Enhancing Child Development Services in Medicaid Managed Care

toolkit

Best Clinical and Administrative Practices for Medicaid

CHCS
Center for
Health Care Strategies, Inc.

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A Best Clinical and Administrative Practices℠ Toolkit for Medicaid

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The Center for Health Care Strategies promotes high quality health care services for low-income populations and people with chronic illnesses and disabilities. We achieve this objective by providing training, technical assistance, and grant making to state purchasers of publicly financed health care, health plans, and consumer groups. The Center's program priorities are: improving quality, reducing racial and ethnic disparities, and increasing community options for people with disabilities.

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Preface and Acknowledgements

The Center for Health Care Strategies (CHCS) thanks the many people who supported the production of this toolkit. We recognize Peggy Oehlmann, formerly of CHCS, for leading the development and early implementation of the BCAP Workgroup on *Enhancing Child Development Services in Medicaid Managed Care*. We thank Beth Smith, MD, of Dartmouth-Hitchcock Concord; Susanne Salem-Schatz, ScD, of HealthCare Quality Initiatives; and Jane Deane Clark, PhD, of CHCS, for helping plans embrace the importance of measurement. We acknowledge Christina Trank of CHCS for her careful review of this toolkit and are grateful to Rosa Novatkowski of CHCS, who provided administrative support. We thank Melinda Abrams and Edward Schor, MD, of The Commonwealth Fund and Stephen Somers, PhD, President of CHCS, for their motivation and for continually underscoring the importance of the work and the opportunities that lie ahead.

We also recognize the highly committed members of the *Enhancing Child Development Services in Medicaid Managed Care* workgroup who drove systems-level improvements for Medicaid beneficiaries.

How this Toolkit is Organized

This toolkit chronicles the experiences of the 11 Medicaid managed care organizations in piloting activities to improve early childhood screening and anticipatory guidance, with an emphasis on preventive pediatric care. The toolkit reviews the BCAP Quality Framework and highlights strategies used to improve the delivery of child development services, including early identification of developmental disabilities, improving outreach to members, enhancing provider partnerships, improving reimbursement and referral practices, and recognizing potential returns on investment. Case studies illustrate how plans applied the BCAP Quality Framework to improve child development services in Medicaid managed care. It is our hope that health plans, states, and other stakeholders committed to improving the quality of children's health care can glean ideas from this toolkit on how to systematically enhance the effectiveness of child development services.

FOREWORD:
GIVING CHILDREN THE RIGHT START

Every year, tens of thousands of young children enter school unprepared to succeed. Many in this group are low-income children covered by publicly-financed health care programs like Medicaid and the State Children's Health Insurance Program. Many have had minimal exposure to preventive services and high exposure to detrimental social and emotional environments, due to family circumstances like poverty, low levels of education, lack of social support, or due to their own health problems. The early life experiences of these children often leave them behind their peers in terms of cognitive, social, physical, and emotional development. Research shows that many of these children will persistently lag behind their peers throughout their school years.[1] Providing these children with good quality early intervention programs and clinical services can prevent or ameliorate some of these problems and place "at risk" children on a more positive and successful developmental trajectory. It is critical to reach these children as early as possible to change their life course. Neurobiological, behavioral, and social science research has shown the importance of early life experiences on early brain development and on subsequent development and behavior.[2] Unfortunately, in spite of their eligibility for Medicaid and its Early Periodic Screening, Diagnosis, and Testing (EPSDT) program, many of these at-risk children are not identified as having developmental problems prior to school entry, though systematic observation and assessment can identify most problems before age three.

Nearly all children age three and under participate in some level of well-child care, making it an ideal setting for monitoring development. As such, pediatric health care practitioners are in a unique position to identify children with developmental problems and those at risk for developmental problems, evaluate developmental status, and initiate appropriate interventions and referrals. For children covered by state Medicaid programs—both in managed care approaches and in the fee-for-service system—preventive care is required to include developmental screening as a core component of EPSDT services. Currently, however, the practice of developmental screening and the promotion of optimal development in primary pediatric care practice vary tremendously. Many children (i.e., more than 40 percent) do not receive structured developmental assessments from their health care providers.[3]

There are many—often complex—reasons why child health care professionals fail to screen and identify young children who could benefit from early intervention services. These barriers are not unique to developmental screening, but affect most components of preventive pediatric care, including providing anticipatory guidance to parents. Children's and families' needs are not being met due to time constraints, low levels of reimbursement for preventive pediatric care, lack of reimbursement for specific developmental services, lack of training in child development, lack of trained non-physician staff members, limited access to community services to support families and children, and few external incentives for providers to do better.[4]

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[1] J. Wirt, S. Choy, S. Provasnik, P. Rooney, A. Sen and R. Tobin, "The Condition of Education 2003," (Washington, DC: US Government Printing Office, 2003).

[2] J.P. Shonkoff and D.A. Phillips, eds., "From Neurons to Neighborhoods: The Science of Early Childhood Development," (Washington, D.C.: National Academy Press, 2000).

[3] N. Halfon, M. Regalado, J. Sareen, M. Inkelas, et al., "Assessing Development in the Pediatric Office." *Pediatrics* 113, no. 6 (2004):1926-1933

[4] American Academy of Pediatrics, "Periodic Survey of Fellows 46," (Elk Grove Village, IL: American Academy of Pediatrics; 2001).

Despite these barriers, there is a growing body of experience to show that the frequency and quality of developmental screening, as well as other aspects of preventive care, can be substantially improved. The Healthy Steps for Young Children project demonstrated that families that receive a structured menu of developmental services from primary health care practices were more likely to remain with the practice. These families were also more likely to receive developmental screens, discuss a variety of developmental issues, receive timely well-child visits and immunizations, and be more satisfied with care.[5] In North Carolina, Medicaid, in partnership with physicians and community coordinating councils and funded by The Commonwealth Fund, developed a structured approach to systematic developmental screening in the pediatric sites of Guildford Child Health.[6] Following this initiative, screening rates of young children increased from 15 percent to 66 percent and referrals for early intervention tripled. Managed care organizations (MCOs) that participated in the recent BCAP workgroup of the Center for Health Care Strategies, *Enhancing Child Development Services in Medicaid Managed Care*, also found that they could increase screening rates by educating members and working with provider practices to facilitate screening and linkages to appropriate developmental services.

Managed care plans, particularly those serving significant numbers of at-risk children covered under Medicaid, are positioned to work with members and providers to improve early developmental screening. MCOs can take steps to educate and motivate child health care providers to provide appropriate developmental services and refer children suspected of having developmental problems (or those at risk) to appropriate community-based intervention and support services. MCOs can also take steps to engage and activate parents and caregivers about the health and development of their children. Operationally, improving developmental screening requires all staff of pediatric practices, and not just physicians, to adopt a screening protocol that includes the use of a standardized, parent-completed instrument. Community referrals are facilitated when physicians and office staff are personally familiar with developmental service providers and have established collaborative relationships with them. Better quality developmental services are more likely to occur when payers have clear standards for screening, specify a schedule for preventive services, and provide adequate reimbursement.

Improving the quality of developmental services may require identifying new or additional resources, but the amount required is modest. This BCAP Toolkit provides strategies for managed care organizations to systematically improve early developmental services through partnerships with parents, providers, community organizations, and state agencies.

Edward L. Schor, MD
Vice President
The Commonwealth Fund

[5] C.S. Minkovitz, N. Hughart, D. Strobino, D. Scharfstein, et al., "A Practice-Based Intervention to Enhance Quality of Care in the First 3 Years of Life." *Journal of the American Medical Association* 290 (2003):3081-3091.

[6] H. Pelletier and M. Abrams, *"ABCD: Lessons from a Four-State Consortium,"* December 2003, www.nashp.org/Files/CW9_ABCD_Lessons_Learned.pdf.

Enhancing Child Development Services in Medicaid Managed Care

Online Toolkit

Visit www.chcs.org for additional resources and tools developed by the *Enhancing Child Development Services in Medicaid Managed Care* workgroup.

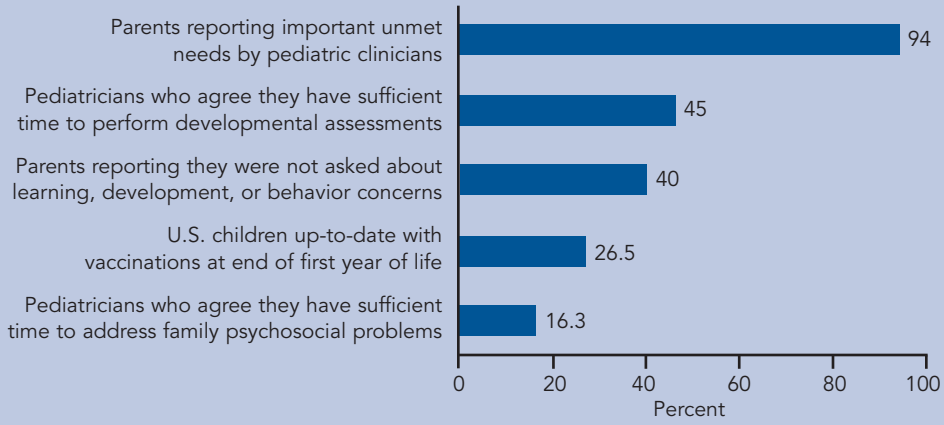
With Medicaid and SCHIP enrollment of children in managed care on the rise,[7,8] Medicaid managed care organizations face a greater challenge to ensure delivery of consistent and high quality child development services. The Commonwealth Fund asked the Center for Health Care Strategies (CHCS) to create a Best Clinical and Administrative Practices (BCAP) initiative to develop, document, and spread best practices among health plans. This toolkit reflects the experiences of the BCAP Workgroup on *Enhancing Child Development Services in Medicaid Managed Care*. This workgroup (Table 1) of 10 health plans and one state primary care case management program collaborated to develop, pilot, and refine best practices around enhancing child development services.

These 11 workgroup teams devoted time and resources to an area that does not necessarily offer an immediate return on investment. We value their commitment to improving care for populations in need and their resourcefulness in identifying how to leverage opportunities to enhance child development services within their organizations.

The Need to Enhance Child Development Services

Assessing young children's development at specified intervals makes it possible to identify and treat developmental disabilities at the earliest stage and to help children lead active and healthy lives.[9] However, while approximately 15 to 18 percent of children have disabilities such as speech-language impairments, mental retardation, learning disabilities, and emotional/behavioral disturbances, fewer than 30 percent of these children are identified with these problems prior to school entrance. Though guidelines endorse routine developmental assessments for young children, parents of many children do not report receiving these assessments.[10,11] Both parents and providers are dissatisfied with the current state of well-child care (Figure 1). Late and low identification of developmental problems in early

Figure 1: The State of Well-Child Care: A Snapshot



Source: Multiple studies, cited in E. Schor, "Rethinking Well-Child Care," *Pediatrics* 114 (July 2004).

[7] The Centers for Medicare and Medicaid Services, "Managed Care Trends," www.cms.hhs.gov/medicaid/managedcare/trends04.pdf.

[8] V.K. Smith, D.M. Rousseau and M. O'Malley, "SCHIP Program Enrollment December 2003 Update," July 2004, www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&pageID=44443.

[9] Halfon, et al., op. cit.

[10] American Academy of Pediatrics, Committee on Children With Disabilities, "Developmental Surveillance and Screening of Infants and Young Children," *Pediatrics* 108, no. 1 (2001): 192-195.

[11] M. Green and J.S. Palfrey, eds., "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents (2nd ed.,rev.)," (Arlington, VA: National Center for Education in Maternal and Child Health, 2002).

Table 1: *Enhancing Child Development Services in Medicaid Managed Care* Workgroup

Organization Name	State	Workgroup Participants	Number of Medicaid/ SCHIP Members*	Number of Medicaid/ SCHIP Members (0-3 yrs old)*
ABC Health Plan	NY	Kwame A. Kitson, MD Virna Little	9,544	1,120
BlueCross BlueShield of TN	TN	David Moroney, MD** Kathy Lovin	506,441	40,779
Managed Health Services	WI	Bruce Barter, MD Jan Larson	300,000	23,750
DC Chartered Health Plan	DC	Joshua Holloway, MD Brenda Murray	32,000	4,110
Health Plus	NY	Arthur Levin, MD Osiris Marte	180,000	563***
Lovelace Health Plan	NM	Jeannette Velarde, MD Denita Richards	60,000	14,000
CommunityCARE	LA	Janis Souvestre Cindy French	916,050	150,000
Missouri Care	MO	Thomas R. Cheek, MD** Lisa Ross**	30,000	4,200
Molina Healthcare of Michigan	MI	Michael Kobernick, MD, MS** Dana Brown	34,391	3,490
Network Health	MA	Albert K. Yee, MD, MPH** Peggy Waters	49,382	8,882
Virginia Premier	VA	Melvin Pinn, Jr., MD, MPH Linda Hines	70,249	19,982
Total			***2,188,057***	***270,876***

*Member statistics reflect plan membership at the start of the Workgroup in 2003.
**No longer with the health plan
***Health Plus identified 567 Medicaid/SCHIP members as at-risk for developmental delay through their pilot project.

childhood years hinders early intervention. Research shows that children who participate in timely early intervention programs are more likely to graduate from high school, hold jobs, live independently, and avoid teen pregnancy, delinquency, and violent crime.[12,13] The substantial number of children who do not receive these routinely recommended services illustrates a burgeoning need to improve child development services.

[12] D. Bricker, "The Goal: Prediction or Prevention?" *Journal of Early Intervention* 20 no . 4 (1996): 294-296.

[13] J.P. Shonkoff, op. cit.

What are Child Development Services?

Child development services are an integral component of well-child care and are designed to promote children's healthy development. Broadly, child development services fall into four categories described below.[14,15,16] The BCAP Workgroup on *Enhancing Child Development Services in Medicaid Managed Care* focused primarily on the first two categories.

Developmental Screening, Surveillance and Assessment

Screening and surveillance is the collective effort by parents and providers to ensure that children with potential developmental delays are identified and referred, if necessary, to appropriate health care services. Surveillance is a "flexible, continuous process, in which knowledgeable professionals perform skilled observations of children during child health care. The components of developmental surveillance include eliciting and attending to parental concerns, obtaining a relevant developmental history, making accurate and informative observations of children, and sharing opinions and concerns with other relevant professionals."[17] This ongoing process can be facilitated by the use of standardized screening tools,[18] which can help providers and parents assess child development and behavior. The American Association of Pediatrics (AAP) Committee on Children with Disabilities, along with many leading organizations, recommends the use of standardized screening tools at well-visits.

Developmentally-Based Health Promotion and Education

Health promotion and parent education, including anticipatory guidance, informs parents on child development and ways of promoting their child's learning and growth. Developmental topics addressed include areas such as sleeping patterns, encouraging learning, discipline, toilet training, and injury prevention. Age-specific information is typically given to parents by providers at well-child visits, but also can be provided creatively by health plan member education coordinators, through day-care facilities, social services agencies, public service campaigns, etc.

Developmental Interventions

Early interventions for developmental problems are usually carried out by professional educators, but often involve other health professionals such as speech and language therapists and occupational therapists. Early intervention services for children and families commonly occur outside of the traditional health care system, often through educational or social service contacts.

Care Coordination

Care coordination is required for a comprehensive and child-centered approach to early child development services. There are often multiple entities involved in the care of a child in need of developmental intervention and early intervention and other services must be coordinated.

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[14] M. Regalado and N. Halfon, "Primary Care Services Promoting Optimal Child Developmental from Birth to Age 3 Years," *Archives of Pediatric and Adolescent Medicine* 155 (2001): 1311-1322.

[15] K. VanLandeghem, D. Curtis and M. Abrams, *"Reasons and Strategies for Strengthening Childhood Development Services in the Healthcare System,"* The Commonwealth Fund, October 2002.

[16] N. Halfon, M. Inkelas, M. Abrams and G. Stevens, *"Quality of Preventive Health Care for Young Children: Strategies for Improvement,"* The Commonwealth Fund, May 2005.

[17] P.H. Dworkin, "Detection of Behavioral, Developmental, and Psychosocial Problems in Pediatric Primary Care Practice," *Current Opinion in Pediatrics* 5 (1993): 531-536.

[18] For more information, see the Early Identification Using Standardized Developmental Screening Tools section on page 17.

An Early Intervention Success Story

Miguel* is 20 months old. His mother, Paula, completed the 20-month Ages and Stages Questionnaire (ASQ) as part of a well-child visit at a CommunityCARE provider clinic in Louisiana. The ASQ is one of six developmental screening tools introduced at all of the CommunityCARE clinics in the state. Miguel's scores on the questionnaire were above the cutoff points, except for communication and problem solving, for which his scores were below or near the cutoff points. Paula expressed concern in response to the question, "Do you think your child talks like other toddlers his (or her) age?" She shared how Miguel was very expressive and often led her by the hand to reach things out of his reach, but used gestures rather than words. At 20 months, though he understood and followed commands, he only said two words, "Ma-Ma" and "up." The doctor discussed options with Miguel's mother and gave Paula a list of activities and milestones for a 20-month-old child. He also gave her the 24-month questionnaire and corresponding activities to help the family watch for skills that Miguel should begin to develop. Miguel's family was taught skills to enhance his speech. At the 24-month visit, Miguel was referred to an ear, nose and throat specialist and started receiving speech therapy.

Because of timely screening, a strong partnership between parent and provider, and appropriate referrals, Miguel is showing remarkable signs of improvement. Now, after one year, Miguel is using two and three word phrases and likes to imitate animal sounds. He has learned to cue play partners about his wishes with both gestures and words. Miguel's family and physician are excited about his wonderful progress and will continue to monitor his development.

* Miguel's story represents a fictional composite of members screened at a CommunityCARE clinic in Louisiana.

How Can Health Plans Improve Child Development Services?

Medicaid managed care organizations can play a crucial role in improving the quality of child development services by building partnerships with providers, families, public agencies, and policy makers working to improve child health.

Examples of how plans can improve early child development services include:

- Educating providers about the benefits of using standardized screening tools.
- Educating parents about developmental milestones and what to expect when their child is due for a developmental screening.
- Standardizing practices across a provider network (e.g., provider profiling to identify children due for screening, member education at the provider site, provider education on available screening tools).
- Motivating providers to apply best administrative and clinical practices through incentives or creative reimbursement.
- Partnering with local agencies to facilitate referral and linkages between medical and community providers for their members.
- Using data to help providers identify children at risk for developmental delay.

Plans participating in the BCAP Workgroup on *Enhancing Child Development Services in Medicaid Managed Care* tested creative variations of these approaches. Several common factors essential for success emerged:

- Using a structured approach to design quality improvement interventions with clear measures to monitor outcomes and test strategies;
- Improving multi-stakeholder collaboration (purchaser, plan, provider, and member);
- Providing sufficient time and backing to sustain successful rapid cycle improvement; and
- Ensuring committed leadership.

Health Plan Incentives to Improve Child Development Services

Capitated managed care, because of the inherent incentives in pre-payment for primary and preventive care, offers a unique leverage point to drive effective delivery of child development services. Because so many children "churn" in and out of Medicaid coverage, some of the benefits for identifying chronic problems early may accrue to other payors and health plans. Health plans committed to this line of business, however, realize that children are likely to "churn back" into their membership, so it behooves all payors and plans to invest in preventive services. Furthermore, plans that promote quality improvement in child development services can reap other rewards, including greater member and provider satisfaction, enhanced reputation in their communities, and recognition from their state Medicaid agency.

In addition to heeding the growing evidence of the need for early detection of developmental problems, plans joining the BCAP Workgroup on *Enhancing Child Development Services in Medicaid Managed Care* reported a variety of reasons for participating:

1. ***Raise Performance Ratings:*** Plans that report to the National Committee for Quality Assurance (NCQA) create performance report cards that are used by Medicaid agencies when making contracting choices and by members when making enrollment choices. Improving best practices around child development services improves plan ratings for quality of care and also improves member satisfaction.
2. ***Build Collaboration:*** Plans saw the workgroup as a vehicle to collaborate with state agencies and enhance relationships with providers. For example, BlueCross BlueShield of Tennessee presented the results of the pilot project to the TennCare Bureau and the Tennessee Chapter of the American Academy of Pediatrics, which contributed to a statewide revision of guidelines on early childhood screening.
3. ***Reach At-Risk Populations:*** Focusing on improving child development services provides an opportunity to connect with hard-to-reach populations. Lovelace Health Plan of New Mexico partnered with the state correctional system to reach children of parents in prison; ABC Health Plan of New York partnered with the Urban Institute for Family Health to reach families in low-income neighborhoods; and Network Health of Massachusetts used the Visiting Nurse Association to reach families in their homes.
4. ***Avoid Disincentives:*** Some states deploy a disincentive or penalty for poor performance. DC Chartered Health Plan, for example, sought to improve both the timeliness and the quality of well-child visits at their provider sites to avoid fines for children who did not receive timely well-child visits.

And finally, the overriding motive for the plans that joined the BCAP workgroup to enhance child development services was to meet the needs of the children and families they serve more effectively. The high interest level and outcomes of this workgroup indicate that health plans can serve as unique and important leverage points to drive improvement of child development services.

How Can States Improve Child Development Services?

State Medicaid agencies are positioned to promote high-quality, comprehensive, and well-coordinated preventive and developmental services that can help assure the healthy development of young children.

The Assuring Better Child Health and Development (ABCD) initiative,[19] coordinated by the National Academy for State Health Policy and funded by The Commonwealth Fund, seeks to enhance the capacity of state Medicaid programs to deliver and finance health care that promotes children's development. In the first phase of ABCD (2000-2003), four states — North Carolina, Utah, Vermont, and Washington — developed strategies to improve delivery and financing of child development services. In the second phase of ACBD, which started in early 2004, five states —California, Illinois, Iowa, Minnesota, and Utah — are working to improve health care that supports children's healthy mental development. Below are some examples from the first round of ABCD.

The North Carolina project developed a "best practices" model for integrating child health and development services into local health care delivery systems, targeting children from birth to five years of age. The model includes standardized developmental screening, referral, service coordination, and the provision of educational materials and resources for parents and clinicians serving Medicaid children. Since 2000, the screening rate has increased from less than 20 percent to more than 85 percent in areas using the ABCD model. Seven percent of these children were referred for additional services, compared to the 2002 statewide average of 2.9 percent.[20] Surveys have found widespread support for the ABCD model among healthcare providers.[21] In July 2004, this project's success led to revisions in Medicaid policy to mandate the use of evidence-based, standardized developmental screening tools in North Carolina.

Washington state's Medicaid agency developed a new well-child care encounter form to standardize the delivery of developmental services for low-income children during EPSDT visits and to enhance the state's capacity to review patient records for quality. The encounter forms provide guidance and information to both physicians and parents and address age-specific issues in development. For practitioners who serve children in foster care, use of the forms is required to claim a significantly enhanced fee for EPSDT exams.

In Vermont, several home visiting services were underutilized due to limited referrals. The state sought to strengthen and expand the delivery of child developmental services to Medicaid-eligible families by integrating home visiting programs; streamlining referral paperwork; and expanding eligibility from 12 months to five years. Additional services developed include home visiting with case management, phone consultation, targeted educational materials that highlight child development, and group education for parents and caregivers. Through these modifications, Vermont increased the number of families accepting home visits from 43 percent to 50 percent.

[19] More information on the Assuring Better Child Health and Development initiative can be found at www.nashp.org.

[20] Pelletier, op. cit.

[21] The Commonwealth Fund, "North Carolina is Assuring Better Health and Development," September 2005, http://www.cmwf.org/publications/publications_show.htm?doc_id=294570#north (27 September 2005).

Enhancing Child Development Services Using the BCAP Quality Framework

Since 2000, more than 130 Medicaid managed care organizations, including health plans and PCCMs, representing nearly 14 million Medicaid beneficiaries in 37 states, have participated in CHCS' Best Clinical and Administrative Practices (BCAP) initiatives. These organizations work to improve health care services for millions of Medicaid beneficiaries by developing quality improvement projects using the BCAP Quality Framework.

Elements of the BCAP Quality Framework are adapted from learning models developed by the Institute for Healthcare Improvement (IHI) and others focusing on chronic disease such as the Improving Chronic Illness Care (ICIC) program at the McColl Institute for Healthcare Innovation. The BCAP Quality Framework includes four components:

- **BCAP Typology** lends consistent structure to quality improvement activities.
- **Rapid Cycle Improvement** allows testing of small changes and systematic analysis of improvement processes.
- **Measurement and Evaluation** enables health plans to measure short-term process changes and long-term outcomes and to evaluate organizational capacity.
- **Sustainability and Diffusion** promotes ongoing use of best practices and/or systematic use of BCAP Quality Framework across an organization and/or region for long-term success.

BCAP Typology for Improvement

The BCAP Typology offers a template for designing quality initiatives that can be customized per clinical or administrative focus area. The four typology categories and examples of how plans applied each category to enhance child development services are listed below.

Identification	How does the health plan identify their 0-3-year-old members?
Stratification	How can the plan identify all children due or overdue for developmental screening? How can the plan stratify providers to maximize the potential of pilot activities?
Outreach	What can the health plan staff do to effectively reach families with member education materials or incentives for well-child visits? How can health plan staff communicate the importance of developmental screening to their providers?
Intervention	What changes affect the rate of developmental screening for children age 0-3? How can systems be changed to improve flow and efficiency in the provider office during a well-child visit? What can be done to improve referral practices?

While the typology is useful to provide structure in designing a quality improvement initiative, there also can be overlap between typology categories. A successful effort to improve identification, for example, can often promote activities in stratification, outreach, and intervention.

Rapid Cycle Improvement

Structuring quality improvement goals using the BCAP Typology is followed by PDSA (Plan, Do, Study, Act) cycles, which test changes in systems and processes. PDSA cycles guide teams through a quick-turnaround analysis and improvement process. Typically, the health plan develops an overall aim for the project and then develops specific aims, measures, and changes for each typology category. This method helps BCAP participants divide large quality improvement projects into manageable pieces and encourages testing the specific components of the typology separately.

For example, DC Chartered Health Plan set an aim to improve screening rates by implementing the standardized screening at a provider clinic. The following cycles outline how DC Chartered Health Plan optimized a provider site intervention through cycles of change:

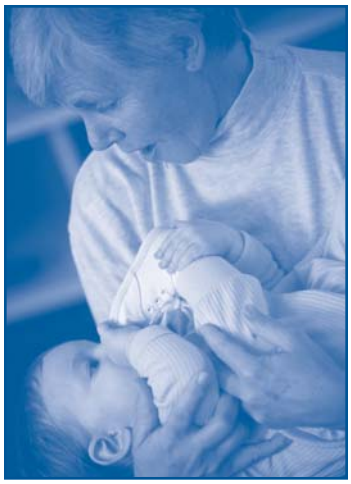
Cycle 1: The health plan hosted several meetings to introduce the developmental screening program and to better understand workflow at the health center pilot site. They determined the need to decrease the administrative burden on the health center for successful implementation.

Cycle 2: To streamline the screening process, a color-coded file cart, which included the screening tool questionnaires sorted by age group, was developed for each exam room. Once completed, the questionnaires were faxed back to the health plan for scoring and follow-up.

Cycle 3: To further assist the clinic staff in quickly picking the correct tool for each child, a "cheat sheet" was developed and included on each patient file indicating the appropriate screener to use.

Cycle 4: Individually faxed screens were difficult to read and unreliable. Bundled completed screens sent through interoffice mail was more reliable and efficient. Once familiar with the screening tool, the clinic staff found the "cheat sheet" to be too redundant and unnecessary and so it was removed from patient files.

This example shows how a health plan can incrementally roll out a quality improvement pilot, test changes, and make modifications to improve processes.



Measurement and Evaluation

Demonstrating the success of any quality improvement initiative requires consistent and frequent data collection. Three categories of measurement are used in the BCAP Quality Framework to evaluate short- and long-term successes:

Pilot measures describe individual improvement team results in each BCAP Typology category and reveal where changes are working and where adjustments are necessary.

Common measures aggregated across several organizations create normative data. The measures also allow BCAP participants to compare their progress against baseline.

Capacity measures examine team capabilities, organizational processes, and systems changes.[22]

Establishing baseline data for each of these measures and collecting data in frequent intervals are critical to demonstrating the success of an initiative.

Sustainability and Diffusion

Sustainability means ensuring that a successful pilot project is institutionalized so that it will continue after the improvement team has been disbanded. This means moving from a pilot project to a permanent program. For example, Health Plus piloted a financial incentive to providers to improve developmental screening and observed a significant improvement in its rates. Because of Health Plus' pilot success, the plan institutionalized the incentive and offered reimbursement for developmental screening to all of its providers.

Diffusion is the spread of both the best practice proven by the pilot project and the application of the BCAP Quality Framework methodology to other quality improvement projects. For example, beyond the developmental screening quality improvement work initiated in this workgroup, Molina Healthcare of Michigan is now applying the BCAP Quality Framework to its lead screening program and its emergency room utilization program for young children.

[22] BCAP workgroups that started prior to 2003, including *Enhancing Child Development Services in Medicaid Managed Care*, used pilot measures to allow each plan to measure improvement against its own baseline. As of 2003, CHCS added common measures and capacity measures.

BCAP QUALITY FRAMEWORK

COMPLEX MEDICAID = POPULATION & SYSTEM

TYPOLOGY FOR IMPROVEMENT

Structure quality improvement activities consistently, addressing barriers unique to serving Medicaid enrollees. The categories are:

Identification:	How can the health plan identify its 0-3-year-old members?
Stratification:	How can 0-3-year-old members be stratified to reflect those who are due or overdue for developmental screening?
Outreach:	How does the health plan effectively reach children in need of developmental screening and their families?
Intervention:	What changes can improve developmental screening rates for 0-3-year-old members?

RAPID CYCLE IMPROVEMENT

Test changes in each of the BCAP Typology categories using the Model for Improvement.[23] Measure progress early and often to make "real-time" refinements to quality efforts based on preliminary successes or setbacks.

MEASUREMENT AND EVALUATION

Build realistic measures into quality initiatives to establish baseline data, set goals, guide improvement efforts, and demonstrate the success of change strategies.

SUSTAINABILITY AND DIFFUSION

Promote tools to preserve and spread best practices to ensure the long-term success of quality efforts.

[23] Langley G, Nolan K, Nolan T, Norman C, and Provost L. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. Jossey-Bass, 1996.

Early Identification Using Standardized Developmental Screening Tools

Early and accurate identification of infants and young children who have developmental delays is critical to timely delivery of early intervention services. One strategy to improve appropriate identification of young children is to use standardized developmental screening tools during well-child care visits. The goal of developmental screening is to identify the infants and young children who require more extensive evaluation. In order to impact large numbers of children, screening procedures should be easy to administer, appropriate for diverse populations, and relatively inexpensive.[24] Screens do not diagnose problems, but can quickly provide direction about whether more testing is needed. Efficient administration and scoring of screens frees time for follow-up, resource identification, member education, and treatment.

The American Academy of Pediatrics Committee on Children with Disabilities recommends various developmental screening tools.[25] Many of these tools allow parents to complete self-guided screening tools at home or while they wait for appointments. Clinicians, office staff, or health plan staff need only score and interpret the results, saving substantial amounts of professional time.

Many Medicaid managed care plans in the BCAP Workgroup on *Enhancing Child Development Services in Medicaid Managed Care* worked to incorporate standardized developmental screening into EPSDT well-child visits. Health plans recognized that implementing the use of standardized screening tools could lead to more timely identification of developmental delay, early intervention, strengthened parent-provider partnerships, as well as improved clinical and administrative practices. Types of screening tools used include parent questionnaires, direct elicitation (history/interviews), and observation. Figure 2 shows a comparison of commonly used developmental screening tools.

Recommendations on Developmental Surveillance and Screening of Infants and Young Children

The American Academy of Pediatrics Policy Statement on Developmental Surveillance and Screening of Infants and Young Children provides recommendations for screening infants and young children and intervening with families to identify developmental delays and disabilities.[26] This statement is noteworthy for acknowledging the importance of parents in assessing their children's development. In particular, the AAP highlights several standardized parent report tools —the Parents' Evaluation of Developmental Status (PEDS), Ages and Stages Questionnaires (ASQ), and Child Development Inventories (CDI)—and the emerging scientific data to support use of these tools to facilitate ongoing developmental surveillance.

[24] J. Squires, L. Potter and D. Bricker, "The ASQ User's Guide," (Baltimore, MD: Paul H. Brooks Publishing Co, 2002).

[25] American Academy of Pediatrics, op. cit.

[26] Ibid.

Figure 2: Comparison of Screening Tools

	Ages and Stages Questionnaire (ASQ)[27]	Bayley Infant Neurodevelop-mental Screener (BINS)[28]	Brigance Screens[29]	Infant Development Inventory Parent Questionnaire (IDI-PQ)[30] and Child Development Review Parent Questionnaire (CDR-PQ)[31]	Denver Developmental Screening Test II (Denver II)[32]	Parents' Evaluation of Developmental Status (PEDS)[33]
Type	Parent Questionnaire	Direct Elicitation	Direct Observation and Elicitation	Parent Questionnaire	Direct Elicitation	Parent Questionnaire
Ages	4mos-5yrs	1mo-42mos	0-8yrs	0-18mos (IDI-PQ) 18mos-5yrs (CDR-PQ)	0-6yrs	0-8yrs
Staff Required	Para-professional	MA or equivalent	Para-professional	Para-professional	Para-professional	Para-professional
Time to Administer	10min	15-25min	10-15min	10 min	20-30min	<10min
Cost Per Kit	$199 (one time cost)	$225	$248	$12.50 for 25 (IDI-PQ) $46 (CDR-PQ)	$90 kit, $185 training videos	$30
Refills	No limit on copying	$35 for 25	$38 for 30	$12.50 for 25	$25 for 100	$15 for 50
Languages	English, Spanish, French, Korean	English	English, Spanish	English, Spanish	English, Spanish	English, Spanish, Vietnamese
Reading Level	4th-6th grade	NA	NA	6th grade	NA	5th grade
Contact Information	800-638-3775 www.pbrookes.com	800-228-0752 www.psychcorp.com	800-225-0248 www.curriculum associates.com	612-850-8700 http://www.childdevrev.com	800-419-4729 www.denverii.com	615-776-4121 www.pedstest.com

Developmental screening tools have improved over the years, and instruments that are extensively tested and easy to use in an office setting are now available. Plans should choose a tool that has a documented high level of accuracy and effectiveness.

Measures of accuracy and effectiveness include:

- Specificity (percent of normal children that are correctly identified)
- Sensitivity (percent of children with developmental disabilities that are correctly identified)
- Reliability (the extent to which a tool measures consistently)

Good developmental screening tests that document the validity of results have sensitivities and specificities of 70 to 80 percent. This is largely because of the nature and complexity of measuring the continuous process of child development.[34]

[27] D. Bricker and J. Squires, "Ages and Stages Questionnaire," www.brookespublishing.com/tools/asq (22 September 2005).

[28] N. Bayley, "Bayley Infant Neurodevelopmental Screener," http://harcourtassessment.com/haiweb/Cultures/en-US/dotCom/Bayley-III/Sub-Nav/Bayley-III.com+Home.htm (22 September 2005).

[29] A. Brigance, "Brigance Screens," http://www.curriculumassociates.com/order/newproduct.asp?title=brigscreeninfant&s=&grade=&Type=SCH&CustId=102537312660923091444 3 (22 September 2005).

[30] H. Ireton, "Infant Development Inventory – Parent Questionnaire," www.childdevrev.com/idi_new.html (22 September 2005).

[31] H. Ireton, "Child Development Review – Parent Questionnaire," http://childdevrev.com/cdr.html (22 September 2005).

[32] W. Frankenburg, J. Dodds, A. Fandal, E. Kazuk, and M. Cohrs, Denver Developmental Screening Test II, http://www.denverii.com/DenverII.html (22 September 2005).

[33] F. Glascoe, "Parents' Evaluation of Developmental Status," http://www.pedstest.com/content.php?content= peds-intro.html (22 September 2005).

[34] F.P. Glascoe, "Developmental Screening," in: M. Wolraich, ed., "Disorders of Development and Learning: A Practical Guide to Assessment and Management," 2nd ed, (St Louis, MO: Mosby, 1996):89-128.

All participants in the BCAP workgroup sought ways to more effectively incorporate developmental screening tools into routine well-child care. Many plans initiated provider surveys to learn whether standardized tools were being used during well-child visits. Some plans examined whether their providers were billing for developmental screening and assessment and if they were aware of the proper coding or reimbursement for these services. Many of the health plans in the workgroup chose to pilot parent questionnaire screening tools. Both the Ages and Stages Questionnaire (ASQ) and the Pediatric Evaluation of Developmental Status (PEDS) tools are parent-completed instruments that are validated and have high levels of sensitivity and specificity.[35] Many health plans in the workgroup (Figure 3) selected one or both of these tools for their pilot projects. The advantages and limitations of both of these tools are described below.

Figure 3: Developmental Screening Tools Used by BCAP Health Plans

Organization Name	PEDS	ASQ	Other	Screening Method
ABC Health Plan		✓		Parent questionnaires mailed to parents of children at high risk for developmental delay.
BlueCross BlueShield of TN	✓			Parent questionnaire administered during well-visit.
DC Chartered Health Plan		✓		Parent questionnaire administered during well-visit; plan scored the questionnaire and provided feedback to provider and members.
Lovelace Health Plan	✓*	✓		Practice site and health fair administration of parent questionnaires by health professionals.
CommunityCARE	✓	✓	✓	Practice site could choose from a menu of six accepted tools.
Missouri Care		✓		Parent questionnaire filled out in the waiting room.
Network Health		✓		Parent questionnaire administered at home visit.
Virginia Premier		✓		Parent questionnaire administered during well-visit.

*Lovelace used a modified PEDS questionnaire in a health fair setting.

Ages and Stages Questionnaire (ASQ)

Advantages

• *Parent involvement*

The ASQ relies on parents to observe their child and to complete simple questionnaires about their child's abilities. The basic premise is that parents can reliably assess their child's development when asked, "Can your baby do _____ now?" ASQ helps health care providers involve parents in a conversation about the child's health and development.

• *Fast and simple design*

Each questionnaire includes a title page with instructions, an information sheet for identification, 30 simply worded activities – six for each of the five developmental areas (communication, gross motor, fine motor, personal-social, and problem solving), and an information summary sheet for scoring and general comments. The

[35] F. P. Glascoe and H. Shapiro, "Introduction to Developmental and Behavioral Screening," March 2005, www.dbpeds.org/articles/detail.cfm?TextID=5.

questionnaires are written at a fourth- to sixth-grade literacy level and are available in multiple languages (English, Spanish, French, and Korean).[36] The questionnaire is tailored to address issues specific to the child's age. Each questionnaire takes approximately 10 minutes to administer.

- *Adaptable implementation*

The questionnaires can be mailed to the child's home; completed during a home visit, in a physician's office/ waiting room; or completed during telephone interviews with parents. A health plan may choose to implement a combination of these strategies.

- *Easy scoring*

Scoring, which takes only one to five minutes, can be done by clerical staff or para-professionals who have been instructed by professional staff. To score a questionnaire, the parent's responses—yes, sometimes, and not yet—are converted to points–10, 5, 0 respectively–and are totaled for each area.[37]

- *Accurate and effective*

Sensitivity ranges from 70 to 90 percent at all ages except the four-month level and specificity ranges from 76 to 91 percent.[38]

- *Cost-effective*

After initial purchase, users can make additional photocopies at no additional cost.

Limitations

- Does not address behavioral/emotional issues; however, there is an ASQ: Social-Emotional screen that can be used as a supplement.
- Some programs may need to assess infants or children at intervals not covered by the ASQ (e.g., one or two months of age).[39]

Parents' Evaluation of Developmental Status (PEDS)

Advantages

- *Parent involvement*

Uses parent concerns about their child's developmental and behavioral status and promotes parent-provider collaboration and family-centered practice by eliciting parents' concerns.

- *Fast and simple design*

PEDS identifies when to refer, screen further, or refer for additional screening through a questionnaire of 10 carefully constructed questions. It takes less than 10 minutes to administer and score. The questionnaire is written at a fourth- to fifth-grade reading level and is available in multiple languages (English, Spanish, Vietnamese). The same 10 questions are used across the age range of PEDS from birth to age eight.

[36] J. Squires, L. Potter, D. Bricker and S. Lamorey, "Parent-Completed Developmental Questionnaires: Effectiveness With Low and Middle Income Parents." *Early Childhood Research Quarterly* 13, no. 2 (1998): 345-354.

[37] J. Squires et al. "The ASQ User's Guide." op. cit.

[38] Ibid.

[39] Ibid.

• *Adaptable implementation*

The questionnaires can be mailed to the child's home; completed during a home visit, in a physician's office/ waiting room; or completed during telephone interviews with parents. A health plan may choose to implement a combination of these strategies.

• *Easy scoring and administration*

PEDS can be administered by a range of professionals and paraprofessionals, including office staff. New users only need to read the brief scoring and administration guide to score and categorize members as high, moderate, and low risk for developmental and behavioral/mental health problems.

• *Accurate and effective*

PEDS was developed out of four cross-validation studies on a nationally representative sample of families. Sensitivity ranges from 70 to 80 percent at all ages and specificity ranges from 70 to 80 percent.[40]

Limitations

- Providers at one BCAP Workgroup pilot site reported that the questionnaires were often incomplete or inappropriately filled out. For example, for the first question ("Please list any concerns about your child's learning, development, or behavior") parents had responded with answers such as "Johnny is acting bad." This led them to believe that this screener would work better as an interactive conversation tool, rather than an independently filled-out questionnaire.
- Some providers thought it would be difficult to determine what "normal" child development was if they did not even understand "normal."
- The PEDS test requires refills which pose an additional cost.

[40] F.P. Glascoe and H. Shapiro, "Introduction to Developmental and Behavioral Screening," March 2005, www.dbpeds.org/articles/detail.cfm?TextID=5.

Reaching out to Members

Many American parents report that health care providers do not regularly provide information regarding their child's development. In particular, minority or economically disadvantaged parents are two to four times more likely to express dissatisfaction with the health care their children receive than white, non-poor, insured families.[41] A Commonwealth Fund survey found up to 77 percent of parents with children from birth to 36 months reported that a health professional had not discussed one of six age-appropriate childrearing topics with them; more than one third had not discussed any of the topics.[42] Parents who discussed more topics with their health care provider were more likely to report that they received excellent care.

> "Although anticipatory guidance is considered an important component of well-child care, the majority of parents reported that they had not discussed most standard topics with a clinician…. Effort is required to provide parents with the information they need to take good care of their children."[43]

Health plans can empower parents to play more significant roles in assessing their child's development. Using parents to complete developmental questionnaires may enhance the accuracy of screening assessments because of the intimate information parents have about their children. Additionally, health plans can support member needs by providing materials on childrearing topics, reminders for well-child office visits, and age-appropriate developmental milestone materials. Educating families about what to expect in their child's development and helping families to ask appropriate questions can also improve communication with providers.[44]

Health plans in the BCAP Workgroup on *Enhancing Child Development Services in Medicaid Managed Care* employed various member outreach strategies including mailing materials, offering member incentives, telephone outreach, conducting home visits, and creating outreach events. These approaches increased the number of children who had timely EPSDT visits and the number of children who were formally screened for developmental delay.

[41] E.L. Schor. "Rethinking Well-Child Care." *Pediatrics* 114, no. 1 (2004): 210-16.

[42] Commonwealth Fund Survey of Parents with Young Children, as reported by Schuster et al. (2000).

[43] M.A. Schuster, N. Duan, M. Regalado and D.J. Klein, "Anticipatory Guidance: What Information Do Parents Receive? What Information Do They Want?" *Archives Pediatric Adolescent Medicine* 154 (2000):1191-1198.

[44] C.S. Nelson, L.S. Wissow and T.L. Cheng, "Effectiveness of Anticipatory Guidance: Recent Developments." *Current Opinions in Pediatrics* 15 (2003): 630–635.

Member Mailings

Almost all of the health plans in the BCAP workgroup reached out to members through mailings, including developmental screening questionnaires, anticipatory guidance materials, well-visit reminders, and information about age-appropriate developmental milestones.

Health Plus

Health Plus set an aim to engage families and encourage well-child care as a part of their pilot project. The plan sends birthday cards (Figure 4) for six-, 12-, 18- and 24-month-olds that include developmental milestone information and a well-child check-up reminder. This activity coupled with the plan's provider outreach[45] led to a 26 percent increase in their preventive visit rate and a threefold increase in developmental screenings that used CPT code 96110 for high-risk children from birth to age four. Health Plus defined high-risk children using a list of ICD-9 codes compiled by the New York City Infant Child Health Assessment Program (ICHAP).[46]

Figure 4: Health Plus Happy Birthday Postcard

Happy First Birthday

Your baby should have a 12 month old check-up with his/her doctor!

By now your baby is probably walking holding on to furniture! By 12 months your baby should be able to say one or two words and should know who Mama and Dada are.

HEALTH PLUS wants to remind you to take your baby to see his/her doctor for the 12 month well visit.

Here are some services that the doctor should perform at this visit:

- A Complete Physical Examination
- Check your baby's height and weight
- Measure your baby's head
- Check your baby's teeth
- Give several immunizations (shots)
- Do a blood test for lead poisoning
- Answer questions for you

If you need assistance making this appointment or have any questions please call HEALTH PLUS at 1-888-743-3508 or your Baby's Doctor. And don't forget, see your doctor for well-child visits and immunizations at 15 months, 18 months and 2 years.

[45] Health Plus' provider outreach is discussed on page 32.

[46] The ICHAP ICD-9 list of criteria available in the online toolkit at www.chcs.org.

CommunityCARE

CommunityCARE set a goal to increase awareness about KIDMED[47] program services. A brochure, "Improving Your Health," is mailed to every new eligible child and once a year during open enrollment. The brochure describes the "KIDMED" program and the importance of regularly-scheduled well-child visits, periodic developmental screening, and immunizations.[48]

Molina Healthcare of Michigan

Through member outreach, Molina Healthcare sought to educate parents regarding the components of the EPSDT visit. For its pilot project, the health plan developed a new member education mailing in English and Spanish that explained the components of a well-child visit as well as health tips, milestones, and available resources. The accompanying letter included a tear-off portion for members to bring to their well-child care visit for the practitioner to fill out and return to the health plan.[49] The letters were mailed every 60 days or until the child received all recommended EPSDT visits. Parents who received member outreach mailings from Molina asked more questions and brought up issues about their child's development, growth, and behavior.[50]

Member Incentives/Rewards

A few health plans in the workgroup offered member incentives as a part of member outreach efforts. For example, Virginia Premier Health Plan offered a free Sears portrait to targeted high-risk mothers who brought their children in for timely well-child visits and developmental screening.

To encourage literacy promotion and positive parent-child interactions, Molina Healthcare of Michigan sent age-appropriate, bilingual board books to each child who was brought in for an EPSDT visit. Molina confirmed the visit through a check-off list from providers indicating that a developmental assessment was completed.

In both of these cases, the health plans learned that the real incentive for members was to have an opportunity to discuss their child's health and well-being with a health care provider who was listening. By piloting the incentive approaches with targeted populations using rapid cycle improvement techniques, the health plans quickly learned that these member incentives did not correlate with increased well-child visit rates, or with developmental screening rates. Both plans subsequently stopped their incentive strategies and enhanced focus on providing educational materials to help members better understand age-related milestones and bring concerns to their provider's attention.

Learning from Members

CommunityCARE, Louisiana's primary care case management program discovered that approximately 30 percent of members, age 0-21, missed scheduled appointments, according to self-reported data from two pilot sites. CommunityCARE conducted a nurse-administered member survey via telephone to understand and evaluate the reasons for missed well-visit appointments, and to improve both well-visit and standardized

[47] KIDMED is the name of Louisiana's EPSDT program.

[48] Community Care's "Improving Your Health" brochure is available in the online toolkit at www.chcs.org.

[49] Molina Healthcare's member mailing materials are available in the online toolkit at www.chcs.org.

[50] Center for Health Care Strategies, "Improving Developmental Screening: One Child at a Time," September 2004, http://www.chcs.org/info-url3969/info-url_show.htm?doc_id=241085.

developmental screening rates. CommunityCARE learned that lack of public transportation was a significant barrier to regular well-visits. As a result, CommunityCARE included information about Friends and Family, a program providing non-emergency transportation for Medicaid recipients in a newly developed Provider Training Guide,[51] developed as a result of survey responses.

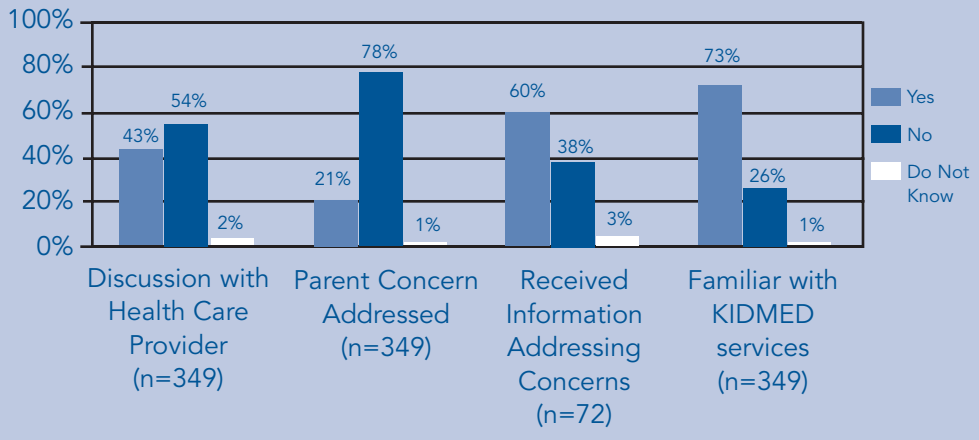
Additionally, CommunityCARE used the phone conversation to give age-appropriate anticipatory guidance to parents and caregivers. When parents were contacted, they often had questions regarding the health of their child. The nurses were able to address their concerns and share age-appropriate information about their child's development.

Recognizing unmet needs expressed by members, CommunityCARE added the following questions related to child development services to its annual member satisfaction survey:

- In the past 12 months, did your child's doctor or other health care provider (nurse) talk to you about your child's learning, development, or behavior?
- In the last 12 months, did you have any concerns about your child's learning development or behavior? If so, did your doctor or nurse give you specific information on how to address these concerns?
- Are you familiar with KIDMED screening services? If so, has your child received a KIDMED screening in the past two years?

Figure 5 represents initial findings from the annual member satisfaction survey. CommunityCARE will be monitoring these results and is working to increase member awareness of KIDMED services and ensure that more providers and parents have discussions about the child's learning, development, and behavior. CommunityCARE plans to distribute information sheets listing learning, development, and behavior milestones for providers to share with the parents and

Figure 5: CommunityCARE Member 2004 Survey Results Related to Child Development, Learning and Behavior



[51] CommunityCARE's Provider Training Guide is available in the online toolkit at www.chcs.org.

age-specific "Step by Step" developmental information sheets directly to members.[52] Conducting the telephone member survey led to the creation of the Provider Training Guide and to the addition of questions relevant to child development services to CommunityCARE's member satisfaction survey.

Home Visits

If children and their parents or caregivers are not able to visit a provider's office, public health nurses, social workers, and other trained home visitors can deliver child development services through home visits. For example, a trained home visitor could administer a developmental screening, provide parent education and counseling, and identify local community resources for families. A home visit may be required when parents are unable or unwilling to keep appointments because of work schedule conflicts, cultural or linguistic factors, lack of transportation, or other challenges faced by many low-income families. Two of the workgroup members, Network Health of Massachusetts and Managed Health Services of Wisconsin, piloted variations of home visit approaches with their member populations.

> *"Parents are usually more relaxed at home, and visitors can see things in homes that pediatricians can't see in the office."*[53]
>
> —Albert Yee, MD, of Network Health

Network Health and the Visiting Nurse Association

Network Health's overall aim was to improve screening for children between six and 18 months of age. The plan targeted its third largest pediatric practice to implement the ASQ. Network Health partnered with the Visiting Nurse Association (VNA) to conduct the ASQ screening tool during home visits with children who were not reached at the pilot provider site. The following criteria were developed to stratify at-risk children at 10 months of age targeted by the VNA:

- Low birthweight infants not receiving other services.
- Infants for whom VNA has reported concerns.
- Mother with reported psychiatric history that may cause concern for developmental delays due to lack of attention.
- Maternal history of postpartum depression.
- Maternal learning disabilities.
- Infants identified as failure to thrive.
- Teenage moms under 18 who have not accepted case management.

During the pilot phase, 299 children were identified as eligible for the program, of whom 73 percent were reached by family service workers. Forty-one percent of eligible children were screened using ASQ (57 children were screened at home; 32 additional children were screened at an office visit). Ten children were referred to early intervention based on ASQ screening. A subsequent provider and member survey indicated that 60 percent of physicians in the practice found ASQ helpful in focusing conversations with the family; 80 percent found it helpful to identify children in

[52] Samples of CommunityCARE's members mailings sheets are available in the online toolkit at www.chcs.org.

[53] *The Commonwealth Fund Quarterly*. Summer 2003 Vol 9, Issue 2.

need of services. Ninety-four percent of members felt the ASQ helped them better understand what questions to ask their child's doctor. Select member responses include:

- "I found it very helpful, because I was ready when I went to the doctor's office to ask the right questions."
- "I think it is wonderful. It is a great tool. This is my first baby and I feel I got great help. I am very happy with both [the plan], and my pediatrician."
- "I thought it was a good program. It helped me better understand my child."
- "I found the pilot program very helpful. I wish I had this when I had my first child."

Network Health's physician group added developmental benchmarks based on the ASQ screener to its well-visit forms that reside permanently in the patient charts. Network Health is exploring the feasibility of providing additional home visits for members identified as being at-risk during the post-partum home visit.

Managed Health Services Home Visit Program

Managed Health Services (MHS) designed a home visit program called HealthCheck to reach children who were overdue for a well-child visit. To set up the home visit appointment, MHS staff first called the family. If phone contact was unsuccessful, they sent a postcard requesting that the member call MHS. If a member reached by phone declined a home visit (which only occurred twice), then information on early childhood development was sent by mail and information was reviewed during a phone call. This phone call was also used to link members without a provider with a primary care physician.

Initially, MHS tried to collaborate with an ongoing home visitation program at the City of Milwaukee Health Department. The health department conducted limited home visits to high-risk infants who met specific criteria. MHS developed a referral form that would be sent to the health department whenever an MHS member met the city's high-risk criteria. After multiple attempts to launch the program, the City of Milwaukee Health Department withdrew due to limited resources and concerns regarding the potential volume of home visits.

Due to this barrier, MHS has taken full responsibility to reach members who were overdue for a well-child visit through home visits, telephone contacts, mailing of a "call us" postcard, and mailing of information on early childhood development. From December 2003 to May 2004, MHS contacted 88 percent of MHS newborns who were overdue for a well-child visit. During this period, 72 percent of the members reached received HealthCheck home visits as a result of successful outreach.

Member Outreach Events

Through outreach events — community fairs, health fairs, parent training groups — paraprofessionals can conduct developmental screenings for children in their communities. Parent-guided questionnaires can be distributed at events and returned via mail or at an upcoming well-visit. An outreach event also can be used to conduct on-site screenings and enroll children in a longer-term screening program. Member outreach events also offer an opportunity to distribute anticipatory guidance materials and engage parents as partners in the healthy development of their children.

Lovelace Community Health Plan

Lovelace created Well-Child Round-Ups to encourage members to schedule preventive care visits as part of its *Healthy Trails* program to improve well-child care. Well-Child Round-Ups take place one day a month at two clinic pilot sites. Lovelace's Healthy Trails mascot, *Hank, the Healthy Trails Horse*, visits the clinic armed with health education materials. Hank entertains children, while parents fill out the Ages and Stages Questionnaire in preparation for the well-visit. Families are also given Healthy Trails calendars that come with stickers for developmental milestones and reminders for when well-child visits are due. This new initiative has been very successful with parents and children. Typically, 35 to 45 members have their well-child visits on Well-Child Round-Up days.

CommunityCARE

During its annual open enrollment week, the CommunityCARE program hosts a luncheon for members and providers where early intervention success stories are shared. The children featured in the success stories, their families, along with the providers and their staff, are honored. Through use of personal testimony, this outreach event has been highly successful in increasing awareness of the benefits of developmental screening and early intervention for both parents and providers.

Working with Providers

Primary care practitioners play an especially important role in the early identification and referral of children with developmental delays under three years of age. The National Survey of Early Childhood Health shows that 95 percent of young children between four months of age to their third birthday had a doctor's visit in the last 12 months.[54] Physicians who care for infants and toddlers are in a unique position to observe developmental progress, identify children with developmental problems, counsel parents on developmental issues, and make appropriate referrals for children requiring intervention.

Health plans can work with providers to help reduce administrative burden and improve workflow; reward quality through incentives; and provide trainings on the importance of developmental screening and early intervention, new screening tools, community resources, and efficient navigation of the reimbursement process. The health plan participants in the BCAP Workgroup on *Enhancing Child Development Services in Medicaid Managed Care* implemented several provider strategies to improve child development services.

Reducing Administrative Burden and Improving Workflow

Health plans can reduce administrative burden on provider practices by providing tools for, and potentially administering and scoring, standardized developmental screens. Health plans can also improve workflow by providing critical utilization data to providers. For example, health plans can use reminder systems to encourage the use of preventive services, or provide feedback to physicians on utilization to encourage better processes of care. Following are examples of how participants in the BCAP Workgroup supported their providers.

> *"Molina's efforts brought a lot more children to us for well-child exams, particularly the two- to three-year-olds. It really took a lot of the work from us in not having to contact people ourselves. Seeing these kids on a more timely basis obviously helps us to identify problems early and reduce potential aggravations of problems."*
>
> —Gary Detwiler, Physician Assistant at Sparta Health Center in Sparta, Michigan

Missouri Care

Missouri Care aimed to implement use of the ASQ screener and increase the percentage of 18-26-month-old children receiving developmental screening to 80 percent at pilot clinics. Clinic staff identified Missouri Care members presenting for a 24-month EPSDT check-up. Parents were encouraged to complete the ASQ while in the waiting room. Nurses scored the completed ASQs and tracked the referrals made to specialty care for follow-up. From June to August 2004, 85 ASQs were handed out to parents presenting with their children for a 24-month EPSDT visit, 36 ASQs were completed, and five children were referred to specialty care.

Molina Healthcare of Michigan

Molina was able to reduce administrative burden at its provider sites by implementing a regular system for contacting members through outreach mailings, which significantly increased the number of children visiting the pilot site for well-child

[54] L. M. Olson, M. Inkelas, N. Halfon, M.A. Schuster, K.G. O'Connor and R. Mistry, "Overview of the Content of Health Supervision for Young Children: Reports From Parents and Pediatricians," *Pediatrics* 113, no. 6 , Suppl., (2004):1907-1916.

visits. In addition to contacting members, Molina developed educational materials for provider offices that explained the components of an EPSDT exam, additional services required for Medicaid beneficiaries, proper CPT codes, billing instructions, referral sources for children with developmental delays, and plan contact numbers. Providers were appreciative and extremely supportive of Molina's efforts to get children in for well-child visits.[55]

DC Chartered

DC Chartered Health Plan worked with two high-volume provider sites to implement consistent use of ASQ as a screening tool for plan members. DC Chartered staff trained provider office staff on using ASQ, and worked with the sites to implement additional office system changes. These included color-coding for age-specific forms, providing information about how the forms are scored, and working with the clinic to assure appropriate referral and follow-up for children identified at risk. After the questionnaires were completed, the health plan scored each one and provided follow-up information to providers and parents.

Four months into the pilot, 275 children born between April 1, 2000-April 1, 2001, were seen at two high-volume provider sites for well-child visits. Out of the 275 children, 175 ASQs were completed during these visits (64 percent). None of these children were previously screened for developmental delay. Thirteen children out of 175 (seven percent) were identified as at risk; five of the 175 (three percent) were referred for a developmental evaluation. A developmental milestone chart and information about available resources were mailed to the remaining eight families. DC Chartered has continued this program beyond the conclusion of this workgroup.

CommunityCARE

Louisiana's EPSDT Program, KIDMED, developed standardized flowsheets[56] to help guide EPSDT visits at each age interval. The flowsheets were introduced at CommunityCARE's annual provider training. Each flowsheet includes sections on developmental assessment and anticipatory guidance. These forms help providers remember what preventive and child development services should be covered at each KIDMED visit. Most CommunityCARE providers are using the flowsheets and report positive feedback. In particular, providers appreciate that the flowsheets are comprehensive as well as user-friendly. Many providers use the form for all of the patients in their practice, not just those who are eligible for the KIDMED program. The standardization across the state has been useful for chart monitoring and performance evaluation.

Health Plus

Health Plus set a goal to increase well-visits (including developmental assessments) by 20 percent in members 0-4 years. The plan identified select ICD-9 codes from claims data to identify 563 children, age 0-4, at risk for developmental delays.[57] The health plan sent letters to providers notifying them of high-risk members and offered instructions on office-based screening (Figure 6). By identifying children for providers, Health Plus was able to reduce provider site administrative burden. Health Plus' pilot resulted in a 26 percent increase in developmental screening

[55] For more information about Molina's member outreach, see pages 25 and 47.

[56] CommunityCARE's documentation flowsheet is available in the online toolkit at www.chcs.org.

[57] The ICHAP ICD-9 list is available in the online toolkit at www.chcs.org.

Figure 6: Health Plus Reminder Letter Written to PCP

Dear Health Plus Participating Physician:

Health Plus is making a special effort to see that our youngest members receive recommended preventive exams, including developmental screenings and other early childhood services. The American Academy of Pediatrics recommends developmental screenings of infants and children at their regular preventive care visits with referral to specialists as appropriate. The Academy also recommends referral, with parental consent, to early intervention and early childhood development programs as appropriate.

Health Plus has identified the following member of your panel who has a high-risk diagnosis on our claims file:

Member name: HP ID#:
DOB:

Please ascertain the date of this member's last preventive visit and, if needed, schedule a routine preventive exam and developmental screening. As part of our commitment to improve developmental assessments for our child members, Health Plus is reimbursing providers for conducting developmental tests (CPT codes 96110-96111). If you wish to refer this member for a more complete developmental assessment our case manager can provide you with a list of Health Plus participating providers and assist you with this referral. Our case manager can also help with referral to early intervention/early childhood development programs or other specialized services, if needed. For assistance call ___ at _____.

We hope you find these case management services helpful to you.

Very truly yours,
Medical Director

claims during the third quarter of 2003; based on this success, the plan has sustained its efforts to increase well-visits.

ABC Health Plan

ABC Health Plan developed a partnership with the the Institute of Urban Family Medicine and ICHAP to reduce administrative burden for their providers. Health plans in New York can collaborate with ICHAP to help providers with standardized developmental screening efforts using the ASQ approach. New York City's Early Intervention Program uses ICHAP to reach children, age 0-3, who are at risk for delay (i.e., do not have an actual or suspected delay). The partnership with ICHAP involves:

- The PCP, who initially introduces the ASQ approach to the family, obtains their consent to enroll the child in ICHAP, discusses ASQ results with the family at later health visits, and takes the lead in any decision to refer the child to the Early Intervention Program;
- ICHAP, which mails the ASQs at appropriate age intervals between six months and 27 months, scores them, and shares the results with the practitioner and the family; and

- The family, which completes the ASQs, mails them back to ICHAP, and is involved in early intervention referral decisions.

To enroll a child in the ICHAP ASQ program, the child must:

- Be 0-3 years of age;
- Live in New York City; and
- Have one or more ICHAP risk factors.[58]

ABC created a registry of high-risk 0-3-year-old members based on claims data indicating ICHAP risk factors. With parent permission, members on the registry were enrolled in the ICHAP ASQ program at the provider site.

ABC and ICHAP found that a large proportion of participating families returned the questionnaires on a regular basis. ICHAP's ASQ approach supports ongoing developmental screening, is integrated into the child's primary care medical home, spares the pediatrician's time and resources, is cost efficient, and fully involves the family in developmental assessment.

Targeting Providers for Maximum Impact

BlueCross BlueShield of Tennessee maximized resource use by stratifying its "high-leverage" providers for a quality improvement intervention. Through claims data, the plan identified the percentage of providers who were conducting a standardized developmental screen in their EPSDT preventive visit. Only 8.9 percent of the preventive visits showed a documented developmental screen, suggesting significant opportunity for improvement. BCBST stratified PCPs serving six- to 36-month-olds by the number of preventive visits, and by the percentage of preventive visits with standardized developmental screen using the following definitions:

- "High-Volume" = PCPs with 100 or more preventive visits per year.
- "High-Opportunity" = PCPs with fewer than 50 percent of preventive visits with standardized developmental screen.
- "High-Leverage" = PCPs stratified as both high-volume and high-opportunity.

Through this innovative stratification approach, BCBST determined that 34 PCPs performed close to 80 percent of preventive visits and also had a preventive visit developmental screening rate of less than 50 percent. BCBST targeted its outreach efforts on these high-leverage PCPs to maximize the potential of improvement activities, and saw improvement in screening rates at these sites.[59]

Provider Outreach

Managed care organizations can support providers through trainings on the importance of developmental screening and new tools available. Several plans in the BCAP workgroup piloted approaches to increase provider/office staff awareness and offer training for early childhood development screening.

[58] The ICHAP ICD-9 list is available in the online toolkit at www.chcs.org.

[59] See the case study on page 51 for more information.

BlueCross BlueShield of Tennessee

BCBST provided training on the PEDS Test for 34 provider sites through their Regional Clinical Network Analyst (registered nurse/outreach worker). The outreach worker had direct contact with all the targeted provider sites through telephonic outreach and at least one visit to each office. Training packets were developed for the outreach worker to use when visiting PCPs and training office staff.[60] The training focused on how and when to administer the PEDS test as well as how to navigate the reimbursement process. To reinforce the training, an article was placed in the provider newsletter.

Lovelace Community Health Plan

Lovelace aimed to improve screening and referral rates by training providers about standardized screening and the Family Infant Toddler (FIT)[61] referral process. Lovelace oriented providers to the ASQ screener by visiting selected pilot site practices and reviewing the ASQ with providers. Lovelace staff learned that although all of their providers had heard of the ASQ, and understood the importance of timely and quality well-visits, none of the providers had seen the questionnaire and some thought that it had to be administered at every EPSDT visit. Providers responded positively to the ASQ training, recognizing that ASQ offers an easy tool that could be used throughout the office. Lovelace also sought to educate providers on the FIT Program referral process. Many providers were making referrals for therapies that were non-covered services and many providers did not know how to make a referral to the FIT program. Lovelace developed a list of local FIT providers and covered services for each pilot site. Through provider outreach, the health plan was able to educate providers on how to incorporate standardized screening into well-child care and how to appropriately navigate the referral process.[62]

CommunityCARE

CommunityCARE set a goal to increase provider knowledge of standardized developmental screening tools. CommunityCARE staff was trained on Bright Futures Guidelines (see Bright Futures, page 36) and added the PEDS and ASQ screeners to the tools available to providers. It was originally envisioned that increasing the number of available tools would increase flexibility for providers and thus improve screening rates. CommunityCARE reports that increasing the number of screening tools did not yield an increase in referral rates in most cases. They learned that increasing the number of accepted tools requires time-intensive training and awareness building around the pros and cons of each tool.

CommunityCARE also developed and distributed a Provider Training Guide to help providers direct members to appropriate services. The guide includes community resources, best practices for data collection, and anticipatory guidance materials. Among the community resources included were: "Friends and Family," a program providing non-emergency transportation for Medicaid recipients; "Nurse-Family Partnership," nurse home visiting program for first time, low-income mothers and their families; and the "Early Steps Program," Louisiana's early intervention program.

[60] BlueCross BlueShield's Provider Training Packet are available in the toolkit online resources at www.chcs.org.

[61] The Family Infant Toddler Program is New Mexico's early intervention program.

[62] See the case study on page 57 for more information on Lovelace's pilot.

To promote Louisiana's "Early Steps" intervention program, CommunityCARE recruited parent liaisons to share their personal stories at provider offices. Parent liaisons discuss the importance of developmental screening and share personal stories. For example, one of the liaisons shares her experiences of having a daughter with developmental disabilities. When her daughter was born, there was no program like Early Steps that could come into the home and work with her daughter. The parent liaison describes how she had to drive two hours, twice a week to take her daughter to therapy with her two-year-old son in tow. Physicians have responded very positively to this personalized outreach that validates the need for quality and timely screening and referral.

CommunityCARE's provider outreach efforts have contributed to more consistent referrals and provider tracking of referral rates.

Bright Futures

Bright Futures, initiated by the Maternal and Child Health Bureau over a decade ago, is dedicated to ensuring that every child deserves to be healthy, and that optimal health involves a trusting relationship between the health professional, the child, the family, and the community. As part of this initiative, *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (2nd Edition), was developed to provide comprehensive health supervision guidelines, including recommendations on immunizations, routine health screenings, and anticipatory guidance. In the upcoming 3rd Edition, each age stage (infancy, early childhood, middle childhood, and adolescence) is divided into 11 themes. These themes can be found at the beginning of each age stage and are carried throughout each well-child visit. The themes are:

- Promoting child development
- Promoting family development
- Promoting mental health and emotional well-being
- Promoting nutritional health
- Promoting physical activity
- Promoting oral health
- Promoting healthy sexuality
- Promoting safety and injury prevention
- Promoting community relationships and resources
- Transitions
- Physical examination and screening tests

The new revised guidelines will be available at http://brightfutures.aap.org/web/.

Reimbursement for Developmental Screening and Testing

In 2003, the Centers for Medicare and Medicaid Services approved two CPT codes related to child development — 96110 for developmental screening and 96111 for developmental testing — thereby forging a path for reimbursement for the services covered by these codes.[63] Health plans can encourage delivery of standardized developmental screening by reimbursing providers for codes 96110 and 96111 in addition to reimbursement for preventive visits. Several BCAP Workgroup participants — Lovelace, Health Plus, Virginia Premier, Managed Health Services, DC Chartered, and BCBST — implemented or reinforced provider incentives as a part of their pilot projects.

Lovelace Community Health Plan

In New Mexico, both health risk assessments and developmental questionnaires were considered part of the EPSDT exam and were not reimbursed separately. Lovelace approached the Medicaid Department of the Health and Human Services Department (DHHS) and requested permission to reimburse for use of the ASQ screener. Initially, DHHS determined that Lovelace would not receive extra reimbursement from the state and thought that Lovelace could reimburse for the ASQ screener as an enhancement to its services.

The Lovelace BCAP team presented an economic justification to the Medical Director of Lovelace Health Plan. They showed that the average age of referral to the Family Infant Toddler program was 17 months and that most children were in the program for two years. They convinced the leadership at Lovelace that encouraging early screening through the ASQ could possibly improve the early referral rate to FIT and save unnecessary costs on more complex therapies and services at a later age. Lovelace saw the potential to reduce costs to the health plan and decided to pilot a reimbursement of $10 per questionnaire at the pilot sites. This incentive led to improved screening and referral rates and, as a result, the reimbursement was expanded to all Medicaid providers at Lovelace. In addition, Lovelace went back to DHHS and convinced state policy makers to reimburse an additional amount ($14) for standardized developmental testing.

Health Plus

Health Plus sought to increase physician awareness of the need for developmental screenings as part of well-child visits and added an incentive of $25 for physicians who submitted claims for developmental screening and testing. The plan promoted this new incentive through letters to providers serving children at risk for developmental delay and also through two articles in a quarterly provider newsletter. The plan reports that these efforts doubled their developmental screening claims during their pilot phase. There was also a 26 percent increase in preventive visits for children between the ages of 12 months and four years. Through the pilot project, Health Plus learned that increasing physician awareness and providing monetary incentives can help ensure that infants receive developmental screening as part of the preventive exam. Because of the success of the pilot project, Health Plus permanently extended the intervention to all providers.

[63] M. Macias and L. Wegner, "Coding Conundrums - Screening and Developmental Testing Codes," March 2005, www.dbpeds.org/articles/detail.cfm?TextID=384.

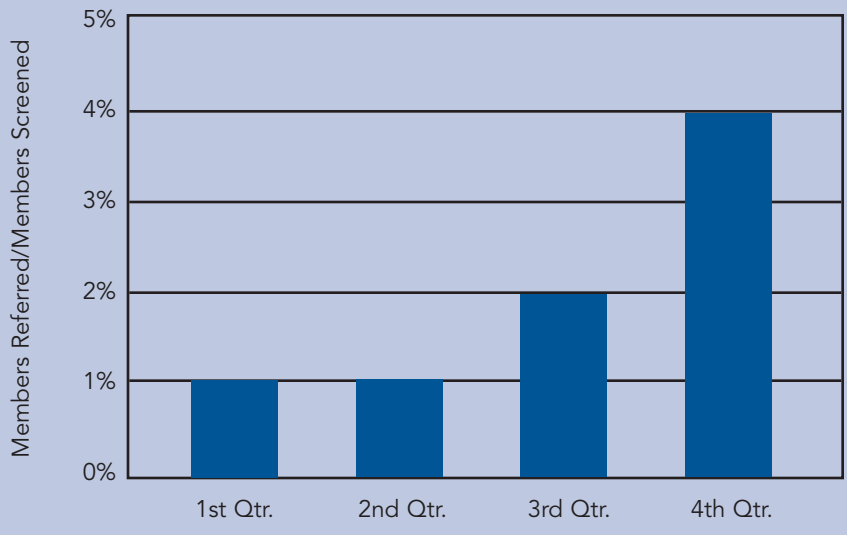
Tracking Referrals

What happens when developmental screening determines that a child needs additional services and follow-up? Who is tracking if a child is referred to an appropriate early intervention program? Was the appointment made? Did the member go to the appointment? Did the child receive necessary services? A few of the workgroup participants sought to evaluate and improve referral practices at their health plans.

CommunityCARE

When a child requires a referral, providers in Louisiana must document in the medical record that the child keeps the appointment and receives the services. CommunityCARE implemented use of a standardized referral tracking form[64] to facilitate monitoring of referral rates. Previously, there was no formal way of tracking referrals. Now, when a provider makes a referral, she or he uses the form to indicate the date of the referral, where the referral was made, and the reason for the referral. When the member makes the appointment and receives services is also noted in the form. The form allows for time-efficient internal provider office tracking and also monitors compliance of follow-up child development services for children identified at risk for developmental delay. Each month CommunityCARE collects these referral data from participating providers to ensure that necessary referrals are made. By creating a much needed system of tracking referrals, CommunityCARE's referral rate grew from one to four percent over one year at one high-volume urban pilot provider site (Figure 7).

Figure 7: CommunityCARE Referral Rates at Pilot Site in 2003



[64] CommunityCARE's referral tracking form is available in the online toolkit at www.chcs.org.

Lovelace

Lovelace participated in New Mexico's Senate Joint Memorial Task Force to examine appropriateness and timeliness of referrals to the Family Infant Toddler program, New Mexico's early intervention program. This 35-member task force included medical personnel, Family Infant Toddler program providers, parents of children with developmental delays, advocates, relevant state personnel, and Lovelace's medical director. The task force identified barriers[65] to appropriate and early referrals, developed strategies for addressing those barriers, and prioritized strategies. The task force identified four major outcomes and a number of strategies to address each of the outcomes.

Outcome #1: Training and information for medical providers

- Train physicians about how to refer children to the FIT program and the benefits of early intervention at Grand Rounds, during residency training, and in their offices.
- Develop medical society "position statements" endorsing early intervention.

Outcome #2: A statewide public awareness campaign

- Create a campaign directed to the general public to provide information on early brain development from birth to age three and the importance of intervention if a child has a developmental delay.

Outcome #3: Developmental screenings and referrals to the FIT program

- Promote use of developmental screening tools at medical providers' offices.
- Clarify and streamline the FIT referral process.
- Emphasize that a referral to the FIT program is a referral for a "developmental evaluation" and that the child may or may not need ongoing FIT program services.
- Recommend modifications to the Medicaid Early and Periodic Screening and Diagnostic Testing to emphasize child development.
- Explore reimbursement possibilities for physicians to conduct developmental screening.
- Promote existing databases to identify children with conditions that place them at high risk for developmental delays.
- Pilot use of a FIT Developmental Specialist placed in medical offices to conduct developmental screening.

Outcome #4: Effective communication with providers

- Encourage input from medical providers on FIT services.
- Follow-up with findings after referrals are received.
- Recommend to Governor's office that a representative of the Pediatric Society be added to the Interagency Coordinating Council for infants and toddlers.

[65] A list of barriers identified by Lovelace is available in the online toolkit at www.chcs.org.

CHCS EPSDT Modernization Initiative

In partnership with the George Washington University Center on Health Policy Research, CHCS is working to modernize how Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services are accessed, financed, delivered and monitored. Families and providers are faced with many challenges in receiving and delivering the numerous services that fall under EPSDT. Several critical changes have occurred since the inception of EPSDT, such as the evolution of managed care, a change in the role of the public health system, increasing state and federal fiscal pressures, and changes in our understanding of effective child health and development services. CHCS' EPSDT initiative will develop a set of policy and procedural recommendations that address key deficiencies in the current system and give child-serving agencies and managed care organizations concrete tools to re-orient EPSDT toward integrated service provision, continuous quality improvement, and measuring key health outcomes. The proposed recommendations will be tested in partnership with at least one state, its managed care contractors, and providers in a model demonstration project.

CHCS' EPSDT initiative is funded by the Commonwealth Fund, The David and Lucille Packard, The Annie E. Casey, and The Robert Wood Johnson Foundations.

More information about CHCS' EPSDT initiative can be found at **www.chcs.org**

Conclusion: What is the Return on Investment for Health Plans?

Like many quality improvement efforts undertaken by health plans, it may be difficult to demonstrate a traditional financial return on investment for activities designed to improve the quality of child developmental services. Nonetheless, the experience of health plans in the BCAP Workgroup on *Enhancing Child Development Services in Medicaid Managed Care* suggests that there is the potential for significant improvements worthy of health plan investment:

- All plans recognized the opportunity to improve health and socioeconomic outcomes for children who are screened earlier, identified as having a developmental delay, referred, and treated in a timely fashion.
- Several health plans were able to improve their HEDIS measures for well-child visit rates and member satisfaction. These measures are used by Medicaid state agencies in determining their contracting choices and by members when making enrollment choices. In the case of DC Chartered, improving well-visit rates allows the health plan to avoid penalties given if a plan demonstrates poor performance.
- Improving quality of child development services can lead to recognition and reputational value for health plans as leaders in quality improvement by purchasers, policy makers, and other health plans. Molina Healthcare of Michigan received the Michigan Association of Health Plans Pinnacle Award for their "Babysteps Toward Health" program. State policy makers in New Mexico approved additional reimbursement for developmental screening and testing as a result of Lovelace Health Plan's quality improvement efforts.
- Improving services for Medicaid recipients often leads to improved services for all plan members as a result of practice and plan-wide enhancements. BlueCross BlueShield of Tennessee providers are now encouraged to use standardized screening tools for their entire patient population. Louisiana's screening documentation flowsheet has been applied universally for all well-visits.
- Lessons learned can be transferred to other population groups served by the health plan. Molina Healthcare of Michigan is using the BCAP Quality Framework for a statewide lead screening program and also is planning to use the BCAP approach for mammography reminders and cervical cancer screening reminders.
- Programs developed for one purpose or population can positively impact other populations. Molina's M.O.M. (Moms of Molina) program was created to identify pregnant women to promote the value of timely EPSDT services, but also served to improve identification of pregnant women for Molina's prenatal program.

Beyond a clear financial return, there are clearly many cases to be made to invest in enhancing child development services in Medicaid. A healthier population with a resulting higher quality of life will continue to be the ultimate reward for health plans that invest in children's health quality as well as for society at large.

Case Studies

APPLYING THE BCAP QUALITY FRAMEWORK

The previous sections highlight general areas where health plans can implement interventions to improve early childhood development assessment and screening within their enrollee populations. The following case studies detail how three plans used the BCAP Quality Framework to structure quality improvement activities:

- Molina Healthcare of Michigan
- BlueCross BlueShield of Tennessee
- Lovelace Community Health Plan

I Molina Healthcare of Michigan

Molina Healthcare of Michigan developed a pilot program, "Baby Steps Towards Health," to increase Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) visits for children from birth to age three. Molina's BCAP pilot project goal was to increase the number of EPSDT visits for children from birth to age three to 80 percent by linking the member, practitioner, and health plan as well as increasing parent involvement. Through outreach to members, Molina sought to educate parents about the importance of well-child visits and provide age-specific information on what to expect during each well-child visit. The project also included provider education about EPSDT components, proper documentation, coding, and referral sources for children with developmental delays. Provider offices were asked to provide a developmental assessment during the members' regularly scheduled EPSDT visits. The pilot project, implemented July through December 2003 in Kent County, Michigan, involved 1,537 children from 11 provider offices. Prior to the "Baby Steps Towards Health" pilot, Molina's EPSDT rate for children from birth to age three was 46 percent (January –July 2003). The pilot program increased the EPSDT rate for this age group to 76 percent.

IDENTIFICATION

To improve delivery of EPSDT services and developmental screening, Molina set a goal to identify all children, from birth to age three, as well as all expectant mothers. Molina developed an EPSDT database to facilitate identification and began efforts in Kent County, which was targeted because of its high volume of practitioners and members (23 percent of Molina's membership) as well as established community resources.

Aim:

1. To identify 100 percent of children in Kent County, from birth to age three, enrolled in Molina Healthcare of Michigan.
2. To identify 100 percent of expectant mothers in Kent County enrolled in Molina prior to delivery.

Measure:

1. $\frac{\text{Children, age 0-3 years, in Kent County, enrolled in Molina Healthcare}}{\text{All children, age 0-3 years, enrolled in Molina Healthcare}}$

2. $\frac{\text{\# of expectant mothers identified prior to delivery in Kent County, enrolled in Molina Healthcare}}{\text{\# of deliveries in Kent County, enrolled in Molina Healthcare}}$

Change:

Molina implemented the following strategies to improve identification of children, from birth to age three:

- Developed an EPSDT database to generate a monthly list of children in need of EPSDT services. The database generates an age-specific list of members by county and displays the age at which the child's next EPSDT visit is due.
- Created a newborn notification form for Utilization Management nurses. This information was then forwarded to Molina's Education Department. Newborns were added to the program after the health plan received their identification number from the state.

- Sent a letter to mothers of newborns in Kent County in their welcome packet asking them to call Member Services and select a primary care provider as soon as possible. If the mother selected a provider site that was participating in the pilot project, she was sent the program materials.

To identify expectant mothers, a Maternal Child Nurse was hired in August 2003 to implement a new program (M.O.M.- Moms of Molina) to identify and provide educational information to pregnant members.

Results:
Through these efforts, Molina identified 1,537 children, birth to age three, who were eligible for the pilot program in Kent County. In addition, Molina increased identification of expectant mothers from 33 percent at the beginning of the pilot period to more than 90 percent by August of 2004.

STRATIFICATION

Molina set a goal to identify 100 percent of children, from birth to age three, who had no EPSDT visits or only one EPSDT visit. The EPSDT database used claims data to automatically stratify and identify children in need of EPSDT services.

Aim:
Stratify 100 percent of children in Kent County identified by claims data as either having at least one EPSDT visit or having no EPSDT visits.

Measure:
$\frac{\text{\# of children in the Kent County pilot with at least one EPSDT visit}}{\text{Total \# of children in Kent County}}$

$\frac{\text{\# of children in the Kent County pilot with no EPSDT visit}}{\text{Total \# of children in Kent County}}$

Change:
To stratify children, from birth to age three, Molina developed a database of children needing an EPSDT screen. The database was updated monthly by Education Department staff.

Results:
During the initial pilot phase, from July 2003 to November 2003, Molina increased the identification of children with at least one EPSDT visit from 46 percent to 72 percent.

Stratification	July 2003	Nov 2003
# of children with EPSDT visit / Total number of children	527 / 1,137 = 46.3%	624 / 862 = 72.3%
# of children with no EPSDT visit / Total number of children	610 / 1,137 = 53.6%	238 / 862 = 27.6%

Molina Healthcare of Michigan

OUTREACH

MEMBER OUTREACH

Molina set a goal to provide education regarding developmental milestones and what to expect during the well-child visit to 90 percent of parents in the pilot program.

Aim:

Educate 90 percent of parents in the pilot program about developmental milestones.

Measure:

$$\text{Contact rate} = \frac{\text{\# of successful follow-up calls to parents of children who had no visit}}{\text{\# of parents attempted to reach by phone}}$$

$$\text{Successful mail rate} = \frac{\text{\# mailed - \# returned}}{\text{Total \# mailed}}$$

Change:

Molina implemented the following outreach strategies to educate families about EPSDT services and well-child visits:

- Sent letters to all parents providing education about developmental milestones.
- Sent reminder letters, along with age-specific developmental milestone information, to parents of children who were overdue for well-child visit. Letters were mailed every 60 days or until the child received all recommended EPSDT visits.
- Made phone calls to parents of children with no well-child visits to schedule a preventive care visit.
- Attempted to correct addresses on all returned pilot project mailings. When letters were returned, Education Department staff checked the system for a second address, and, if found, materials were re-mailed. This second mailing included a note requesting the member to call the plan to verify the correct address.

Results:

Molina achieved a 33 percent contact rate for these calls. Due to the low success rate of telephone outreach for their population, Molina focused on mailing address confirmation. Taking the extra step of confirming addresses paid off: Molina achieved a 96.7 percent successful mail rate for the pilot program.

PROVIDER OUTREACH

Molina set out to improve provider awareness of well-child care and developmental screening practices. Molina identified 11 provider offices in Kent County to serve as pilot sites. These practices represented a diverse membership in both urban and rural service areas.

Aim:

Conduct provider site training sessions on EPSDT components, proper documentation, coding, and referral sources for children with developmental delays at 100 percent of the participating provider offices.

Measure:

$$\frac{\text{\# PCPs who attended provider training sessions}}{\text{Total \# provider offices in Kent County participating in the project}}$$

Change:
Education Department staff conducted training sessions for provider office staff at all 11 identified provider practices. To ensure buy-in from providers, Molina's Provider Service Representative spoke with practitioner office staff about the pilot project prior to the training to allow them to give the plan feedback on the format of the session. Training focused on the importance of detecting developmental delays early, referral sources for children with developmental delays, EPSDT visit components, proper documentation, and coding of EPSDT/Well-Child visits.

Communication was frequent to the provider pilot sites throughout the project. Program progress letters were sent to each provider site at two months and five months into the program. The letter included a report indicating the number of check-off slips received verifying the developmental screening and referrals for follow-up if applicable.

INTERVENTION

To increase the number of infants and toddlers receiving appropriate well-child visits, Molina implemented strategies to educate members about the importance of preventive care and to help them recognize warning signs of potential problems in their child's development. The plan also developed provider materials to facilitate developmental screening within EPSDT visits and assist in referrals.

Aim:
1. To ensure that 80 percent of Molina members in Kent County, from birth to age three, have an appropriate EPSDT visit.

2. To track and improve the number of children who received developmental screens and referrals through claims data.

Measure:
1. # children identified needing EPSDT visit sent reminder letter and program materials
   Total # of children due or overdue for an EPSDT visit

   # of EPSDT claims (July – Nov 2003)
   Total # of children due or overdue for an EPSDT visit

2. # of developmental screenings
   # of EPSDT visits identified from claims/encounter data

   # of referrals
   #of screenings

Change:
Molina implemented the following member and provider education strategies to increase the number of children, from birth to age three, who received EPSDT screenings and appropriate developmental screenings:

I Molina Healthcare of Michigan

MEMBER EDUCATION

Molina developed an age-specific educational mailing for parents that explained the components of the EPSDT exam, provided health tips and milestones, and offered the incentive of a baby board book for members who scheduled well-child visits. The mailing included a tear-off form for members to take to the provider's office. During the visit the provider office completed the form, indicating services rendered, developmental screening performed, tests performed, and referral(s) made, and sent it to Molina. Upon receipt of the form, Molina sent a board book as a gift to parents for their child. Between July through December 2003, 833 books were mailed.

PROVIDER EDUCATION

Molina developed educational materials for provider offices on EPSDT components, coding, and referral sources for children with developmental delays. Providers received the following laminated sheets:

- Overview that explains components of EPSDT exam, additional services required for Medicaid recipients, proper CPT codes, billing instructions, referral sources for children with developmental delays, program outline, and plan contact numbers.
- List of CPT codes to bill for the EPSDT exam.
- EPSDT schedule of services.
- Summary of developmental assessment tools, including information on the specificity and sensitivity of the tool, the age groups covered by the tool, a description of the tool, the cost, length of time to complete, and where to purchase the tool.

Molina worked with the Kent County Health Department to develop a list of area organizations that provide services to children with developmental delays. Each pilot site was given information on area referral sources. Molina found that some of the offices were not aware of or were not familiar with other referral sources that address the needs of children under the age of three. All offices were provided with contact information and a summary of the services available for children three and under.

OVERALL PROGRAM RESULTS

At the end of the six-month pilot program, Molina's EPSDT rate for children from birth to age three increased from 46 percent to 76 percent. Twelve children (5.6 percent) were identified through developmental screening and were referred for follow-up intervention. Additionally, the EPSDT exam rate for three-year-olds rose from 46 percent to 63 percent.

SUSTAINING AND DIFFUSING THE PROGRAM

Based on its success in increasing EPSDT rates, the "Baby Steps Towards Health" Program was incorporated into Molina's existing statewide EPSDT reminder program. As of February 2004, children from birth to age three (13,000 members) due for an EPSDT visit are mailed a Well-Child Visit Sheet providing age specific information about the components of the EPSDT visit, information about any immunizations/tests due, and developmental milestones. In the mailing, parents are asked to schedule an appointment and bring a list of their questions or concerns to the well-child visit. Visit

sheets are mailed at least 30 days prior to the recommended EPSDT visit for children from birth to 18 months, and every 60 days to children age 20 to 36 months who are due/overdue. In March 2004, the program was extended to include four-, five-, and six-year-olds, bringing the total number of children enrolled to more than 23,000. These age groups were added because Molina's HEDIS scores for well-child visits for children, ages four, five, and six, have been below the NCQA 75th percentile.

Although many members appreciated receiving the board books in the initial pilot, Molina found that it was not an effective incentive to encourage parents who were overdue in scheduling well-child visits. As a result, Molina will pilot an incentive of a $10 gift certificate to encourage members whose children are overdue for EPSDT visits and who already have received two reminders to schedule well-child exams.

Molina Healthcare of Michigan also is extending the use of the BCAP Quality Framework to other quality improvement initiatives. The plan will apply BCAP to design and measure the results of a statewide lead screening program and also is planning to use the BCAP approach for mammography reminders and cervical cancer screen reminders.

II

BlueCross BlueShield of Tennessee

BlueCross BlueShield of Tennessee (BCBST) set an overall aim to encourage more providers to perform standardized developmental screening in children, age six to 36 months, during preventive visits. BCBST used the BCAP Typology to stratify "high-leverage" primary care providers (PCPs) by number of preventive visits and by preventive visits with standardized developmental screening. BCBST defined high-leverage as providers identified as both "high-volume" and "high-opportunity." High-volume equals PCPs with 100 or more preventive visits per year. High-opportunity equals PCPs with fewer than 50 percent of preventive visits inclusive of a standardized developmental screening.

During the pilot phase, outreach nurses from BCBST, called Regional Clinical Network Analysts (RCNA), visited 34 high-leverage sites to train providers on how to administer, score and submit reimbursement for the PEDS tool. The screening rate for these high-leverage providers increased from 0 to 43.5 percent during the pilot phase. Because of the potential realized after the initial BCBST pilot, the Tennessee Chapter of the American Academy of Pediatrics now trains on EPSDT at provider sites throughout the state.

IDENTIFICATION

BCBST set a goal to identify all preventive care visits for members, age six to 36 months, to determine which members were not receiving standardized developmental screening, as well as which providers were providing preventive care.

Aims:

1. Identify 100 percent of preventive visits for members age six to 36 months.
2. Identify the percentage of preventive visits by PCPs for members age six to 36 months for which standardized developmental screening was performed.
3. Identify the PCPs who perform preventive visits for members age six to 36 months.

Measures:

1. # of preventive visits for members age six to 36 months = 5,934

2. $$\frac{\text{\# of preventive visits for members age six to 36 months with standardized developmental screening}}{\text{\# of preventive visits for members age six to 36 months}} = \frac{528}{5{,}934}$$

   Percent of preventive visits with concurrent screen = (528/5,934)*100 = 8.9%

3. # of PCPs performing preventive visits in members age six to 36 months = 114

BlueCross BlueShield of Tennessee

Change:
BlueCross BlueShield of Tennessee implemented the following strategies to improve tracking of preventive visits and developmental screens performed by PCPs for children age six-36 months of age:

- Conducted quarterly queries of claims database. Analysis of the claims data included PCP number, PCP name, PCP specialty description, # of preventive visits with standardized developmental screen by same PCP, # of preventive visits, date and region.
- Used CPT codes (99381, 99382, 99391, 99392) to identify preventive visits and CPT 96110 to identify standardized developmental screen for children six to 36 months of age.
- Made analytical comparisons for each provider whose name appeared in the quarterly claims queries.

Accomplishment:
Through this effort, BCBST was able to identify the percentage of providers who were and were not conducting a standardized developmental screening in their EPSDT preventive visit. Of the 5,934 preventive visits performed by 114 PCPs, only 528 (8.9 percent) documented a standardized developmental screen at the time of the preventive visit, suggesting an opportunity for improvement.

STRATIFICATION

BCBST set a stratification goal to identify "high-leverage" providers, that is those providers with high volume of preventive visits each year and a weak track record of performing standardized developmental screening. Through this unique stratification approach, the plan identified 34 "high-leverage" providers to target for additional intervention.

Aim:
Stratify 100 percent of PCPs by number of preventive visits and by percentage of preventive visits with standardized developmental screen to determine "high-leverage" PCPs, those physicians stratified as both high-volume and high-opportunity.

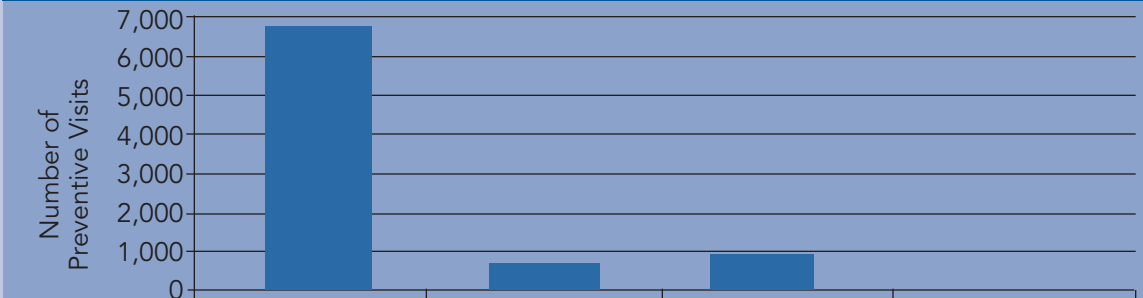
Working Definitions:
- "High-Volume" = PCPs with 100 or greater preventive visits per year.
- "High-Opportunity" = PCPs with fewer than 50 percent of preventive visits with standardized developmental screen.
- "High-Leverage" = PCPs who are stratified as both high-volume and high-opportunity.

Measures:
of "High-Volume" PCPs
of "High-Opportunity" PCPs
of "High-Leverage" PCPs = High-Volume PCPs + High-Opportunity PCPs

Change:
To maximize the potential of their intervention, BCBST developed a report of high-leverage PCPs containing individual PCP data as well as data aggregated by number of preventive visits performed and percent of preventive visits with documented standardized developmental screen. The report divided providers into four indicator groups by calculating all four possible volume and opportunity ratios:

- High-Volume and High-Opportunity
- High-Volume and Low-Opportunity
- Low-Volume and High-Opportunity
- Low-Volume and Low-Opportunity

Figure 8: PCP Indicators Based on Preventive Visits



	High-Leverage = High-Volume and High-Opp PCPs	High-Volume and Low-Opp PCPs	Low-Volume and High-Opp PCPs	Low-Volume and Low-Opp PCPs
PCPs #	34	3	86	1
PCPs %	27.4%	2.4%	69.4%	0.8%
Visits #	6,696	838	1,153	9
Visits %	77.0%	9.6%	13.3%	0.1%

Results:
Through this innovative stratification approach BCBST determined that 34 PCPs performed the majority (77 percent) of preventive visits and also had a preventive visit standardized developmental screen rate of less than 50 percent. By targeting outreach efforts to these high-leverage PCPs, BCBST could maximize the potential of their intervention activities. The stratification report allowed the plan to quantitatively track their progress over time.

OUTREACH

After identifying the 34 high-leverage provider practices, BCBST devised an outreach strategy to encourage these practices to improve the delivery of standardized developmental screening within EPSDT appointments.

Aim:
To conduct provider education in-services at 100 percent of the high-leverage provider sites (34).

Measure:
# of high-leverage providers receiving educational in-service
# of high-leverage providers

Change:
BCBST made the following changes to facilitate training and outreach to the identified high-leverage provider sites:

- Distributed stratification report to nurse outreach worker.
- Modified PCP contact database to include standardized developmental screening field.
- Developed training packets for the nurse outreach worker to use when visiting PCP offices. The training covered background on the PEDS screening tool, how and when to administer it, and the reimbursement process.
- The nurse outreach worker contacted each PCP office by phone and conducted at least one in-service at each site.

Results:
All (100 percent) of the 34 high-leverage providers and their office staffs received an educational in-service. Providers and office staff learned how to obtain the PEDS test and additional information was included to assist with referrals for problems identified through the PEDS test, if necessary. The training packet included contact information for the Tennessee Early Intervention System, which offers a directory of programs, resources, and professionals for infants and toddlers with disabilities and their families.

INTERVENTION

BCBST set a goal to ensure that all identified high-leverage providers perform a standardized developmental screening within at least half of their pediatric preventive care visits for children, age six- to 36-months.

Aim:
To ensure that 100 percent of high-leverage PCPs perform a standardized developmental screening as part of preventive visit at least 50 percent of the time.

Measure:
# of high-leverage PCPs with greater than 50 percent rate for standardized developmental screening
# of high-leverage PCPs

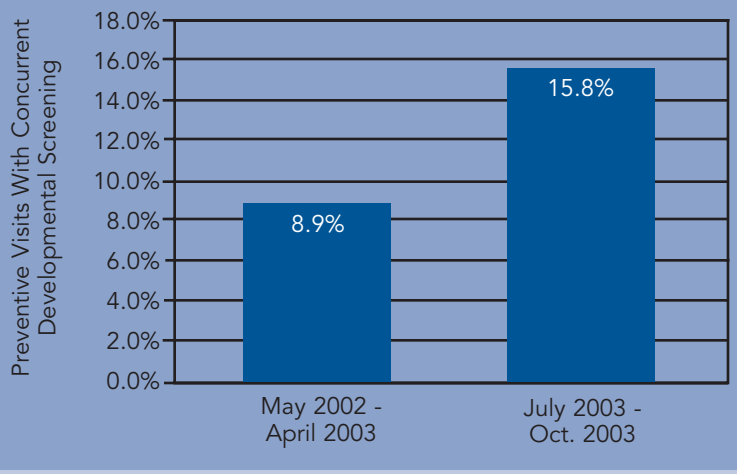
Change:
BCBST made the following changes to encourage providers to incorporate standardized developmental screening into preventive care visits for children, age six to 36 months:

- Providers were reminded about fee-for-service reimbursement for standardized developmental screening (CPT 96110) separate from and in addition to preventive visit reimbursement.
- Resource packets were left at each PCP office following personal in-service training.

Results:
At the end of the pilot phase the percent of high-leverage PCPs with greater than 50 percent developmental screening rate increased from 0 percent to 43.5 percent. Increases in the preventive visit and screening rates can be attributed to the education, training, and RCNA physician outreach efforts.

Overall Accomplishments:
Baseline data from May 2002 to April 2003 showed an 8.9 percent preventive visit rate with concurrent developmental screening (528 of 5,934). One hundred percent of high-leverage provider offices received an outreach visit by September 2003. The next quarter (July 2003 through October 2003) during and immediately following the outreach intervention, this rate increased to 15.8 percent (414 of 2,626). This 6.9 percentage point increase in the preventive visit rate with concurrent screening observed in the pilot project phase, can be attributed to the successful outreach effort by the RCNAs and to the outreached providers who were willing to adopt change to their preventive visit methods.

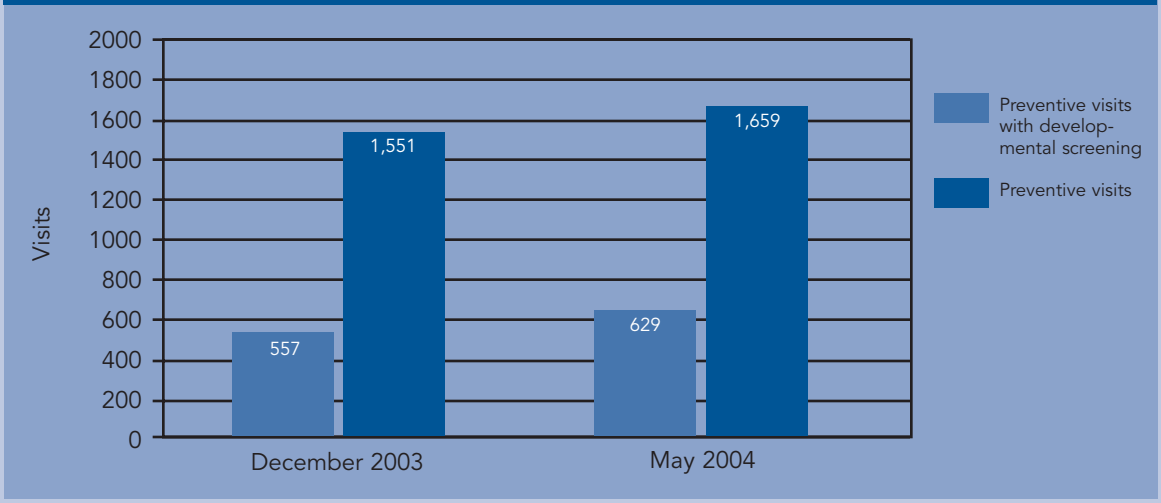
Figure 9: Preventive Visits with Concurrent Developmental Screening



In addition to the high-leverage providers, nine additional providers who were in the same offices as the high-leverage providers, as well as those who had offices in the county or surrounding area, also received provider training on standardized screening when available.

BCBST continued to monitor the compliance of the 34 pilot project providers, as well as the additional nine providers (43 total providers) who received a training visit, by an RCNA during calendar year 2004. BCBST compliance monitoring between December 2003 and May 2004 showed that 58 percent of these providers (25 of 43) visited by BCBST experienced an increase in their preventive visit rate. Both the number of pre-

Figure 10: Preventive Visits and Preventive Visits With Standardized Developmental Screenings at BCBST across 43 Providers



ventive visits and the number of preventive visits with concurrent developmental screening increased each quarter. For example, from December 2003 to May 2004, the number of preventive visits increased by seven percent, going from 1,551 to 1,659. During the same time period, the number of preventive visits with concurrent developmental screening evaluations increased by 13 percent, going from 557 to 629. This group of 43 providers was used as an indicator of the effectiveness of BCBST's education outreach.

SUSTAINING AND DIFFUSING THE PROGRAM

To ensure the long-term viability of this pilot project approach, BCBST is using a medical record audit tool to measure provider use of standardized developmental screening. The medical record audit process allows the health plan to monitor provider use of recommended screening tools. Standardized developmental screening has been incorporated into their processes at these provider sites and providers are encouraged to use the PEDS tool as well as other standardized tools with all of their patients. In this way, the benefits of standardized screening are spreading beyond those served by Medicaid, to the commercial sector as well.

Lovelace Community Health Plan

Forty-five percent of children 0-3 years of age in New Mexico are currently enrolled in Medicaid. In working with the New Mexico Department of Health, Lovelace Community Health Plan learned that the state's average age of referral to its early intervention program was higher than the national average and the percent of 0-3-year-olds served by early intervention services is lower than national averages (Figure 10). Not only were fewer children being referred to early intervention services, but they were being referred at a later age.

Figure 11: Early Intervention Rates for New Mexico and US Medicaid Services

	United States	New Mexico
Percent of 0-1-year-olds served by Early Intervention	0.9%	0.4%
Percent of 0-3-year-olds served by Early Intervention	2.1%	1.4%
Average age of referral to Early Intervention services	15.5 months	16.8 months

Lovelace set the ambitious goal of improving referral practices and making early intervention services accessible earlier in the life of a child. To pursue this goal, Lovelace participated in a statewide Senate Joint Memorial Task Force to examine appropriateness and timeliness of referrals to the Family Infant Toddler program (FIT), New Mexico's early intervention program. The task force met over the summer of 2003 and identified barriers to appropriate and early referrals, and developed and prioritized strategies for addressing those barriers.[66]

Lovelace focused on integrating the use of standardized developmental screeners during well-child visits as a way of improving screening and referral rates. They used the BCAP Quality Framework to implement the Ages and Stages Questionnaire and improve referral practices at pilot provider sites.

IDENTIFICATION/STRATIFICATION

PILOT SITE IDENTIFICATION

Lovelace chose pilot practice sites representing urban, suburban, frontier, and rural counties. Four pilot sites were chosen and 25 providers agreed to participate in the pilot project.

MEMBER IDENTIFICATION

Lovelace aimed to improve data tracking of children in need of EPSDT well-child exams.

[66] More discussion about the work of the Senate Joint Memorial Task Force can be found on page 40.

Cycle 1:
Lovelace asked the data vendor to generate a monthly list of children in need of an EPSDT well-child exam each month for each pilot site. By comparing this list to a list of EPSDT well-child exam claims for each pilot site, Lovelace could continually assess their well-child visit rates.

Cycle 2:
Based on day-to-day work experience, Lovelace staff expressed concern that the number of children on the list could be less than 50 percent of the correct number. The source of error was difficult to troubleshoot because the health plan was in the midst of a change in data system vendors.

Cycle 3:
The new vendor improved coding methods and improved the integrity of the claims data.

Cycle 4:
Once accurate lists were generated and reminders made to parents, Lovelace realized that most PCPs have a four- to eight-week lag between the date that the member makes an appointment and the actual date of the appointment.

Cycle 5:
Lovelace asked the new vendor to produce a monthly EPSDT list two months before the expected exam month, instead of during the month of the required EPSDT exam. This enabled the health plan's outbound callers to contact the members and for reminder postcards to go out in a timely manner. These efforts led to improved identification of children in need of well-child visits.

OUTREACH

PROVIDER OUTREACH

Lovelace implemented provider site systems changes that improved their screening and referral practices.

Aim:
Train 100 percent of pilot providers on implementation of the Ages and Stages Questionnaire and the Family Infant Toddler referral process.

Measure:

$$\frac{\text{\# of providers oriented to the Ages and Stages Questionnaire}}{\text{\# of providers in study}} = \frac{25}{25} = 100\%$$

$$\frac{\text{\# of providers oriented in the proper referral process to the FIT program}}{\text{\# of providers in study}} = \frac{25}{25} = 100\%$$

Change:
Lovelace held lunch trainings at each of the four provider sites. All 25 providers were trained across the sites. Lovelace's Medical Director discussed New Mexico's low referral rates and provided information about how to implement the ASQ tool and how Lovelace would help providers navigate the FIT referral process. The following system changes were implemented to improve screening and referral practices:

- The receptionist hands out the ASQ tool to the caregiver to be filled out in the waiting room prior to selected (six-, 12-, 18-, and 24-month) well-visits as well as whenever the caregiver or provider has a concern.
- The provider reviews the questionnaire with the caregiver during the well-visit exam.
- Through a "fax-back program" office staff bundle all score sheets indicating reason for follow-up evaluation and fax them to Lovelace weekly.
- Health plan Outbound Caller contacts the caregivers of children who are eligible for a FIT evaluation and helps the caregiver set up an appointment.
- The Outbound Caller contacts FIT and provides them with the scoring sheet.
- The Outbound Caller follows-up with the caregiver after the appointment to ensure that the child has been evaluated.
- If the family misses an appointment, it is referred to case management for further intervention.

Results:
Lovelace purchased the ASQ screening tool and manual and made copies for each of their pilot sites. Through hands-on training, providers learned how standardized screening could easily be incorporated in well-child care visits. Providers responded positively and continue to use the ASQ screener with all of their patients.

The fax-back program proved to be difficult for providers over time and Lovelace had a low fax response rate. This was due to providers dealing with multiple payor sources and serving several non-Lovelace members. The provider site staff found it inefficient to cull out only Lovelace member ASQs. As a result, Lovelace introduced the idea to the New Mexico Department of Health and Human Services (DHHS). By implementing the fax-back program at a state level, providers would be able to send all score sheets indicating reason for follow-up to a single place. Lovelace developed a list of local FIT providers and covered services specific to each pilot site. Providers have found this to be very useful in helping families navigate the referral process.

MEMBER OUTREACH

Lovelace set a goal to reach out to members through development of member education materials and the development of "Well-Visit Round-Up" days at the four pilot sites. Building on Lovelace's existing Healthy Trails Program, the health plan created a mascot, Hank the Healthy Trails Horse. On monthly Well-Visit Round-Up days, Hank the Horse visits the waiting rooms at the four pilot sites, armed with health education materials and parental resources on developmental topics such as toilet training, nutrition, and language and literacy development.

Lovelace Community Health Plan

Aim:
Engage Lovelace families as partners in the child's growth and development.

Measure:
Number of participants in Well-Visit Round-Up days.

Change:
Lovelace implemented the following outreach strategies to educate families about EPSDT services and well-child visits:

- Sent well-visit reminder postcards to all caregivers.
- Developed and posted posters with Hank the Horse inviting children and caregivers to Well-Visit Round-Ups in the waiting rooms of each of the four clinic sites.
- Developed and distributed caregiver education materials and a Healthy Trails calendar with stickers to indicate important developmental milestones and reminders for well-visits.
- Called all caregivers of children eligible for EPSDT to encourage participation in "Well-Visit Round-Up" days.

Results:
Families and providers have responded positively to Well-Visit Round-Up Days. At Lovelace's Consumer Advisory meetings, members have expressed that they find the member education materials useful and that their children enjoy Hank the Horse at the doctor's office. They also reported that the ASQ screener is easy to fill out while they are in the waiting room. Lovelace reports that each clinic typically sees 35-45 children on Well-Visit Round-Up days.

INTERVENTION

Lovelace implemented a monetary provider incentive as a means of improving their screening and referral rates.

Aim:
Improve screening and referral rates through provider reimbursement.

Measure:

$$\frac{\text{\# of children at six, 12, 18 and 24 months of age}}{\text{\# of children with EPSDT exams at six, 12, 18 and 24 months of age}}$$

$$\frac{\text{\# of children with initial FIT evaluation}}{\text{\# of children eligible for initial FIT evaluation}}$$

$$\frac{\text{\# of children served with FIT 0-1 population}}{\text{\# of children 0-1 years}}$$

$$\frac{\text{\# of children served with FIT 0-3 population}}{\text{\# of children 0-3 years}}$$

Change:

Cycle 1:
Lovelace approached the Medicaid Department of the Health and Human Services Department (DHHS) and requested permission to reimburse for use of the ASQ screener.

Cycle 2:
DHHS determined that Lovelace would not receive extra reimbursement from the state and thought that Lovelace could reimburse for the ASQ screener as an enhancement to their services.

Cycle 3:
The Lovelace BCAP team presented a convincing economic justification to upper management at Lovelace and as a result, Lovelace decided to pilot a $10 reimbursement per questionnaire only at the pilot sites.

Cycle 5:
This incentive led to improved screening and referral rates and, as a result, the reimbursement was expanded to all Medicaid providers at Lovelace.

Cycle 6:
Lovelace went back to DHHS and convinced state policy makers to reimburse an additional amount ($14) for standardized developmental testing.

Results:
Providers have responded positively to the additional reimbursement and claims for standardized developmental screening continue to increase across all provider sites. Lovelace indicates a modest improvement in screening and referral rates. The referral rate measures have been adopted by the State of New Mexico to evaluate their Family Infant Toddler program, which will allow Lovelace to compare its results with the state.

SUSTAINING AND DIFFUSING THE PROGRAM

Positive provider and member feedback has encouraged Lovelace to spread lessons learned to provider offices beyond the four pilot sites. Providers at the pilot sites are now routinely using the ASQ screener and therefore best practices piloted in Medicaid are impacting children from the commercial sector as well. New Mexico's Department of Health and Human Services has also been very interested in the progress demonstrated at Lovelace and is considering implementation of referral fax-back program piloted at Lovelace at a statewide level. And lastly, Lovelace has extended the successes of its pilot programs in a variety of ways. Lovelace has made presentations to provider groups, the Governor's Cabinet and the Legislature's Children's Cabinet about the need to improve child development services in New Mexico and the importance of timely screening and referrals. These efforts have led to a statewide policy change and reimbursement for standardized screening.

Directory of Online Toolkit Resources

Many of the plans in the BCAP Workgroup on Enhancing Child Development Services in Medicaid Managed Care used innovative tools and resources as a part of their quality improvement pilot projects. These can be found in CHCS' online Resource Library.

Visit www.chcs.org to access these online resources:

1. BCAP Pilot Summary Form
2. BCAP Quality Framework
3. ICHAP ICD-9 Codes to Identify Developmental Delay Risks
4. Molina Healthcare member mailing materials:
   - 12-month well-child visit
   - 12-month well-child visit – Spanish
   - 12-month milestones
   - EPSDT and LEAD reminder letter
5. CommunityCARE Provider Training Guide
6. CommunityCARE Sample Mailing
7. CommunityCARE Documentation Flowsheet
8. BlueCross BlueShield Provider Training Packet
9. CommunityCARE Referral Tracking Form
10. Lovelace List of Barriers to timely screening and referrals identified by Senate Joint Memorial Task Force

Learn More about BCAP Enhancing Child Development Services in Medicaid Managed Care

The Center for Health Care Strategies website offers a wealth of resources for organizations committed to measurably improving health care quality for Medicaid beneficiaries. Visit **www.chcs.org** to:

- Learn about the **BCAP Quality Framework**.
- Explore previous **BCAP Toolkits** on:
  - *Improving Birth Outcomes*
  - *Improving Preventive Care Services for Children*
  - *Achieving Better Care for Asthma*
  - *Improving Managed Care for Children with Special Needs*
- Register for **CHCS Network Exchange Calls** to learn about best practice strategies.
- Join the **BCAP Network Listserv** to share information about quality improvement techniques with professional peers across the country.
- Sign up for **CHCS Monthly Topics** for e-news updates regarding upcoming opportunities to participate in BCAP workgroups or other educational sessions.

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