment via telepractice.

Clinicians should remain mindful to:

- Follow professional best practice recommendations and respective ethical codes
- Follow telepractice regulations and legal requirements from federal, state and local authorities, licensing boards, professional liability insurance providers, and payors
- Develop competence with assessment via telepractice through activities such as practicing, studying, consulting with other professionals, and engaging in professional development.

Clinicians should use their clinical judgment to determine if assessment via telepractice is appropriate for a particular child, referral question, and situation. There are circumstances where assessment via telepractice is not feasible and/or is contraindicated. Documentation of all considerations, procedures, and conclusions remains a professional responsibility.

The Bayley-4 has two administration methods: The Social-Emotional & Adaptive-Behavior scales, questionnaires completed by parents or caregivers, and the Cognitive, Language and Motor scales, administered by a qualified professional through observation and direct interaction with the child.

For telepractice administration, **The Social-Emotional & Adaptive-Behavior Questionnaires** can be administered in 2 ways:

1. using Q-global for Remote On-Screen Administration (ROSA) which does not require video contact;
2. using Q-global for On-Screen Administration (OSA) via video-conferencing.

For ROSA, clinicians use Pearson's Q-Global system to email a link (URL) to parents or caregivers who then use the link to access and complete the questionnaire using any internet connected device; upon completion the questionnaire is immediately ready for reporting in Q-global. For OSA, the items may be read aloud to the parent/caregiver using the guidelines on page 270 of the Bayley-4 Administration Manual. This requires the use of video-conferencing and screen sharing to allow the parent/caregiver to view the questions and responses as they are read aloud by the clinician. Details regarding the Q-global system and how it is used are provided on the [Q-global product page](#).

Either approach allows the clinician to calculate raw scores and derive norm-referenced scores for the Bayley-4 Social-Emotional and Adaptive Behavior scales.

Bayley Scales of Infant and
Toddler Development, Fourth
Edition (Bayley-4)

[See pricing options](#)

The Cognitive, Language and Motor subtests *cannot* be administered in a standardized format via telepractice. However, the clinician can interact with and observe the child via telepractice to obtain qualitative information on cognitive, communication and motor skills (e.g., attends to the clinician on camera, shifts attention when name is called, babbles, reaches and grasps objects etc.). The clinician can review the Bayley-4 items at the age-appropriate start point in order to identify developmentally relevant skills. Information can be obtained through observation or caregiver questions; however, items involving specific manipulatives cannot be administered remotely.

Refer to the **Item Presentation Summary** located in the Q-global resource library for full details of items for which information can be obtained through observation or caregiver questions. This document is also hosted in the Q-global resource library. Further guidance on using the document is available in the following recorded presentation:

[Bayley-4: Considerations if using Telepractice](#)

Further guidance on developmental risk indicators is available in Appendix A of the Bayley-4 Technical Manual, and in Chapters 8, 9 and 10 of the *Bayley-4 Clinical Use and Interpretation* (Aylward, 2020).

This approach does not allow for calculation of scores for the cognitive, language and motor scales, but clinicians can use observations and information from the caregiver to inform their clinical opinion. The term “informed clinical opinion” appears in the regulatory requirements for the implementation of Part C of the Individual with Disabilities Education Act (IDEA) as an integral part of an eligibility determination. Using quantitative and qualitative information from the Bayley-4, along with information on the child’s developmental history, interviews with parents, and information from medical providers, social workers, and educators, clinicians can make recommendations about the child’s current developmental status and the potential need for early intervention.

Conducting Telepractice Assessment

Conducting a valid assessment in a telepractice service delivery model requires an understanding of the interplay between a number of complex issues. In addition to the general information on our [telepractice overview page](#), professionals should address five factors (Eichstadt et al., 2013) when planning for administering Bayley-4 via telepractice:

1. Telepractice Environment & Equipment

Computers and connectivity

Two computers with audio and video capability and stable internet connectivity—one for the examiner and one for the caregiver/examinee—are required. A web camera, microphone, and speakers or headphones are required for both the examiner and the caregiver/examinee. It is recommended that the examiner have a second computer screen so that he or she can view the Administration and Scoring Manual, but the paper format manual can also be used. The second computer or large screen also tends to make sharing test content more straightforward for the examiner.

Teleconference platform

A teleconference platform is required. Screensharing capability is required if anything other than items with verbal stimuli and responses are administered.

Video

High-quality video (HD preferred) is required during the administration. Make sure the full faces of the examiner and the caregiver/examinee are seen using each respective web camera. The teleconference platform should allow all relevant visual stimuli to be fully visible to the caregiver/examinee when providing instruction or completing items; the view of the examiner should not impede the caregiver/examinee's view of visual test stimuli.

Test item security in the audiovisual environment

The examiner is responsible for ensuring test item security is maintained, as outlined in the Terms and Conditions for test use. The examiner should address test security requirements with the caregiver/examinee (and facilitator, if applicable) during the informed consent process. The examiner should make it clear that the video should not be captured, photos should not be taken, and stimuli should not be copied or recorded, as this is a copyright violation. The caregiver/examinee must agree that they will not record (audio or visual) or take photos or screenshots of any portion of the test materials or testing session, and not permit anyone to observe the testing session or be in the testing room (except for a facilitator, when necessary).

Peripheral camera or device

A stand-alone peripheral camera that can be positioned to provide a view of the session from another angle or a live view of the examinee is helpful. Alternately, a separate device (e.g., a smartphone with a camera or another peripheral device) can be connected to the teleconference and set in a stable position to further capture observations of the examinee. The device's audio should be silenced, and microphone should be muted to prevent feedback.

Audio considerations

For audio interaction during the administration, make sure the audio is working as expected. Test the audio prior to the administration through the caregiver/examinee's speakers to ensure a high-quality audio environment is present

Manage audiovisual distractions

As with any testing session, the examiner should do everything possible to make sure the caregiver/examinee's environment is free from audio and visual distractions. If the examiner is unfamiliar with the caregiver/examinee's planned physical location, a visual tour of the intended testing room should be given during the initial virtual meeting. The examiner can then provide a list of issues to address to transform the environment into one suitable for testing. For example, remove distracting items, silence all electronics, and close doors. The examiner should confirm that these issues have been addressed at the time of testing. If possible, the caregiver/examinee should be positioned facing away from the door to ensure the examiner can verify through the caregiver/examinee's camera that the door remains shut and can monitor any interruptions. The examiner should confirm that all other applications on the computer, laptop, or peripheral device are closed, the keyboard is moved aside or covered after the session is connected, and alerts and notifications are silenced on the peripheral device. Radios, televisions, other cellular phones, fax machines, smart speakers, printers, and equipment that emit noise must be silenced and/or removed from the room.

Lighting

Good overhead and facial lighting should be established for the examiner and caregiver/examinee. Blinds or shades should be closed to reduce sun glare on faces and the computer screens.

Disruptions

The examiner should record any and all atypical events that occur during the testing session. This may include delayed audio or video, disruptions to connectivity, the caregiver/examinee being distracted by external stimuli, and any other anomalies. These should be noted and considered during interpretation and described in the written report.

2. Assessment Procedures and Materials

Copyright

Permission must be obtained for access to copyrighted materials (e.g., stimulus books, response booklets) as appropriate. Pearson has provided a [letter of No Objection \(PDF | 75.02 KB\)](#) to permit use of copyrighted materials for telepractice via teleconference platform and tools to assist in remote administration of assessment content during the COVID-19 pandemic.

Digital assets

The examiner should practice using the digital assets until the use of the materials is as smooth as a face-to-face administration. It is not recommended that the examiner display items from paper stimulus books on a camera.

Monitor the test session and the respondent's interaction with the test materials to ensure confidentiality and test session integrity as appropriate

Responding to Caregiver Questionnaires

For ROSA ensure that the person completing the rating forms has a working email address in order to access the forms.

For ROSA and OSA, emphasize to the respondent(s) to follow the instructions as stated on the forms. For ROSA, provide valid examiner contact information in case the respondent has a question or problem with the online administration.

3. Examinee Considerations

Appropriateness

The examiner should first ensure that a telepractice administration is appropriate for the examinee and for the purpose of the assessment. Clinical judgment, best practice guidance for telepractice (e.g., APA Services, 2020; ASPPB, 2013; IOPC, 2020), information from professional organizations and other professional entities (e.g., licensing boards, legal resources, professional liability insurance providers, payors), consultation with other knowledgeable psychologists, existing research, and any available federal or state regulations should be considered in the decision-making process. Consideration should be given to whether the necessary administrative and technological tasks involved in a telepractice session can be accomplished without influencing results.

Preparedness

Before initiating test administration, the examiner should ensure that the caregiver/examinee is well-rested, able, prepared, and ready to appropriately and fully participate in the testing session.

Facilitator role

If using a facilitator, the role of the facilitator must be explained to the caregiver/examinee so participation and actions are understood.

Mouse

On some teleconference platforms, the examiner can pass control of the mouse to allow the caregiver to point to indicate responses; this is an option if it is within the capabilities of the caregiver. However, best practice guidelines provide cautions about this. For example, the IOPC guidelines suggest examiners be alert throughout administration, return control of the screen once the task is finished, and never leave the computer unattended while the caregiver/examinee has control over the examiner's computer (IOPC, 2020).

4. Examiner Considerations

Practice

Practice the mechanics and workflow of assigning, starting, and completing the assessment using the On-Screen Administration capabilities of Q-global before you go through this process with a caregiver so that you are familiar with the administration procedures

During the telepractice setup, and before administering to any actual caregiver/examinee, the examiner should rehearse the mechanics and workflow of every item in the entire test using the selected teleconference platform so that the examiner is familiar with the administration procedures. For example, a colleague could be used as a practice examinee.

Standardized procedures

The examiner must follow the administration procedures of in-person administration as much as possible. For example, if a spoken stimulus cannot be said more than once during in-person administration, the examiner must not say it more than once in a telepractice administration unless a technical difficulty precluded the caregiver/examinee from hearing the stimulus.

Administrative and technological tasks

In order to conduct a smooth telepractice session, audiovisual needs and materials must be managed appropriately. The initial virtual meeting involves the examiner, caregiver/examinee, and/or the facilitator (if used), and is the opportunity for the examiner to provide information about the audiovisual needs and materials. During the initial virtual meeting, the examiner should provide training in troubleshooting audiovisual needs that arise during the testing session, including camera angle, lighting, and audio checks. The examiner should provide verbal feedback to guide camera adjustment, checking the onscreen video shown by the peripheral camera/device to provide information about how to reposition it until the proper view is shown.

If used, the facilitator is to assist with administrative and technological tasks and not to manage rapport, engagement, or attention during the testing session. The examiner should direct them not to interfere with the caregiver/examinee's performance or responses. Any other roles and responsibilities for which an

examiner needs support, such as behavior management, should be outlined and trained prior to the beginning of the testing session. The examiner is responsible for documenting all behaviors of the facilitator during test administration and taking these into consideration when reporting scores and performance

5. Other Considerations

There are special considerations for written reports describing testing that takes place via telepractice.

The professional completing the written report should state in the report that the test was administered via telepractice, and briefly describe the method of telepractice used. For example, *“The Bayley-4 was administered via remote telepractice using observations and caregiver questions to elicit information during the live video connection using the [name of telepractice system, e.g., Zoom] platform.”*

The professional should also make a clinical judgment, similar to an in-person session, about whether or not the examiner was able to obtain the examinee’s best performance. Clinical decisions should be explained in the report, including comments on the factors that led to the decision to conduct testing via telepractice and to report all (or not to report suspect) scores. In addition, it is recommended that the report include a record of any and all atypical events during the testing session (e.g., delayed video or audio, disruptions to connectivity, extraneous noises such as phone ringing or loud dog barking, person or animal unexpectedly walking into room, the caregiver/examinee responding to other external stimuli). List and describe these anomalies as is typical for reporting behavioral observations in the written report, as well as any observed or perceived impact on the testing sessions and/or results, and consider these in the interpretation of results. For example, *“The remote testing environment appeared free of distractions, adequate rapport was established with the caregiver/examinee via video and s/he appeared appropriately engaged in the task throughout the session. No significant technological problems were noted during administration, and the results are considered to be a valid estimate of the examinee’s skills/abilities.”*

Conclusion

The Bayley-4 has two administration methods: The Social-Emotional & Adaptive-Behavior scales, questionnaires completed by parents or caregivers, and the Cognitive, Language and Motor scales, administered by a qualified professional through observation and direct interaction with the child. Provided that you have thoroughly considered and addressed all five factors and the special considerations as listed above, and based on the available research, there is little reason that you should have concerns about the reliable and valid delivery of the Bayley-4 Social-Emotional & Adaptive-Behavior questionnaires via telepractice as well as the use of the normative data. However, the Cognitive, Language and Motor scales of the Bayley-4 were not standardized in a telepractice mode, and this should be taken into consideration when using the observations and caregiver responses to inform clinical opinion. For example, the examiner should consider relying on convergence of multiple data sources and/or being tentative about conclusions.

You may use the Bayley-4 via telepractice *without additional permission from Pearson* in the following published context:

Bayley-4 Social-Emotional & Adaptive-Behavior form On-Screen Administration (OSA) or Remote On-Screen Administration (ROSA) via Q-global, or paper record form.

Bayley-4 manuals, Behavior Observation Inventory, and Observation Checklist

Bayley-4 Item Presentation Summary, located in the Q-global resource library

Any other use of the Bayley-4 via telepractice is **not** currently recommended. This includes, but is not limited to, scanning the paper stimulus books, digitizing the paper record forms, holding the stimulus books physically up in the camera's viewing area, or uploading a manual onto a shared drive or site.

References and selected research to date

See Bayley-4 **Item Presentation Summary** located in the Q-global Resource Library

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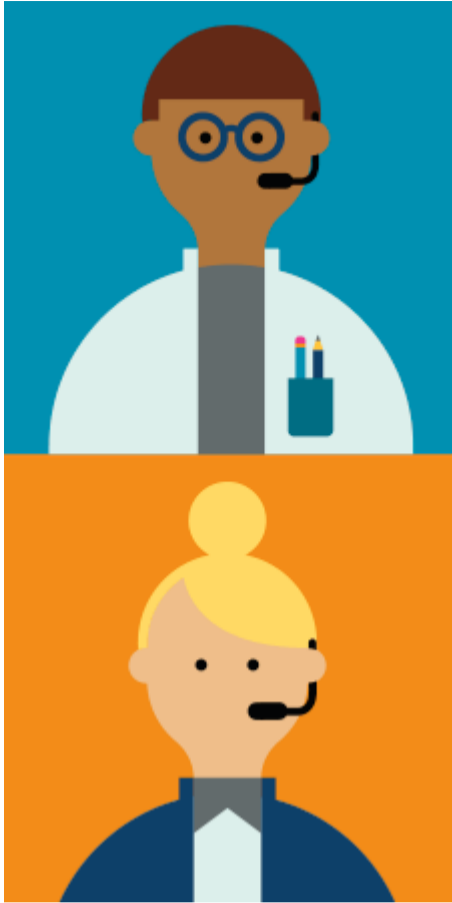
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A customer reflects on using Q-global digital stimulus books and manuals:

Q-Global has been a great solution for us. Managing testing materials between a variety of sites and districts could be very tricky. The online testing materials have completely resolved any access challenges we faced. Observing and recording the client's response through telepractice continues to require a good deal of coordination- particularly for pointing activities. However, the clinician being able to directly manage test stimuli and present them to the client through screen share technology makes that process much less cumbersome.

Thank you for being so proactive with making your tools accessible to telepractitioners!

Nate Cornish, MS, CCC-SLP
Clinical Director
VocoVision

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