

Developmental and Behavioral News

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Notes from the Chair



Lynn Mowbray Wegner MD, FAAP
Chapel Hill, NC

Greetings from the Chair!

This special issue of the Section on Developmental and Behavioral Pediatrics (SODBP) Newsletter is being provided to keep you abreast of the current recommendations and practices in primary care developmental screening. A special thanks to Stuart Teplin, MD, SODBP Executive Committee member, for serving as the editor of this issue. We hope you'll enjoy this and find the information useful in improving your practice habits. We are a very practical Section and we eagerly and enthusiastically welcome new members. If you aren't a current member, we invite you to join us! You can download a Section application from the AAP Web site at www.aap.org/member/SectionMbrreq.htm.

For those current SODBP members, you may recall a survey I e-mailed to you in September 2006. The topics were: coding expertise and coding/practice habits relating to developmental screening/testing and non-face-to-face services involved in providing patient care for developmental and behavioral health concerns of children and adolescents. Eleven percent of membership responded with 96% physicians as respondents. Here are a few highlights!

- 75% assigned ICD-9-CM and CPT codes themselves
- 51% are NOT using 96110 "Developmental Testing-Limited" to describe their formal screening

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Section Executive Committee

Lynn Mowbray Wegner, MD, FAAP Chairperson
Morrisville, NC
E-mail: braindoc1951@hotmail.com

Jill Fussell, MD, FAAP
Little Rock, AR
E-mail: fusselljillj@uams.edu

Michael Ian Reiff, MD, FAAP
Minneapolis, MN
E-mail: reiff001@umn.edu

Laurence Sugarman, MD, FAAP
Rochester, NY
E-mail: laurance@laurencesugarman.com

Stuart W. Teplin, MD, FAAP*
Chapel Hill, NC
E-mail: steplin847@nc.rr.com

Robert G. Voigt, MD, FAAP
Rochester, MN
E-mail: voigt.robert@mayo.edu

Newsletter Editor*

Frances Page Glascoe, PhD
East Berlin, PA
E-mail: frances.p.glascoe@vanderbilt.edu

Immediate Past Chairperson

Henry Shapiro, MD, FAAP
Saint Petersburg, FL
E-mail: shapiro@dbpeds.org

AAP Staff

Linda Paul, MPH, Manager
Division of Developmental Pediatrics
and Preventive Services
American Academy of Pediatrics
Office: 800/433-9016, 7787
Fax: 847/228-7320
E-mail: lpaul@aap.org

Ngozi Onyema, CHES
Coordinator, Committees & Sections
Division of Developmental Pediatrics
and Preventive Services
E-mail: nonyema@aap.org

Mark A. Krajecki, Pre-Press Production Specialist
Department of Education
Division of Scholarly Journals
and Professional Periodicals

*Dr Teplin served as the newsletter editor of this issue

Notes from the Chair *continued from page 1*

- 43% said they use 96110 ONLY to describe developmental screening
- 22% said they use 96110 to ALSO describe emotional/behavioral screening
- 3% said they use 96110 to ALSO describe maternal postpartum depression screening
- 2% said they use 96110 to ALSO describe emotional/behavioral screening of the parent
- 1% said they use 96110 to ALSO describe screening parental ADD; parental overall stress

When the data is all analyzed, we'll put the results on our Web site www.dbpeds.org.

As a final comment, this is my last Chair letter as I complete my second term at the AAP National Convention and Exhibition in October 2007. (Michelle Macias, MD steps up as Chair.) I cannot begin to tell you how much I have appreciated this opportunity to serve as the "fearless leader" for this group! I have worked with stellar AAP staff (including Mary Crane, Linda Paul, Ngozi Onyema, and Effie Tonkovic to name just a few). The SODBP Executive Committee has worked long and hard to manage the many tasks offered to our Section. I have met in person and corresponded with incredibly articulate, energetic and imaginative DB'ers. I have been able to participate in change. I leave the Chair position being extremely glad I am a member of the AAP as I have seen the Herculean work done by this organization to improve children's lives.

Lynn

Welcome to a Special Issue of Developmental-Behavioral Pediatrics News!

In this newsletter devoted to developmental screening and referral of young children for early intervention, we will briefly review the AAP's new policy on early detection of developmental delays and will discuss:

- Why early detection of delays is important
- How screening with standardized and validated tools saves time and money
- How to establish consistent payment for screening
- How to efficiently implement screening tools in your practice
- How to select or modify an electronic record system with an eye toward screening
- Where to find services for children and families
- Why improved early detection methods can improve your and your patients' parents satisfaction with care
- What resources are available to help you and your staff learn more about developmental screening
- What resources are available to promote sound and efficient developmental screening habits for pediatric residents, fellows, and other physicians-in-training
- Why you will want to join the AAP's Section on Developmental-Behavioral Pediatrics!

We have placed each article from this newsletter on our Web site, www.dbpeds.org and also have posted this newsletter in its entirety, so you can download it to share with others.

We thank the many members of the SODBP who contributed to this issue including:

Stuart Teplin, MD, FAAP (Chapel Hill, North Carolina), Special Issue Newsletter Editor

Janiece Doran-Slovak, RN, BSN (Arizona Chapter, AAP)

Margaret Dunkle, MA (George Washington University)

Michelle Macias, MD, FAAP (Medical University of South Carolina), SODBP Chair-Elect

Paul H. Lipkin, MD, FAAP (Kennedy Krieger Institute)

Michael Reiff, MD, FAAP (University of Minnesota)

Alison Schonwald, MD, FAAP (Harvard University)

Robert Voigt, MD, FAAP (Mayo Clinic)

Lynn Wegner, MD, FAAP (University of North Carolina-Chapel Hill), SODBP Chair

Timing and Content of Developmental Screening: The New AAP Policy on Early Detection

The recent AAP policy statement *Identifying Infants and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening* was a collaborative effort among members from the Council on Children with Disabilities (Paul Lipkin, MD, Chair and John Duby, MD), the Section on Developmental Behavioral Pediatrics (Lynn Wegner, MD and Michelle Macias, MD), Bright Futures Steering Committee (Paula Duncan, MD and Joe Hagan, MD), the Medical Home Initiatives for Children with Special Needs Project Advisory Committee (Nancy Swigonski, MD and Carl Cooley, MD), the Council on Clinical Information Technology (Paul Biondich, MD), and liaison representatives from the Centers for Disease Control and Prevention (CDC) and the Maternal Child Health Bureau (MCHB). The statement (July, 2006)¹ notes the enormous and critical value of early identification of, and intervention for young children with possible developmental problems. It particularly emphasizes the value of screening and prior to school entrance. The statement embraces **periodic screening** with accurate tools, along with **surveillance** and discusses:

- Surveillance ensures that clinicians see the big picture of children's and parents' lives— such as risk and resilience factors. It calls on clinicians' keen skills of observation and elicitation of key social information, such as limited parental education, non-optimal parenting practices, family violence, housing and food instability, etc. Surveillance is remarkable for its potential to help clinicians address such problems before they have an adverse impact on development.²
- Screening periodically is nonetheless necessary to ensure that delays (often extremely subtle in the early years and virtually invisible without measurement) are detected and addressed via interventions of sufficient intensity that they are likely to work.

Within the new policy statement, the following recommendations are made and discussed:

- **Elicit and address parents' concerns at every visit.** Several commonly used screening tests embrace this concept, thus enabling the encounter to focus carefully on families' needs for advice or referral.
- **Maintain a developmental history** by routinely monitoring developmental milestones. Again, quality tools can help with this, provide milestones predictive of long-term outcome, and provide accurate cutoffs that ensure evidence-based referral decisions.
- **Screen at 9, 18, and 24 or 30 months and beyond.** This will have been addressed if well-validated tools are already in place for monitoring of milestones and eliciting/addressing parents' concerns.
- **Administer an autism specific screen** at 18 and again at 24 months (see www.dbpeds.org for options among measures).
- **Observe parent-child interactions and** maintain updated family medical and psychosocial history. Tools to help also can be found on www.dbpeds.org.
- **Identify risk and protective factors.** These include parental mental health and/or substance use, poverty, limited education, ethnic minority, frequent household moves, more than 3 children in the home, and chronic illness of either the parent or child. Resiliency indicators include: parents who, even if risk factors are present, read to their children, are comfortable allowing children to explore new objects and places, talk about children's interests, model language, etc. Measures of these issues are valuable at intake and should be re-administered, in whole or part, in the first and second year of life. They can be found on www.dbpeds.org.
- **Refer promptly.** There is no value to a "wait and see" approach when screens are failed or when risk factors are present. Development develops. Developmental problems do also.
- **Intervene in problematic parenting styles.** Parenting is not easy. Even skilled parents sometimes benefit from feedback and advice. Many parents, *especially those with limited education*, don't know that you are interested in developmental and behavioral issues over and above your routine "medical" care. For some parents, you may need to actively elicit their observations and concerns about their child's development and behavior. Such questions alert parents to your interest and willingness to guide them. Good questions also help level disparities in care, ensuring that parents who don't express concerns spontaneously still get the help they need.
- **Recognize the limitation of brief interventions.** A 15-minute encounter with only a few of those minutes devoted to parenting issues is not enough for many parents. It is important to monitor the impact of your advice and the effectiveness of information you've given parents (eg, handouts). When parental concerns persist at the next visit, one option is to schedule a follow-up appointment solely devoted to the concern. You also can refer the parent and/or child for more intensive services (eg, parenting classes, highly rated preschools, Head Start, or early intervention programs for children with delays).
- **Screen and screen again** and with accurate tools!

Screening with Validated Instruments Saves Time and Money

Many clinicians think screening with a published, validated instrument takes too much time, but **consider these questions:**

- How much time do you spend asking parents about their children’s development and well-being?
- How much time do you spend trying to get children to demonstrate milestones such as those typically shown on age-specific encounter forms?
- How many “Oh, by the way...” concerns about development do you encounter every week? How does addressing concerns “on the fly” interrupt your patient flow and reduce your efficiency?
- How often do you reassure concerned parents, only to discover later that their child could have benefited from early identification and referral?

Use of a well-validated developmental screening instrument can significantly minimize these problems because they can:

- Be self-administered by many parents in waiting or exam rooms, or even at home, prior to the clinical encounter.
- Help you know with greater precision when to counsel parents vs. refer — thus enabling you to enter the exam room equipped with essential materials.
- Increase attendance at well-visits, as parent-completed screening tools can help focus the visit on their concerns.³
- Reduce or eliminate “the grenades of the day.”⁴
- Enhance the “teachable moment” and focus the visit.⁴
- Emphasize the role of parents as collaborators with you as an expected part of pediatric care.^{5,6}
- Establish developmental-behavioral care as an integral element of health care, something many parents are not aware of.^{5,6}
- Ease the task of giving “bad news” because parents’ observations are already identified in the screening process.

Screening with validated instruments costs (a little), but facilitates payment.

Costs of Accurate Screens

So, what is meant by the term “validated?” Proof of accuracy! Good measures have proven sensitivity and specificity (at least 70% to 80% for each). Screening should no longer include informal milestone checklists or items “cherry-picked” from larger instruments. These informal techniques are known to miss about 70% of children with problems.⁷

If you are wondering whether your approach to screening is working, consider your referral rate: 1 out of 200? 1 out of 100? 1 out of 25? For children of school age, it should be about 1 out of 6!⁷ Because some eventual developmental problems are unnoticeable early on, prevalence in the preschool years increases with age: about 4% are detectable at age 2, 8% by age 3, and 12% by age 4.⁷

For a list of validated developmental screening instruments, go to www.dbpeds.org and type “Screening Tools” in the search engine.

All validated developmental screening instruments are currently proprietary products and therefore should be considered a practice expense; however, this cost is relatively minimal. The per-visit costs of validated tools range from \$0.02 to about \$0.50 (either from the actual instrument copies purchased from publishers, access to online screening measures, or from the cost of photocopying, when permitted by publishers). High quality screening instruments are expensive to develop, maintain, and translate. They also may need periodic updating due to changing demographics and developmental abilities of children of varying socio-economic North American backgrounds.

Payment to Medical Providers for Screening

The relative value units (RVUs) associated with the CPT code for screening (**96110**) do not cover physician time. The code was written for a service administered (explained to the parent and the screening copy scored) by a non-physician. The physician then interprets the ‘score’ and discusses the results with the parent, but this ‘work’ is already assumed to be included in either the pre-

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Screening with Validated Instruments . . . continued from page 4

ventive service or evaluation and management (E/M) codes. This means that screening should be administered and scored by office staff, with interpretation of findings conducted by the primary care clinician. The lack of RVUs for physician time make it essential to train staff as to why early detection is essential and working with them to determine the optimal flow of extra papers through the office (eg, whether screens should be distributed to families in waiting rooms or exam rooms; who will score the screen, attach results to the chart, identify resources, create referral letters, etc?).

Here are examples of correct coding for various types of visits:

Ex. A: Preventive service visit (aka “well child check-up”) with screening = **99393-25, 96110**. This is the proper manner to code for the preventive service visit and the screening if the payer does not ‘bundle’ screening into the preventive service.

Ex. B: Evaluation and management service with screening = **99213-25, 96110**. The code would be **99214-25, 96110** if additional concerns about the child’s health status and/or developmental attainment resulted in longer ‘time’ for the visit.

Ex. C: Evaluation and management consultation service with screening = **99244-25 (or 99245-25), 96110**

Note: You append the modifier -25 to the E/M code because it is a significant, separate service from the screening procedure.

Finally, 96110 may be coded as many times on the billing sheet as screening instruments were administered.

Ex. D: Evaluation and management visit **99214** with screening instruments having been previously completed by child’s mother, grandmother, and pre school teacher: **99214-25, (3) 96110**.

You may properly code multiple units of **96110**; however, payers may not always agree to pay you for multiple units. Please let the AAP Committee on Coding and Nomenclature (COCN), AAP staff liaison, Linda Walsh, lwalsh@aap.org know if payers in your area are restricting payment to only ONE unit of 96110 per visit!

The fact that Medicare has allocated only \$10.34 for each unit of **96110** (2006 data) may seem like “small change.” However, if you have ever watched a ‘penny jar’ fill up; you’ll understand how these small amounts can make a big impact over a year’s revenue!

Need Help with Implementation of Tools in Clinics

On www.dbpeds.org there is a helpful worksheet to guide practices in developmental screening implementation. This was contributed by the faculty of the Assuring Better Child Development (“ABCD” project). You also will find a “must read” for office staff on why screening is important (“Introduction to Developmental and Behavioral Screening”).

The Web site www.developmentalscreening.org has an inspiring video of pediatricians sharing their reservations about systematically adding a screening tool in their practices and their subsequent surprise at both the ease of use and improved detection rates. The site offers strategies for implementing a new tool in the primary care setting and is especially strong in its messages about how to overcome obstacles to integrating routine screening into practice, and how to create a referral system for management of children identified with possible developmental needs.

Information about Intervention Resources: Finding it, Maintaining it, and Using it

Intervention takes many forms and includes in-office parent education, most commonly through patient education handouts. Of importance is the fact that using quality screens will inevitably increase the need for guiding parents regarding optimal methods of child-rearing. Efficiency in providing this invaluable service is essential, as is a well-organized information storage/filing system for managing patient education handouts.

How best to disseminate patient education materials:

- Brochures in waiting rooms can be problematic: Children play with them, parents take but don't read them, and this approach does not confer the power and prestige of professional involvement. A better way is to have a bulletin board showing the topics you are prepared to discuss. Some clinics provide a checklist of topics so parents can select among them. Once in the exam room, and preferably knowing in advance what parents want to know, you can provide a written handout and highlight essential details.
- Handouts are valuable in helping parents understand information after they leave the office. They also can discuss these materials with friends and family. Increasingly, parenting information is available in various languages, as described in the list of Web sites below.
- When parent education is ineffective or when problems are evident (ie, psychosocial risk or measured delays in any area of development), more intensive services are needed. Not all children with delays or risk factors qualify for intervention services, so creativity and willingness to explore other available resources are necessary (eg, good quality child care and preschool programs, parenting classes).
- Clinicians are not always aware of what services for young at-risk children are available in their communities or are frustrated about not getting feedback from intervention service providers/agencies. Some non-medical service providers are unaware how helpful it is for pediatricians to receive updates and/or brief results of their assessments and treatments. Some may wish to collaborate in decision-making with medical providers, but may mistakenly assume that health providers don't value their input. These interventionists need to know you are interested and do desire information-sharing in both directions. Establishing two-way consent forms and a functional referral process is invaluable.

Below are links to national Web sites leading you to local services or parenting information:

To Find Local Services

| Web site | Description |
|--|---|
| www.nectac.org | Links to state, regional, and local early intervention and testing services for young children with suspected or known disabilities |
| www.ehsnrc.org/ | Help finding Head Start Programs |
| www.childcareaware.org | Links for finding Child Care Resource & Referral information for any given zip code |
| www.naeyc.org/ | Assistance locating quality preschool and child care programs |
| www.patnc.org | Information about parent training classes |
| www.mentalhealth.org | Help finding local mental health services through National Mental Health Information Center |

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To Find Parent Education Information:

| Web site | Description |
|--|---|
| www.dbpeds.org | This site has many downloadable information handouts that can be customized and shared—on topics such as building speech-language skills, addressing problems with social skills, preparing children for school success, etc. |
| www.kidshealth.org | Nemours Hospital’s searchable database on a wide range of health and developmental-behavioral topics for parents and adolescents. |
| www.aacap.org | The American Academy of Child and Adolescent Psychiatry has numerous handouts that can be downloaded without cost. The handouts are written in English, Spanish, and French, and address such topics as divorce, recovery after a disaster, how to choose a psychiatrist, etc. |
| www.cyh.sa.gov.au | Child and Youth Health has in-depth articles on bullying and numerous other psychosocial issues, using Australian terminology, eg, “nappies” for diapers, “glue ear” for “otitis,” etc. The reading level is relatively high, but the content is especially thorough. |
| www.bccf.bc.ca | British Columbia Council for the Family can provide individual and bulk copies of books and brochures (in English, French, Vietnamese, and Chinese) on such topics as adolescence, marriage, family cohesion, child development, etc. The site describes a parenting program, “Nobody’s Perfect” and its training manuals. There also is an online service called, “Parents’ Resource Almanac” with a list of books, periodicals, associations, and research centers devoted to parenting topics. |
| www.rch.org.au/ecconnections | Royal Children’s Hospital, Melbourne, Australia, has downloadable handouts in multiple languages including Bosnian, Spanish, Arabic, Chinese, Somali, Turkish, Vietnamese, etc. |
| www.aap.org | The American Academy of Pediatrics has parenting brochures that can be purchased in large quantities. These cover violence, television, single parenting, toileting, hospital stays, health and safety issues, etc. The AAP Web site also offers child-care books, videos, hand-held health records, waiting room magazines, etc. |

Many other sites offer good quality, condition-specific information for both parents and professionals, including:

- www.asha.org (speech-language and hearing impairment),
- www.ldaamerica.org (learning disabilities and attentional problems)
- www.firstsigns.org (autism)
- www.ucp.org (motor disorders)

Telling Parents about Your Screening Initiative

When initiating a systematic screening program with a standardized tool for all young patients in your practice, **parents need to know that:**

- Screening children's development and behavior is a significant aspect of pediatric care and that optimal development and behavior are critical for children's success in school and in life.
- Your practice is using a validated, published instrument at regular intervals in their child's development and/or when you or the parent has concerns about development. This is a separate service and will carry a separate charge. If their insurer does not pay for this, the parent will be expected to pay, as they would for any "non-covered" service. As with all denied claims, your office will advocate for changes in insurers' policies regarding developmental screening denials.
- Your practice wants parents to value screening and surveillance as one of the most important services you provide.

The fact sheet below can be disseminated to parents to make it easier to provide essential information about the new screening initiative in your practice. It is also freely downloadable and customizable at www.dbpeds.org:

Customizable Information Notice to Share with Parents:

New Policy on Child Development and Behavior in Our Practice: What Parents Need to Know

A very important part of our well-child visits, is a check-up on how children are learning, behaving, and developing. This means asking you to complete one or more brief developmental-behavioral screening questionnaires at most well-child visits.

These developmental screening questionnaires help us see whether your child is at risk for problems, now or in the future, and if so, what to do next. The screening tools we use also give you a chance to talk to us about what you need to know as a parent, how you are coping as a parent, and how you are doing as a family. The questions we will ask are important because they help us to help your child become as successful in school and in life, as he or she can.

We must charge for this extra service in the amount of about (*insert usual reimbursement (times the number of screens used)*) for each screening questionnaire completed. You will see this on your billing sheet as procedure 96110. Most insurers pay for this service, however, if the claim is denied by your insurer as a "non-covered" service, you will be responsible for the payment. Please be assured we are working with the American Academy of Pediatrics to make sure this service will become fully covered by all insurers and Medicaid.

If you do receive our bill for developmental-behavioral screening after denial of the claim by your insurer, please understand how important this service is to your child's well-being.



Explaining the Results of a “Failed” Screen

Some clinicians are understandably reluctant to inform parents of screening test results. However, as noted elsewhere in this newsletter, keep in mind that when screens relying on collaborative information from parents are used, the parents will be interested in the results. This makes the process of delivering difficult news easier than you might fear. Here are some guidelines on what to say:

- Prior to administering a screening tool, have a member of your staff **explain** to the parent **why they are being asked to complete the questionnaire**. This should help ensure that parents understand what is happening and better prepare them for the results.

For example: “Here at BEST PRACTICES PEDIATRICS, we feel it’s important to monitor each child’s developmental progress, and your input is a valuable part of this process. So, we would like for you to complete this brief developmental questionnaire about Mary’s skills as you see them. There also is space to let us know about any questions or concerns you might have about Mary’s development or behavior. If you have any questions about any of the items, please don’t hesitate to ask. After you finish, please give us the form, and I’ll make sure that Dr. Jones reviews it before she meets with you.”

- **Remember the purpose of screening**, ie, screening does not diagnose developmental disorders. As per the policy statement on early detection, positive (ie, abnormal) results of screening should yield (a) referral for early intervention services (even if a diagnosis is not yet identified) and (b) further medical/diagnostic evaluation (eg, through consulting subspecialty services or evaluation teams). This is also important for parents to understand.
- **Use language consistent with the child’s need for more comprehensive assessment**. Phrases like the following can be used: “*may be delayed,*” “*this suggests...*,” “*this may indicate...*,” “*may be having difficulties compared to other children his age,*” “*may be behind other kids,*” “*seems to be learning more slowly,*” “*could be having difficulty learning.*” These are effective terms but not devastating ones. They encourage families to seek additional evaluation without causing paralytic fear often associated with terms like “disabilities” or “handicaps.” If the parent specifically asks about a particular disability, you can acknowledge that possibility, but then emphasize that the main goal of the screening is to identify children at risk, regardless of the cause. This identification could lead to early intervention, which evidence shows is clearly beneficial. Other diagnostic work-ups may also be indicated, depending on the parents’ and your levels of concern.
- **Provide telephone numbers and descriptions of services**. It is likely that families who have the necessary information to follow through are better able to do so. Descriptions of programs may enable families to visualize participation and increase the chance they actually will.
- **Offer ongoing support**. Parents may be faced with family members who have minimal investment in your recommendations for further evaluations and services. This may be the result of observing the problem but rationalizing its meaning, (eg, “*his dad was just like that as a boy and he’s doing fine now*” or “*It’s just a phase, she’ll grow out of it*”). You may want to:
 - Alert the accompanying parent to anticipate possible resistance (in themselves and significant others) and, acknowledge their fears or likely bouts of wishful thinking (eg, observing their child very carefully for signs that contradict delays)
 - Invite parents to return with dissenting family members so that you can re-explain your findings.
 - Let parents know that if they get “cold feet” and decide not to go, you want to be informed, (eg, “*It’s just as if I prescribed medicine and you decided not to give it to him, I’d want you to talk with me about it. Treat this prescription/recommendation in the same way. Don’t be afraid to talk with me if you have reservations about following through.*”)
- **Consider providing all families the names and numbers of local parent support networks**. This is particularly important for parents who are observably anxious or have numerous other life stressors. However, parents may not always reveal when they are distressed and it is probably best to have a uniform approach to offering parents on-going support.
- **If at all possible, avoid giving screening results over the telephone**. If this is not possible, alert parents that the information may be confusing and invite them to call back later if they have questions. This should reduce problematic recall and anxiety. Whether conveying results in person or over the phone, provide written information (eg, a brochure about the referral source, a copy of the referral letter you write, etc). This should help ensure that parents fully understand the results and implications.
- **Identify a social worker to help families** who are likely to have multiple barriers to following through with recommendations (eg, single parents with low incomes and multiple life stressors).
- **Provide accurate written and verbal information**. Communication about less than optimal screening test results should clearly

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indicate that screens only tell whether a child is *more likely* to have a problem and that screens, while often correct, are not perfect: Children with true difficulties may not be identified and children who are coming along normally may fail a screen. Specifically, parents who raise serious concerns but whose children perform well on additional screening should benefit from being told that your office will follow their children carefully and give them some suggestions about how to help in the interim (eg, a parent education sheet on how to stimulate children’s language). In this way, you have prepared parents for the possibility that screens may over- as well as under-identify difficulties, and you will have capitalized on a “teachable moment” by giving parents guidance in how to promote their child’s development.

- **Follow carefully those children who fail screens but are not found to have problems.** Most are performing below average and have many psychosocial risk factors.⁸ They need developmental promotion, but also referrals to services for children at risk, such as Head Start, quality child care, after-school tutoring, and summer programs. Their parents also may need additional training or social work services.

When children pass screening tests, offer praise and reassurance that learning and development appear to be coming along well. Also ask parents if there is information on child-rearing or behavior that would help them.

Electronic Health Records (EHRs) and Developmental-Behavioral Screening

Increasingly, clinicians are using Electronic Health Records (EHRs) in their practices. Almost all EHRs come with milestones imbedded in their age-specific encounter forms. These are not valid screening tools and are known to miss the majority of children with problems. Such milestones checklists should be ignored or eliminated.

Software vendors have yet to integrate quality screens into their software, although many appear to be working on this, however slowly. Strategies for spurring progress include:

- **Assigning a point person** from your office to tackle the issue and to maintain weekly contact with the vendor and software consultant assigned to each practice.
- **Group advocacy** is likely to be more effective than isolated requests. If available, **join the pediatric users group associated with your EHR** or ask for contact information of other clinicians-users. If that approach is not an option, contact the publisher of the screening tool(s) you wish to use and ask if they can connect you with other clinicians who are interested. Sharing experiences with other EHR users (and in some cases sharing programming costs), should speed the process. One notable approach is that of the Arizona Chapter of the AAP, where a point person from the Chapter identifies clinicians using various EHRs and helps advocate with vendors.
- Increasingly, **online screening/scoring services** are available; others are in development. These can often be accessed even without complete EHR integration by placing a link into the electronic record. Online screening services offer a plethora of time-savers such as automated scoring, generation of appropriate ICD-9 and procedure codes, customized summary reports for parents and referral letters to share with other professionals when indicated. Results can be captured and pasted into the EHR, emailed to other professionals, etc.

How Some Practices are Implementing Screening in an EHR Environment:

While tools relying on information from parents are the most efficient approach to screening (since parents have time to complete them in waiting or exam rooms, freeing clinicians to spend more time on parent education and referral when indicated), the challenge with EHRs is how to get parents’ responses or test results into the system. Below are a number of approaches that practices are using. All require appropriate licensing from publishers/screening software vendors:

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- Providing computer kiosks in waiting or exam rooms so that parents can complete screens electronically.
- Placing screens on the EHR's patient portal. Many parents can complete the measure(s) online, at home (or in libraries or public schools) prior to the visit, with the results transmitted to the office.
- Having parents complete screens on paper and asking staff to type in their responses (eg, into an online screening service). While this may seem laborious, there is still much savings given time otherwise lost to hand-scoring, report writing, finding resources, etc.
- Using paper-pencil forms in waiting or exam rooms, and then having staff hand-score and record results in the electronic encounter form.
- Creating, with help from publishers and EHR vendors (or outside software consultants), interactive, offline versions of each screen's scoring forms. This still requires hand-scoring, but can enable a single, updatable, longitudinal document to remain in the electronic record.
- Administering screens by interview (eg, when the physician extender enters the exam room) while typing the results into an online scoring service or EHR.
- Using scannable versions of the printed forms for each screen used. While these do not interface with online services, they appear to be a common transitional step for many clinicians who have switched to EHRs but do not have kiosks or ready internet access.

“And now a brief word from our sponsor...”

Please join the AAP *Section on Developmental Behavioral Pediatrics*! A portion of membership dues supports our wonderful Web site, www.dbpeds.org, its discussion list, and semi-annual newsletters such as this one.

References

1. American Academy of Pediatrics, Council on Children With Disabilities; Section on Developmental Behavioral Pediatrics; Bright Futures Steering Committee; Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. *Pediatrics*. 2006; 118: 405-20
2. Blair M, Hall DMB. From health surveillance to health promotion: the changing focus in preventive children's services. *Archives of Diseases of Childhood*. 2006; 91: 730-735
3. Smith PK. Case Study: Blue Cross Blue Shield of Tennessee Stratifies Providers for High-Yield Results and BCAP Toolkit: Enhancing Child Development Services in Medicaid Managed Care (includes the experiences of 10 health care plans in a primary care case management program - that collaborated to develop best practices for enhancing child development services implementing early identification services. *Center for Health Care Strategies*, 2005 (<http://www.chcs.org/>)
4. Glascoe FP, Kundell S. How to Improve Patient Flow, Satisfaction, and Quality of Care. *Patient Care*. 2002; 36:77-80, 83-4
5. Oberklaid F, Goldfeld S, Moore T. Community based services and the needs of families: is there a mismatch? *Journal of Paediatrics & Child Health*. 2003; 39: 93-4
6. Young KT, Davis K, Schoen C, et al. Listening to parents. A national survey of parents with young children. *Archives of Pediatrics & Adolescent Medicine*. 1998; 152:255-262
7. National Center for Health Statistics, Department of Health and Human Services. 1994 National Health Interview Survey on Disability, Phase 1. *CD-ROM Series 10-8*. Hyattsville, MD: National Center for Health Statistics; 1996
8. Glascoe FP. Are over-referrals on developmental screening tests really a problem? *Archives of Pediatrics & Adolescent Medicine*. 2001; 155: 54-59

Developmental Surveillance and Screening Policy Statement Implementation Project: A Collaborative Effort Towards Practice Change

Upon publication of the July 2006 policy statement *Identifying Infants and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening*, the AAP, the Centers for Disease Control and Prevention (CDC), and the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration developed the Developmental Surveillance and Screening Policy Implementation Project (D-PIP) to test the feasibility of implementing the developmental surveillance and screening (DSS) algorithm. The recently completed project involved 17 diverse pediatric practices from across the United States, including community health centers, private practices, and academic medical center residency continuity clinics. The goals of the D-PIP were to determine how practical and realistic it was to implement the policy recommendations, specifically the algorithm, and to identify strategies used and barriers associated in implementation. Practice teams consisted of a pediatrician team leader and 2 office staff involved in the screening process (eg, nurse, office manager, etc). Practice teams developed an office system for DSS implementation including buy-in from practice leadership and staff, and continually made improvements in their efforts. A September 2007 workshop focused on opportunities for sustainability and spread, including working with chapters and nationally through the AAP's Medical Home Surveillance and Screening Program, a cooperative agreement with the National Center on Birth Defects and Developmental Disabilities at the CDC.

As part of the D-PIP, the participants will serve as "mentor" practices and offer guidance to other practices interested in implementing developmental screening. The mentor practices are:

- Alexandria-Lake Ridge Pediatrics (Alexandria, VA)
- Boys Town Pediatrics (Omaha, NE)
- Charter Oak Health Center at Connecticut Children's Medical Center (Hartford, CT)
- Children's Hospital of Pittsburgh Primary Care Center (Pittsburgh, PA)
- Hospital of Saint Raphael Pediatric Primary Care Center (New Haven, CT)
- Marshall University Pediatrics (Huntington, WV)
- North Arlington Pediatrics (Arlington Heights, IL)
- Ohio Pediatrics, Inc (Huber Heights, OH)
- The Children's Clinic (Long Beach, CA)
- The Kids Clinic (Lawrenceville, GA)
- Wishard Primary Care Center (Indianapolis, IN)
- Ypsilanti Health Center (Ypsilanti, MI)

Data was collected during this project to determine the practice changes that occurred with implementation of the new policy and to understand the modifications that allowed for successful implementation of DSS in the medical home. Results of the D-PIP are currently being analyzed, with planned dissemination of these findings over the coming year.

The 2006 DSS policy statement and the D-PIP represent new methods for collaborative policy development and implementation within the AAP. It is hoped that these efforts will improve the practice of DSS in the medical home and result in earlier and better identification of children with developmental disorders in order to provide them earlier intervention, and related medical and developmental evaluations and treatments.

For more information on the D-PIP, please visit <http://www.medicalhomeinfo.org/screening/DPIP.html> or contact Jill Ackermann at jackermann@aap.org.

