Engage Physicians, Ensure Screening, and Enhance Sustainability

Evaluation Report

December 2013

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Help Me Grow

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Introduction

In 2013, Help Me Grow Orange County (HMG) received a grant from the Nicholas Endowment to engage physicians, increase the number of physician practices that routinely screen for developmental delays using standardized developmental screening tools, and encourage billing for developmental screens as a way to pay for the service. Another goal of the project was to determine the feasibility of creating a fee-for service screening support service that could be implemented by HMG.

The project began in January 2013 with the recruitment of physician practices and ended in December 2013 with the completion of this evaluation report. Despite the short duration, it was enough time to learn some of the challenges and successes with making developmental screening a routine part of physician practices and billing for the service. This report will provide both quantitative and qualitative information on

- How many children were screened and the results of the screening
- How many screens were submitted for payment to insurers
- How successful the practices were in receiving payment
- How many children were referred for additional assessment or intervention services
- Descriptions of the challenges the physician practices had in implementing routine screening and receiving payment from insurers

Methodology

From January through March, the HMG Manager and HMG Educating Providers in the Community (EPIC) Coordinator, who is responsible for outreach and training to physician practices, contacted 16 physician practices by phone or in person to invite them to participate in this project. An informational handout was provided to offices to help them understand the project and what their commitment would be. HMG specifically looked for physician practices that had a variety of insurance payers and were not already screening for developmental delays. Because recruitment took place during cold and flu season, it was difficult to get physician offices to respond to inquiries. Three were not interested because they were already using the Ages and Stages Questionnaire (ASQ); two expressed initial interest but then decided they were too busy to participate. By the end of March, four practices had committed to participating in the project and agreed to the Understanding of Responsibilities (see attachment) about their participation. Responsibilities included conducting developmental screening using a standardized tool and coordinating with HMG

to collect, score, and interpret results; submitting claims to the child's insurance carrier for payment; providing payer source and reimbursement information to HMG, and participating in an end-of-project interview with HMG's evaluator.

The four practices recruited for this project are identified as Practice A, B, C, or D to maintain their anonymity. In interviews, the practices indicated they were interested in participating because they were aware of the American Academy of Pediatrics recommendation to include developmental screening as a routine part of well-child checkups. Some noted that they had attended Help Me Grow presentations on developmental screening in the past and were interested in implementing this best practice. One physician hoped that being part of a project might make it easier to convince other physicians in the practice to start using a standardized screening tool. All said they asked questions about the child's development as part of well-child check-ups, but this was a way to formalize the screening. Each participating practice is described below.

Practice A is located in Tustin. It has 9 pediatricians and had used the M-CHAT to screen for autism prior to participating in this project, but had not used an evidence-based tool for developmental screening. Their payer mix is 40% PPO, 30% CalOptima; and 30% HMO.

Practice B operates in Santa Ana with one pediatrician who had used the PEDS screening tool in the past, but was not using a standardized tool when this project began. This office had used the M-CHAT to screen for autism. Nearly all the patients qualify for CalOptima.

Practice C is located in Mission Viejo. This practice has 2 pediatricians and 1 nurse practitioner. They use the M-CHAT to screen for autism at 18-months, but were not conducting routine developmental screening using an evidence-based tool before this project began. Their payer mix is 70-80% PPO and 20-30% HMO.

Practice D has its office in Anaheim Hills, with 5 pediatricians and 1 nurse practitioner. Prior to this project, they were using the Denver Developmental Screening Test, which has low to moderate sensitivity and has not been validated. Their payer mix is 70% PPO, 25% HMO, and 5% CalOptima. This practice ultimately did not implement the ASQ.

Each practice was provided training by the EPIC Coordinator on how to administer, score, and interpret the Ages and Stages Questionnaire, which was to be used by all four practices. Each practice received an ASQ kit, which includes the parent questionnaires, users guide, and activity sheets that are used in completing the screening.

The HMG EPIC Coordinator kept a log of her contacts with the physician practices, which documented the efforts to recruit and assist the practices with implementation of the project. Billing information was provided by three of the participating practices. Practice D was not asked to provide billing information because it never used the ASQ or PEDS for developmental screening. In addition, CHOC Children's Primary Care Services, which has used the PEDS developmental screening tool and the M-CHAT for several years, provided billing information for this project, but did not participate in other aspects of the project.

The American Academy of Pediatrics recommends routine developmental screening of children at their 9- 18- and 24 or 30-month well-child checkups. There are ASQ questionnaires for 21 different age intervals from 1 month to 66 months (5 ½ years). The age interval of the questionnaire was recorded for each completed screen.

Practice B implemented the ASQ in April; Practices A and C went live in May. Practice D completed the training and participated in the end-of-project interview, but did not implement the ASQ.

The ASQ is a questionnaire that is typically completed by parents. Practices B and C handed the questionnaire to parents when they brought their child to their 9- 18- 24- or 30-month well-child checkup. Parents then completed the questionnaire in the waiting room and/or the examination room. Practice A emailed the ASQ to the parents a week before the child's appointment. About a third of the parents printed the questionnaire out and completed it prior to the visit. The other two-thirds were provided the questionnaire when they arrived for the appointment. Both Practices A and B commented on the added chaos when the parent complete the questionnaire in the office, especially if they had other children with them and had low literacy.

Practices A and C scored the ASQ in their offices using their own staff and provided the screening results and referral/follow-up information to HMG by fax. Practice B had HMG pick up the completed questionnaires for HMG to score, provide results to the parents, and make referrals if needed. In this case, both the scores and referral information were provided back to the office.

The HMG Evaluator met with the four physician practices towards the end of the project to conduct a half-hour interview and learn more about their experiences with implementing and billing for the ASQ as well as their plans to continue routine screening once the project is complete.

Results

Training

At total of 8 physicians/nurse practitioners and 21 medical office staff were trained on how to administer, score and interpret the ASQ.

Table 1. Number of Individuals Trained to Administer the ASQ

	Physicians/NPs	Medical Assistants/Admin
Practice A	0	8
Practice B	2	3
Practice C	4	5
Practice D	2	5
TOTAL	8	21

Screening

From the time the practices began screening in April or May through November, when data collection ended, the three participating practices screened 593 children. Table 2 shows the number and percent of screens conducted at or near the recommended intervals. Of those conducted at 12 months or less, 76% were conducted at exactly 9 months; of those from 14-20 months, 86% were at the 18-month interval; and 81% of the 22-42 month screens were at 24, 27, or 30 months.

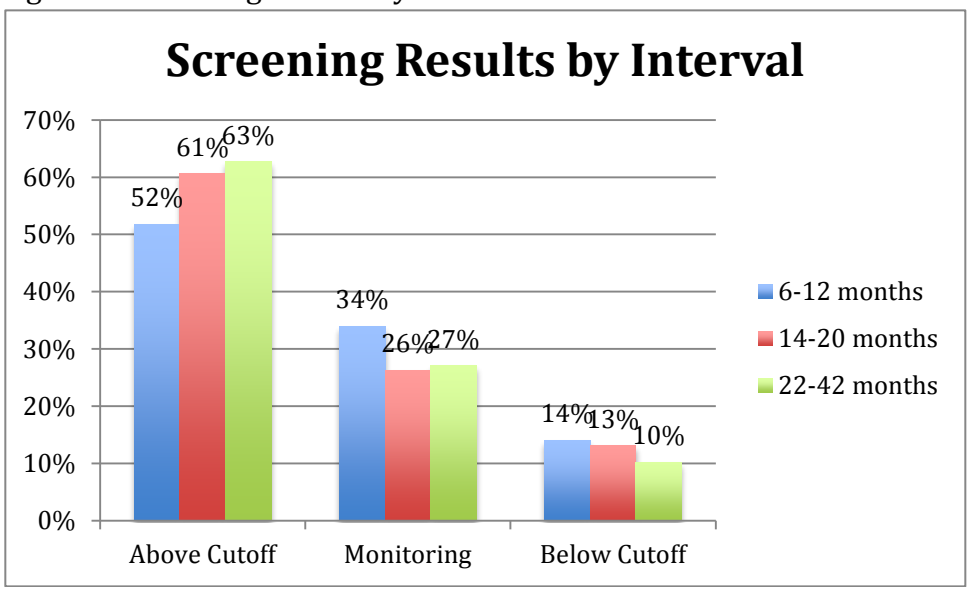
Table 2. Number of Screens Conducted by ASQ Interval

Interval	**Number**	**Percent of all screens**
12 months or younger	191	32.2%
14-20 months	236	39.8%
22-42 months	166	28.0%
TOTAL	593	100%

Each ASQ provides a result of Above Cutoff, Monitoring, or Below Cutoff in five domains – Communication, Gross Motor, Fine Motor, Problem Solving, and Personal/Social. Results were recorded by whatever the lowest score was in any of the five domains, so if the child was Above Cutoff in four areas, but Monitoring in one area, the result was recorded as Monitoring. A total of 346 children (58.3%) scored Above Cutoff in all five areas of the ASQ; 172 (29.0%) were in the Monitoring range in at least one domain; 75 (12.6%) had at least one area that scored Below Cutoff.

Figure 1 shows the screening results by child's age. Fewer children in the 6-12 month range scored Above Cutoff than at later ages. The youngest children also were more likely to have at least one area in the Monitoring range.

Figure 1. Screening Results by Interval



There were differences among the three practices in terms of the number of children screened, the percentages of children screened by interval, and in the results. Practice A had the largest number of pediatricians participating in the project and completed 491 screens. Practice B had just one physician participating and completed 60 screens. Practice C has two pediatricians and completed 43 screens during the project period.

Figure 2. Percent of Screens Completed at each Interval by Practice

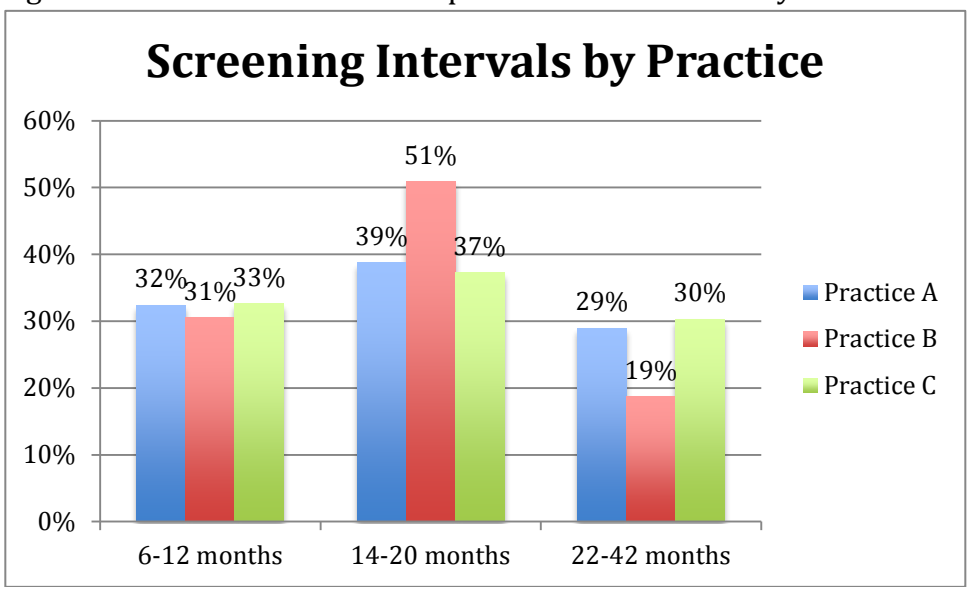
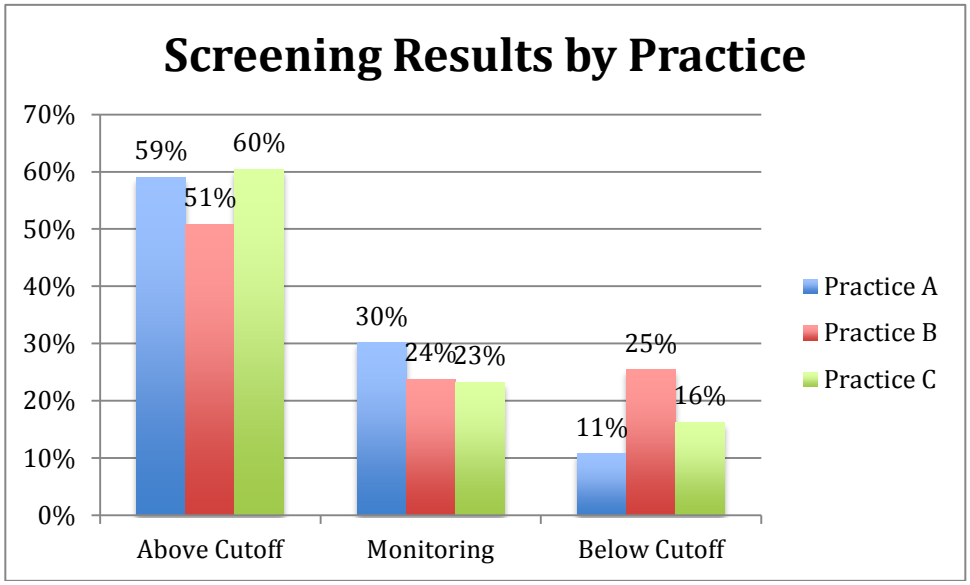


Figure 3. Percent of Screens Above Cutoff, Monitoring, or Below Cutoff by Practice



As seen in Figure 2, Practice B completed a larger percentage of screens around the 18-month interval and fewer at the 24-30-month interval. It is unclear why this occurred. Practice B also had a larger percentage of children score in the Below Cutoff range (Figure 3). This could have occurred because they did not score the ASQs in the medical office, so there was no opportunity to immediately ask the parent about how the ASQ was completed and to re-score the ASQ if there were errors in completing the questionnaire (see the last paragraph of this section). It also could be related to the patient population, which is nearly all low-income and Spanish-speaking.

During the interviews, the physicians had mixed opinions about whether the ASQ had identified concerns that they would not have found otherwise. Practice A felt there were no instances when the ASQ found something they were not already aware of. Practice C thought there were a few cases, but not many. On the other hand, Practice B said there were a number of times when the ASQ uncovered delays that the parent had not reported. This physician said this typically happened with first-time mothers who did not know what typical development was for their child's age and did not know enough to report or be concerned about the child's progress or shortfalls. "Some of the mothers didn't know what their children should be doing, so they wouldn't bring up delays. Sometimes parents are clueless. They don't even know to bring up the problem."

Both Practice A and C questioned the validity of the 9-month ASQ, saying they thought it identified too many kids as having a potential delay. The physician at Practice C specifically questioned the validity of testing Problem Solving in 9-month olds.

Practices A, B, and C all commented on the additional time it took office staff to implement the ASQ, including time to copy the questionnaires, identify which children with appointments were due for the ASQ, and score the tool. Practice A noted the additional

cost to print the forms when the parents did not print it at home. For Practice A, which emailed the questionnaire to the parents before their appointment, the workflow challenges to identify which children were due before appointment day were especially acute. However, Practice A also noted that when parents brought the completed form to the appointment, it made the time with the pediatrician quicker and more efficient because all the developmental questions had already been asked and answered.

Although the instructions tell parents to leave questions unanswered if they don't know the answer, Practice A found that parents often answered all the questions, even when they weren't sure of the answer. When this occurred, it led to additional time discussing the responses with the parents and rescoring the results to correct for the initial error. Practices B and C said they did not have this problem. However, the HMG Developmental Screening Coordinator, who scored the ASQs for Practice B and then contacted the parents directly if a referral was indicated, said one of the reasons parents did not need a referral was that they had completed the questionnaire incorrectly and the child had more skills than the screening showed.

Referrals

A total of 39 children received referrals and another 7 were already receiving services at the time of the screening. Of the children provided a referral, 1 scored Above Cutoff on all five domains; 16 had at least one area in the Monitoring zone; and 22 had at least one score in the Below Cutoff range. In interviews, physicians indicated they often responded to scores of Monitoring or those just into the Below Cutoff range by providing the parents with age-appropriate activity sheets from the ASQ Kit. Depending on the severity and nature of the concern, the practices also made referrals to HMG, the Regional Center, or other providers.

One practice noted that older physicians were less likely to make a referral based on the result of the ASQ, basing their decision more on their years of experience than the results of a screening tool. "It didn't change behavior of our docs and get them to buy-in to developmental screening. The ones who were Below Cutoff and nothing was done, half of them belonged to one doctor. It's a generational thing. The younger doctors agree that you've got to screen – it's so ingrained – that there should be early intervention."

HMG's Developmental Screening Coordinator indicated there are several other reasons a child may not have received a referral, including 1) inability to contact the parent; 2) the parent was not concerned and did not want a referral; 3) the child had gained skills since completing the ASQ so there were no longer any concerns; and 4) the child was already receiving services.

Billing and Payment

Practices A, B, and C all submitted bills to children's insurers using the 96110 billing code for developmental screening. None of the practices had any difficulty submitting bills for developmental screens. All three practices said they did not receive payment if the child was enrolled in a capitated insurance plan, such as an HMO or CalOptima. Fee-for-service Preferred Provider Organizations (PPOs) were much more likely to provide payment. Practice A charged $50 per screen and received $10.06 on average when they were paid for a developmental screen (with a range of $6.12 to $15.65). Over the course of the project, Practice A received a total of $1,840.83 for the 491 screens they completed. Practice C charged about $70 per screen and received $6 to $10 per screen; the total amount received was not available. Practice B did not report billing information because nearly all their children are in a capitated payment system and they received no additional payment.

Practice A noted that when the insurance companies denied payment, they would appeal. They won on appeal at least twice, but were denied about 20 times. When they lost on appeal, the insurance would then make it a patient responsibility and then the practice would bundle it in as a non-covered benefit rather than have the parent pay.

CHOC Children's Primary Care Services provided billing information for 1791 PEDS (Parents' Evaluation of Developmental Status) screens that were conducted from January 1 through October 31, 2013. They charged $22 for each screen. Table 3 shows how many screens were paid by insurers and how many were not, as well as the average payment amount.

Table 3. Payment by Screening Type at CHOC Children's Primary Care Services

Screening Type	Number	Percent	Avg. payment amt.
PEDS – no payment received	1776	99.2%	
PEDS – payment received	15	0.8%	$20.40

Of the screens for which CHOC Children's received payment, all 15 of the screens were in a capitated plan. On average, it took CHOC Children's 59 days to receive payment for the PEDS.

All the practices commented on their frustrations with the lack of additional payment from capitated plans and the low payment from fee-for-service insurers. One noted that under the capitated plans, "we don't get any more money for doing it. If an office wants to cut corners, they don't use developmental screens. In an HMO, doctors have to see maybe 6-8 patients an hour. You can't do a developmental screen in that amount of time. You have to do everything else in that time." Another said about capitated plans: "The well-child checkup is paid the same amount whether the screening is done or not – and the screening is not required. There's no pay for performance; no bonus for doing developmental screening. And if you generate more referrals, you risk looking like you are referring too much."

The practices also said the amount they receive from fee-for-service plans was generally not enough to cover their additional costs. This was especially true for Practice A, which spent more time distributing the ASQ in advance of the child's appointment.

Will the Practices Continue Screening?

Three of the four practices expressed a strong desire to continue screening. Practice A was uncertain whether they would continue, given the low reimbursement rates and the time it took to implement. Practice B was concerned about the cost and time of having staff score the ASQ, but definitely want to continue using it, even though they do not receive additional reimbursement. Practice C felt that by offering the ASQ, parents would perceive them as offering the best service – that it is good for public relations and marketing. This physician seemed indifferent about the reimbursement rates, feeling that anything was better than nothing, and it would not influence the decision to continue. Practice D, which never implemented the ASQ, plans to continue using the Denver, as they have for over 10 years.

Other Comments from the Practices

All four practices appreciated the support of HMG in implementing the ASQ and as a referral resource for their families.

In additional comments:

Practice A found that the ASQ helped parents learn what types of things their child should be doing at certain ages. They did not find that the ASQ raised undue concerns among the parents. When parents completed the ASQ correctly in advance and the child was Above Cutoff, there was more time during the office visit to talk about safety and nutrition.

Practice B commented that the ASQ was easier for parents to complete than the M-CHAT, especially for parents who spoke primarily Spanish and had low literacy. This physician appreciated the comprehensive nature of the ASQ.

Practice C noted that using a standardized test – either the ASQ or M-CHAT – helped when communicating the results to the parent. When the pediatrician recommended a referral, it wasn't just because HE thought there might be a problem, it was because the screening results indicated a potential concern. It made it harder for the parent to refute the pediatrician.

Practice D was concerned that implementing the ASQ would unnecessarily raise concerns among parents about their child's development and that parents would request referrals even when no referral was warranted. They also were concerned about the length of time it takes parents to complete the ASQ.

Summary

Three physician practices began using the ASQ as a routine part of well-child checkups as a result of this project and 593 children were screened at the recommended intervals. Twenty-nine physicians and medical office staff were trained on implementing the ASQ.

Just over 58% of children screened in the Above Cutoff range, meaning there were no developmental concerns; 29% had at least one area that fell in the Monitoring range; just under 13% were in the Below Cutoff range in at least one domain.

There were differences in the screening results among the three practices (Practice B had a greater percentage of children in the Below Cutoff range) that could be related to how and when the ASQ was scored, differences in the patient populations, or a combination of both.

The practices that had the fewest complaints about implementing the ASQ were the ones that handed the questionnaire to the parent when they brought their child to the medical office for a checkup. The practice that emailed the questionnaire to the parent in advance of the appointment had the most struggles with incorporating the ASQ into their standard practice.

Referrals were documented for 39 children and another 7 children were already receiving services for a developmental delay. Among the reasons a child may not have received a referral is that the physician decided not to make a referral, the parent could not be contacted, the parent refused the referral, the ASQ was not completed correctly, they were already receiving services, or the child's development progressed and a referral was no longer needed.

Payment for developmental screening was generally not received if the child was in a capitated plan (HMO). Fee-for-service plans (PPOs) were more likely to pay, but the payment amounts were small – around $10 per screen. Practices noted that HMOs do not mandate developmental screening as part of well-child checkups so there is no incentive to screen when they cannot receive additional payment for it. They also felt the amount of payment they received from PPOs was too little, but two practices thought any amount of payment was better than none. The third practice is unsure whether they will continue screening in part because of the low reimbursement rates that do not cover their costs.

Two of the four practices would like to continue using the ASQ as a routine part of the care they provide if they can keep it affordable; a third practice will make a decision after discussing it with all their physicians and considering the economic impact on their practice. The fourth practice will continue using the Denver rather than the ASQ.

This project provides insight into the successes and challenges with implementing standardized developmental screening as a routine part of well-child checkups. Much of the success depends on how smoothly the medical practice can implement the

questionnaire and how interested and committed the physicians are to adding this to their routine. Payment for developmental screening, or lack thereof, also is a factor in decisions on whether to make screening a routine part of patient care. As HMG continues to promote developmental screening using standardized screening tools, the lessons learned from this project should help them find new ways to support physician practices, address concerns upfront, and offer suggestions for how to integrate screening into their routines. Over the long term, this should result in greater success with engaging physicians in developmental screening.