

Expanding Innovation through Networks: The Assuring Better Child Health and Development (ABCD) Project

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The North Carolina Assuring Better Child Health and Development (ABCD) Project began in 2000 with a grant from the Commonwealth Fund. North Carolina was one of four states that received a grant after responding to the request for proposal (RFP) sent to state Medicaid agencies to develop and enhance a program to provide child development services. Utilizing the infrastructure of the Community Care of North Carolina (CCNC) networks (then called Access II/III), the NC ABCD Project began as a quality improvement initiative, which was piloted in one network and then rapidly expanded to networks covering 11 counties by the third year of the grant, and, in the years since, has encompassed the entire state.

North Carolina ABCD History

The project developed a “best practice” comprehensive community model that had two components:

- Introduction and integration of a practical, standardized, and validated screening tool (Ages and Stages Questionnaire—ASQ) at selected well-child visits.
- Collaboration with local and state agency staff and families in developing this system for identifying and serving children.

Shortly after the practices began integrating the screening tool, a State Advisory Group was formed of representatives from key agencies who could assist with removal of administrative barriers and who could facilitate policy change. This group continues to meet quarterly, and this has enabled the project to be expanded and enhanced to include social-emotional screening, maternal depression screening, and autism screening. The Office of Rural Health and Community Care (ORHCC) has been the convener of this group. The advisory group includes representatives from ORHCC, Medicaid, North Carolina Pediatric Society, North Carolina Academy of Family Practice, Early Intervention Program (Part C), Interagency Coordinating Council (ICC), North Carolina Department of Public Instruction Preschool Services, Division of Public Health, Smart Start, and the Family Support Network.

To help practices integrate screening and referral successfully, an office systems approach was used. Multiple trainings of practice teams were provided by the ABCD work group with collaboration from the Early Intervention Program (Part C), the state ICC, Medicaid managed care consultants, the North Carolina Pediatric Society, and the North Carolina Academy of Family Practice. Practices were trained using the ABCD Getting Started Worksheet to follow steps to incorporate the process into their office flow and to network with their community partners to establish relationships and communication processes for referral and follow-up.

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In addition, the CCNC care managers were given additional training which prepared them to assist their network practices in linking families with community resources. They were also able to help practices with office processes.

Data on Outcomes Drives Policy Change

Data collection in the pilot networks was facilitated by care managers who served as early intervention coordinators for the period of the grant. Baseline data from the 1999 Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program audit was available for use as a comparison. In 1999 the rate of developmental screening throughout the North Carolina Medicaid systems (Access I, Access II/III, and HMO) averaged 15% for children by age two. After just one

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year, the rate was 70% in the pilot practices. These results led to policy changes, both in the Division of Public Health and the Medicaid program. Public Health (Child Health) transitioned clinics and community nursing to a menu of valid, standardized developmental screening tools in 2003. Medicaid changed EPSDT policy (Health Check) effective July 1, 2004, requiring a valid, standardized developmental screening tool when screening children at the 6, 12, 18, or 24 month visits and at the 3, 4, and 5 year visits. The ABCD work group published an article in *Pediatrics* in July 2006 describing the project, including details on the implementation of screening, referral, and follow-up in primary care practice which was accomplished through utilization of the CCNC infrastructure as a quality improvement initiative.¹

Replication, Spread, and Sustainability

Replication to other CCNC networks brought ABCD to 11 counties by 2003 (the end of the grant) and, after the 2004 policy change, it moved more rapidly with practice team trainings and distribution of a training DVD and workbook created by project staff. The ABCD Quality Improvement Group, consisting of CCNC network care managers, Medicaid managed care consultants, EPSDT staff, Smart Start ABCD coordinators, and ORHCC staff continues to meet quarterly to share strategies and discuss program enhancements. The Smart Start coordinators are in practices in 23 counties to assist with screening integration and linkage to community referral partners. They collaborate with the CCNC network care managers in those locations.

Currently, according to data from the EPSDT claims reporting, more than 90% of all primary care practices in North Carolina are doing developmental screening, and 84% of all appropriate EPSDT claims for children ages 0-5 years include developmental screening. Since 2004, when the 96110 billing code for screening was introduced, screens have increased from 50,000 in 2004 to 230,000 in 2008. Paralleling this trend, the referrals to Part C have likewise increased from 4,719 in 2003-2004 to 20,000 in 2007-2008. Referrals from physicians make up 35% of those referrals. Increasing the identification and referral of eligible children has been longtime goal of the North Carolina Part C program.

As the ABCD Project has continued to develop, adding screening for maternal depression, social-emotional development, and autism, it has contributed tools, processes, and strategies to the Mental Health Integration (co-location) Project for CCNC. It can also assist the Aged, Blind, and Disabled Project in understanding referrals and systems for children who have disabling conditions.

The ABCD Project has also been able to accomplish spread and sustainability by aligning its goals with those of Part C, the Department of Public Instruction Preschool Services, EPSDT, Smart Start, and the Family Support Network. As a result of these collaborations and participation on the ABCD State Advisory Group, the partners have endorsed a statewide

referral process and single-page referral form for primary care practice use, one for Part C and one for Part B. There is also agreement on the medical home needing to receive feedback on their referrals. The Kindergarten Health Assessment completed by the primary care provider for children entering public school now requires the results from the developmental and behavioral screening tool.

North Carolina as a Model for other States

The Commonwealth Fund awarded grants to five more states for ABCD II from 2003-2006. NC ABCD periodically provided consultation to these states. Then in 2006 the NC ABCD medical director and project director were offered a grant to provide technical assistance to five additional states (Colorado, Michigan, New Mexico, Oklahoma, and Rhode Island). As part of this Setting the Stage for Success Project, a state manual was developed for Medicaid agencies to work with primary care practices and early childhood agencies to implement screening, referral, and follow-up systems. In 2007 the Commonwealth Fund sponsored a multi-state Screening Academy for which the NC ABCD directors participated as part of the faculty. The North Carolina project is seen as a model for other states to replicate.

Lessons Learned

In all of these consultations with other states, the significance of the CCNC infrastructure emerged as a key factor in the success of ABCD in North Carolina. Three factors provided through CCNC stand out: 1) practices that have experience with quality improvement; 2) care coordination made possible through the network care managers; and 3) a culture of using data to drive best practice and improvement.

In the initial pilots, the practices involved were known to be "early adopters." They had already implemented quality improvement protocols for asthma and diabetes in their networks. They therefore had already become familiar with office systems strategies. ABCD was a prevention protocol rather than a disease management protocol, but the tools could be integrated similarly.

ABCD challenged practices to network with new community partners—Early Intervention (Part C), preschool programs including Head Start, child service coordinators (CSC) in Public Health, and the Family Support Network. These groups had some experience with networking, and the care managers often facilitated referrals and linkages for families. The ABCD referral study tracked 291 children who were referred for services between 2000 and 2002, and 95% made it to the referral due to the efforts of the care managers. Care managers were also learning about this array of services for young children, which they were able to incorporate into their other work with families.

Throughout the ABCD Project, data have been used to drive improvement and policy change. Practices have been

able to see their rates of screening and referral and to capture information on children who were referred. Through the Office of Rural Health and Community Care, claims data have provided information on the progress of the project with screening rates. Care managers enter data on children who have at-risk scores on the screening and record their management and follow-up into the management information system. In this way practices can know their referral rates and track whether and when children receive services.

The experience of ABCD has moved those practices who serve young children well on their way to meeting the criteria for a medical home. Use of parent-completed screening tools includes parents as experts on their children, making the care more family-centered (a key feature of the medical home). Practices have become more comprehensive in the care of

children at risk for developmental and behavioral problems and they have learned to coordinate care in the community.

All of the partners involved in the ABCD State Advisory and Quality Improvement Groups continue the work of ABCD as the ABCD enhancements (maternal depression screening, social-emotional screening, and autism screening) are spread statewide. ABCD and EPSDT are working together with Medicaid managed care consultants, network care managers, and Smart Start staff to monitor all of the preventive screening components of EPSDT—developmental and behavioral screening, vision screening, and hearing screening—and to give feedback and/or assistance to practices for screening, referral, and follow-up. The infrastructure of CCNC continues to be key for reaching out to practices and promoting community collaboration. **NCMJ**

REFERENCE

- 1 Earls MF, Hay SS. Setting the stage for success: implementation of developmental and behavioral screening and surveillance in primary care practice—the North Carolina Assuring Better Child Health and Development (ABCD) Project. *Pediatrics*. 2006;118(1):183-188.

Eat Smart, Move More Health Tip



Choose to Move More Every Day

Physical activity is essential for all of us. Children, adults and seniors can benefit from moderate activity every day. Take a walk with a friend, take the stairs instead of the elevator, or work in your yard. Dancing works too and is great fun! Thirty minutes or more of motion for adults and 60 minutes for children on most days can help keep you in shape and feeling good. Can't find a 30 minute chunk of time? Break it up throughout the day.

For more tips on how to move more every day where you live, learn, earn, play and pray, visit

www.EatSmartMoveMoreNC.com

