

# 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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### References

1. Social Security Act §1905, 42 USC §1396d (2008).
2. Dang BN, Van Dressel L, Hanke J, Hilliard MA. Birth outcomes among low-income women—documented and undocumented. *Perm J*. 2011;15(2):39-43. <http://www.thepermanentejournal.org/issues/2011/spring/731-birth-outcomes.html>. Accessed October 14, 2012.
3. Bright Futures, American Academy of Pediatrics. Recommendations for Preventive Pediatric Health Care. American Academy of Pediatrics Web site. 2008. <http://www.aap.org/en-us/search/pages/results.aspx?k=Recommendations%20for%20Preventive%20Pediatric%20Health%20Care>. Accessed October 30, 2012.
4. Division of Medical Assistance, North Carolina Department of Health and Human Services. North Carolina Title XIX, as of date: 03/31/2012. <http://www.ncdhhs.gov/dma/healthcheck/CMS-416FY1011.pdf>. Accessed January 17, 2013.

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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