

The Importance of Routine Screening for Strengths and Risks in Primary Care of Children and Adolescents

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Providing a medical home for a child or adolescent and his or her family means establishing a longitudinal relationship between the primary care clinician (PCC) and the family. PCC's, by implementing routine screening and surveillance, have the opportunity at every encounter with the family to promote healthy development—motor, language, cognitive, and social-emotional.

Providers of primary health care for children have long recognized the importance of developmental screening and surveillance in helping families to optimize a child's acquisition of skills, to understand the child's behavior, and to facilitate learning. For young children who have developmental differences or delays, screening provides the opportunity for early identification and referral for intervention. From the time a child starts school through adolescence, screening promotes earlier identification of learning problems, behavior problems, and social-emotional or mental health issues—before these reach crisis level. For young people of all ages, screening, discussion, referral, and follow-up help maintain and enhance patient and family function.

Clinicians who care for children and adolescents have the opportunity at every encounter with the family to promote healthy motor, language, cognitive, and social-emotional development. The promotion of healthy development is a central emphasis of Bright Futures, a national initiative of the American Academy of Pediatrics (AAP) [1]. Bright Futures health promotion themes include family support, child development, and mental health.

When the family has a medical home, promotion of healthy development begins as early as the prenatal visit and continues throughout the longitudinal relationship that the primary care clinician (PCC) has with the child and family [2]. That longitudinal relationship is a key component of the "primary care advantage" described in the AAP policy statement regarding mental health competencies for pediatric primary care [3]. It is a dynamic relationship that engages parents as partners in the care of their child. This engagement begins early—with elicitation of strengths and weaknesses and screening for risk factors—and supports

and communicates an openness to discussion about concerns or issues as they arise.

From the beginning of well-child care, the PCC's relationship with the family is built on communication about the whole child, within the context of the family and the community (child care, school, etc). The PCC screens for psychosocial risks and strengths, and for the child's developmental and social-emotional skills. Screening is not a one-time event, but is done periodically over the course of the relationship (surveillance), building on the communication exchange.

Search Institute provides good information regarding family assets that optimize success and regarding factors that put children and families at risk [4]. Awareness of these allows for early recognition and early intervention, and for prevention of unwanted outcomes. Routine discussion of assets and risks is an essential promotional and preventive strategy. Opportunities for promotion and prevention in primary care practice are provided by prenatal visits, psychosocial screening (including screening for postpartum depression), developmental and behavioral screening and surveillance, and social-emotional and mental health screening for children and adolescents at risk.

The use of routine standardized screening tools at recommended intervals enhances surveillance and improves the ability to identify risk early. PCCs utilize the "primary care advantage" to partner with the family, providing assessment, encouragement, and support, linking them to resources, making referrals if necessary, and communicating and collaborating with specialists, schools, and other providers in the care of the child or adolescent.

Routine, formalized screening done periodically over the course of the PCC-family relationship is effective for identifying risk, for recognizing strengths and progress, and for maximizing developmental and behavioral health. When screening tools are parent-completed, it engages them as

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North Carolina's Health Check Program

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The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) provisions of the Social Security Act [1] define Medicaid's package of health benefits for beneficiaries under 21 years of age. Medicaid covers 35% of all children, and more than 60% of poor children nationwide. Through the EPSDT benefit, Medicaid has played a critical role in improving the health of our nation's low-income children. Under federal EPSDT requirements, states must provide outreach to children with actual or potential health problems; ensure the availability of health and developmental assessments and of vision, dental, and hearing services; and ensure that medically necessary treatments are available to children.

Health Check is North Carolina's comprehensive Medicaid well-child benefit. The goal of Health Check's prevention-oriented services is the early identification and treatment of conditions that can adversely impact children's healthy growth and development.

Low-income children are more likely to be born at a low birthweight, which is a significant risk factor for poor health over a lifetime. Impoverished children are more likely to be in fair or poor health, to experience significant environmental and interpersonal stress, to have problems with nutrition, to develop chronic medical conditions, and to suffer developmental delays or learning challenges [2]. For these children, early screening and intervention are essential, and these services are supported by North Carolina's Health Check Program.

Bright Futures' recommendations for preventive pediatric health care [3] are theory- and evidence-based guidelines specifying the content of such care and the intervals at which it should be offered. Providers are advised to perform basic psychosocial and behavioral assessments as well as developmental surveillance at all well-child preventive care visits. North Carolina's Health

Check program currently covers the preventive care services outlined in these Bright Futures recommendations and has been a national leader in implementing bundled rates for financing this menu of comprehensive wellness services.

Pediatric Preventive Care Challenges in North Carolina

All states are required to report their rates of participation in preventive services annually to the federal government's agency for Medicaid administration, the Center for Medicaid and Medicare Services (CMS). In North Carolina in federal fiscal year 2011, based on claims paid, 96% of Medicaid-eligible children younger than 1 year of age received screening and preventive care as recommended by Bright Futures. In 2011 only 84% of North Carolina children were still receiving all of the recommended care by the end of their second year of life, and by the end of their fifth year of life, only 75% were doing so [4].

School systems require vaccinations for enrollment, and parents demonstrate high rates of compliance with those requirements to ensure their children's participation in public education. After age 6 years, participation in wellness visits declines significantly, suggesting that parental burden and the incidence of childhood illness, rather than a wellness focus, have begun to drive frequency of visits to primary care providers. In 2011, North Carolina's wellness-visit participation rate for Medicaid-eligible children aged 6-14 years was reported to CMS as 45%. For children aged 15-18 years, the reported rate was 33% [4].

Preadolescence is a time of rapid social and emotional growth, when health attitudes and a sense of personal responsibility and empowerment take shape. This stage of growth is ripe with teachable moments. A predisposition to value relationships with mentors and helping profes-

experts on their child and helps make screening feasible in a busy practice. Also, adolescents may self-report, using screening tools that give them an opportunity to discuss their strengths and concerns. Screening is optimized by surveillance, because periodic screening gives a longitudinal perspective on developmental progress.

The need for screening and surveillance is consistent with what we know about development prenatally and thereafter: that experience has a significant impact on brain development (neurogenesis, cell migration, synapse formation, and remodeling); that growth, development, and behavior are inextricably linked; and that emotional development occurs in the context of relationship. Recent understanding of brain development has highlighted the importance of social-emotional development for language, memory, and cognitive skills. Experience affects brain development, both prenatally and postnatally. The implications for prevention and inter-

vention are profound. Therefore, screening is most effective when the whole child is considered. If practice "separates the head from the body," care is fragmented and crucial linkages may be missed.

Because children and adolescents develop in the context of the family, screening and surveillance also involve helping families build on strengths and minimize the impact of risk factors. Factors that increase risk for developmental, behavioral, and social-emotional problems include poverty, maternal depression, domestic violence, and substance abuse. Routinely and periodically asking parents and adolescents about these issues invites nonstigmatizing discussion and support, and it conveys the message that any of these issues can be brought up at another time as well. A conversation about the screening identifies the child's strengths and weaknesses, gives a template for anticipatory guidance, and elicits and respects parental concerns. In this

sionals can be nurtured and enhanced during this developmental period.

The experience of personal health is the outcome of biological, psychological, and social factors. The presence of supportive mentors and teachers is critical if children are to build a foundation of health awareness and positive health attitudes that maintain well-being. Primary care providers offer exceptional human value in their important mentoring relationships with growing children. The dedicated and conscientious participation of primary care providers is a cornerstone of support for the learning and internalization of good health habits. Providers cannot accomplish this alone, however. The challenge of raising health-conscious children will require the commitment, enthusiasm, and coordinated efforts of an entire community of caring people.

Outreach to Preadolescent and Adolescent Populations

Statewide outreach to underserved and at-risk populations is a critical element of Medicaid's EPSDT program and integral to NC Health Check. The North Carolina Division of Public Health encourages highest-risk children and families to seek thorough health care. The North Carolina Division of Social Services informs families of the availability of critical health services and provides logistic support. Through contracts with North Carolina Community Care Networks, there are more than 60 local Health Check outreach coordinators throughout the state. Currently, their primary task is follow-up contact with children who have missed well-child appointments or have failed to schedule them.

Health Check has a unique opportunity to re-envision its strategies of outreach. Using the power of North Carolina's Children's Health Insurance Program Reauthorization Act (CHIPRA) quality demonstration grant, Health Check can carefully craft its future interventions to focus on the highest-risk subpopulations of Medicaid enrollees, while also ensuring that all beneficiaries receive appropriate and timely information on preventive services. Health Check is studying carefully model programs of outreach

to high-risk young people that are being implemented across the country, highlighting use of electronic media, local leaders, grandparents, schools, key arts and entertainment personalities, sports professionals, medical experts, and influential peer groups. North Carolina's Health Check Program and the North Carolina Community Care Networks are in the beginning stages of evaluating their current outreach efforts and are considering these model programs in other places for implementation in North Carolina. NCMJ

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way, parental self-efficacy and confidence is promoted. The sharing of age-appropriate books from an early age should be encouraged, because it has benefits for the parent-child relationship, develops language skills, and facilitates success in mastering early reading skills. Children with at-risk scores on screening measures should be referred to early-intervention services. For a parent whose child has a medical condition or developmental problem, a connection to a family support network can provide parent-to-parent support.

It is the PCC's role to elicit strengths and concerns. From an early age the child should participate in reporting his or her strengths and concerns. This builds the relationship with the child and prepares well for communication between the PCC and the adolescent. When social-emotional, behavioral, or mental health concerns are voiced, the AAP Task Force on Mental Health recommends employing a "com-

mon factors" approach and using motivational interviewing skills to engage the family in developing a plan for addressing the issue together and considering follow-up and referral if necessary [5, 6]. A common factors approach consists of techniques used to increase patients' optimism, feelings of well-being, and willingness to work toward improvement, regardless of the specific diagnosis or problem identified (for example, finding agreement on healthy activities/practices such as exercise, time outdoors, limits on media, balanced and consistent diet, sleep, one-on-one time with parents, reinforcement of strengths, open communication, pro-social peers).

The PCC does not need to become an expert at diagnosing and managing developmental and behavioral disorders or to become a mental health professional. Rather, the PCC has the role of sounding board, partner in finding information, facilitator to negotiate the system, resource for

Surveillance for Behavioral Health Problems and Developmental Disabilities in Pediatric Primary Care

Emma J. Miller

The Bright Futures initiative of the American Academy of Pediatrics (AAP) promotes the provision of health, developmental, and preventive services to address children's health needs in the context of family and community [1]. Social workers trained in integrated care can contribute to pediatric and family practices and help provide surveillance for a range of issues that place children and their families at risk. Social workers with training in infant mental health can better help behavioral health teams implement Bright Futures recommendations in the early years when surveillance is more frequent.

Both medical and nonmedical community agencies are involved in addressing the developmental context for children and youth with mental health problems and in providing assistance. Primary care practices and agencies providing educational instruction, early intervention, child mental health and substance abuse services, juvenile justice services, social services, and family education and support can help when caregivers and families are overwhelmed by many challenges. Therefore, a multidisciplinary approach is required because the issues and the interventions called for are often beyond the scope and expertise of a single discipline or practice or agency.

At the present time, there is movement toward an interdisciplinary approach via the integration of behavioral health with primary care. Earls and Spring [2] list the following as benefits of an integrated model of pediatric primary and behavioral health care: stigma reduction; family convenience; better communication between the primary care provider and the mental health provider, with opportunities to encourage therapeutic goals; improved adherence to treatment; and opportunities for the primary care provider and the mental health provider to learn from one another.

Collins and colleagues [3] foresee that administrative and service delivery structures will be streamlined in the name of cost containment and quality improvement. In their view, the coming decade will bring an opportunity to redesign primary care and mental health care so that they are delivered in a "holistic and patient-centered manner, using an integrated approach that is able to meet the full spectrum of a patient's physical and behavioral health care needs" [3]. Social workers integrated into primary pediatric practices can partner with families of children at every age to prevent problems and provide early intervention.

The 30-year-old field of infant mental health is multidisciplinary and has produced information applicable to a variety of health care settings. According to Zeanah and colleagues, unique features of infant mental health care include its "multidisciplinary nature, developmental orientation, multigenerational focus, and emphasis on prevention" [4].

Both infant mental health care and pediatric care recognize that parents and families play a pivotal role in the lives of children and have therefore adopted a 2-generational model of care. According to the AAP, "the health and well-being of children are inextricably linked to their parents' physical, emotional and social health, social circumstances, and child-rearing practices" [5]. The AAP also points out that "when a family's distress finds its voice in a child's symptoms, pediatricians are often parents' first source for help" [5]. This is true not just of pediatricians but of other primary care providers as well, especially when the practice serves as a medical home and provides periodic health supervision that engenders trust in the medical professionals and social workers who have established a

referrals for further assessment and interventions, and co-manager of care with other specialists. If the practice has integrated a mental health professional (eg, a licensed clinical social worker or a licensed professional counselor) into the medical home team, the PCC can do a "warm handoff" during the same visit when a screen is positive for a social-emotional, behavioral, or psychosocial issue.

Anticipatory guidance that addresses these issues in a timely fashion and an atmosphere of openness to parental concerns are tools that a PCC can use to promote success. Using well-child care visits to focus on the child in the family, employing screening tools, and making the discussion of sometimes uncomfortable topics a matter of routine will establish the practice as a resource for information, support, referral, and connection to other community providers.

Community Care of North Carolina (CCNC), which consists of 14 regional community care networks serving low-income children and adults, has facilitated wide-

spread implementation of screening for developmental and behavioral issues through several quality initiatives. These include the Assuring Better Child Health and Development (ABCD) program, 2 initiatives for mental health integration in primary care, the establishment of behavioral teams in every network, and Medical Home Learning Collaboratives funded through the North Carolina's Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant.

The ABCD program began in 2000. North Carolina was in the first group of states to receive funding from The Commonwealth Fund to promote the provision of developmental services in primary care for the period of early childhood. The CCNC infrastructure facilitated piloting and spread of the ABCD program, so statewide implementation was well on its way in just a few years [7, 8]. In 2007, North Carolina led the nation in rates of developmental and behavioral screening for children 0-5 years of age [9]. As a result

relationship with the family.

Anticipatory guidance is an element of medical homes under comprehensive care, and Bright Futures offers recommendations regarding what the content of such guidance should be and when it should be offered [6]. The Michigan Association of Infant Mental Health takes an approach similar to that of Bright Futures, saying that infant mental health interventions are “designed to support children and families within the context of relationships and communities” (7).

In their webinar on primary and behavioral health integration in pediatrics [2], Earls and Spring identify 4 opportunities for health promotion and prevention in primary care: the prenatal visit, psychosocial and maternal depression screening, developmental and behavioral screening and surveillance, and social/emotional screening for children identified as being at risk. Such opportunities are also present during office visits for preventive care. Establishing surveillance in the workflow of a medical practice helps a family understand, from infancy onwards, that regular monitoring of health and development is a usual part of care. Clinical social workers with training in infant mental health can assist practices, making possible greater parent satisfaction and ensuring appropriate surveillance in the younger years and beyond. This redistribution of surveillance responsibilities eases providers’ time constraints, and provides opportunities for the clinical social workers to provide assessment, diagnosis, and treatment should mental health or substance abuse problems become apparent.

The AAP Report of the Task Force on the Family [5] acknowledges that some primary care providers may not be willing or ready “to provide care that considers and encompasses the family.” Barriers cited include lack of the following: training, experience, referral networks, reimbursement, and time. Social workers can be a solution, because they can coordinate services, link the family to community resources, and mediate feedback from those community resources to the primary care provider. NCMJ

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of ABCD, children with developmental needs are identified earlier. Referrals to CCNC’s Early Intervention Program are on average made at an earlier age and have more than quintupled since 2004. Since 2010, routine screening for autism at the 18-month and 24-month well-child visits has been incorporated into the ABCD Project.

But early screening is not just about finding problems. An equally important benefit is that discussion of screening between parents and the PCC supports parents in developing parenting skills, promotes child and family strengths, and enhances parents’ understanding of healthy development. With better understanding of development, parents report better ability to manage their child’s behavior and to have appropriate expectations.

Medical practices that are involved in the Medical Home Learning Collaboratives as part of CHIPRA are focusing on developmental services and behavioral, social-emotional, and mental health services for patients 0-20 years of age

and their families. They are using routine screening and, very importantly, are building systems in their practices and networks for communication, referral, and linkages to community resources. They have implemented processes in their practices to use screening tools for postpartum depression and for assessment of developmental concerns, strengths, and risks for school-age and adolescent patients, in addition to the ABCD screening they were already doing. They have developed relationships with other professionals in order to co-manage care for Children and Youth with Special Health Care Needs (CYSHCN).

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is the federal regulatory guideline that lists all the medically necessary health care services that Medicaid must provide to Medicaid-eligible children. EPSDT has general requirements for a comprehensive health and developmental history, a physical health development assessment, and a mental health development assessment. States may be more

or less specific about these requirements. NC Health Check (NC EPSDT), in accordance with Bright Futures (periodicity schedule and guidelines from the American Academy of Pediatrics for preventive care), requires general developmental and behavioral screening at specified well-child visits for ages 0-5 years, as well as routine autism screening at the 18-month and 24-month visits. In addition, routine screening of social-emotional development and mental health risk is recommended for school-age children and adolescents. A few years ago, Health Check recognized the need for annual preventive visits for these latter 2 populations and changed the EPSDT periodicity schedule to reflect this. More recently, Health Check has added recommendations for screening school-age children and adolescents for strengths and risks. CCNC quality measures now include an EPSDT Profile that reports quarterly data on EPSDT screening components and on the EPSDT rates themselves. These Quality Measures and Feedback (QMAF) indicators have been expanded to include not only rates for well visits, dental visits, and dental varnishing, but also rates for EPSDT components such as body mass index, vision, and hearing, and rates for ABCD screening, autism screening, and screening for school-age children and adolescents.

In summary, screening and surveillance need to be a regular part of well-child care. Growth, development, and behavior are inextricably linked. Using parent-completed and patient-completed questionnaires from the beginning of the family-PCC relationship includes parents as experts on their child and provides the basis for the establishment of the medical home for the child and family. Finally, in linking family, medical practice, and community, collaborative relationships among providers in the community constitute best practice. In North Carolina, both CCNC and Health Check have embraced these principles and supported their integration into primary care. That said, there is still considerable work to be done in assuring that these services occur reli-

ably in all practices that serve children and adolescents, and in promoting families' knowledge of and request for these services. **NCMJ**

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