**Oregon ABCD Early Childhood Screening Initiative: GOALS, OBJECTIVES**

*(based on Steering Committee Planning, August, 2007)*

| Desired Outcomes: | Primary Care Practice | Measurement and Performance | Education and Outreach | Family Participation |
|---|---|---|---|---|
| ***Goal, Objectives***<br><br>***I. Increase Standardized Screening and Surveillance in the Medical Home***<br><br>▪ Screening available to all children<br>▪ Screening tool guidelines<br>▪ Physician champion to implement screening<br>▪ Spread screening practice, promote tools<br>▪ Train and educate providers, medical school<br>▪ Parent access to tools<br>▪ Rural areas access to screening | All infants are screened within first year of life. Screening is available for all children in common settings; surveillance at every visit (as defined by AAP) | Physicians have access to integrated data systems (i.e. Public Health-FamilyNet) and can input their own data (immunizations, newborn screening, and development screening.). Electronic systems track and record with access by all interacting with the family | Physicians/medical community is aware of and promotes early identification of developmental and social emotional needs. | Parents will be confident and competent in understanding and meeting their children's health and social/emotional needs |
| | Physicians will enthusiastically administer standardized screening tools and use results to shape their anticipatory guidance; Distinction is made between screening and evaluation. | Regular and ongoing feedback to the practitioners about how well they are doing (monitoring % of children screened), helps build the momentum not only up. | Knowledge and skill base of providers is variable; inconsistent medical homes, esp. in rural and frontier communities where care is provided by family practice and allied health. Include in professional training models | Parent completed tools (validated) that can be filled out/completed before a visit, supplemented with provider observational screening; Example: all parents with live birth go home with ASQ to bring to a future well-child visit |
| | Providers must be engaged and involved in selection of tools and development of processes; one tool may work well in one practice, another tool in another practice; web-based approach is good for some and not for others | PCP's have Electronic Medical Records (EMR). Screening tools integrated into physician electronic record; Screening outcomes data used to promote increase in funds for intervention services. | Screening will be taught in medical school and students tested on skills | PCP offices have electronic access (websites, kiosks, laptops) for on-line screening tools for families at home, in waiting rooms; include nursing support for families to try developmental activities in the wait room |
| | Implement standardized screening of child *and* family at specific visit, using family centered approach and provider/office staff centered approach; standard part of well child visit, use only with concerns. There should be flexibility in approach to screening that allows good judgment to intercede | | Promote set of screening tools that have valid reliability for development social/cultural and specific disorders e.g. Autism, ADHD, maternal depression screening and referral, plus substance use, weapons, tobacco use, domestic violence, used by all primary care on a schedule similar to vaccine schedule | |

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| | Implement screening tool utilizing the 3-4 periodic targeted well visits (9-12; 18; 24; 36 visits); postpartum mood disorder screen at 2 months. | | | |
| | To implement screening, a physician champion is imperative to success and to create system that sustains when champions change; screening has to be integrated into the office flow, not an "add on." | | | |
| | Motivation for practice change requires additional energy to sustain new practice. Approach to use of standard screening as should not be: "you need to change." Change happens "within" self-motivation. External motivation comes from parents; public health nurses—major source of motivation. | | | |
| ***Goal, Objectives*** ***II. Clarify Coverage and Reimbursement for Standardized Screening*** | Universal, standardized developmental and psychosocial screening will be established as best practice for both Medicaid and non-Medicaid primary care providers. | Mandate paid well-child visit with screening, return higher payment rate. Sustainability a challenge without a link to the payment system | Oregon has clarity on reimbursement of screening, as well as child mental health codes, as they relate to the state's EPSDT requirements | |
| ▪ Screening is best practice in Medicaid ▪ Clarify tools and billing codes | Health care providers are appropriately reimbursed for their efforts to use a best practice model | Variation in use of Medicaid survey (Oregon specific) regarding reimbursement; contracted providers, utility of interpretation, adequacy of referral sources and | Medicaid clarifies its expectations regarding the criteria for appropriate screening tools and the billing code allowances describing the use of such tools, | |

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| ▪ Appropriate reimbursement for screening<br>▪ Mandated well-child visits, screening<br>▪ Private systems clarify tools, reimbursement | | re-evaluation; provider perceptions | so that reimbursement encourages the use of systematic standardized screening. | |
| | Sufficient financial resources are available to fund providers to administer screening, anticipatory guidance, referral, assessment and follow up. Sustainability has different challenges in a managed care environment | | Providers with clout in Oregon have to make a public statement. Private systems need to be clear with its expectation, clear regarding use of standard tools | |
| ***Goal, Objectives***<br>***III. Increase Linkages with Medical Home and Referral Services*** | Community systems are tied to primary care to mutually support and integrate for best care to families/children. Children identified at risk have appropriate follow up. Mental health providers will be integrated into all primary care practices for follow up and consultation | Providers receive/input data on developmental and behavioral screening. Referrals should be able to receive/give/input information on immunizations, as well as screening. | Providers know what two do with results, internally and externally. | Children and families will have early access to the services, supports and screening, follow-up. Appropriate and comprehensive referrals including multi-disciplinary coordinated, collaborative. |
| ▪ Mutual support and communication<br>▪ Reduce duplication of screening<br>▪ Clear, simple referral process<br>▪ Link with mental health services<br>▪ Data systems track screening, follow up<br>▪ Services are family-centered | Improve cross-systems communication: Medical home and community services. System assures no duplication of services. There is a dialogue between screening source and intervention source (PCP - EI Specialist.) | | | Family centered community services share results to reduce duplication of screening and services. Point to hand off child between clinic and early intervention, education for follow up providers, has to be thought through |
| | There must be a clear and simple referral process and promptly available resources to refer kids for assessment and follow-up. Referrals generated with screening – not successful linking mental health to primary care | | | |

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| | Challenges include the transfer of information, issues of confidentiality. Screening at Head Start or other organizations – using same tools (ASQ); need coordination in transfer of information | | | |
| | Capacity to address and follow up for those identified children needs to be expanded and connected to those services; possibly physicians have access to 800 number to find referrals; physicians have simplified way to referrals. | | | |