

Pediatricians and Part C State Programs

Common Ground

2013 IDEA Leadership Conference
July 29, 2013 Washington, D.C.

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2013 IDEA Leadership Conference: Objectives

- 1. Discuss core components of the upcoming Clinical Report on the medical home and early intervention**
- 2. Offer resources for medical home personnel and families to support better collaboration**
- 3. Discuss strategies for engaging and collaborating with physician referral base**
- 4. Explore the barriers to collaboration and strategies to overcome them**

**Early Intervention,
IDEA Part C Services, and the Medical Home:
*Collaboration for Best Practice and Best Outcomes***

AAP Clinical Report. *Pediatrics*

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Council on Children with Disabilities, AAP 2013

Publication Date: October 2013

***Guidance for the Clinician in Rendering
Pediatric Care***

Important areas to Discuss with the Medical Home

- * Common values and purpose of IDEA Part C and the medical home**
- * Evidence of the value of medical home and EI programs for infants/toddlers with special needs**
- * What are evidence-based best-practice models for effective early intervention services**
- * Explore systematic barriers to identification/integration of infants in EI services**
- * Offer resources for medical home personnel and families to support on-going collaboration**

Part C, IDEA

- Provide *comprehensive, coordinated, family-centered, multi-disciplinary system*
- Relies on coordination with other agencies, public & private, for best services
- Provides a measureable “process of care”
- Face fiscal challenges
Face staffing challenges
- “Child find” a core component

Medical Home

- The Medical Home is not so much a place, but a measureable “process of care”
- Provides accessible, family-centered, continuous, comprehensive, coordinated, and culturally effective primary care.
- Developmental surveillance, identification of developmental delays / disorders, appropriate referral

“Global” Evidence-Based Principles

- **Access to basic medical care critical**
- **Promotion of supportive relationships and rich learning experiences for infants and toddlers**
- **From legislative and policy perspectives, investment in early childhood intervention is fundamental for community economic development.**

Models for Intervention

**Translating Evidence-Based Neuroscience *into*
“Best Practice” Early Childhood Services**

**1. Creation of frequent opportunities that allow for
“learning in the natural environment”.**

2. Utilizing methods of *“coaching”* as a model

- families • medical home**
- early intervention programs**

1. Creation of frequent opportunities that allow for *“learning in the natural environment”*.

- **Learning takes place in the *context* of relationships**
- **Intervention strategies should *enhance* – not disrupt – *typical activities unique* to the family**
- **Key agents for infant’s development**
 - *parents / siblings / extended family / others*
- **Emphasis is on *supporting those change agents* and their abilities during everyday activities**
- **Focus is on function**

2. Utilizing methods of *"coaching"* as a model

- **Build capacities of parent / caretaker**
- **Support strategy for use by therapists / early childhood specialists / care coordinators**
- **Requires confidence in specific roles being played by each of the participants in the infant's learning**
- **Active – not passive – process, with close collaboration being a key component**

Elements in the Coaching Process

Element	Examples for Application
Joint planning	Agreement by coach and parent on actions assumed by coach and subsequent opportunities for the parent to practice
Observation	Consider the family's actions / routines to better develop new skill sets, strategies in the natural learning environment
Action	Spontaneous or scheduled events, occurring in real-life situations, allowing the family to practice, refine, or analyze new skills
Reflection	The coach re-visits the existing strategies to assure they are in keeping with evidence-based practices and consider if / when modifications are needed
Feedback	After the family member is allowed to reflect on strategies employed, actions being applied, and opportunities to practice new skills in the natural learning environment, the coach provides information affirming the parent's understanding or adds information to deepen the parent's understanding.

***Several “High-Risk” Groups Seen in the
Medical Home Needing Service***

- **Infants in Environments of Abuse or Neglect**
- **Infants/Toddlers with Mental Health Issues**
- **Infants from Culturally Diverse Backgrounds**
- **Infants from Economically Deprived Backgrounds**

Infants in Environments of Abuse or Neglect

Child Abuse and Prevention Treatment Act (2010)

- **Sought to advance effective practices promoting effective practices that promote “*collaboration between the child protective services system and the medical community, involving providers of *mental health* and *developmental disability services*, and providers of early childhood intervention services.”***

Infant Mental Health: Medical Home & Part C

Family and Associated Environmental Factors	Child Factors
<p data-bbox="137 425 581 475">Low SES / poverty</p> <p data-bbox="137 529 736 579">Low maternal education</p> <p data-bbox="137 634 836 684">History of domestic violence</p> <p data-bbox="137 738 880 788">Maternal/paternal depression</p> <p data-bbox="137 842 875 892">History of parental criminality</p> <p data-bbox="137 946 761 996">Parental health problems</p> <p data-bbox="137 1051 942 1100">Parental mental health disorders</p> <p data-bbox="123 1155 904 1296">Family history of mental health disorders</p>	<p data-bbox="996 425 1389 475">Premature birth</p> <p data-bbox="996 529 1412 579">Low birth weight</p> <p data-bbox="996 634 1721 768">“Difficult” temperament and/or poor “goodness of fit”</p> <p data-bbox="996 822 1696 1035">Exposure to “toxic stressors” (alcohol, drugs, traumatic events, lead, etc)</p> <p data-bbox="996 1089 1524 1139">Cognitive dysfunction</p> <p data-bbox="996 1193 1454 1243">Genetic conditions</p>

I-HELLP Social History Screener

Area of Interest	Example Questions
<u>I</u> Income General <u>Food Security</u>	Do you have fear of running short of money by the end of the month? Do you or anyone in the family ever skip meals because there is not enough money for food? Food Stamps?
<u>H</u> Housing Associated utilities	Is housing or payment for housing a problem for you? Trouble or concern about electric/gas/water bills?
<u>E</u> Education / Developmental / Early child programs	Do you have concerns about how your infant is developing? Is your child in a program to assist you in supporting her development? Do you feel the need?
<u>L</u> Legal status	Do you have questions about your immigration status or about benefits/services for you and your infant/toddler?
<u>L</u> Literacy	Do you have trouble reading forms given from our office or agencies? Do have difficulty in reading generally? Do you read to your child each day
<u>P</u> Personal safety	Do you feel that you and your infant/toddler are safe in your present situation/relationship? Domestic violence?

***“Identifying Infants and Young Children with
Developmental Disorders in the Medical Home”
AAP Policy Statement 2006***

- **Demonstrated the need for and the importance of early identification of children with developmental disorders**
- **Offers roadmap and valuable resources for identifying and referring eligible infants for E.I. services**
- **Outlined algorithms, decision trees, tools for use, etc**

Tools for the Medical Home: Challenges of Collaboration

- Earls (2006) published longitudinal study of developmental / behavioral screening in a North Carolina project with similar suggestions for the Medical Home
 - **office resource guide (how-to-implement, billing)**
 - **curricula / workbooks (CME available)**
 - **talking guides for clinicians (re: developmental screening and scores)**
 - **posters for waiting rooms, etc**

Like the AAP Policy Statement: good ideas based on good evidence

“Implementing Developmental Screening and Referrals: Lessons Learned from a National Project”

King, Tandon, Macias, et al. *Pediatrics* 2010

- **Assess the degree to which a national sample of pediatric practices could implement the 2006 recommendations.**
- **Quantitative and qualitative data from 17 diverse and representative practices distributed across U.S.**
- **Success: implementing the screening as recommended by AAP**
- **Less success: placing referrals and tracking outcomes.**

*“Implementing Developmental Screening
and Referrals: Lessons Learned from a
National Project”*

- **80% of children were screened at recommended target ages (15 of 17 used ASQ or PEDS)**
 - **Lowest rate of screening: November**
-
- **Rate of failed screening = 14%**
 - **Monthly referral rates for failed screens:**
 - **highest: September (78%)**
 - **lowest: January (48%)**
- 61% overall**

Common Themes Re: Screening / Referrals

**** Time and patient flow a concern ****

- **Some chose ASQ to align with state Part C**
- **ASQ allowed for distribution of responsibilities among clinic staff;**
 - **one major negative: staff turnover**
- **Busy season is busy**
- **Multiple delays = Part C Referral;**
 - single delay (“just speech and language”)**
 - **refer for further evaluation by therapist**

Common Themes Re: Tracking

- **Infrastructure (staff) support lacking**
- **Parents didn't understand the process / the expectations / the service protocols / etc**
- **(+) notably better communication with the referral Part C programs**
- **“our referrals to E.I. increased by 60% with no decline in eligibility.”**

Suggestions for Collaboration with the Regional Part C Program

- 1. Improving child-find (screening/identification) and optimizing the referral process**
- 2. Efficient evaluation and coordination of services**
- 3. Advocacy roles of the Medical Home**

1. Improving child-find (screening/identification) and optimizing the intra-office referral process

- **Medical Home should incorporate the AAP recommendations for identifying infants**
- **Once identified, the referral should “set the stage” for collaboration with the Part C program**

**Referral forms are available specific to Part C Program
*(AAP form; Texas form is shown in AAP Clinical Report***

1. Improving child-find (screening/identification) and optimizing the intra-office referral process

• The referral process provides the medical home an educational opportunity:

- expected developmental milestones**
- family goals / expectations**
- physician input to IFSP considerations**
- coordination**

2. Efficient evaluation and coordination of service

- **Practitioners should not wait for a specific diagnosis before initiating a referral to Part C**
- **Early referral should request**
 - **assistance with multidisciplinary assessment**
 - **provision of support to parents (parent-to-parent; etc)**
 - **provision of community resource information**
 - **a preferred mechanism for information return after the assessment**

2. Efficient evaluation and coordination of service

- **To best sustain the *process* of information sharing, the *individuals* at each program should know who one another are and how best to contact the other**
- **For complex and/or psychosocial issues, closer follow-up & direct contact with the Part C Program**
- **On-going sharing of information reassures the family and removes them as “go-betweens”.**

3. Advocacy roles for the Medical Home

- **Note: there are state-to-state differences in policies (eligibility criteria, assessment, & services provided)**
- **Awareness of potential costs to family (public or private third parties; self pay; etc)**
- **Be cognizant of resources (fiscal / profession / staff) available within the state and region**
- **Assign time to meet staff from local / regional Part C**
- **Work with state AAP Chapter for policy-level involvement in the Part C Program**

References / Resources

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- Michaud LJ, and Committee on Children With Disabilities. *Prescribing Therapy Services for Children with Motor Disabilities.* Pediatrics Vol. 113 No. 6 June 2004, pp. 1836-1838.
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- Tools such as the AAP Referral Form for Early Intervention: http://www.medicalhomeinfo.org/downloads/pdfs/EIReferralForm_1.pdf