Implementing Standardized Developmental Screening in the Patient & Family-Centered Medical Home
Welcome!

Type questions into the Questions Pane
Patient-Centered Primary Care Institute
History and Development

• Launched in 2012
• Public-private partnership
• Broad array of technical assistance for practices at all stages of transformation
  – Learning Collaboratives
  – Website (www.pcpaci.org)
  – Webinars & Online Learning
• Ongoing mechanism to support practice transformation and quality improvement in Oregon
Oregon’s PCPCH Model is defined by six core attributes, each with specific standards and measures

- **Access to Care**
  - “Be there when we need you”

- **Accountability**
  - “Take responsibility for us to receive the best possible health care”

- **Comprehensive Whole Person Care**
  - “Provide/help us get the health care and information we need”

- **Continuity**
  - “Be our partner over time in caring for us”

- **Coordination and Integration**
  - “Help us navigate the system to get the care we need safely and timely manner”

- **Person and Family Centered Care**
  - “Recognize we are the most important part of the care team, and we our responsible for our overall health and wellness”

Read more: http://primarycarehome.oregon.gov
Presenters:

Sherri Alderman, MD, MPH, IMH-E, FAAP
START Medical Director &
Developmental Behavioral Pediatrician

R.J. Gillespie, MD, FAAP
General Pediatrician, The Children’s Clinic

Rosalia Messina
Parent presenter

Peg King, MPH, MA
START Program Manager
A Project of:
The Oregon Pediatric Society
Oregon Chapter of the American Academy of Pediatrics (AAP)

Sponsored by:
Ford Family Foundation
Lora L. and Martin N. Kelley Family Foundation Trust
Project LAUNCH
Oregon Health Authority

In collaboration with:
ABCDIII; Oregon Dept. of Education; EI/ECSE; 211; Childcare Resource and Referral; County Health Departments; School-Based Health Centers
Goals & Objectives

• **GIVE** an overview of standardized developmental screening in pediatric practices

• **IMPROVE** provider understanding, utilization and implementation of the Ages and Stages (ASQ) screening tool

• **EDUCATE** pediatric providers in proper documentation, coding, and billing of screenings

• **PROVIDE** a family’s perspective on developmental screening at well child visits
AGENDA

**Part 1**: Standardized Developmental Screening As Evidence-Based Practice

**Part 2**: Recommended Developmental Screening Tools & Coding

**Part 3**: Parent Perspective on Screening (Rosalia Messina)

**Part 4**: Clinic Implementation (Dr. RJ Gillespie)
Did you know?

20% of all visits to the pediatric clinician’s office are developmental or behavioral in nature.

80% of parental concerns are correct and accurate.

Children who fall behind in 1st grade have a 1/8 chance of ever catching up.

High school graduation rates can be accurately predicted by reading level in 3rd grade.
Child Healthcare Providers

THE ONE PLACE NEARLY ALL CHILDREN ARE SEEN

90%

Seen by primary care provider (0-5)

47%

Seen by nursery and preschool (3 & 4)
Myths and Barriers to Screening

- “Not enough time”
- “I know it when I see it”
- Reliance on homemade tools/check lists
- The “wait and see” approach
- Lack of knowledge on standardized tools & billing
- Literacy issues (health & academic)
- Lack of knowledge of referral resources
The Facts About Developmental Screening

Developmental screening = higher family-centered care ratings and higher satisfaction with WCC.

Routine developmental screening using a standardized tool complies with:

- Oregon’s Patient-Centered Primary Care Home (PCPCH)
- Coordinated Care Organization’s (CCO) performance metrics
- American Academy of Pediatrics (AAP) Policy Statement – Screen at all 9, 18 and 30 (or 24) month well child visits
- Bright Futures guidelines
Implementing ASQ in Practice

REFERRAL RATES DRAMATICALLY INCREASE

At 12 months, referrals 8X higher
At 24 months, referrals 2.5X higher
EARLY REFERRAL & INTERVENTION SERVICES

WORK

- El programs can help **improve** IQ, motor, language and academic achievement.

- Average total expenditure per child in EI is **$15,740**.

- **50%** of children who receive EI services no longer need services by 3 years of age.

- Estimated cost of failing to provide intervention for children living in poverty is as high as **$100,000** per child.
What’s the difference?

Surveillance vs. Screening vs. Diagnosis
SURVEILLANCE

Flexible

Continuous

Identifies risk and resiliency

Professional’s skilled observations of children during child health care in consultation with other professionals and caregivers

Surveillance is NOT screening
Surveillance

5 COMPONENTS

1. Parents’ concerns
2. Developmental history
3. Risk and protective factors
4. Observations of the child
5. Documenting process and findings
Screening

- Set point in time
- Objective
- Standardized tool
- Differentiates children that are "probably ok" vs. "needing additional investigation"
WHAT IS DIAGNOSIS & EVALUATION?

1. Diagnosis is **the next step** when screening identifies child as “needing additional investigation”

2. Diagnosis is **done by a professional** with expertise in developmental evaluation

3. Aimed at **identifying specific developmental disorders** affecting the child, “diagnostic”

4. Done in conjunction with a **medical diagnostic evaluation**

   Every child diagnosed with a developmental delay should receive a medical evaluation to assess for possible co-existing medical conditions.
Benefits of Screening

- Better Patient Care
- Improved Patient/Family Satisfaction
- Earlier Identification & Referral
- Improved Child/Family Outcomes
- Reimbursable
- Cost Effective
- CCO and PCPCH metric

EARLY INTERVENTION IS PREVENTION
Advantages of Using Parent-Completed Screening Tools

- Can be used to focus the visit on parental concerns
- Enhances teachable moments
- Helps avoid “oh, by the way” questions
- Parents/caregivers can provide rich information about child across settings
- Improves patient flow
- Improves patient/family satisfaction
Ages & Stages Questionnaire

Sensitivity: 76-90%
Specificity: 76-91%
Cost: $225, unlimited copying
Ages: 2 months to 5 ½ years (adjust for prematurity)
Format: parent questionnaire, 5 domains
Languages: English & Spanish
Reading Level: 4th to 6th grade level
Time required to score: 3 minutes
Interpretation: white, gray, black

Website for info and to order:
www.agesandstages.com
Preparing Parents & Caregivers

• Explain tool and purpose to parents

• Normalize developmental screening

• Assess ability to complete tool properly
## Ages & Stages™ Sample Item
### 9 Month Questionnaire - Scoring

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Sometimes</th>
<th>Not Yet</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. While your baby is on her back, does she put her foot in her mouth?</td>
<td>☑️</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Does your baby drink water, juice, or formula from a cup while you hold it?</td>
<td>□</td>
<td>☑️</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ASQ™ Scoring

• Be sure each item has been answered.

• Corrections can be made if two or less items are left blank.

• The scoring grid below shows the cutoff score for each domain, indicated by the dark bar.

• Any score touching or in the dark bar indicates further evaluation is needed.

• Gray area corresponds to 1.5 SD below mean, black area corresponds to 2.0 SD below mean

<table>
<thead>
<tr>
<th>Area</th>
<th>Cutoff</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>13.97</td>
<td>🟧</td>
</tr>
<tr>
<td>Gross Motor</td>
<td>17.82</td>
<td>🟩</td>
</tr>
<tr>
<td>Fine Motor</td>
<td>31.32</td>
<td>🟧</td>
</tr>
<tr>
<td>Problem Solving</td>
<td>28.72</td>
<td>🟩</td>
</tr>
<tr>
<td>Personal-Social</td>
<td>18.91</td>
<td>🟧</td>
</tr>
</tbody>
</table>
The goal of the dual consent is to enhance communication by allowing child health providers and EI/ECSE to release important information to one another, better ensuring children and families are getting the care they need.
Coding and Documentation of Developmental Screening

• **Coding 96110 is multi-purpose:** tracking screening rates, CCO and PCPCH metrics reporting, +/- billing

• To submit code for reimbursement or not? Requires **careful consideration of pros and cons** by each clinic (See OPIP resource)

• Typically reported when performed during **preventive service visit**

• Scoring can be done by physician, nurse, or MA; **Discussion of results must be done by medical provider**

• Document name of tool administered, total score, interpretation (pass / fail), and “**discussed with family**”
Coding 96110

- Decision to bill or not and amount must be applied to all insurance types. **To not bill uniformly is an unacceptable billing practice.** (See OPIP coding and billing resource)

- 96110: “Developmental screening with interpretation and report, per standardized instrument form” (CPT 2013)
  - may be billed multiple times during a visit if more than one tool is used
  - Attach -25 modifier to well child code
  - Attach -59 modifier to 96110 code only if multiple codes billed

- **If claim is rejected**, send AAP letter (see resources) to Medical Director of insurance plan along with copy of AAP developmental screening guidelines
Next Steps

- Encourage communication and follow-up on referrals.

- Use the Common Referral Form and establish a feedback loop with referral agencies.

- Schedule a START clinic-based training for a more detailed training on workflow, quality improvement strategies, and how to connect with your local community resources and agencies.
Continuous PDSA Cycles

Hunches, theories, ideas

Changes that result in improvement
What does a parent have to say?
A conversation with Rosalia Messina

- What was your experience with your child's developmental screening at the doctor's office?
- What feedback do you have for doctors?
- What would you like to say to other parents about the developmental screening process?
Implementation in the clinical setting
A conversation with R.J. Gillespie, MD

1. Clinic history
2. Change
3. Barriers
4. Implementing screening and START’s role in the process
5. Challenges in monitoring
6. Screening today
7. The future
Additional Trainings

• Autism
• Post partum depression
• Social emotional development
• Adolescent depression
• and more

• START provides CME and MOC for medical providers’ participation in trainings
For more information or to schedule a training, please visit:

www.oraap.org/start

For more information:
Peg King, 503.334.1591 x101 or margaret.king@oraap.org
Questions?

Type questions into the Questions Pane
Resources

- American Academy of Pediatrics: The Medical Home
- Referral Form
- CCO Guidance Document – Developmental Screening for Young Children
- OPIP Billing Slides
- Sample Claim Letter

Available on www.pcpici.org attached to webinar

Thank you! Please complete our post-webinar survey!
References

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- Hollie Hix-Small, Kevin Marks, Jane Squires and Robert Nickel, Impact of Implementing Developmental Screening at 12 and 24 Months in a Pediatric Practice, Pediatrics 2007;120;381
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- AAP Policy - Pediatrics 2006; 118; 405-420