



**Developmental Screening in Primary Care:
Flagship of Bright Futures Recommended Well Child Care and Community
Based Care Coordination**

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Goals

- Provide perspective as a front-line clinician on why developmental screening is a flagship measure
 - Bright futures recommended care
 - Awareness and referral to community based providers
 - Care Coordination
 - Ultimate goal: Enhanced development and Kindergarten Readiness
- Provide input to CCOs in focusing this area
 - Building off momentum and learnings in Oregon
 - Efforts proceeding ABCD III
 - ABCD III PIP Learning Collaborative
 - Community engagement
 - Focus was BEYOND screening
 - Key Lessons from ABCD III for the CCO
- Provide Links to Resources and Contact Information for Questions

Why do the guidelines exist?

- About 1/3 of children need some help to be prepared for Kindergarten.
- Surveillance alone was failing to identify children in need of services.
 - Only 30% of children with developmental disabilities are identified without the use of a standardized tool (Palfrey, 1994).
 - Tools were generally being used only in the context of parental concerns (AAP Periodic Survey, 2002).
- AAP guidelines from 2006 broke down the identification of children at risk into three parts: surveillance, standardized screening, diagnosis.
 - Included that the Medical Home has a critical role in initiating screening, making referrals, coordinating care with community agencies and medical services, and organizing a diagnostic process when necessary.
 - Clearly stated that developmental PROMOTION is a key element...not just screening but figuring out how to move a child's developmental attainment.
- Oregon Pediatric Society launched a statewide training effort in 2008, my practice was one of the first to participate and then implement screening (November 2008)
- Has been a measure I've advocated for in Metrics & Scoring due to its importance in early childhood preventive care / Kindergarten Readiness.

Common Myths or Barriers about Screening that Can be Addressed

1. Not feasible to do in a primary care setting (time!)
2. Surveillance is “good enough”
3. It is happening in the community, I don’t need to do it
 - *Only 2-3% of children under the age of 3 are receiving Early Intervention services in the state of Oregon*
 - *Only 3238 children under the age of 3 are enrolled in Head Start in the entire state*
 - *Only 1858 children aged 0 -17 years received CaCoon services in the entire state (FY 09)*
 - *Oregon ranked as the LEAST affordable state for daycare / childcare services*
4. I can’t get reimbursed for it
5. MA/Nursing staff can just ask the parents, we don’t need a parent completed tool
 - *Literature shows that this is a biasing approach (leading questions are the default)*
 - *Standardized tools (like ASQ) require actually testing skills with children*
6. I use an EMR and paper based tools don’t fit into my EMR
7. If I provide a one-time training to providers then it will happen (CCO myth)

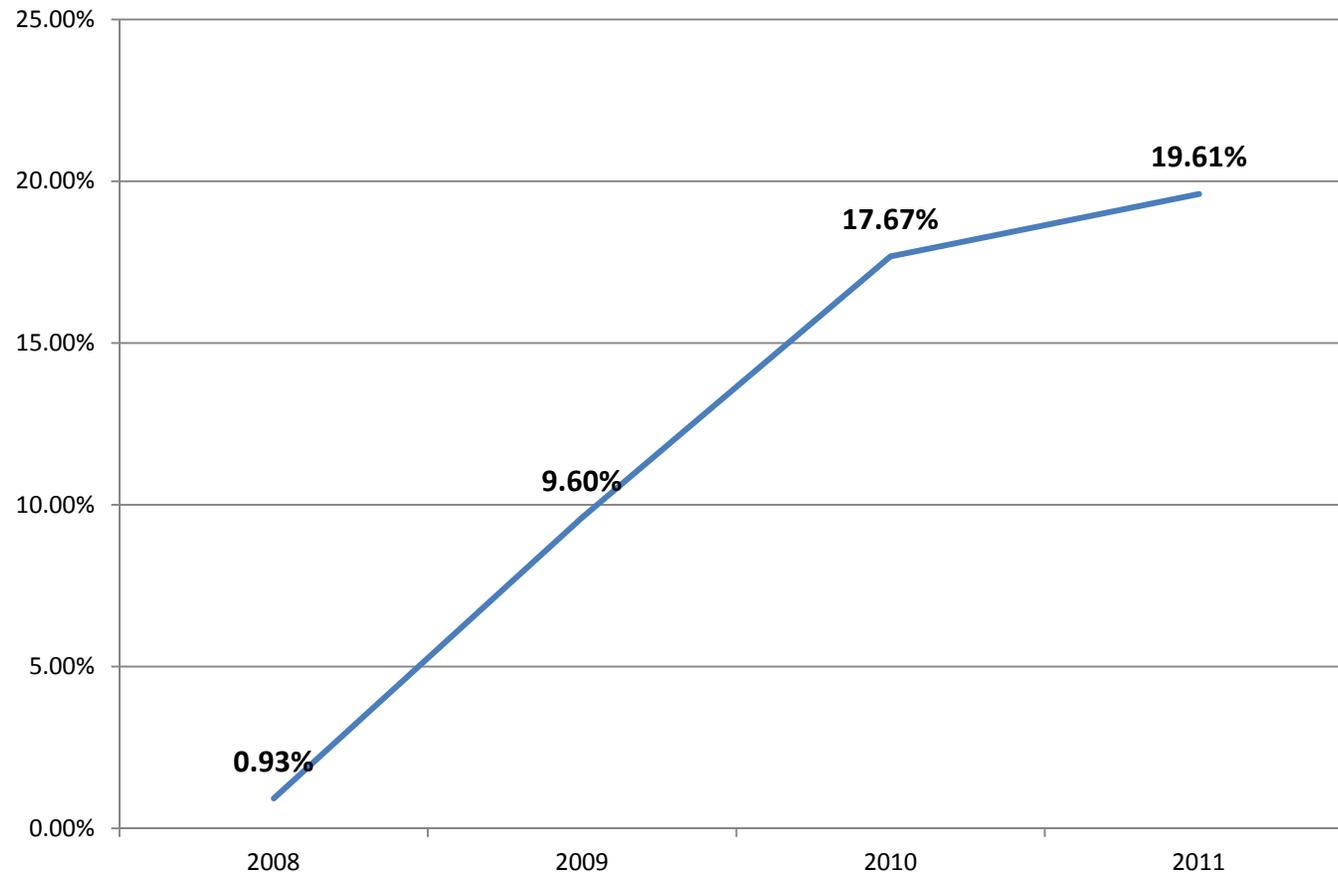
Where Training Alone Fell Short

- Traditionally no communication between PCP and EI (HIPAA / FERPA rules). This still continues in most regions (some regional variation).
 - Common Referral and Release Form allows for parent consent when the screening starts in the PCP office...but nothing comes if referred into EI from another source (including self-referrals).
 - Also don't know when parents don't go to EI, what happens after the initial evaluation, or when children complete a course of treatment.
 - Lack of two-way communication is also true of home visiting nursing programs, Head Start, daycares / schools.
- Didn't adequately address reimbursement...better now but initially less than half of the private plans covered screening, or shifted it onto a patient's procedural deductible. Can't do different billing processes for Medicaid and private plans (fraud!).
- Our practice-based measurement does not include those patients who miss well visits. Implementing workflows for screening are weakened by no parallel process for functional patient recall systems.
 - Had to learn how to do internal measurement to ensure screening was occurring.
 - Leads to limited believability of health plan measures around developmental screening.
- No training or help on referral tracking and management...care coordination efforts are practice-dependent and very dependent on a practice's adaptive reserve.
- While we were told what needed to do for documentation within the EMR to obtain reimbursement, we still had to program that ourselves.

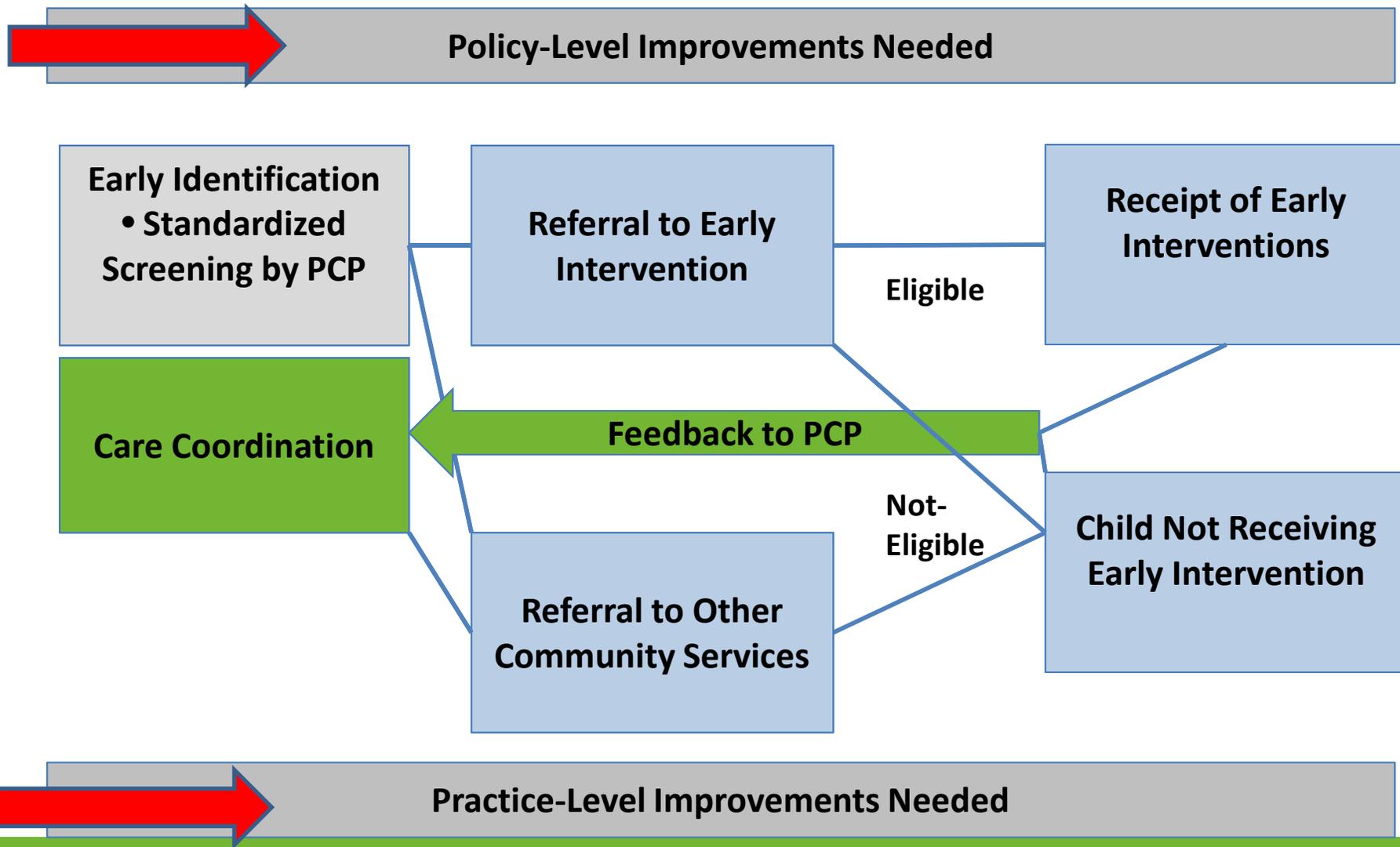
Building Off Momentum: Ground Swell of Policy and Practice Based Efforts Focused on **Developmental Screening**

- Incentive based payment
 - 96110 included in bonus payment for some plans/organizations to up preventive services use (Carrot for practices to do the START training)
- ABCD Screening Academy
 - Pilots in KPNW
 - Clarification to provider manual
 - Development of educational materials to providers and parents
 - Common Referral Form to EI that includes FERPA, allows for two-way communication
 - Reuland (OPIP ED) developed CHIPRA Core Measure on Developmental Screening
- START Training
 - Academic detailing model
 - Identification of community resources, attendance at training
 - MOC credit for providers that implement screening, collect measures
- ABCD III : Performance Improvement Project, Learning Collaborative
 - MCO-Level Effort (Eight MCOs)
 - Focused on screening and referral and care coordination with EI
 - Important EI level partnership, modifications to EC web and reporting templates back to providers
 - Community-level engagement
 - Medical chart review measures of screening, referral and care coordination accepted by the NQMC (Lead Author: Reuland)
 - Learnings about merging Medicaid and EI data
 - Learnings about MCO-based efforts that do and don't work when engaging the front line
- PCPCH
 - Included in standards
 - Community based referrals and tracking could be part of care coordination measure

Oregon *Statewide* Medicaid-CHIP Screening rates



Pillars of ABCD Performance Improvement Project



Three -Staged Community Engagement Process: Using Community Based Process to Inform QI Design and Engage Partners

1. Community Cafes (CC) with Parents

“Harvest” from café of potential solutions, current perceptions of process and barriers, anchored to principles of ABCD III

2. Strategic Interviews and Engagement with Community Providers

Participants include Early Intervention and other community providers (*including home visit nurses and mental health agencies*), front-line PCPs and health plans AND the parent leader from the community café.

-- Feedback to parents who participated in the community cafes (cc)

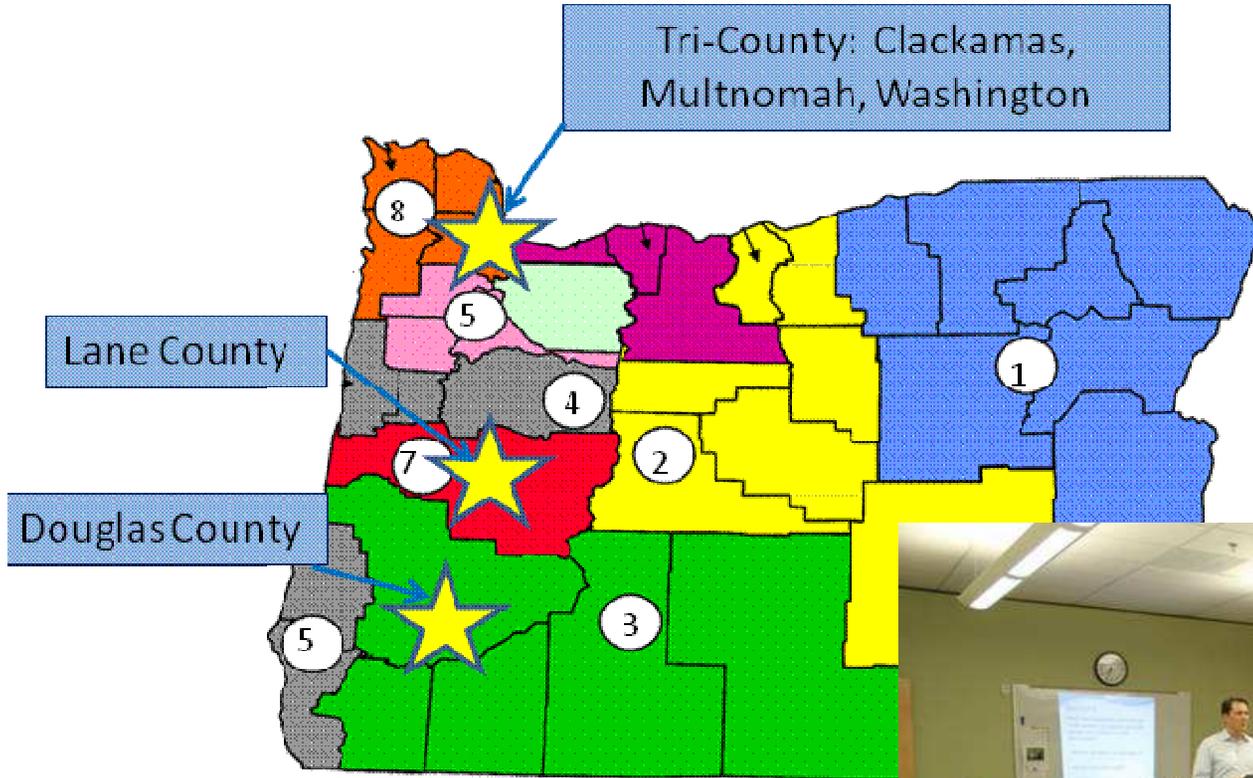
3. Engagement/Group Meeting of Community Providers

Participants are those who participate in Tier 2.

Blended model of community café/Infrastructure meeting

-- Feedback to parents who participated in the community cafes (cc)

Communities of Focus for the Community Engagement



Key Learnings Relevant for CCOs Addressing Developmental Screening

- Improvement requires policy-, system-, and practice-level interventions.
- Improvement interventions need to be multi-layered and anchored to the needs and opportunities that exist within the community
- Intervention needs to go beyond screening, but should take an approach that maps to the concepts of medical home, community-based care with community-based providers, and behavioral health integration that are heavily emphasized throughout various requirements

CCO Incentive Pool Metric: Developmental Screening

Suggestions from OPIP about Leveraging Efforts Around this Metric

TRACK 1: Primary Care Providers who ARE screening

- Address 96110 billing
 - More than half of the children who had a screen in the chart, did not have a 96110 claim
 - Some providers not billing, as they are not doing in the way that maps to goal/intent of the recommendations and requirements around 96110
- Address providers who are JUST doing the MCHAT at the 18 and 24 month visits
 - Not included in this measure
- Ensure referral of children identified at risk
 - Not all children identified at risk are referred
- Referring with intent to hear back so that primary care can serve coordination and medical home role
 - Use of common referral form
 - 40-50% of children referred for services, don't go to Early Intervention
 - » Use of community based providers to address fundamental health literacy issues
- Address family risk factors that may be putting the child at risk
 - Maternal depression screening

TRACK 2: Primary Care Providers Who are Not Screening

- Reasons they are not screening are NOT about lack of awareness about the recommendation
- START Training
 - Great model for practices with adaptive reserve and QI skills
- Practice facilitation
 - Demonstrated success
- Incentive/Carrot Based Approaches

CCO Incentive Pool Metric: **Developmental Screening**

Suggestions from OPIP about Leveraging Efforts Around this Metric

– **Community-based screening, avoiding duplication and incentivizing shared communication**

- Particularly relevant/important given the Early Learning Council Efforts
- Models for sharing screening results based on what happens in community
 - Exploring models for PCPs to bill a 96110 if they receive the full screen and facilitate conversations an developmental promotion with the family based on these results

– **Parent engagement and education**

- Value and role of screening
- Value and role of community based intervention services

Questions?

- For Questions about ABCD III
 - R.J. Gillespie (gillesrj@ohsu.edu) 503-494-5231
 - Colleen Reuland (reulandc@ohsu.edu) 503-494-0456
- Resources
 - Overview of ABCD III: <http://oregon-pip.org/projects/abcd.html>
 - Coaching Practices on Billing for 96110: <http://oregon-pip.org/resources/OIPCoachingStrategiesfor96110.pdf>
 - Referral Form to EI/ECSE <http://www.ohsu.edu/xd/outreach/occyshn/programs-projects/dev-screening-and-referrals.cfm>
 - Referral Form to CaCoon Program: <http://www.ohsu.edu/xd/outreach/occyshn/programs-projects/cacoon.cfm>
 - NQMC endorsed medical chart review tool focused on screening, referral, care coordination: http://oregon-pip.org/resources/ABCD%20III_MedChartReview-%20FINAL%2006-04-13.pdf