



# **Preschool Speech and Language Outcome Measurement Guide**

June 2015

## **Background**

Preschool Speech and Language (PSL) is funded by the Ministry of Children and Youth Services (MCYS) and is supported to provide services that are evidence-based, child and family-centred, equitable and easily accessible. Also, as PSL is a publicly-funded program, it is dedicated to promoting maximally efficient use of public resources.

A standard approach to outcome measurement promotes improved equity across all 31 PSL regions as well as the delivery of consistent, evidence-based services. PSL outcome measurement supports:

1. For children and their families:
  - a. Increased involvement in monitoring their children's speech and language development;
  - b. A shared language with program staff regarding their children's progress; and
  - c. A consistent approach for tracking and monitoring their children's progress.
  
2. For PSL clinicians:
  - a. Standard measures of children's outcomes across the provincial program with a focus on capturing functional, meaningful change;
  - b. Improved communication with families and other clinicians; and
  - c. Improved effectiveness and efficiency of service delivery.
  
3. For the provincial program:
  - a. Descriptions of patterns of children's progress within PSL; and
  - b. A measure of the impact of the PSL Program.

The use of standard outcome measures was introduced in 2009. The current measures described below have been in use since 2012.

## **Approach**

Outcome measurement in PSL involves two tools:

1. FOCUS<sup>®</sup>; and
2. Communication Function Classification System (CFCS)

### **1. The FOCUS<sup>®</sup>**

Focus on the Outcomes of Communication Under Six (FOCUS<sup>®</sup>) is a clinical tool designed to evaluate change in communicative-participation in preschool children. 'Communicative-participation' is the child's communication and interaction in "real world" situations at home, school, or in the community (Eadie et al., 2006).

The FOCUS<sup>®</sup> is a valid, reliable, responsive therapy outcome measure that captures 'real world' changes following speech and language therapy. Based on the World Health Organization's (WHO) International Classification of Functioning, Disability and Health - Children and Youth (ICF-CY), the FOCUS<sup>®</sup> links speech and language therapy to the child's ability to communicate and participate in their world (WHO, 2007).

## **2. The Communication Function Classification System (CFCS)**

The Communication Function Classification System (CFCS) was developed by a research team led by Dr. Mary Jo Cooley Hidecker with the University of Central Arkansas. The CFCS is used to classify everyday communication performance. Everyday communication performance refers to an individual's typical, day-to-day communication. Although it was originally developed for children with cerebral palsy, research has shown that it is valid for children with a variety of communication disorders.

The CFCS levels are:

- Level I: Effective Sender and Receiver with unfamiliar and familiar partners
- Level II: Effective but slower paced Sender and/or Receiver with unfamiliar and familiar partners.
- Level III: Effective Sender AND Effective Receiver with familiar partners.
- Level IV: Inconsistent Sender and/or Receiver with familiar partners.
- Level V: Seldom Effective Sender and Receiver with familiar partners.

Results from each administration of the PSL outcome measures are entered into HCD-ISCIS along with specific demographic information provided by the SLP. Demographic information includes confounding factors, language, goals targeted and additional supports. See Appendix 1 for the form details and definitions.

### **When to Administer the PSL Outcome Measures**

Outcome measurement will be completed on every child receiving PSL services from the age of 18 months onwards. Timing of administration is intended to capture change that may occur over a period of intervention and as such, the FOCUS<sup>®</sup> and CFCS will be completed:

1. At Initial Assessment (IA) only when the first intervention is accessed at the same visit;
2. At the beginning of the first intervention (if not at IA)
3. At all Re-assessments\*; and
4. At discharge from the PSL program.

Exceptions to the above include:

- children who are seen for Feeding/Swallowing only;
- children identified with permanent hearing loss; and

- children who are receiving a re-assessment as a result of being “transferred in” and an intervention is not being accessed on the same date

Please see the Healthy Child Development-Integrated Services for Children Information System (HCD-ISCIS) Data Tracking Manual for PSL Clinical Staff for the definition of Re-assessment.

\*The frequency of re-assessments for an individual child is determined by the local PSL program and clinicians. Wherever possible, it is preferable that outcome measures be completed (and linked to a re-assessment) at the beginning and end of an intervention. The intervention period is recommended not to exceed 6 months and is inclusive of the consolidation period (if applicable).

- Should an intervention change without the need to reassess the child’s skills, (e.g. finish a home program after 1 month in order to access parent training) a new FOCUS does not have to be completed.
- Should a child be receiving on-going intervention, it is recommended that a re-assessment be conducted at a minimum of every 6 months to monitor progress and inform clinical decisions.
- If the FOCUS was not able to be administered at the beginning of an intervention, then administer it at the beginning of the next intervention period; DO NOT administer the FOCUS mid intervention unless that intervention is ongoing as described above.

Examples illustrating when to administer FOCUS are included as Appendix 2.

### **How to Administer the PSL Outcome Measures**

The CFCS is to be completed by the PSL speech language pathologist, using their best clinical judgment and information provided by the parent.

Additional information on the CFCS can be obtained at: [www.cfcs.us](http://www.cfcs.us)

FAQs regarding the use of the CFCS can be obtained at:

[http://www.hollandbloorview.ca/research/FOCUS/FOCUS\\_pre-training.php](http://www.hollandbloorview.ca/research/FOCUS/FOCUS_pre-training.php)

The FOCUS<sup>®</sup> is completed by the child’s parent/primary caregiver. Wherever possible, it should be completed by the same parent/primary caregiver at each administration. If the parent/caregiver needs assistance to complete the FOCUS<sup>®</sup>, then it is possible to do the FOCUS<sup>®</sup> as a parent interview. The amount of coaching by an SLP has not shown to affect the validity. There is also an audio version of the FOCUS<sup>®</sup> which has visual support for the rating scales. The FOCUS<sup>®</sup> items are read aloud to facilitate completing the FOCUS<sup>®</sup>. When interviewing the parent, record the parents’ answers for them using the Parent Form.

If the parent/primary caregiver cannot complete the FOCUS<sup>®</sup> or prefers not to complete the FOCUS<sup>®</sup>, the speech language pathologist can complete the Clinician FOCUS<sup>®</sup> form. If this is the case, for the sake of consistency the clinician form should continue to be used as the outcome measure for that child (i.e. do not continuously change between the Parent FOCUS<sup>®</sup> and the Clinician FOCUS<sup>®</sup> forms, however changing from a parent to a clinician form may be indicated if, in the clinician's judgement, it no longer seems appropriate to ask the parent to complete it).

Should the Clinician FOCUS<sup>®</sup> be used, it is not necessary that the same speech language pathologist complete the clinician form at each administration point. The FOCUS<sup>®</sup> has proven inter-rater reliability between clinicians and, therefore, can be reliably completed by different clinicians on the same child. If the speech-language pathologist is completing the FOCUS<sup>®</sup>, they may need to consult with the parents. This increases the reliability for speech-language pathologist FOCUS<sup>®</sup> scores.

### **Scoring and Interpreting the FOCUS<sup>®</sup>**

#### 1. FOCUS<sup>®</sup> Total Score

Change is measured using the FOCUS<sup>®</sup> Total Score. The numbers from the columns on each page are calculated and then the totals from Part 1 and Part 2 are added together to compute the FOCUS<sup>®</sup> Total Score. The Total Score can then be recorded on the front page of the FOCUS<sup>®</sup>.

When interpreting the FOCUS<sup>®</sup> change score (i.e., the difference between the two FOCUS<sup>®</sup> administration Total Scores), the following guidelines apply:

- < 9 difference: not likely a meaningful clinical change
- 10-15 difference: possibly a meaningful clinical change
- 16 difference: considered significant clinical change

The above guidelines are helpful in guiding clinical decision-making, however, speech-language pathologists should always base their clinical decisions on a combination of factors including clinical observations and other test information. Note that these guidelines can only be applied when comparing two FOCUS scores that were administered a maximum of 6 months apart.

#### 2. FOCUS<sup>®</sup> Scoring Profile – Optional (For Clinical Use Only)

The purpose of the scoring profile is to provide additional clinical information. This information can be used for treatment programming and goal setting. Scores from the specific items should be entered into the scoring profile. An average score needs to be calculated for each category so that the speech-language pathologist can compare scores across categories. The Scoring Profile will help the speech-language pathologist see which communication areas have made

most change throughout treatment and whether or not there are skill areas that have not improved. This information is useful for treatment planning.

Additional information on the FOCUS<sup>®</sup> can be found in the FOCUS<sup>®</sup> Abridged Manual and FOCUS<sup>®</sup> User Manual. These documents can be obtained at:

<http://www.hollandbloorview.ca/research/FOCUS/index.php>.

The speech-language pathologist is encouraged to review the FOCUS results and change scores with the parent/caregiver after scoring.

### **HCD-ISCIS Coding and Data Entry for Outcome Measures**

Outcome measurement data (FOCUS and CFCS) can only be entered into HCD-ISCIS within the following services:

- Initial Assessment (IA);
- Re-Assessment (RA); and
- Discharge Service (DS).

Should a FOCUS be administered at an intervention visit that is not considered a Re-Assessment by definition, (e.g. at a first intervention session with a CDA; no SLP present), it may be entered into HCD-ISCIS as a RA for the purposes of entering the FOCUS data.

**Early Abilities Preschool Speech and Language (PSL) Program  
Outcome Measures (OM) Questions and Answers  
March 2018**

**Submitting OMs**

- Q1: How should Outcome Measures be accurately captured on the PSL Client Tracking Form?
- A1: Whenever possible, outcome measures are to be completed with families at first intervention, all re-assessments and at discharge. Simply indicate whether an outcome measure has been completed for a client in the "OM" column on the PSL Client Tracking Form.
- Q2: Whose stats should the outcome measures summary form be attached to? Oftentimes outcome measures are completed at the first intervention session with supportive personnel not the SLP.
- A2: So long as the outcome measures completed for the month are submitted with client tracking for the same month, it does not matter who the outcome measures are attached to.

**Frequency of OM Administration**

- Q3: Due to the waitlists we often do not bring children back within 6 months. What should we do?
- A3: While it is preferable to have outcome measures completed at a minimum of every 6 months, it is understood that this may not always be possible.
- Q4: If more than 6 months passes in between administration of outcome measures does this invalidate the FOCUS tool/ change score?
- A4: No. FOCUS change scores need to be interpreted with caution if more than 6 months pass in between. Research indicated that a 10 point change could be attributed to maturation/ development over a 6 month period. There is not enough data to indicate how much change might occur due to development in a period longer than 6 months.
- Q5: Do outcome measures need to be completed for Junior Kindergarten (JK) nominated children who only receive one block of intervention?
- A5: No. Because these children will not be returning for a subsequent block of intervention there would be no comparison outcome measures available.
- Q6: It is not always possible to do a final re-assessment or client visit at discharge. Consequently outcome measures will not be completed. Is this a problem?
- A6: While it is preferable to have outcome measures completed at discharge, it is understood that this may not always be possible.

### **Neonatal Follow-Up Clinics**

- Q7: Should OMs be completed for children seen in neonatal follow-up clinics?
- A7: MCYS acknowledges that the workload of SLPs and the fast-paced nature in these clinics may not be conducive to completing OMs. It is also acknowledged that PSL OMs may not always be appropriate in these settings. If local neonatal follow-up clinics see the value and benefit in completing OMs, MCYS supports this. However, it is understood this may not always be consistently feasible or appropriate.

### **Communication Function Classification System (CFCS)**

- Q8: Why are we using the CFCS tool?
- A8: The CFCS tool provides additional clinically relevant information to inform clinical practice. The CFCS is used to classify everyday communication performance. Additional information regarding the CFCS can be obtained at [www.cfcs.us](http://www.cfcs.us) and [http://www.hollandbloorview.ca/research/FOCUS/FOCUS\\_pre-training.php](http://www.hollandbloorview.ca/research/FOCUS/FOCUS_pre-training.php)