Developmental Screening: The Primary Care Perspective

OR

“Things I Think” about Developmental Screening in Practice

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WARNING: This discussion contains a lot of “thoughts” that are not necessarily shared by anyone else in the known universe.

BUT that’s OK because the point is just to get you thinking about standardized developmental screening and Quality Improvement in your own practice.

THING # 1: Many pediatricians are not doing developmental screening because they are overwhelmed.

Developmental screening using standardized instruments is the standard of care. That has been true since the publication of the guidelines and algorithm by the AAP in 2006. Those guidelines were reaffirmed by the Academy in February of 2010. So everybody does developmental screening in their practices, right? Unfortunately, no. DHHS did not even give us data on developmental screening based on the CPT code for it, because the code is so seldom used.

So what’s the problem? Well, for one thing, pediatricians are overwhelmed by all of the changes that have continued to come our way. In fact, many of us are paranoid. We feel like we are in a science fiction story. You know, one of those where aliens are coming to get us. Or maybe one of those where they are trying to turn us all into something that we don’t want to be. The response by many pediatricians has been to resist as many changes as possible for as long as possible. Hopefully, with the presentation by Dr. Kelly and as we think through this issue from a primary care perspective, we can begin to feel that we are in one of those sci-fi stories where something wonderful is discovered or new friend is made. Maybe we can decide that developmental testing is, in fact, cool.

THING#2: Group practices need to find a way to get everyone to go along.

I assume that most of the people at this meeting are interested in improving their practices and/or their communities or they would not be here. However, many of you may not be doing standardized developmental screening in your practice because you have had a hard time getting your fellow physicians to go along.

You may have a partner who believes that formal screening is not needed. He believes that he does a good job diagnosing developmental problems. After all, he can take a history and he can come to a conclusion. Why does he need a formal screen? You may have another partner who is very adept at
getting from room to room and she knows that changes interfere with an efficient practice. No margin, no mission. She doesn’t want to do screens because she sees change as a risk.

You see their point, but you also know that developmental screening is the best thing for your patients and that QI activities work best if they are done as a group. So, how do you convince your fellow physicians to go along? Tough question, and I’m not sure I know the answer, but I can suggest a couple of key words. The first one is STUCK. Tell them that they are STUCK. Developmental screening using standardized instruments is the standard of care. Moreover, it ought to be the standard care. They are STUCK with that fact. They simply have to start doing screening.

If the word STUCK doesn't help, try using the word PAID. You are not going to get rich doing developmental screening, but you can charge for it and these days every bit helps.

THING # 3: The easiest way to be successful in meeting the guidelines may be to do MORE than is required.

That may sound crazy, but I actually do a PEDS or an MCHAT at every checkup from age six months through first grade. How did I arrive at such a lofty standard? Or maybe the question should be- what sent me off the deep end? Simple: PREVIOUS TOTAL AND COMPLETE FAILURE. We are creatures of habit. That is especially true for me. I am consistent with things only to the extent that they are part of my routine. I tried following the algorithm. I failed at doing standardized screening at 9 months, 18 months, and 24/30 months. I just didn’t remember. However, I've been very successful with doing it at every visit.

Surprisingly, it does not take more time. Remember that the guidelines call for "surveillance" at every visit. Surveillance means that we are supposed to ask about parental concerns, make observations of the child, somehow discuss the child's development with the parent, etc. I have always done at least part of this- asking questions about development at each visit. The PEDS is a simple and quick lead-in to that conversation. I find that this approach takes no more time and sometimes less time. I substitute the MCHAT for the PEDS at 18 and 24 months.

THING # 4: It is probably best to have a clear plan on how to do developmental surveillance.

I assume most pediatricians will not take my approach of doing a standardized screening at every checkup. If so, they need to take the surveillance piece even more seriously. The Academy statement defines developmental surveillance as "a flexible, longitudinal, continuous, and cumulative process whereby knowledgeable health care professionals identify children who may have developmental problems. There are five components of developmental surveillance: eliciting and attending to the parents concerns about their child's development, documenting and maintaining a developmental history, making accurate observations of the child, identifying the risk and protective factors, and maintaining an accurate record and documenting the process and findings". WOW! While many
Pediatricians are doing a lot of this without realizing that it is in the guidelines, they are probably not doing it in a deliberate way or documenting it very well. Recently, I have begun to try out the Bright Futures pre-visit questionnaires as a way to get at some of this more efficiently. Whatever you choose to do, you need to have a plan for every visit.

THING # 5: You need to have more than one kind of screen in your office and you need to know how you might utilize each one.

I suspect most of you have what I have- the PEDS, the MCHAT, Ages and Stages, and the Vanderbilt. I believe that we will all have more standardized instruments in the future.

Many times the most appropriate response to a positive screen is to simply do another screen. If you have a positive PEDS, but what you think is a normal child, then doing Ages and Stages may make a lot more sense than making a therapy referral. You may need to schedule the patient for a follow-up appointment, but that’s OK. You can’t afford to turn a check-up into an hour long visit and I think that Ages and Stages is better done at home over a period of time anyway. I usually give the caregiver a stamped, addressed envelope to mail it back, so that I have it scored before the follow-up visit. My nurse scores it for me. I have a fairly good record of parental compliance with this approach. Obviously, the Vanderbilt to be used the same way if the patient is a school-age child with hyperactivity or school difficulty.

Sometimes, I skip the PEDS. PEDS is really a measure of parental concern. It correlates with developmental problems because parental concern correlates with development problems. That falls apart if the caregiver does not actually know the child very well. Foster care is the classic example. I send home an Ages and Stages screen on every new foster patient. This is a high-risk population and these kids deserve a particularly thorough screen, but the foster parent who just took the child doesn’t know them well enough to do any screen accurately. I always see them back and review the results of the screen is part of the follow-up.

Another possible pitfall in working with the PEDS is what I call the "Grandma effect". More and more, we have caregivers, other than the mother, bringing the children in for checkups. You may have a grandmother, or other caregiver, who is concerned about everything -every question is positive, or one who falsely sees their grandchild as "perfect". Often I seem to have one who doesn’t know the answer to any question I ask. In this situation, it may be prudent to pull out your list of developmental milestones or to send a screen home for the mother to complete.

THING # 6: You need to charge for the screen using the 96110 code, but don't charge very much!

Pediatricians deserve to be paid fairly for the services that they provide. However, nothing will derail your developmental screening program faster than parental complaints about being charged for it. Medicaid pays a very modest fee for the screen, but many private insurance companies do not reimburse for 96110 at all. We will never change the policies of private insurance companies if we do
not continue to submit the code. By the same token, an increasing number of families with private insurance have high deductibles and may be paying for all of well-child care out-of-pocket. Others will resent paying more than their co-pay. Your practice needs to have thought about these issues in advance. My best advice is to charge and to submit the code, but keep the charge modest enough that you will receive few complaints from those paying out-of-pocket.

So, what do you do when your fellow physicians don’t want to charge? Once again, you probably need to remember your keywords: STUCK and PAID. Doing the screenings is the standard of care. Payment may soon be related to more than just the reimbursement from 96110. In the not-too-distant future, practices may receive extra money if they are NCQA certified as medical homes. Doing developmental screenings as part of health maintenance are part of NCQA certification criteria. It may be hard to document that you are doing developmental screenings if you are not coding for them. Especially with EMR, you may need the code to lead you to the screen.

THING #7: Don’t be afraid to change the score.

It is probably most efficient to let your nurse score the screen- so that it will be scored when you enter the room. However, no matter how simple the screening questions may seem, many parents misunderstand them. Further, some parents will use the form to list common behavior problems. Their concern does not necessarily indicate a developmental problem. Remember, the screen is not a sacred document. Moses did not bring it down from the mountain. It is a tool. It is your tool. As you discuss the screen with the family, write on it, and adjust it as you see fit. You want it to be clear in your note whether you considered it a positive screen. That's the main thing.

THING #8: If you have a positive screen, you need to do something about it.

This may seem obvious, but I think the fear of having to deal with a positive screen at a check-up and that derailing your schedule is one reason that many pediatricians are not doing developmental screens. However, I have also seen records of patients transferring into my practice that included abnormal developmental screens that were never noted. This is like getting 3+ blood on a U/A or getting a low hemoglobin result and then not mentioning it.

This does not have to be hard. Making the referrals should take you no more time than referring a kid for PE tubes. Within your community, the menu of resources is probably fairly small. If the child is under three, you may simply start with Babynet. Whatever your approach, it helps if you have thought about your menu in advance and you can mentally select a menu item corresponding to a resource or cluster of resources for that child’s problem. We all want to reassure parents, but the best reassurance is that the problem will not be ignored.

One day, HELP ME GROW may help us with this tremendously.
THING # 9: Never underestimate the value of a follow-up visit both for you and for your patient.

You will never make a living simply adding on things to do at check-ups. A check-up and a 99214 will always pay better than just the check-up and two 99214s will always pay better than one 99215. That’s just the way it is. You will not be there to help your patient if you go broke. SO, we have to learn to break complex problems into multiple visits and code appropriately for what we do or pediatricians will become an endangered species! Let me hear you say AMEN.

At the same time, follow-up visits are vital for the patient. A follow-up visit made just to determine whether there is delay often reveals additional information after the parent has had time to reflect on your questions from the first visit. You may have obtained a second screen. The second visit helps you tailor your evaluation.

On-going follow-up is the backbone of your coordination of that patient’s care. Children with developmental delays are children with special health care needs. Obvious, right? So, do we remember that they need routine periodic rechecks just like kids with asthma or seizures or ADHD? You may have referred them to Speech and Developmental Peds and Genetics, but your job is to take the pieces and look at the whole picture. Multiple assessments also give you a much better feel for that child, just like multiple measurements give you a more accurate growth curve.

You also have to make sure that kid doesn’t fall through the cracks. Are they still in therapy? Did the mother follow through with the specialty visit? The parents of children with developmental delays are disproportionately likely to be poor advocates for their children. If you aren’t seeing them back, you don’t know if they are getting what they need.

One interesting aside is the value of a PEDs screen in a child known to have a developmental problem. Because I do a PEDS at almost every check-up, I eventually saw kids with Down Syndrome, ex-premies in therapy, kids with birth defects, etc. whose parent filled out the PEDS. My first thought was that I shouldn’t be screening those kids, but then the screens turned out to be interesting. Many of them had negative screens! That is not because they don’t have developmental delay, it is because the delay had been evaluated and the mother felt good about the therapy the child was receiving. So, for me, the PEDS is a good lead- in for the question of whether the child is getting what he needs. Something we should also be assessing at every check-up and follow-up visit.

THING# 10: If you are just starting to two formal QI in your office, PDSA cycles on developmental screening are a good place to start.

PDSA cycles are best done and easiest to learn when you can do multiple short cycles with small changes. Developmental screening should lend itself to short cycles because of the relatively high volume- especially in group practice. Improvement may be easily seen because most practices are doing
so poorly now that there is no place to go, but up. So, if QI and PDSA cycles are fairly new to your practice, developmental screening is a good place to start.

There are three parts to the CHIPPRA quality indicator for developmental screening. I have attached the indicator. At first, I would only deal with the first part which is actually doing the screens. You could just do a chart review looking at just 9 and 18 month check-ups to see how many of those kids got screens. You will have to decide about the third time. I suspect very few of us are doing 30 month physicals routinely, so you will probably choose to age three.

In any case, I would suggest that you may want to look at two other things at the same time. Were the screens scored as positive or negative and were they coded for? Those things won’t take much additional time and getting those things right early on will make looking at the other two parts of the indicator later much easier.

In conclusion, let me say that it is not all paranoia. We sort of are in a science fiction story. Changes are coming and we will not like them all. And yes, we are STUCK, but developmental screening is something we should welcome. If 15% of children have a developmental problem, then developmental screening is one of the most important things we do. We should be sure we do it well.

So, don’t fight the future. You are still the captain of the ship. Wisdom and experience still matter. Your special communication techniques are still helpful. Your patients still need you to be the Doctor. And even if developmental screens are not the tools of the future we have always wanted, they can still help us get where we want to go- better outcomes for kids.