American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

American Academy of Pediatrics, California
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March 22, 2019

To: The Department of Health Care Services
From: The American Academy of Pediatrics, California
(For questions please contact AAP-CA CEO Kris Calvin at office@aap-ca.org)
Re: Public Comment: Prop 56 Developmental & Trauma Screening Proposals

We appreciate the opportunity to provide public comment on the Department of Health Care Services (DHCS) Prop 56 Developmental and Trauma Screening proposals. AAP California strongly endorses the intent of these proposals: to consistently integrate developmental and trauma screening into primary care practice. Children, families, communities and primary care providers benefit when we screen for, and address conditions that prevent our children from reaching their full potential. To ensure that these important initiatives best achieve their intended objectives, California pediatricians We offer the following comments and recommendations:

Importance of Immediate and Ongoing Stakeholder Involvement
Families, providers, plans, state entities and others each have critically important perspectives to bring to developmental and trauma screening initiatives. Working collaboratively early in the process and in an ongoing manner will help to ensure that the best ideas are developed and implemented.

AAPCA Comments on Development Screening Proposal

Target Population

The target population for developmental screenings should be extended to 32 months, since the Ages and Stages developmental questionnaire, the most commonly used screening tool for 30-months, is valid up to 31 months and 15 days and many children do not have their well child appointment scheduled exactly at 30 months.

Choice of Tool(s) and Frequency of Screening

We endorse the recommendation to use validated screening tools that meet the criteria set forth by the AAP and the Centers for Medicare and Medicaid Services.
We also endorse the proposed frequency of screening at 9, 18- and 24- or 30-month visits, consistent with AAP/Bright Futures Preventive Guideline

Monitoring and Oversight

We recognize and support the recent intent of DHCS to expand quality measures impacting care for children, including Developmental Screenings in the first 3 years of life and Well-Child Visits in the first 15 months of life. We support adding these NCQA quality measures to the DHCS MCP External Accountability Set (EAS).

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The majority of developmental screens (18 months and 24 or 30 months) are performed at visits that are often missed by busy families. Medi-Cal managed care plans (MCPs) should be required to document their rates of visits at 18, 24 and 30 months as part of the developmental screening quality measure and this should be reported as part of the EAS.

System Integration

We recommend that support be given so that at-risk children and parents are appropriately referred to community resources and intervention programs. Many barriers presently exist, however to successfully referring at-risk children and families to these programs. Managed Care Plans (MCPs) should be required to develop quality improvement programs that measure whether or not the at-risk child received the appropriate follow up evaluation and services We recommend DHCS fund and support pilot programs to facilitate successful referrals to community resources, such as MOUs and partnerships with First 5's Help Me Grow program and local Regional Centers. Along with the efforts of Help Me Grow and pilots for RC; there needs to be language or consideration for actualization of early intervention services beyond referral.

We recommend that DHCS support a statewide initiative to create a community of organizations with MOUs which allow the legal sharing of information and fully support the families within the medical home. Deployment of technology that permits HIPAA-compliant transfer of information between health care, regional centers, and community-based organizations should be considered to facilitate efficient care coordination and communication.

A work group of a larger stakeholder advisory committee (or a separate committee) is recommended to consider expanding the Comprehensive Perinatal Services Program to families and children 0-5 years in order to assist health care providers in meeting the needs for support of families of young children with concerns regarding development, behavior, and/or trauma exposure. The same expanded CPSP program could be used to provide expanded maternal mental health services per recent legislation.

AAPCA Comments on Trauma (ACEs) Screening

Target population

We support the description of the target population of children and adolescents.

Choice of the Screening Tool(s) and Frequency of Screening

We support the proposed frequency of screening for children and adolescents. Pediatric screening initiatives generally have greater success if there is a suggested schedule for screening, which is integrated into the schedule of well child visits. This reduces duplicated and missed screenings.

There is no standardized trauma screening tool recommended by the American Academy of Pediatrics (AAP). The proposed trauma screen developed by the Bay Area Research Consortium (BARC) has no published literature at this time validating its effectiveness.

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Limiting providers to a single tool restricts providers who may find that a validated screening tool that they are already using meets the needs of their population.
We recommend that DHCS adopt the AB340 Advisory Working Group's recommendation that Medi-Cal providers be given 3 options for screening pediatric populations for exposure to trauma:

- The BARC screening tool alongside the existing Staying Healthy Assessment tool or other state-approved Individual Health Education Behavior Assessment (IHEBA)
- The Whole Child Assessment tool, which is a state-approved IHEBA that incorporates preliminary screening for exposure to trauma
- An alternative State-approved tool to screen for trauma which contains all of the items in the BARC tool.

It will also be important to add Resilience Screening when we promote ACEs screening. Many now appropriately promoting ACEs and TIC models to screen a population; however to embark on systematized and focused intervention, there needs to be resilience screening that is tied with ACEs.

Monitoring and Oversight

Before initiating the intervention, consideration should be given (with stakeholder input) to conducting short-term pilot projects across California to clarify the support needed by primary care providers and review the existing capacity of providers to integrate this tool into their practice. AAP policy states that "it is essential that innovative and practical strategies continue to be developed that strengthen the capacity of the medical home to reduce sources of toxic stress and to mitigate their impact on the lives of young children." Trauma screenings take time and resources, both in working with the families to complete the screen, evaluating it and responding to it. A large number of trauma screens will show concerns. A recent study of children less than age 5 showed that a majority of low-income children (77.4%) were exposed to 1 or more ACEs. Pilot studies could look at how screening impacts primary care flow and whether additional time and/or resources are needed to assure successful completions and follow-up of the screens.
At-risk children and parents should be referred to appropriate community resources and intervention programs. There is no evidence that providing families with a phone number of these programs will make a significant impact. AAP policy endorses that "Routine screening for increased vulnerability is useful only if collaborative relationships exist with local services to address the identified concerns." Pilot projects would explore the impact and feasibility of co-located services, care coordination by the practice or MCP, and partnerships with local community organizations in order to support these families. Few pediatricians have access to a database of community organizations for referral that gives them enough information that they can be assured that the family will receive services. Medi-Cal managed care plans (MCPs) should be required to provide a constantly updated electronic database of programs for referral, and feedback to the providers regarding the success of each referral.

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Policies regarding consent for screening and parental reluctance to complete screens should be developed. Families who have suffered trauma are adversely affected because of their sense of a lack of control within their lives.

Prevention of Trauma/ Enhancement of Parent-Child Relationships

Strong parent-child relationships are the key to resilience and set the foundation for both mental and physical health.
Health care providers can support prevention and enhancement of parent-child relationships through facilitated access to refer patients to high-quality preschool and child care programs that have Early Childhood Mental Health Programs, as well as evidence-based home visiting programs such as Nurse Family Partnership.
Local schools should be supported to offer behavioral health and parenting support to families at-risk, funded by local Mental Health Services Act funds and/or MCPs and Specialty mental health plans.

Oversight of Screening Programs/Funding

We recommend that these programs be monitored as part of an MCP-adopted quality improvement initiative.
Reimbursement for trauma screening should be the same as developmental screening. Both screens take additional provider time and require monitoring and oversight by the MCP. A differential reimbursement for the screens will leave the impression that one is more important to complete than the other.
We recommend that DHCS examine how the enhanced reimbursement for the MCPs can directly support providers in this initiative.
Prior authorization would be a barrier to screening or repeat screening and should not be required, since these services fall under the EPSDT federal guidelines as being medically necessary to prevent significant illness or disability.