ABCD:
Lessons from a Four-State Consortium

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The authors wish to thank all those who participated in the first phase of The Commonwealth Fund's Assuring Better Child Health and Development initiative (ABCD). From the start, staff in each of the four states dedicated themselves to the work of strengthening the early child development services offered through their Medicaid agencies. They did so with enthusiasm, creativity, and a deep concern for the children and families they serve. We are grateful for their commitment to this important work. We are also deeply appreciative of the feedback they provided us on early drafts of this report. Their comments served to strengthen this document.

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EXECUTIVE SUMMARY

The Assuring Better Child Health and Development (ABCD) initiative was launched in 1999 by The Commonwealth Fund and is dedicated to strengthening the capacity of the health care system to support the early development of children from low-income families. As part of ABCD, the Commonwealth Fund awarded a grant to the National Academy for State Health Policy (NASHP) to help states improve the delivery of early childhood development services to children through their Medicaid programs.

Medicaid agencies in four states (North Carolina, Utah, Vermont, and Washington) were selected to participate in the first phase of the ABCD initiative, which began in early 2000 and concluded in May 2003. Over the past three years, the four states participating in the ABCD Consortium have focused on a range of early child health and development services and on strategies for delivering them. These efforts have resulted in:

- new child health care services;
- strengthened screening, surveillance, and assessment efforts;
- enhanced training in child development, early intervention, and quality improvement for clinicians;
- new billing and reimbursement policies to facilitate the provision of developmental services;
- revised systems and processes to improve coordination of care; and
- the development of new educational materials for parents.

The first years of life are critical to the long-term health and well-being of children. Policymakers, parents, and health care providers can all take steps to enhance the healthy development of young children. The efforts by the four states involved in the ABCD Consortium to coordinate, integrate, and support these various actions offer a number of promising models worthy of investigation by other states. In addition, the lessons learned by the consortium offer valuable guidance for states interested in developing or expanding strategies for enhancing child development for low-income children and their families. Those lessons include the following:

Medicaid can re-engineer the delivery of care to improve the quality of preventive health care services for young children

Medicaid was the lead agency in each of the four states involved in the ABCD initiative. The accomplishments of those states indicate that Medicaid agencies can significantly improve the quality of the preventive services provided to low-income young children and their families through such initiatives as quality measurement, review, and improvement; delivery system reengineering; changes to provider manuals; training and education of providers; partnering with providers; and standardized assessments.

Coordination and partnerships have proved essential to the successes of the ABCD state projects.

Successful interagency/program coordination and care coordination are central to nearly all of the activities that have been conducted as part of the ABCD initiative. Medicaid agencies in the four states have worked closely with Title V, Part C-Early Intervention, WIC, and/or local health departments in each of the four states. Successful care coordination efforts among state agencies, providers, parents, and case managers have also strengthened the early childhood development services (ECD) offered through state Medicaid agencies. At different points in the development of their projects, the states enlisted assistance from primary pediatric providers in order to achieve their goals.

Medicaid financing and reimbursement strategies can support the provision of ECD services—without necessarily creating new services

Medicaid agencies are uniquely positioned to finance early childhood development services and to develop implementation strategies that encourage their provision. The states involved in the ABCD initiative adopted a number of financing strategies designed to enhance services and achieve their projects' goals. Those strategies include targeted case management, incentive payments to providers, and reimbursement for the services provided children by mid-level professionals.

It is possible for states to strengthen, sustain, and expand early child development services in the current fiscal environment.

Despite significant budget concerns in each of the participating states, all four have been able to embed their initiatives within their Medicaid operations and several are well on their way to achieving broad, systemic change in the way they deliver preventive services to young, low-income children. In each of the states, these successes are the result of states building upon and strengthening existing partnerships and relationships rather than building entirely new (and costly) systems of care.

States faced a number of significant common challenges in their efforts to enhance early childhood development services, and challenges remain.

Challenges commonly faced by the ABCD states have included: the need to improve referral systems between medical and community providers and to build bridges between agencies and the medical community. In addition, reimbursement remains an ongoing challenge as does the need to address the mental health issues of both children and parents. To help states address inadequacies related to mental health services, the Commonwealth Fund has launched a new ABCD initiative to support the work of Medicaid agencies in four states as they seek to build their capacity to deliver care that supports children's healthy mental development.

Please note: An electronic version of this report is available at www.nashp.org and includes direct links to many of the resources and products discussed in this report.

AN OVERVIEW OF THE INITIATIVE AND INDIVIDUAL STATE PROJECTS

The first years of life are critical to the long-term health and well-being of children. Recent studies estimate that 15 to 17 percent of all children—and one-third of low-income children—are at risk of developmental or behavioral delay.[1] While virtually all children have contact with the health care system (99 percent), most problems are not detected until kindergarten when children enter school. Several steps can be taken—by policymakers, parents, and clinicians—to improve the timeliness and quality of preventive health care services that would enhance young children's growth and development.[2] In offering low-income families access to health care and by providing an important and regular point of contact to these families and their children, Medicaid is uniquely positioned to provide high-quality, comprehensive, and well-coordinated preventive and developmental services that help assure the healthy development of our youngest children.

The Assuring Better Child Health and Development (ABCD) initiative was launched in 1999 by The Commonwealth Fund and is dedicated to strengthening the capacity of the health care system to support the early development of children from low-income families. As part of ABCD, the Commonwealth Fund awarded a grant to the National Academy for State Health Policy (NASHP) to help states improve the delivery of early childhood development services to children through their Medicaid programs.

Four states (North Carolina, Utah, Vermont, and Washington) were selected to participate in the first phase of the ABCD initiative, which began in early 2000 and concluded in May 2003. The specific activities of initiative have included:

- providing grants to the four states' Medicaid agencies to develop or expand service delivery and financing strategies that enhance child development for low-income children and their families;
- creating a laboratory of innovation and interagency collaboration comprised of the selected states (the ABCD Consortium);
- providing technical assistance to participating states to assure success; and
- using the results of the state demonstrations to inform and inspire replication in other state Medicaid programs.

Over the past three years, the four states selected to participate in ABCD I have focused on a range of early child health and development services and on strategies for delivering

[1] Committee on Children with Disabilities, American Academy of Pediatrics, "Developmental Screening and Surveillance of Infants and Young Children," July 2001, 108(1): 192-196; Christina Bethell et al., *Partnering with Parents* (NY: The Commonwealth Fund, September 2002).

[2] See, for instance: Karen VanLandeghem, Deborah Curtis, and Melinda Abrams, *Reasons and Strategies for Strengthening Childhood Development Services in the Healthcare System* (Portland, ME: National Academy for State Health Policy, 2002); Neal Halfon, Michael Regalado, Kathryn T. McLearn, et al. *Building A Bridge from Birth to School* (NY: The Commonwealth Fund, May 2003).

them as a routine part of children's health care (Table 1).[3] These services include developmental surveillance, screening, and assessment; developmentally-based health promotion, such as anticipatory guidance; problem-based counseling for those families for whom a problem has been identified; and follow-up and coordination of care.[4] These efforts have resulted in:

- new child health care services;
- strengthened screening, surveillance, and assessment efforts;
- enhanced training in child development, early intervention, and quality improvement for clinicians;
- new billing and reimbursement policies to facilitate the provision of developmental services;
- revised systems and processes to improve coordination of care; and
- the development of new educational materials for parents.

This paper is designed to highlight the lessons learned from the ABCD I initiative and is intended to provide guidance and encouragement to other states interested in developing or expanding strategies that enhance child development for low-income children and their families. This first section of the paper includes overviews of each of the four state's projects including information about their activities, accomplishments, and products. The second section describes the lessons learned across the four states; examples from the individual states are detailed throughout to help policymakers implement or adapt various strategies. The paper also includes information about the next phase of the Commonwealth Fund's ABCD initiative: ABCD II will assist five states in building their Medicaid agency's capacity to deliver care that supports children's healthy mental development.

[3] See Carolyn Berry, Barbara Langner, "The National Evaluation of ABCD: Final Report" (Center for Health and Public Service Research, New York University, October, 2003). Available at www.nashp.org.

[4] Michael Regalado and Neal Halfon, "Primary Care Services Promoting Optimal Child Development from Birth to Age 3 Years," *Archives of Pediatrics and Adolescent Medicine*, Vol. 155, No. 12, December 2001.

Table 1 Initial ABCD I State Project Objectives

	Design and/or implement standardized develop-mental assessment or screening tools	*Identify and recommend improve-ments and/or changes in state Medicaid policy or procedures*	*Establish or expand home visiting program*	*Improve service coordination across agencies*	*Enhance parents' knowledge of child development*	*Improve pediatric clinicians' assessment and counseling skills*
North Carolina	■	■		■	■	■
Utah	■	■	■	■	■	
Vermont	■	■	■	■	■	■
Washington	■	■		■	■	■

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North Carolina

The challenge

North Carolina focused its efforts on improving the rate of developmental screening, surveillance, and referral for low-income children in primary care practice. Although state Medicaid officials had recommended written developmental screening at certain well child (EPSDT) visits, they believed that the average rate of developmental screening across Medicaid systems of care was low. Additionally, a 1999 study indicated that between 8 and 13 percent of the total birth-to-three population in North Carolina could qualify and benefit from Early Intervention services; however, only 2.6 percent were being served.

The approach

Practitioners involved in the North Carolina ABCD project have worked with the state's Medicaid officials to develop, implement, and replicate a best practices model for developmental screening, surveillance, and referral. The model is characterized by the integration of a standardized, validated screening tool into selected well-child visits, which is followed by care management, referral, and information to parents about their children's growth and development. The infrastructure of the state's local community care plans (Access II & III) provides close collaboration between local providers (primary and specialty care) and among local and state agencies as well as a commitment to quality improvement at the local level.

North Carolina's initiative was first piloted at the three pediatric sites of Guilford Child Health (GCH). The Ages and Stages Questionnaire (ASQ) was integrated into the workflow at these practices.[5] In addition, GCH used ABCD funds to hire an early intervention specialist to oversee the collection of information from the ASQs, make referrals to appropriate providers, and provide support to families. The specialist conducts home visits, assists with parent education, and provides resources and referrals to families with specific needs or concerns. In order to expand the model to additional practices, the project developed resources (among them an Office Resource Guide) to assist practices in understanding and integrating screening and referral into local practice and systems of care.

In addition, the North Carolina ABCD project convened a statewide advisory group to address policy, reimbursement, and implementation issues that may affect the expansion of the delivery model throughout the state. It has also teamed with Early Intervention, the North Carolina Pediatric Society, the Academy of Family Physicians, the State Interagency Coordinating Council, and families—in addition to state and local providers—to develop a curriculum on early childhood development screening and early

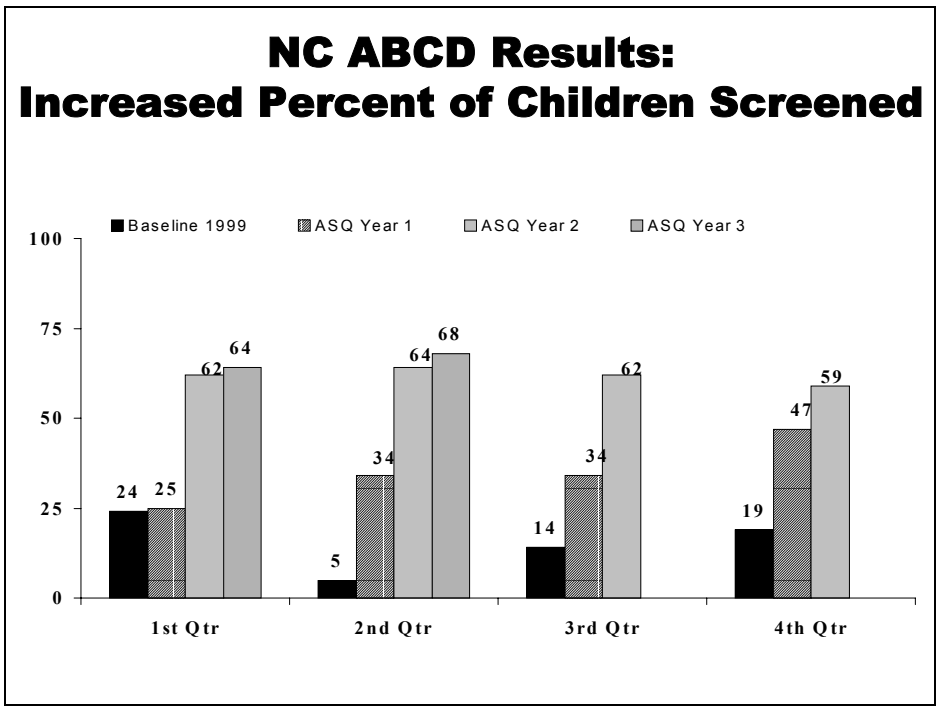
[5] The ASQ is a parent-completed screening tool that identifies infants and young children who may have developmental delays or disorders. Tested as valid and reliable, the ASQ reviews a variety of skills as many as 15 times between birth and age three. For more information see http://www.brookespublishing.com/store/books/bricker-asq/index.htm.

intervention for physicians. Those who complete the curriculum receive 5.5 Continuing Medical Education (CME) credits at no charge.[6]

The results to date

By early 2003, the ABCD model was operating in seventeen practices in three counties.[7] Work is currently underway to replicate the model in sixteen additional practices in eight counties across the state, and discussions with one of the state's largest network of providers – with practices in an additional 32 counties – are also underway. Additionally, fourteen other practices have inquired about the model and/or integrated critical elements of it into practice.

As of March 2003, eleven practices had completed more than 8,300 developmental screens. Seven percent of these children were referred for additional services, compared to the 2002 statewide average of 2.9 percent. As detailed below, the project is also having an impact on statewide policy designed to increase the provision of children development services for low-income children.



Source: North Carolina Office of Research, Demonstrations, and Rural Health Development, *Setting the Stage for Success,* Final Evaluation of the North Carolina ABCD Initiative, May 2003.

[6] For additional information about the North Carolina project, see Helen Pelletier and Melinda Abrams, *The North Carolina ABCD Project: A New Approach for Providing Developmental Services in Primary Care Practice* (Portland, ME: National Academy for State Health Policy, 2002).

[7] While each practice operates somewhat differently, all share an integrated approach to screening, referral, and family support. Some have opted to use the PEDS (Parents Evaluation Developmental Status) assessment rather than the ASQ. Some have incorporated the responsibilities of the early intervention specialist into the work of existing case management personnel, such as Access II & III care managers or child service coordinators.

Final products of the North Carolina ABCD Project include:

- Office Resource Guide for providers to integrate developmental screening and referral in their office practices and communities;
- Physician CME curriculum on early childhood development and early intervention;
- Parent education materials; and
- Evaluation of project interventions, including: comparison of ASQ screenings completed to baseline (Denver) screenings, referrals to follow up services, practice survey findings, parent survey findings, and changes in provider behavior. In addition, the project is beginning to collect outcome data on the children referred and served and to measure differences among three different provider groups (intervention, non-intervention, and ABCD participant groups).

More information on these measures and many of the North Carolina project's resources are available in the ABCD Toolbox at www.nashp.org.

Anticipated outcomes of the ABCD Project include:

- Ongoing replication of the integrated child development services model in practices and counties throughout the state;
- State Medicaid adoption of guidelines for developmental screening;
- A more consistent approach to developmental screening and surveillance across state agencies, including both Medicaid and Public Health;
- Medicaid reimbursement of Child Services Coordinators in the physician's office (these individuals are housed in North Carolina's public health agency and are responsible for the delivery of Title V services for at-risk children);
- Unbundling of developmental screens on physician claim forms;
- Continued use of physician early childhood development curriculum through sustained interest of collaborating partners; and
- Increased coordination and collaboration among the medical community, public health, and other community-based services.

Utah

The challenge

The state lacked standard home visiting protocols for referrals to services and a standardized tool to assess child and family needs. No system existed to ensure that eligible Medicaid families received home visits. In addition, there was limited communication between families and providers.

The approach

The Medicaid agency proposed a targeted case management program for infants, using home visits conducted by local public health departments as the vehicle for providing the case management.[8] The service is designed to facilitate the identification of health and developmental issues in the infant, to improve immunization rates among children enrolled in Medicaid, and to increase the use of well child care and the number of children linked with a primary care provider.

Under the program, public health nurses from each of the state's twelve local health departments conduct home visits to assess children's needs, refer them to appropriate health and social services, make sure that children have a health care provider for regular care, and educate parents about early child development. As the initiative has evolved, so, too, has the role of the public health nurse, from that of direct care provider to case manager linking families to their primary pediatric provider.

The state's Medicaid agency amended its state plan to create this new targeted case management service, established two reimbursement rates to cover the initial visit and follow-up visits, and revised the provider manual for public health nurses to help them implement the service. State project staff developed home visiting assessment forms and parent education materials and have trained more than 100 public health nurses in the new service.

The project has worked closely with the state's Title V agency, the Division of Community and Family Health Services (DCFHS), to coordinate early child development services for at-risk infants and young children. It has also has made significant strides in addressing the mental health issues of infants and toddlers. Through a contract with the Children's Center—a nonprofit agency that provides expertise, consultation, and training on children's mental health issues—the project has facilitated a better understanding among nursing staff at the local health departments of mental health issues for young children.

[8] Targeted case management (TCM) typically denotes needs assessment, care planning, monitoring progress, and the provision of assistance in obtaining necessary services. For additional information about TCM in the context of early child development services, see Sara Rosenbaum and Colleen Sonosky, *Issue Brief: Medical Case Management Services and Child Development* (Portland, ME: National Academy for State Health Policy, 2001).

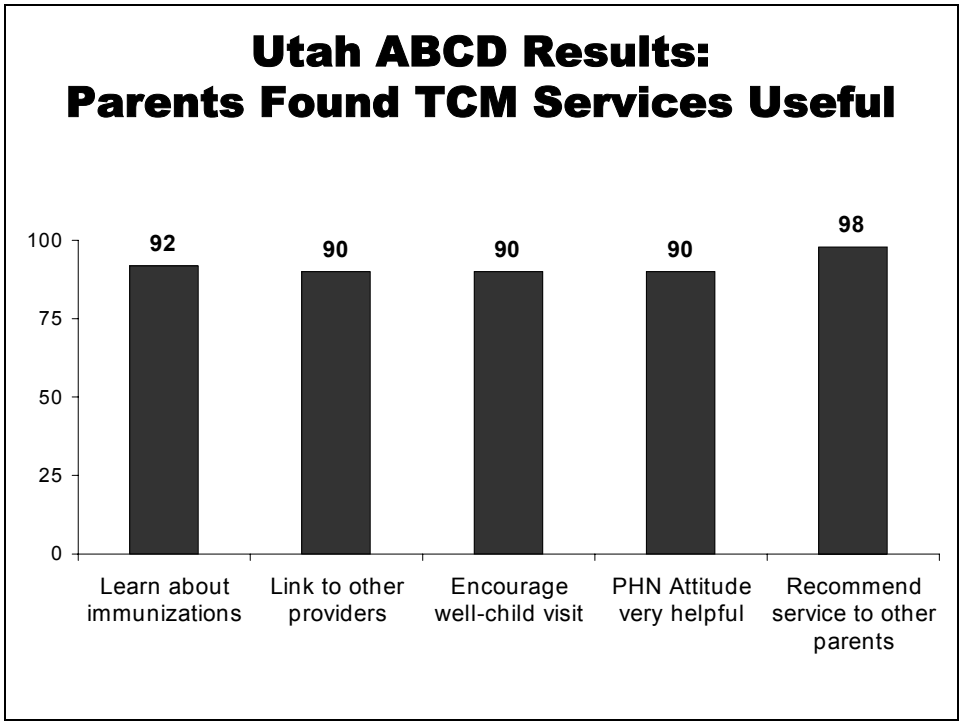
To improve identification of children at risk of developmental or behavioral delay, the Utah ABCD project also launched a community-based developmental surveillance system. During the targeted case management visit, the public health nurse introduces the parent to the ASQ, obtains consent, and leaves the screening form with a self-addressed stamped envelope. The parent sends the completed questionnaire to a central office, where the screen is scored and results are entered into a newly developed tracking system. If a problem is identified, the local health department sends letters to the parents and the child's primary health care provider (if known) indicating the results and resources available for follow-up care. In addition, the local public health nurse makes a follow-up home visit. If no problem is identified, parents receive a letter from the local health department describing their child's developmental status. Pertinent educational materials are enclosed with the letter. Subsequent ASQs are sent to the family by mail at appropriate intervals. The state Maternal and Child Health Bureau, which oversees this program, intends to expand it statewide following feedback from the initial pilot.

The results to date

Between July 1, 2002, and June 30, 2003, one-quarter of all eligible children (a total of 3,982 children, age zero to one) received an initial visit. Fourteen percent (547) of those receiving an initial visit also received a follow-up visit.

By June 30, 2003, nearly 100 percent of those public health nurses eligible to deliver targeted case management services have been trained to do so. Based on a survey of 290 parents who participated in the program, virtually all (98 percent) would recommend the service to other families, and more than 90 percent reported discussions with the public health nurses during the targeted case management visit about immunizations, scheduling a well-child visit, and other community resources.[9] (See chart below.)

[9] Early Intervention Research Institute, Utah State University, *Results of a Telephone Survey of Participants in Utah's Assuring Better Child Development, The Utah Early Childhood Development and Education for Medicaid Children Project* (Logan, UT: 2003).



Final products of the Utah ABCD Project include:

- Policies and protocols for using the Medicaid targeted case management (TCM) service to improve early child development services;
- Medicaid financing mechanisms for TCM, including rate calculations and the use of local health departments;
- An initial assessment tool, in use by both the Medicaid TCM program and the state's Prenatal to Five program;
- Revised manuals for EPSDT providers and public health nurses about child development and the TCM service in particular;
- Parent education materials; and
- Evaluation of project intervention through a parent survey that measures parental knowledge of importance of early childhood development, parental use of techniques to enhance brain development, and pediatric provider instruction on the importance of early childhood development.

A number of these resources and products are available in the ABCD Toolbox at www.nashp.org.

Anticipated outcomes of the ABCD Project include:

- Evidence that parents have an understanding of early childhood development;
- Coordinated approach to service delivery among Medicaid, Title V, and local public health departments;
- Linkages between local health departments and community mental health centers;
- Evolution of the role of the public health nurse from direct care provider to case manager, linking families to their primary pediatric provider; and
- Potential expansion of ASQ pilot statewide.

Vermont

The challenge

Vermont had several underutilized home visiting services and limited referral to those services. The state sought to strengthen and expand the delivery of child health and developmental services to Medicaid eligible families through improvements to its existing system.

The approach

The ABCD grant has enabled the state to shift its approach to providing child development services for low-income children. The new orientation emphasizes the identification and provision of the most appropriate health care for eligible children. Three home visiting programs have been integrated into one (Healthy Babies, Kids, and Families); the paperwork associated with assessment, referral, and monitoring has been streamlined (from seven forms to one); eligibility has been expanded (from 12 months to five years); and services have been added to include home visiting with case management, phone consultation, targeted educational materials that highlight child development, and group education for parents and care givers.

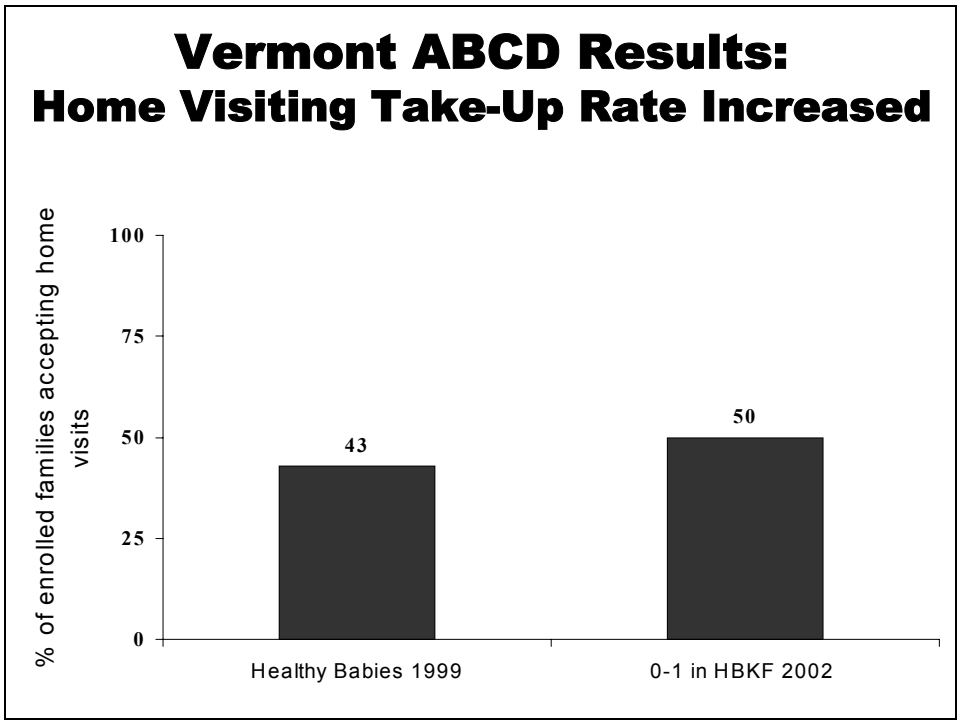
Vermont has also trained 900 physicians, public health providers, child care providers, and government officials in developmental issues using Touchpoints (a curriculum that emphasizes the building of supportive alliances between parents and professionals around key points in the development of young children). In doing so, Vermont has effectively changed the focus of its work with families to a developmental approach, rather than a risk-based one.

To make the new program feasible, the Medicaid agency collapsed certain billing codes into a new billing structure. Payment rates were revised for home visits and established for phone consultation and were adopted in the summer of 2002. In addition, all HBKF providers in the state have adopted a new form for communicating with one another. The C-Tool, as it is known, is designed to provide timely, pertinent, and non-duplicative information to participating agencies and to help ensure a more coordinated delivery of services for individual clients.

To encourage better coordination of care for the highest risk families, Vermont implemented intensive home visiting (IHV) on a pilot basis in four counties that serve 42 percent of the HBFK population. The pilot includes teams of service providers that review each case and 1) decide what services the family should receive, 2) develop a care plan, and 3) determine which agencies should provide the care. The services are designed to be holistic and comprehensive, to focus on prevention and early intervention strategies, and to provide outreach, support, and education to targeted families. The state's Department of Health and its Medicaid agency worked together to implement incentive payments to local providers who participate in these teams; a new case management billing code was authorized by Medicaid to support provider time spent at weekly clinical team meetings and other case management activities.

The results to date

Since the ABCD program was initiated, the number of families accepting home visits has increased from 43 percent to 50 percent. A summary of evaluation data indicates that the project has 1) improved the delivery of developmental services to Medicaid-enrolled pregnant women, infants, and children through age five, 2) changed Medicaid policies and practices, 3) improved providers' delivery of child development services, and 4) improved parental knowledge about child development.[10]



As of March 2003, more than 900 health care and child care providers had been trained in Touchpoints, the equivalent of one trained provider for every 20 Vermont families covered by Medicaid.

Final products of the Vermont ABCD Project will include

- A model of integrated service delivery for children, from birth to age 5, including routine and intensive home visiting, telephone and in-person support services for parents, case management, pediatric office-based services, and improved communication among providers;
- Financing mechanisms for expanded services for intensive home visiting;
- Parent education materials, including the Growing Up Healthy guidebook, HBKF website (http://www.healthyvermonters.info/cph/hbkf/hbkf.shtml), and parent newsletters; and

[10] Annette Rexroad and Judith Shaw, *Healthy Babies, Kids & Families: Program Evaluation Report* (Burlington, VT: Vermont Child Health Improvement Program, University of Vermont, June 2003).

- Evaluation of project activities, including: a phone survey to measure the utility/effectiveness of the new communication tool; phone and written surveys related to Touchpoints training; a written survey of WIC program participants about the delivery of health promotion and developmental services during their clinic visit; and a mailed survey to a sample of HBKF program participants to determine program satisfaction.

A number of these products are available in the ABCD Toolbox at www.nashp.org.

Anticipated outcomes of the Vermont project include:

- Adoption of revised financing mechanism and billing protocols for home visiting services, including case management;
- Sustained change in provider approach to focus on developmental services, fostered by Touchpoints;
- Increased collaboration among state agencies and providers to improve early child development, at both system and direct service levels;
- Continuation of expanded services, among them telephone consultation and parent education classes;
- New revenue code to enable hospitals to bill Medicaid directly for childbirth classes; and
- Potential expansion of the intensive home visiting model to another three counties.

Washington

The challenge

The quantity and quality of EPSDT services being delivered in Washington were below state standards and expectations.

The approach

The ABCD project in Washington used multiple approaches to facilitate improvement in the provision of early child health and development services. Through pilot efforts in three counties and a statewide initiative, the project focused on linking existing developmental health services for children and families, improving EPSDT screening rates, reviewing and promoting the use of developmental screening tools, and enhancing provider training and parent education.

The state's Medicaid agency has developed a new well child care encounter form designed to promote standardization in the delivery of developmental services for low-income children during EPSDT visits and to enhance the state's capacity to review patient records for quality. The encounter forms (available from infancy through age 18) furnish guidance and information to both physicians and parents and address age-specific issues in development. They are free to pediatricians statewide, can be downloaded from the state's website, and are available in seven languages. For practitioners who serve children in foster care, use of the forms is required in order to claim a significantly enhanced fee for EPSDT exams.

Three counties also tested ways to improve access to well-child care and parents' knowledge of the developmental screening services covered by Medicaid.

- In Clark County, the local public health nurse visited pediatric offices to provide information about EPSDT services, provided technical assistance in the use of the new well-child encounter form, and encouraged its use. The pilot also offered child development classes to parents enrolled in WIC and distributed information about early childhood development to families.

- Whatcom County convened local pediatric physicians, agencies, and other children's health service providers to develop recommendations for developmental screening. The County also trained public health nurses and early childhood educators as Health Promoters to encourage families to access well-child care, screen children for developmental problems with a standardized developmental screening tool (ASQ), and educate families about aspects of early childhood development using the Bright Futures protocols.[11] A key component of this pilot was the development and distribution of health organizers, containing numerous resources for parents.

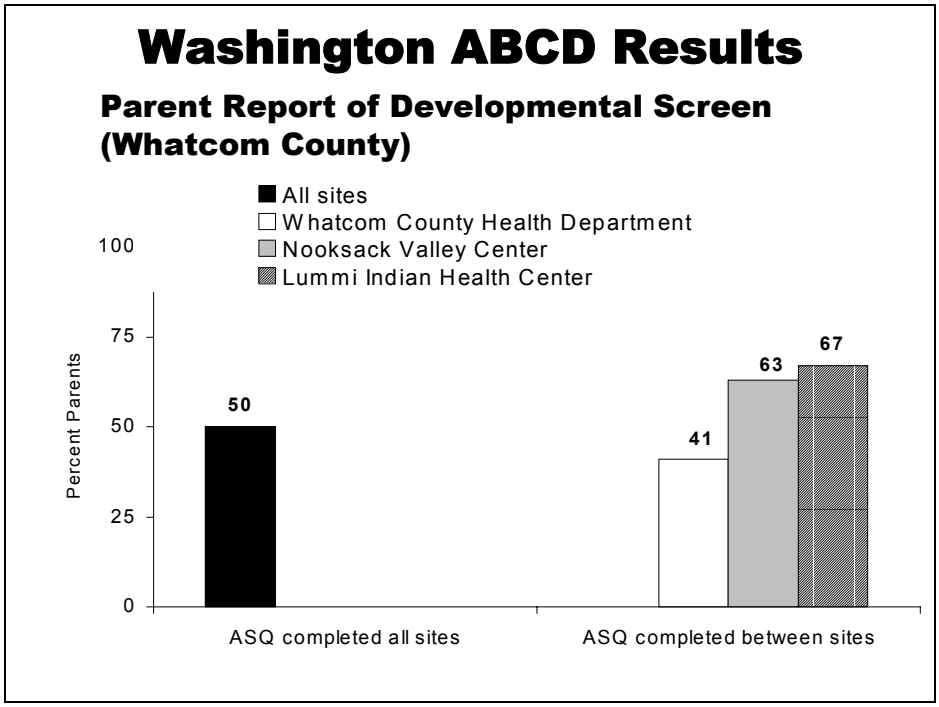
[11] Bright Futures is a national initiative of HRSA's Maternal and Child Health Bureau. For more information, see www.brightfutures.org.

- In Snohomish County, a community-based approach to screen 18-month-old children for developmental delays was pilot-tested. In collaboration with CHILD Profile, Washington State's health promotion and immunization registry system, an ASQ was mailed to parents in conjunction with other health information. Materials included a consent form for parents, a cover letter to parents, a mailer request for the ASQ, and a survey for parents. An introductory letter was also sent to pediatric providers. Findings from the county pilot will not be available until after the conclusion of the ABCD project. In addition to the population based screening project, the role of Medicaid enrollment workers was expanded to enable follow-up (by phone) with newly enrolled families to provide them with information on early development. Finally, in collaboration with the University of Washington, educational materials about child development services (CHILD Health Notes) were developed and disseminated to all health care providers in Whatcom and Snohomish counties.

The results to date

Initial findings (only two months of data) show that physicians are beginning to use the new EPSDT forms. The local evaluation has not documented an increase in EPSDT visits or an improvement in their quality over the first year of use of the revised EPSDT forms.[12] However, widespread uptake of the forms did not occur until after the most recent point of data collection. Long-term follow-up already planned by the Medicaid agency and the external quality review organization should indicate whether the number and quality of well-child visits improves as a result of the charting tool. In addition, the project has provided a unique opportunity for counties to try multiple interventions to improve the delivery of well-child care and developmental surveillance and screening. A number of structural and process changes show promise for improving the delivery of well-child care and developmental surveillance to children in Washington State communities.

[12] Washington local evaluation report, available in the ABCD Toolbox at www.nashp.org.



Final products of the Washington ABCD Project include:

- Well child exam form for EPSDT visits http://www.wa.gov/dshs/dshsforms/forms/eforms.html (or www.nashp.org);
- Two Child Profile developmental charts for children (0-18 months and 19-36 months) have been distributed to all families with young children and translated into multiple languages;
- Parent education materials including a curriculum on infant brain development and early childhood development for women enrolled in WIC;
- Educational materials for providers about child development (CHILD Health Notes);
- Curriculum to train public health nurses and early childhood educators in child development, including developmental screening and Bright Futures' protocols;
- Materials associated with the community-based approach for developmental screening (letters for parents, providers, etc.); and
- Evaluation of project activities, consisting of an EPSDT chart review study that will determine whether developmental screening was conducted, whether problems were identified, and whether the provider used the new well-child exam form. Descriptive data will be obtained from the pilot sites, enumerating the number of health promoters trained, the number of parents participating in education classes, and the number of health organizers distributed to parents.

A number of these resources are available in the ABCD Toolbox at www.nashp.org.

Anticipated outcomes of the Washington project include:

- Statewide adoption of the well-child exam form by pediatric providers, including mandated use of the form with foster care children (providers who use this form for foster care children receive an enhanced fee);
- Ongoing evaluation of developmental screening as a component of EPSDT visits through Washington State's external quality review contract to monitor quality of care provided by managed care organizations; and
- Continued collaboration between Medicaid, Public Health, and other agencies and programs that are focused on early childhood, to improve parent understanding of developmental issues and the delivery of developmental services.

LESSONS LEARNED

The ABCD initiative has included both national and local evaluations. Both were designed to provide assessments of the successes and long-term potential of the state projects. Some of the findings from the individual state evaluations are included in the summaries contained in the first section of this report. Additional findings will be available in the weeks and months ahead. The national evaluation—conducted by a team of researchers from New York University, the University of Kansas, and Northwestern University—was structured as a qualitative process evaluation with a case-study orientation. The final report from the national evaluation team is available in the ABCD Toolbox on the NASHP website at www.nashp.org.

This report is intended to summarize lessons learned—both by the individual states and by the consortium as a whole—as projects were developed, implemented, and revised over the past three years. The efforts by the four consortium states offer a number of promising strategies and models worthy of investigation by other states interested in developing or expanding services to enhance child development for low-income children and their families.

Table 2 Overview: Key Features of ABCD State Projects

	Education/ training efforts	Improved coordination		Changes in financing	Incorporation of developmental screening
		Care Coordination	*Interagency Coordination*		
North Carolina	Establishment of continuing medical education (CME) curriculum and credits for physicians across NC Parent resources Office resources for integrating the model in communities	Early intervention specialist integrated into care coordinator role	Integrated child development services model in practices and counties Established connections between medical professional associations and NC Early Intervention Program and Interagency Coordinating Council	Medicaid reimbursement of Child Services Coordinator services in MD offices	ASQ in providers offices as part of well-child visits Recommended tools and guidelines incorporated into Medicaid policy (2004) and public health policy
Utah	Revisions to Medicaid provider manuals to assist public health nurses in implementing the service Parent resources	Targeted case management	Integration of Medicaid, Title V, and Public Health services	Establishment of new billing rates and the use of public health dollars to provide match for Title XIX funds	Development of initial assessment tool for home visits. Piloting of ASQ at community level
Vermont	Touchpoints (for providers and parents) Parent resources	Intensive home visiting pilot C-Tool	Creation of Healthy Babies, Kids, & Families	Enhanced reimbursement for intensive home visiting & creation of a new billing structure	Touchpoints focus on milestones in a child's development
Washington	EPSDT charting tool: age specific guidance Parent resources	Health Promoters working with families to link them to health care and other needed services	Collaboration between Medicaid, Department of Health, Public Health, and other agencies and programs focused on improving delivery of developmental services	Provider Incentive to use EPSDT charting tool with foster care children	Development & dissemination of EPSDT charting tool Snohomish pilot of ASQ, sent to family in the mail Administration of ASQ by public health nurses and Head Start staff in Whatcom County

Lesson 1: Medicaid Can Re-Engineer the Delivery of Care to Improve the Quality of Preventive Health Care Services for Young Children

Medicaid covers the health care needs of 57 percent of low-income young children under the age of six. As the largest payer of children's health care services in the United States, Medicaid is an important and regular source of contact between families with young children and their health care providers across multiple systems of care. The program's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit provides coverage for a comprehensive array of preventive services that are designed to ensure healthy growth and development.

State Medicaid programs are, of course, complex entities that by their size, nature, and mission are often slow and difficult to change. As a major payer for a range of services delivered by numerous providers, small changes to just one service, say the EPSDT benefit, can have ramifications for schools, local public health agencies, Early Intervention, and managed care organizations. Once changes are made, Medicaid agencies must expend time, energy—and often money—to ensure that providers are informed about the change and willing and able to adapt to it.

In spite of these realities and challenges, the consortium states were generally successful in their efforts to re-engineer pieces of their Medicaid delivery systems to deliver more effectively early childhood development services, without significantly increasing costs.

- Some of the states have made major changes in their systems, merging programs (e.g., Vermont's Healthy Babies, Kids and Families program) or building new models of care (North Carolina's ASQ model).

- Others have introduced new tools and methods to existing programs and services (the well-child care encounter form in Washington, developmental screening tools in North Carolina, Utah, and Washington) in an effort to improve the quality (and quantity) of the services they provide; and

- Some have revised regulations (North Carolina, Vermont), provider manuals (Utah, North Carolina), and policies (Utah and Vermont) that communicate expectations about how care should be delivered.

By design, Medicaid was the lead agency for each of the four states involved in the ABCD initiative. The accomplishments of the participating states indicate that Medicaid agencies can significantly improve the quality of the preventive services they provide low-income young children and their families through such initiatives as:

- Changes to provider manuals,
- Training and education of providers,
- Standardized developmental screening, and
- Quality measurement and review.

Table 3 How Medicaid agencies in the four states re-engineered the delivery of health care to improve preventive & developmental services for young children

	Changes to provider manuals	Provider education	Standardized developmental assessments	Quality assessment & review
North Carolina	Division of Public Health's requirement that all public health clinics use an approved developmental screening tool	CME course & credits Office resource guide Orientations for practice management and provider staff	ASQ completed in providers' offices as part of well-child routine	Focus groups of parents Provider surveys Parent surveys PHDS-PLUS Quarterly assessments of outcomes with reporting to state advisory group and practices Integration of data collection into state web-based case management system Quality improvement teams Comparison of model to other Medicaid systems of care across state (using PRO data)
Utah	Revisions to EPSDT provider manual to encourage developmental screening Development of a TCM provider manual to assist public health nurses in implementing the service	One-on-one and field training of public health nurses about TCM and ASQ	Initial assessment of family strengths and needs by pubic health nurses Statewide ASQ pilot at the community level (through PHNs)	Focus groups of parents Phone surveys of parents
Vermont	Development of HBKF manual for public health providers	Touchpoints training for physicians, public health nurses, child care providers, government officials, etc.		Focus groups of parents and physicians Phone surveys of providers PHDS-PLUS
Washington		EPSDT charting tool Training of physician practices by CDC/ vaccination nurse about child development and new well- child care form Feedback from EQIO during chart abstraction/ Audit Development of physician practice-level templates to report findings from EPSDT and PHDS-Plus	EPSDT charting tool	Focus groups of parents Phone surveys of parents PHDS-PLUS EQRO contract for evaluation and measurement

Medicaid provider manuals

Medicaid agencies use provider manuals to convey to providers their expectations for delivery of services (what providers may or may not bill for and what services they are expected to provide in different circumstances). As the ABCD projects were implemented and refined, two of the states involved in the initiative (Utah and North Carolina) found it necessary to change their provider manuals to reflect either changing expectations or a clearer description of existing expectations.

In establishing its targeted case management service (TCM), **Utah** revised its EPSDT provider manual to encourage developmental screening and developed a TCM provider manual to assist public health nurses in implementing the service. The TCM manual includes detailed information on the services to be provided through targeted case management, the scope of the service, record keeping, service payment, and targeted case management codes. A copy is included in the ABCD Toolbox at www.nashp.org.

In **North Carolina**, the Division of Public Health's Women's and Children Health (WCH) Section now requires that all public health clinics use an approved developmental screening tool (one of which is the ASQ). The state's Medicaid agency also anticipates adopting developmental screening guidelines for providers. These changes are reflected in the policies and procedures distributed by the state to providers.

Provider education and resources

The provider resources developed by the states involved in the ABCD Consortium serve several purposes. Some are designed to increase pediatric provider understanding of early child development and of appropriate interventions and resources. Others are meant to enhance parent and provider interactions. Still others focus on the details of how to establish screening and assessment programs or how to link providers with community-based services and programs.

The **North Carolina** project has teamed with the North Carolina Pediatric Society, the Academy of Family Physicians, and families—in addition to the state Interagency Coordinating Council, Part C staff, and the Family Support Network—to develop a curriculum on early childhood development screening and early intervention for physicians. Those who complete the curriculum receive 5.5 Continuing Medical Education (CME) credits at no charge. (An overview of the CME curriculum is posted to the ABCD Toolbox at www.nashp.org.) The project's Office Resource Guide and practice orientations also provide important resources to practices that adopt the model.

By March 2003, more than 700 physicians, public health providers, child care providers, and government officials in **Vermont** had been trained in Touchpoints, a curriculum that emphasizes the building of supportive alliances between parents and professionals around key points in the development of young children. Funded through the ABCD grant, the training has enabled key players in Vermont to speak a common language when discussing developmental issues with and among parents, providers, and service agencies. For more information about Touchpoints, go to www.touchpoints.org.

The **Washington** Medicaid agency's new EPSDT charting tool—in addition to promoting standardization in the delivery of developmental services for low-income children—includes guidance to physicians and addresses age-specific issues in development. The charting tools are free to pediatricians statewide and can be downloaded from the state's website at http://www.wa.gov/dshs/dshsforms/forms/eforms.html (begin at form 13-683). The parent portion of the charting tool has been translated into multiple languages, and these translated forms are also on the Washington state website. Samples of the charting tool are also posted to the ABCD Toolbox at www.nashp.org. In the Snohomish County pilot, a series of special hand-outs for providers were developed to provide them with additional information about child development.

Standardized developmental screening and assessments

Each of the ABCD Consortium states has taken a slightly different approach to incorporating and encouraging developmental screening. As with other components of a state's Medicaid program, each state's approach was defined by a number of factors that typically included the existing health care delivery system, the involvement of the physician community, potential partnerships and collaboration between multiple agencies and health care providers, and the demographics of the state.

Several states that implemented standardized developmental screens and/or assessments struggled with how to communicate the findings from those tools so that the appropriate provider could incorporate the information into pediatric practice, whether providing care to the child, making referrals as necessary, or providing anticipatory guidance to the parents.

ABCD project staff in North Carolina also noted the challenges of implementing developmental screening and surveillance into well child care while balancing the time constraints of a busy practice. They found that other evidence-based quality improvement initiatives often competed for practice time, and they also met physician resistance to the need for a formal developmental screening tool in order to accurately identify children at risk.

Three of the four states were successful in incorporating and encouraging standardized developmental screening and assessments as part of the early childhood development services offered to low-income children and their families. Specific examples of developmental screening approaches from the ABCD states include:

North Carolina incorporated the Ages and Stages Questionnaire (ASQ) into its integrated child development services model. The project chose the ASQ because of the ease with which it can be administered (considerations included time, cost, reading level, and parent involvement) and its sensitivity and specificity. In the North Carolina model, the parent completes the questionnaire at certain well-child visits, while the child and parent wait to be seen by the child's primary care provider. The physician or nurse practitioner then scores the questionnaire, providing immediate feedback on a child's strengths as well as any need for further assessment. In general, practitioners found that

the use of the ASQ did not disrupt their workflow and actually enhanced the efficiency of their well-child visits since parents' concerns were identified at the outset of the encounter. In the state's pilot project, an early intervention specialist became one of the Medicaid Access II & III network care coordinators and coordinated follow up and referrals based upon the ASQ for the network practices.

The **Utah** ABCD project developed an assessment tool to be used in its home visiting program for Medicaid families with newborns. The tool is not a developmental screening instrument, but is designed to assess a family's strengths and needs through an assessment of the mother's pregnancy and birth experience, the baby's habits, the family environment, and parent-child interaction. Recently, Utah launched a pilot in which public health nurses introduce the ASQ during the targeted case management visit. Parents then complete the screening tool at their convenience and mail the form back to a central location for scoring and follow-up.

The **Washington** ABCD project promoted the use of the state's newly developed EPSDT charting tool (referenced above) to improve provider performance in completing comprehensive EPSDT exams, including developmental screening. Unlike other encounter forms used during preventive visits, the Washington tool addresses age-specific issues in child development and provides guidance to both primary care providers and parents.

The Washington ABCD Project also convened a panel of physicians to assess the usefulness of various developmental screening tools administered via three different approaches: in the primary care office, by community personnel, and by community or statewide distribution. The panel developed recommendations for the use of standardized, developmental screening tools appropriate to each setting. However, due to the broad range of individual differences among young children covered by Medicaid and the diversity of venues at which they are served, the committee refrained from recommending one tool for widespread use.[13]

In addition, two counties in Washington State have initiated community-wide, population-based pilots to identify children at risk of developmental or behavioral delay. In Snohomish county, agency staff are including an ASQ to pre-existing statewide mailing at 18 months, as part of its CHILD Find program. Whatcom County has trained public health nurses to introduce, administer, and score the ASQ during home visits.

Quality measurement and review activities

Both at the start of their ABCD projects and throughout the development of the initiatives, Medicaid agencies in the four states have used a number of different measures to assess the quality of preventive care being provided to young children and their families. They have used the findings from these assessments to improve the delivery of care by addressing parent and provider needs and concerns, streamlining services, reducing redundancies within delivery systems, and maximizing resources.

[13] Katherine TeKolste, et al. Washington State Developmental Screening Committee recommendations. April 2001.

- **Focus groups** with mothers of very young children enrolled in Medicaid were held in each of the four ABCD states in the summer and fall of 2000. Conducted by the firm of Lake Snell Perry & Associates, the groups were designed to expand understanding of what mothers know about child development, how they perceive the developmental services provided by Medicaid, and what their interactions with pediatricians and other clinicians have been like. Each participating state also added questions aimed at informing the design of its ABCD project.[14] For example, in **Vermont**, the results of these focus groups—combined with a series of focus groups with local providers, client satisfaction surveys, and program outcome data—had a significant impact on the planning and implementation of Vermont's new integrated Healthy Babies, Kids, & Families program and on the program's comprehensive parent education materials.

- In collaboration with the ABCD Consortium, the Child and Adolescent Measurement Initiative, which is led by Christina Bethell, Ph.D., conducted a survey in 2000 of parents of children under age four who were covered by Medicaid. The survey's intent was to learn more about the quality of preventive and developmental services provided to low-income children and how parents feel about the care that their children are receiving. The survey, the **Promoting Healthy Development Survey PLUS** (PHDS-PLUS), included a core sample of nearly 2,000 parents in North Carolina, Vermont, and Washington.[15] In **Washington** and **Vermont**, the results were reported back to individual physician practices to help them identify current weaknesses and develop initiatives to improve the quality of care they provide. In addition, the Vermont Medicaid agency has requested extra money be included in the budget for fiscal year 2005 to support a consumer-centered survey, which would include a second round of PHDS-Plus survey administration.

- All four of the ABCD states developed and administered state-specific **parent or provider surveys** at various times during the life of the ABCD initiative to assess and refine their projects. For instance, a survey of family practice staff involved in the North Carolina initiative noted several recommendations for changes in practice workflow related to the administration of the Ages and Stages Questionnaire (ASQ). One simple, but effective recommendation was quickly implemented by some of the practices: give the ASQ to parents while they are in the waiting room, not the examining room, in order to give them more time to focus on and complete the form. (For more detail on the state surveys, see the ABCD Toolbox at www.nashp.org.)

As part of its efforts to improve the quality of EPSDT services, **Washington** includes in its contract with its external quality review organization (EQRO) in-office education to providers on the advantages of the EPSDT charting tool, encourages its use, and conducts an ongoing evaluation of its use by managed care providers. In addition, findings from chart reviews will be linked with the state's PHDS-Plus survey results and developed into reports for physician practices involved in two or three county demonstration projects.

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[14] See Michael Perry and Susan Kannel, *Attitudes of Mothers with Young Children Enrolled in Medicaid* (NY: The Commonwealth Fund, 2001).

[15] See Christina Bethell et al., *Partnering with Parents to Promote the Healthy Development of Young Children Enrolled in Medicaid* (NY: The Commonwealth Fund, 2002).

Lesson 2: Coordination and Partnerships Have Proved Essential to the Successes of the ABCD State Projects

Successful interagency/program coordination and care coordination are central to nearly all of the activities that have been conducted as part of the ABCD initiative. Medicaid agencies in the four states have worked closely with Title V, Part C-Early Intervention, WIC,[16] and state and local health departments. Successful care coordination efforts among state agencies, providers, parents, and case managers have also strengthened the early childhood development services (ECD) offered by state Medicaid agencies. At different points in the projects, each of the states enlisted assistance from primary care providers in order to achieve its goals.

Table 4 Key partnerships contributing to success in each ABCD state

	Agencies	Providers	Parents
North Carolina	Title V Public health (Part C and health departments) Early Intervention State Interagency Coordinating Council Office of Rural Health	NC Pediatric Society NC Academy of Family Physicians Access II & III Networks	ASQ Educational materials informed by parent input Family Support Network State Interagency Coordinating Council
Utah	Title V Local public health departments The Children's Center	Public health nurses Pediatric physician community	TCM home visiting Educational materials informed by parent input
Vermont	Department of Health WIC Local home visiting agencies (Visiting Nurse Service and Parent-Child Resource Centers)	Physicians, public health nurses, office and agency staff who attended Touchpoints trainings Vermont Children's Health Improvement Program (VCHIP)	Through Touchpoints' new strengths-based philosophy that builds on parent knowledge and expertise Educational materials informed by parent input
Washington	Infant Toddler Early Intervention Program (ITEIP) WIC County health departments Department of Health	Leadership at University of Washington Panel of physicians who made recommendations about developmental screening	Educational materials informed by parent input EPSDT charting tool

[16] The Special Supplemental Nutrition Program for Women, Infants, and Children.

Agency partnerships

One of the major challenges for any state or local agency that has responsibility for children's services is to coordinate with the many other services and agencies that also serve children. An individual child can be eligible for services from multiple programs, for which eligibility criteria can be confusing and services fragmented and duplicative. Each of the states has been quite successful in developing a shared vision among certain key players and in entering into specific collaborative agreements, but the effort was often a time-consuming one and presented challenges along the way. Some states found it difficult to forge relationships among agencies and programs because of different approaches to service delivery, different program requirements, and different funding streams and philosophies. Yet, as each state is quick to acknowledge, agency collaboration and coordination are essential to providing a seamless system of care for young children and their families.

Utah's Medicaid agency worked in collaboration with the Division of Community and Family Health Services (DCFH) and the local health departments to develop its home visiting initiative. The process was not been without its challenges. Because DCFH provided home visiting services to children from birth to age five with special needs, its staff had concerns about the potential overlap and distinction between the two home visiting approaches. At the local level, health department nurses had similar concerns. The Utah project worked with these two partners to clarify the distinction between the targeted case management home visiting to all Medicaid newborns and DCFH's home visiting to at-risk children and to ensure that the system of care was understandable and as seamless as possible for children and their families. In the end, when Medicaid's financial ability to support the TCM service was threatened, the local public health departments agreed to use some of their non-federal dollars as the state match for the federal Medicaid funds.

The **Vermont** ABCD project—a partnership between the state's Medicaid agency and the Department of Health—was built on a history of collaboration between the two agencies. (The Department of Health, through its district offices and contracts with home health agencies and parent-child centers throughout the state, provided Medicaid services for the state's Healthy Babies and One to Five programs.) But similar to the experience in Utah, Vermont Medicaid faced challenges in working with other home visiting initiatives. The Family Partnership Program, a three-county pilot program of home visiting for at-risk families, was approved by the Vermont legislature at the same time that the ABCD grant was awarded to Vermont, and the Healthy Families America initiative was conducting a home visiting program in a single community in northern Vermont. These multiple initiatives prompted the formation of an intensive home visiting workgroup to examine the commonalities among Healthy Babies, One to Five, Family Partnership, and Healthy Families America. The workgroup examined and then made recommendations that focused on how best to integrate the most successful elements of each program into a single collaborative team approach.

Partnerships with physicians

The involvement of pediatric clinicians in the delivery of early child development services is also central to efforts aimed at strengthening early child development services. The health care system is the one system that has contact with nearly every child younger than five and can intervene even before a child enters school. Pediatric providers, and physicians in particular, can help solidify a child's trajectory for academic success by assuring that infants are born healthy, that parents receive child development information and support, and that children meet their optimum developmental potential.

Building effective relationships with physicians proved a significant challenge for several of the states involved in the consortium. Nevertheless, the work of the four states confirms that Medicaid can work collaboratively with providers through the development of quality improvement initiatives, workshops and training sessions, advisory committees on delivery and financing of care, written materials, and provider manuals. The experiences of the states offer two different approaches for effectively working with pediatric physicians to improve child development services.

In **North Carolina**, physicians were involved in the state's ABCD initiative from its inception and had a voice in how the model would be integrated into pediatric practice. Marian Earls, M.D., the medical director of Guilford Child Health, Inc. (where the project was piloted), developed the model and devoted considerable time and energy to securing provider buy-in. Her role as physician champion has proved a major factor in the success of the state's efforts. Physicians also took the lead on the development of the CME course, although agency staff and parents are also faculty members.

The second approach involves physicians as consultants who provide leadership and technical assistance on the content of state-based activities.

- In **Washington**, developmental pediatrician Katherine TeKolste, M.D. of the University of Washington, developed the language integrated into the well-child care form, convened a group of pediatricians to develop recommendations on developmental screening, and worked closely with two of the three counties to develop their ASQ community-level pilots.

- The **Vermont** ABCD project was closely linked with the Vermont Child Health Improvement Program (VCHIP), which is a network of pediatric providers (physicians mostly) that work together through collaboratives, conference calls, and listservs to improve the quality of pediatric care for all Vermont children. Although VCHIP was technically the local evaluator of the ABCD project, its role expanded over the three years to facilitate the transfer of information and ideas between Medicaid and the pediatrician community. Vermont Medicaid and public health staff attended meetings of VCHIP's learning collaboratives, and the pediatricians participated in Touchpoints training. As a result of feedback through VCHIP, agency staff modified the Touchpoints curriculum to make it shorter (1 day only) and limit participation to physicians only. Another strategy, although less intense, is the inclusion of physicians or physician leaders (AAP or AAFP chapters) on advisory committees both to obtain guidance and to help disseminate findings and policy changes that occurred as a result of ABCD.

Although each of the projects has forged important connections with primary physicians, some have found it difficult to link those providers with community-based services and programs. Poor communication works in the other direction as well; many physicians find that they do not hear the results of what is discovered during home visits or from other community-based providers. As noted earlier, ABCD project staff in North Carolina confronted the challenges of implementing developmental screening and surveillance into well child care while balancing the time constraints of a busy practice and the integration of other evidence-based quality improvement initiatives. From time to time, the staff in North Carolina also met physician resistance to the need for a formal developmental screening tool in order to accurately identify children at risk.

Partnerships with parents and caregivers

Healthy, nurturing relationships between child and caregiver are essential to promoting healthy early development, and a major objective of the ABCD program has been to support policies and programs that help parents properly nurture their infant's or toddler's development. Since children receive and access care through parents, state and consortium staff have been committed to understanding what parents know, how they feel about child developmental services, and how they can be engaged as partners to obtain high-quality care for their children.

Based on the experience of this limited number of states, three basic strategies emerge for partnering with parents:

- **Obtaining parent input.** As mentioned earlier, all four states used focus groups to obtain parent feedback about their programs or parent education materials. Two states (North Carolina and Utah) also surveyed parents to assess their satisfaction with new services or specific program elements.

- **Encouraging engagement.** In this approach, parents are viewed as experts in their children's health and a unique resource for reliable information about their child's development. Vermont's Touchpoints initiative has been designed to foster communication and understanding between providers and parents, to shift the focus of the relationship from a risk-based approach to a developmental, strengths-based philosophy. Proper use of parent-completed developmental screening tools, such as the ASQ or the PEDS, stimulate positive communication between parents and clinicians by eliciting parents' concerns and involving them in a conversation about their child's care. In addition, North Carolina's project included parents in the development of the statewide CME curriculum and as co-faculty.

- **Increasing demand.** A third strategy tries to raise parents' expectations about the quality of preventive and developmental services they receive. All the states embraced this approach through the careful development of parent education materials that stress what to expect at a given well-child-care visit. The community-level pilot of the ASQ in Washington (in which a parent receives the questionnaire in the mail when the child is 18 months old) serves to help parents quickly screen their child for developmental delay and to convey to parents an

understanding of the kinds of topics they might wish to raise with their pediatric provider. Similarly, the findings from the PHDS-Plus survey provide an indication of the quality of preventive care young children typically receive and serve as an encouragement to parents (among others) to ask their child's pediatrician about issues related to behavior and development.

As the ABCD states have worked to forge stronger relationships between providers and parents, each of them has stressed one troubling reality: parents who are in poor physical or mental health often do not have the motivation or resources to nurture their children. Maternal depression is a particular concern.

Lesson 3: Medicaid Financing and Reimbursement Strategies Can Support the Provision of ECD Services—Without Necessarily Creating New Services

As each of the ABCD state projects has confirmed, Medicaid agencies are uniquely positioned to finance early childhood development services and to develop implementation strategies that encourage their provision.

Multiple strategies exist for financing early childhood development services through existing reimbursement mechanisms, and the ABCD states pursued a number of them. The program's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) rules provide a clear avenue for covering a comprehensive array of preventive services that are designed to ensure healthy growth and development, and states have considerable flexibility in defining the services delivered through the benefit.

Also, as the ABCD states have demonstrated, it is possible for states to identify and implement new services, or to cover as a Medicaid expense certain services delivered through other agencies, and, in the process, obtain the federal financial match to offset some of the state costs of the service.

Finally, because Medicaid is such a major payer for a whole range of services delivered by providers, the program has considerable clout and influence with providers. For instance, its ability—and flexibility—to use certain payments as incentives for particular behaviors can have a direct impact on the success and replication of new services and programs.

Table 5 State financing strategies

	Targeted case management	Incentive payments	Expansion of service site criteria
North Carolina			▪
Utah	▪		
Vermont	▪	▪	▪
Washington		▪	

The following financing strategies were adopted by the ABCD states as they sought to enhance the delivery of early childhood development services:

- **Targeted case management** (TCM): Utah used this financing mechanism to identify children in need of greater support and to connect them with necessary services. Local public health departments—which provided the public health nurses to staff the targeted case management—contributed the state share of Medicaid dollars, which were, in turn, matched by the federal government. In the end, more money flowed to the local health departments through this arrangement.

- Two of the ABCD states have used **incentive payments** to realign resources to be consistent with agency goals:

  - ✓ Vermont has made available an additional case management fee (also through targeted case management) to local providers who agree to participate in a consortium overseeing a pilot intensive home visiting program. A new case management billing code was authorized by Medicaid to support provider time spent at weekly clinical team meetings and other case management activities. (This includes phone consultation related to the development, implementation, and evaluation of the unified care plan.) The incentive is available only to those providers who participate in the consortium.

  - ✓ Washington's primary pediatric providers are reimbursed at higher rate if they use the state's new EPSDT charting tool with children enrolled in foster care.

- Two sites have expanded their **service site criteria** to facilitate delivery of developmental services. North Carolina was able to make the primary pediatric office an eligible site for Child Services Coordinator (CSC) reimbursement. CSCs are now allowed to be reimbursed for providing care coordination services when participating with the family in the office visit with the primary physician. Vermont expanded the list of allowable and billable sites for case management to include telephone consultation.

To add services, merge programs, or expand the sites eligible for reimbursement requires revision of the appropriate billing codes. Vermont overhauled and streamlined its billing codes when it merged three existing programs into one, the Healthy Babies, Kids, & Family program. The addition of telephone consultation as a billable activity under case management in Vermont also required modifications to the existing billing structure. In Utah, the establishment of the TCM service required the addition of a new code and the calculation of two reimbursement rates that will be reviewed and adjusted periodically.

Lesson 4: It is Possible for States to Strengthen, Sustain, and Expand Early Child Development Services in the Current Fiscal Environment

Despite significant budget concerns in each of the participating states, all four have been able to embed their initiatives within their Medicaid operations and several are well on their way to achieving broad, systemic change in the way they deliver preventive services to young, low-income children.[17]

- Through system redesign, new financing strategies, and success in building upon the state's network of local community care plans, **North Carolina** has been able to achieve significant change and improvement to the delivery system without an appropriation of new dollars. The project will continue and will expand to additional counties in the coming months.

- While funding of the states targeted case management has proved a significant challenge in **Utah**, the project was implemented—and will continue—thanks to the innovative partnership between Medicaid and public health.

- As with Utah, **Vermont** faced challenges in finding the resources required to accomplish its ambitious goals. Nonetheless, the state's new integrated system of delivering services to the early childhood population will be sustained and possibly expanded.

- Over the course of the three-year project, fiscal challenges in **Washington** were coupled with the dissolution of managed care in one of the three pilot counties and an inadequate number of providers in another. Nonetheless, the state expects to see increased dissemination and use of its new EPSDT charting tool.

In each of the states, these successes are the result of states building upon and strengthening existing partnerships and programs rather than building entirely new (and costly) systems of care. However, that process has not always been an uncomplicated one. As they have sought to sustain and expand their projects, the four states involved in the ABCD initiative have learned—or had reinforced—some of the following important lessons:

- **Include representation of all participants in the planning process.**

  This includes physicians, Early Intervention, public health nurses, even Medicaid itself. One of the four ABCD states noted that the greatest obstacle to

[17] Each of the states participating in the ABCD Consortium received $100,000 from the Commonwealth Fund for each of the three years of the initiative, and each sought and obtained federal financial participation (FFP) for those administrative activities covered by Medicaid. The bulk of these funds was used for project start-up costs: subcontracts with program consultants, local evaluators, and communications consultants; printing; mailing; etc. No grant funds were used to provide direct services to children. As Lesson #4 details, all of the states will continue the services and activities developed during the three-year initiative (which ended in May 2003), in spite of significant budget concerns in each state.

implementation of its project was the marked difference in philosophy between staff in different agencies. Other states noted the significant challenges they confronted in communicating, collaborating, and achieving buy-in among various county and state players. Clearly, this work takes time and a clear commitment to the task on the part of those leading the effort.

- **Establish an advisory committee that includes statewide agency leadership**

Each of the ABCD projects was housed within the Medicaid agency and enjoyed the support of the state's Medicaid director. Several state projects (Vermont, North Carolina) also were guided by state advisory groups. In North Carolina, a workgroup of senior state officials (and other key players) worked to address policy, reimbursement, and implementation issues encountered by the project. This group proved valuable to the project in two ways: it helped accomplish needed policy change *and* it kept a group of key stakeholders informed of and committed to the project throughout the three-year effort.

- **Institute policies to enable sustainability**

Policy changes are critical to sustaining or expanding a program. Each state instituted one or more changes to Medicaid policy. For example, North Carolina is amending its provider manuals to reflect new standards and guidance; Utah established new services as part of its state plan and issued policy guidelines about how to deliver and obtain payment for providing the service; and Washington changed its reimbursement structure to reward providers for using an improved screening form for children in the foster care system. Because each of these is, in effect, an institutionalized change in the way the Medicaid agency functions, it is likely to be sustained beyond the term of the grant.

Lesson 5: States Faced a Number of Significant, Common Challenges in Their Efforts to Enhance Early Childhood Development Services, and Challenges Remain

The states involved in the ABCD initiative—all of whom have made significant progress in strengthening early child development services—have identified a number of significant challenges that slowed, stalled, or otherwise complicated their efforts. The most common and enduring of those challenges include:

- **Planning, Development, and Implementation**

  As Carolyn Berry and Barbara Langner note in their national evaluation of ABCD,[18] states that did not include appropriate key players in the initial planning process found that they had to devote considerable time and resources during implementation to soliciting support for their projects from the professionals who ultimately were responsible for key services.

  Another key to successful implementation was the ability to identify and build upon existing programs, collaborations, infrastructure, or strategies around child development. Not one state built its program from scratch. For example, Utah and Vermont used their existing home visiting programs as the basis for their ABCD programs. Washington very effectively integrated developmental information into the previously established ChildProfile mailings. North Carolina built its screening programs within its Access II/III system. Building on existing programs, relationships and structures shortened start-up time and allowed resources to spread further, in part by minimizing the necessity to create new positions. Integrating the ABCD program into ongoing efforts also assisted sustainability.[19]

- **Improving referral systems between medical and community providers.**

  As noted earlier, each of the states learned that—regardless of who conducts the screening—effective communication of the results is essential and that such communication is often difficult to establish and maintain. A feedback loop is essential so that the appropriate provider can incorporate the information into pediatric practice, whether providing care to the child, making referrals as necessary, or providing anticipatory guidance to the parents. To that end, partnerships with physicians need to be an integral part of activities designed to strengthen referral systems and need to be built-in at the start of any such efforts.

[18] Carolyn Berry, Barbara Langner, "The National Evaluation of ABCD: Final Report" (Center for Health and Public Service Research, New York University, October, 2003). Available at www.nashp.org.
[19] Ibid.

- **Establishing Effective Measurement and Evaluation**

  States seeking to improve the early childhood development services they offer low-income children and families should also establish reasonable and appropriate evaluation measures as an integral part of program development and implementation. Such measures are important for several reasons: they can provide agency staff with clear evidence of success, evidence that can be critical to efforts to secure legislative and agency support, especially during periods of fiscal uncertainty; and they can help ensure that Medicaid agencies know what they are buying, helping to ensure the quality and effectiveness of the services they offer. These measurements need not result in more, new, or expensive reporting. For instance, the most revealing and relevant findings of the North Carolina ABCD project focused on the percentage of children screened and the percentage referred, information readily available from chart reviews and practice records.

- **Addressing Reimbursement Issues**

  Reimbursement for well child care varies by state. Based on a survey of states conducted by the American Academy of Pediatrics, state payments for a preventive EPSDT visit for an established patient under one year can range from $15.00 to $76.76. Developmental services (i.e., developmental screening, in-depth assessment, anticipatory guidance, parent education and follow-up care) should all be part of standard well-child care. However, in states where the reimbursement rate is woefully inadequate, the lack of financial reward does not recognize the value of these services to children's future health or encourage much innovation. North Carolina's success in integrating the ASQ into pediatric practice was certainly due in part to the fact that the flow of work within the practice was not interrupted, the time spent with families did not increase, and the reimbursement rate for an initial newborn EPSDT visit in North Carolina was (and is) $76.72. (A follow-up newborn visit is $40.58.)

  The developmental screen that is part of the EPSDT visit includes two functions: a developmental screen and an in-depth developmental assessment for those children (identified through a screen) who are considered at risk. State Medicaid agencies should consider modifying definitions, billing codes, and reimbursement rates to reflect the difference and importance of the two distinct activities.

- **Addressing mental health issues.**

  Research and the work of the four states participating in the ABCD initiative confirm that the emotional and behavioral health of families with young children are critically important to early child development, yet they are not adequately addressed by Medicaid or the mental health system. The mental health system funds few services for young children, and rarely, if ever, for prevention. At the same time, many young children at risk of emotional or behavioral problems are not easily classified with a diagnosable "mental illness," making it extremely difficult to intervene early with support services since diagnosis is tied to reimbursement. Without a diagnosis, many children at risk of more serious emotional or behavioral problems are unable to obtain services.

Parental mental health presents another challenge to state policy makers and practitioners. Parental depression, especially maternal depression, is known to adversely affect the health and well-being of children; however, opportunities and resources to support parents are limited since so many low-income parents lack health insurance. In most states, low-income mothers with newborns are only covered up to 60 days postpartum. Many of the ABCD projects developed multiple approaches to provide support to parents through one-on-one consultation, group education, or educational materials; however, all states found that energy and resources are needed to devise a system to meet the mental health needs of parents in order to address the critical developmental issues of children.

To help states address these inadequacies, the Commonwealth Fund has announced a new initiative to support the work of Medicaid agencies in five states as they seek to build their capacity to deliver care that supports children's healthy mental development. The states selected to participate in this initiative will begin their work in January 2004. For additional information about ABCD II, see the NASHP website at www.nashp.org.

Appendix A

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The ABCD Toolbox, which contains many of the resources detailed in this report, is available on the NASHP website at www.nashp.org.