Part Four

Screening in High Performing Medical Homes: Development, Health, and Well-being

Part Four / Key Takeaway Messages

- Practice in the high performing medical home should extend beyond traditional screening for general development in young children to include screening for social determinants of health. This is essential for identifying and responding to social determinants of health and related early childhood risks, with emphasis on affecting health trajectories over the life course, not just addressing immediate health conditions.

- Medicaid’s EPSDT benefit requires developmental screening. *Bright Futures* guidelines recommend that developmental screening tests for young children be administered during the well-child visits at 9, 18, and 30 months. These visits are reflected in the AAP periodicity schedule for preventive well-child visits and in some, but not all, state EPSDT schedules. States have opportunities to improve the financing of these services, as well as the use of validated screening tools and measurement of practice, health plan, and state-level performance.

- The Medicaid/CHIP Child Core Measurement Set includes a measure called “Developmental Screening in the First Three Years of Life.” The measure can be used to monitor how Medicaid providers, managed care plans, and state programs overall are performing in terms of developmental screening of young children. Not all states have yet adopted this measure.

- Screening for social-emotional development increasingly is used in pediatric primary care for young children. Screening for social-emotional/behavioral/mental health is part of the EPSDT benefit. Now more than ever, providers are offering and Medicaid is financing social-emotional-behavioral screening designed specifically for young children and some also are conducting maternal depression screening (one core social determinant of health for young children) as part of well-child visits.

- Screening for social determinants of health is an emerging area, with new tools, practice approaches, and financing opportunities. Responding to SDOH risks and needs identified through screening requires discussions between health providers and families, as well as referrals and follow up.

Screening as a Core Part of a High Performing Medical Home

As part of a high performing medical home and during a well-child (or other) visit, the primary child health practitioner follows a protocol for assessing the child’s health and development and also engages in “surveillance,” a technique designed to identify other issues and concerns that may not be part of the established protocol. Beyond general surveillance, the well-child visit can include specific screening related to the child’s health and development or to conditions around the child affecting that development. As part two describes, these activities can be billed separately, and adequate reimbursement is needed to sustain the practice in both conducting and using the screens. In terms of content, this includes screenings related to both the child’s development and well-being (including developmental and social and emotional well-being) and screening related to conditions around the child (social determinants of health) that affect healthy development. This section discusses screening in the context of a high performing medical home for both developmental and social determinant concerns.
Addressing the Roots of Health and Well-being in a High Performing Medical Home

Research shows that young children’s health and development has impact throughout the life course, affecting child and adult health and well-being. As scientific knowledge has expanded, and advances have been made in medical care, a broader conception of health and the role of health practitioners in advancing health has emerged. The term “health” has been redefined beyond clinical diagnoses and treatment or management of disease and disability. The term now recognizes that health is more than the absence of disease or disability and is about optimal health and well-being. Increasing focus has been placed on responding to social determinants of health and related early-childhood risks, with emphasis on affecting health trajectories over the life course, not just addressing immediate health conditions.

For young children, many of the social determinants of health apply directly to the parent or primary caregiver and the home environment, and indirectly to the child. During the first years of life, the safety, stability, and nurturing in the home environment is foundational to healthy child development — physical, cognitive, social, and emotional. When caregivers lack parenting skills or experience stress, depression, substance use, and social marginalization, such factors can have profound effects on children’s health trajectories. The research on adverse childhood experiences and toxic stress shows that family tur-
moil during early childhood is particularly damaging to children’s development and over the life course can lead to subsequent preventable chronic medical conditions. They can also affect educational, social, and emotional conditions, including justice system involvement, employability and earnings, and roles in the community and as parents of the next generation.\textsuperscript{13 14 15 16}

In short, the objectives of health and health-related services for young children can and should be on improving the child’s health trajectories, but this cannot be achieved without a focus on the child’s family. This is in contrast to adults, where family plays a smaller role in determining an adult’s health. The schematic below suggests the special foci on families and the supports around the child that are needed for very young children. These require different metrics and practices than for adults. Child well-being is mediated through social determinants related to household economic well-being, parental personal well-being, family social well-being, and parent-child relationship well-being.

There are multiple definitions of these SDOH, with most focusing on non-medical factors related to policy, social context, material, and environmental factors.\textsuperscript{17} Drawing substantially from the initial definition and factors established by the World Health Organization,\textsuperscript{18 19} Bruner and others have developed a definition more specifically directed to young children, recognizing that the safety, stability, and nurturing in the family home environment is core to healthy development.\textsuperscript{20} As shown in Figure 11, these can relate to the physical and material home environment, parental health, the family’s social supports and connections, and the parent-child relationship.

As discussed earlier in this sourcebook, children’s primary health care is undergoing a transition to increase focus on early development of health and well-being, which requires attention to social as well as bio-medical determinants of health. Innovators in child health have developed more ecological approaches to identifying and responding to young children in primary care, starting with broader approaches to screening that goes beyond specific child health risks and conditions to more fully engage families through supportive discussions and practice regarding factors influencing the whole well-being of children and families.\textsuperscript{21 22} Many approaches available for use in the pediatric primary care setting have yet to be widely adopted and could be advanced through Medicaid policy and financing.

**Developmental Screening and EPSDT**

Developmental screening at specified visits with objective screening tools, as well as ongoing developmental surveillance, is recommended by the AAP and other primary care provider organizations. The goal is to identify risks and possible delays in growth and development early and take follow up action to intervene. Conducting developmental screening is the role of primary health care providers and responding to identified risks is one of the key roles of a high performing medical home.

The federal Medicaid statute does not list “child development” as a benefit category, but these services are specifically covered under the EPSDT child health benefit. CMS affirms that developmental and behavioral health screenings are required for all Medicaid-enrolled children under EPSDT and are also covered for children in CHIP.
Periodic developmental and behavioral screening during early childhood is essential to identify possible delays in growth and development, when steps to address deficits can be most effective. These screenings are required for children enrolled in Medicaid...

Comprehensive well-child visits through EPSDT include developmental screening based on professional guidelines and standards of care such as Bright Futures. During early childhood, screening for physical and mental/behavioral health and other risks is essential to identify risks and possible delays in development. Developmental screening at specific times in early childhood, developmental surveillance at each well-child visit, and follow-up diagnosis and treatment are recommended for all children to ensure early intervention to correct or ameliorate conditions. Developmental screening is a covered service for children enrolled in Medicaid, including children enrolled in Medicaid expansion CHIP. CMS has identified resources to support states in ensuring Medicaid enrolled children receive developmental screening.

Bright Futures guidelines recommend that developmental screening tests be administered during the well-child visits at 9, 18, and 30 months. These visits are reflected in the AAP periodicity schedule for preventive well-child visits and in some, but not all, state schedules. Standards of practice and EPSDT federal rules call for screening of young children across six primary domains of development, including: 1) gross motor, 2) fine motor, 3) communication skills or language development, 4) self-help and self-care skills, 5) social-emotional development, and 6) cognitive skills. In addition to screening for these categories of general development, state Medicaid programs are required to cover screening for vision, speech-language-hearing, and dental needs.

Even though no specific list of screening instruments is mandated, federal rules call for use of culturally sensitive and validated tools, and some states recommend specific tools. State agencies often identify a
set of standardized, objective screening tools recommended or required for use in Medicaid/CHIP. State Title V Maternal and Child Health programs and other child health professionals play an essential role in advancing evidence-based practice, recommending tools, and promoting widespread use of developmental screening.

Recommendations in pediatrics call for general developmental screening of young children; however, research suggests social-emotional development, in particular, is important as an initial indicator of general well-being versus risk. Screening for social-emotional/behavioral/mental health is part of the EPSDT benefit. Increasingly, providers are offering — and Medicaid is financing — social-emotional-behavioral screenings designed specifically for young children, while also offering maternal depression screening as part of well-child visits. For example, the combined efforts of a team of state leaders in Minnesota led to success in expanding use of screening for general development and social-emotional development. Minnesota reviewed 15 commonly used tools and made recommendations to promote developmental screening.

One validated tool that has been widely used in health, early care and education, and other settings is the Ages and Stages Questionnaires: Social-Emotional (ASQ:SE). Studies of its use as a universal screening tool have been conducted. Additionally it has been used to assess the effect of integrated behavioral health (i.e., collocated psychologist) over time.

In line with Bright Futures recommendations, new tools to screen for social determinants of health are being used in a small, but growing number of pediatric primary practices. This involves asking about more than the child’s health, behavior, and developmental status.

The Medicaid/CHIP Child Core Measurement Set, includes a measure called “Developmental Screening in the First Three Years of Life.” (See part seven for the full Child Core Set of measures.) This measure reports the percentage of children screened for risk of developmental, behavioral, or social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday. The measure can be used to monitor how Medicaid providers, managed care plans, and state programs overall are performing in terms of developmental screening of young children. It also can be used in quality improvement efforts to help providers and managed care organizations improve their performance. Not all states have yet adopted this measure since it was released in 2016. As shown in Figure 12, among the 26 states reporting data in FFY 2016, the average was 36 percent. In 2016, developmental screening rates for children under age 3 ranged from 1.6 percent in Alaska to 77.5 percent in Massachusetts. These data point to opportunities for improved performance in every state.

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Having billing codes and adequate reimbursement rates, combined with measurement and quality improvement efforts, can improve performance in terms of developmental screening. As reported by the National Academy for State Health Policy in 2016, many states now use distinct billing codes for developmental screening, but approximately 20 states do not recommend or require validated screening tools, and only six states set reimbursement above $20 for screening (Arizona, California, Iowa, Hawaii, Kansas, and Kentucky).
A number of states have implemented initiatives to use legal, data, and quality improvement strategies to increase appropriate use of developmental screening in pediatric practices. State efforts in Iowa, North Carolina, Oregon, Texas, Vermont, and Washington have been widely recognized. For example, in North Carolina attention to and training for office processes resulted in a significant increase in screening rates to more than 70 percent of the designated well-child visits. This project led to a change in Medicaid policy, and screening in EPSDT well-child visits improved statewide. In Washington, state legislation was enacted in 2015 that adopts the *Bright Futures* recommended schedule for developmental and autism screening as its standard for kids covered by Medicaid.

When a developmental screen indicates a risk or condition, follow-up action to complete a fuller diagnostic assessment is a critical next step. For children enrolled in Medicaid, such diagnostic services are financed by Medicaid unless financed under the Individuals with Disabilities Education Act (IDEA) Part C Early Intervention Program for Infants and Toddlers or Part B Special Education Program. In many states, Medicaid has developed partnerships with Part C and maternal and child/family health programs to maximize use of Medicaid and improve outcomes. Medicaid financing is used by virtually all states to finance a portion of Part C Early Intervention services. Making referrals, service delivery, and payment practices efficient and effective helps to reduce cost and improve outcomes. Projects across the country have demonstrated ways to streamline administrative practices, achieve cost efficiencies, maximize available providers, and better serve families with young children, including partnerships with pediatric medical homes.

At the same time, states set different eligibility criteria for Part C, with many requiring very substantial developmental delays or disabilities to be eligible for services. Nationally, only about 3 percent of all young children are receiving Part C services, although many more have some diagnosable delay. Screening and then referring to Part C does not fulfill the practitioner’s responsibility to respond to developmental delays, although it can be an essential service to those who then qualify for assistance.

States have shown success in increasing developmental screening for young children enrolled in Medicaid. An increasing number of states are using a national measure to monitor performance. Taking action and financing interventions for identified risks and conditions is equally critical. Best practices used by states to focus on developmental screening in Medicaid include the following.

- Require use under EPSDT of the American Academy of Pediatrics *Bright Futures*-recommended periodicity schedule and guidelines for well-child visits.
- Recommend or require age-appropriate, validated screening tools (i.e., for general development, social-emotional development, and social determinants of health) in rule, provider manuals, and managed care contracts.
- Adopt the available billing codes and communicate them to plans and providers.
- Use the Medicaid/CHIP developmental screening measure. Require that providers and plans report using the measure and aggregate and report statewide data to CMS.
• Permit separate billing for screening (unbundle).

• Pay separately or at a higher reimbursement rate for enhanced pediatric primary care screening (e.g., social-emotional, maternal depression, SDOH, ACE), including screening delivered on the same day as well-child visit.

• Clarify that EPSDT interperiodic visits (as defined in federal law) are permitted for developmental screening when parents or other providers have concerns about development.

• Use performance incentives (financial and non-financial) for pediatric primary care providers and/or health plans to increase use of developmental screening, using the CMS measure to monitor performance.

• Set clear payment rules between Medicaid and IDEA Part C or Part B programs, and identify children enrolled in both Medicaid and IDEA Part C or Part B services to reduce prior authorization and related administrative burden.

• Use Medicaid to finance developmental services for children with identified risks who do not have delays or conditions severe enough to qualify for IDEA programs, in order to prevent worsening of conditions.

• Use Medicaid to support augmentation of pediatric practice staff capacity to support development and address identified risks, such as addition of care coordination staff, HealthySteps specialists, behavioral health staff, etc. (See part five of this sourcebook.)

Screening for Social Determinants of Health

Screening for SDOH in pediatric primary care and well-child visits is an emerging area of practice. In fact, primary care practitioners are seeking ways to screen for SDOH across the lifespan. The use of an objective screening tool for SDOH is that it can better identify families who can benefit from attention to their home circumstances and help the practitioner initiate a discussion with and exploration of family concerns. Research shows practitioners often miss the most at-risk children and families when they rely only on their observations.

One dilemma is having appropriate, acceptable, objective, validated, and useful screening tools. Reviews of existing screening tools for all ages have been conducted. Many questions or series of questions around particular factors (e.g., adequacy of housing, food sufficiency) have been validated as part of research studies; others have been put into practice without having studies of their reliability and validity. In the context of young children and their families, the validity of questions is important. It is equally important to use the process to promote educational, supportive, and problem-solving discussions between health providers and families — and to assist care coordinators in linking young children and their families to services that enhance healthy child development by responding to those social determinants.

As part of a Child and Adolescent Health Measurement Initiative Technical Working Group (TWG), Bruner conducted a review of the published and the grey literature using the four domains described above (material well-being, psychological well-being, social well-being, and relationship well-being). This yielded a broad set of questions, which were synthesized and formulated into a screening tool composed of 18 questions, designed for use in the first years of life. This composite screening tool covers the four domains, drawing as much as possible on validated screening questions and existing tools in practice and
an additional cross-walk between the screening questions in the tool and the different questions presented in Bright Futures guidelines.\textsuperscript{52}

Responding to SDOH risks and needs identified through screening requires discussions between health providers and families. Asking parents to respond to sensitive questions about themselves, without providing the opportunity to discuss them, can produce anxiety, shame, or the reliving of negative experiences (one of the reasons the TWG selected not to include questions regarding ACEs). Not asking about these topics that clearly impact health can also result in similar anxiety, shame and negative experiences.\textsuperscript{53} Select practices, including a number of Help Me Grow sites, have incorporated the Well-Visit Planner into their structure, by encouraging parents to complete that online tool prior to their well-child visit and share the results with the practitioner. The Well-Visit Planner not only includes a number of screening questions, particularly around the child's development, but also offers immediate resources to parents regarding issues and suggests specific concerns to raise with the practitioner during the well-child visit. Research suggests the Well-Visit Planner benefits practitioners by making better use of well-visit time with the family; both the child and the family also benefit by understanding the child's needs and encouraging timely solutions to concerns.

As discussed in part three of this sourcebook, for an estimated 10 to 30 percent of families overall and half or more in certain poor and isolated communities,\textsuperscript{55} follow up involves more than anticipatory guidance typically provided by the practitioner in the well-child visit. In some cases pediatric practices can provide interventions, but response to most SDOH will require a referral and follow up. Effective follow up entails a “warm handoff” from the health provider practice to a care coordinator, social worker, family advocate, resource navigator, or other individual — either within the office or through an outside resource.

An objective screening tool for social determinants of health can better identify families who can benefit from attention to their home circumstances and help the practitioner initiate discussion of family concerns.

Again, the screening tool is simply a starting point for referral and further discussion with a care coordinator; often, such a discussion results in identifying family goals, ideas, or positive actions that are not evident from or directly tied to the survey responses. When additional services are needed, families generally benefit from the support care coordination can provide when navigating multiple systems of care.
References

24. Centers for Medicare and Medicaid Services. What you need to know about EPSDT. Available at: https://www.medicaid.gov/medic-


