March 19, 2019

**Comments on Proposition 56: Trauma Screening**

The following comments identify a series of issues that are likely to arise if Proposition 56 is adopted as policy. I believe each comment should be considered by the DHCS prior to moving forward. This is not to say that the Proposition is flawed, merely that it will raise a large number of foreseeable issues that the Department needs to be prepared to address.

- **Instrument selection** – There appears to be no easy access to the BARC screening too, so it is not possible to comment on its recommendation. There are a number of potential screening instruments, none of which is clearly superior. Selection should depend upon not only the instruments' reliability and validity but also on how well it fits the population being screened and the clinical setting in which it will be used. Consequently, it is suggested that the state or health plans offer practices a choice of acceptable instruments.

- **Burden on practices** – Introducing a new procedure into a practice/system is disruptive. It has implications for duration of visits, staffing ratios and responsibilities, record-keeping and information storage and transfer, and patient flow. Practices will rightly want information about these issues before they are willing to consider adopting a new screening procedure.

- **Options of other setting for screening** – Although health care settings may seem idea for screening, especially during the early years of life, they may not be the only or best setting depending on the population and local circumstance. Child care settings, schools, community centers, etc. could be screening sites,

but many issues such as how they would be reimbursed, monitored etc., would have to be considered.

- **Reimbursement** – The rate for screening is generous, but the expectations for that process need to be very clear. Does that rate cover referral when a screen is positive? Is further assessment indicated and how would that be covered? screening or screening & referral

- **Age specific schedule** – Developmental screening for young children is recommended at ages 9, 18 and 24/30 months. Should the proposed screening be done at the same time or interspersed. What if a screening instrument such as the SWYC is used that includes screening for development and social determinants? How would that be handled logistically and financially?

- **Pre-natal screening** – Most situations that place young children at risk are present prenatally and some prior to conception. Should the proposed screening be included in prenatal and postnatal obstetric care? How would screening results and consequent referral information be transferred to the child health care provider?

- **Communication with practices** – How will medical practices and practitioners learn about this new screening expectation, policy and reimbursement? In general, physicians require direct, face-to-face communication about such things, as letters and other such devices tend not to be effective.

- **TA to practices** – As noted above, changing practice procedures is difficult. The best outcomes are achieved when in-office, technical assistance is provided. What are the plans for technical assistance on screening processes, interpretation of results, and effective processes for referrals?

- **Referral expectations** – What are the Department's expectations for actions following a positive screen? What assistance and reimbursement will be provided?

- **Referral processes** – Positive screens will trigger additional assessment and potentially referrals to a variety of community resources. Each community program/service provider will have different procedures for receiving and responding to referrals. How will they be educated and what kinds of relationships will be necessary between health care providers and other service providers for this process to work smoothly?

- **Referral assistance** – Experience shows that referrals to community agencies and service providers can take, on average, 8-9 telephone calls to establish. Very few, if any, practices are staffed or reimbursed to do this. What assistance can the state, county or health plans offer to ensure referral completion?

- **Capacity of community service providers** – Given the research on such screening, positive screens are quite common, especially in Medicaid-enrolled populations. This leads to a substantial increase in referrals to community service providers, frequently in excess of what they are able to receive and manage. How will those service providers be assisted, since absent an effective referral process, screening is largely a waste of time.

- **Monitoring screening** – How will the Department monitor the rate and quality of screening? Will it be based solely on billing data? What will be considered an adequate screening rate for a health plan? What action will be taken by the health plan and the state to address low rates?

- **Private sector involvement** – What thought has been given to expanding screening expectations into the privately insured population? Does the state, as an entity responsible for the health of all residents, have an obligation to ensure that everyone benefits from what screening offers?

- **Primary prevention Vs. secondary prevention** – Screening children for having had traumatic experiences should be a second choice of how to use resources.

The first choice should be to identify situations that place a child or their family at risk and then intervene to address those potentially risky situations so trauma does not occur.  Such identification/screening can occur prior to conception or birth.  For some populations, i.e., children in foster care, screening is not indicated, and services should focus on comprehensive assessment and effective intervention.

Sincerely,

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