Promoting the Social and Emotional Health of Children through Early Identification

Iowa's ABCD II Demonstration Project Results

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This past December, Iowa's Assuring Better Child Health and Development II (ABCD II) project completed the testing of a model for a public-private system of collaborative practice to:

- Promote social and emotional health in children
- Develop stronger relationships among community resource networks

The primary objective of this project was to better equip primary health care providers with the tools and resources they need to provide systematic surveillance, screening and follow-up of a child's social-emotional development.

ABCD II goals included:

- Identifying, as part of each well-child exam, risk factors in the child and the family
- Connecting providers to a network of resources to help carry out an integrated plan of care that responds to a family's strengths, needs, and choices

Rural and urban demonstration sites

Two group practices, an urban pediatrics practice and a rural family medicine practice, agreed to implement the model. Evaluation was based primarily on audits of medical records for children who received Medicaid services, information in public health records from care coordinators assisting families, and feedback from medical professionals about the costs and benefits of changes in their practices. Providers were given:

- Health Maintenance Clinical Notes forms that include the Iowa Development and Behavior Checklist
- Iowa guidelines for the identification of young children at three levels of care Referral resources
- Training on such topics as social-emotional concerns in the young child, autism, and maternal depression

Surveillance/screening rates

At baseline, surveillance/screening for general developmental problems was adequate for 89% of children in the urban pediatric practice and 70% of children in the rural family medicine practice (see tables 1 and 2), indicating reasonably capable screening performance in both group practices, but especially in the pediatric practice. After implementation of the enhanced surveillance/screening procedures, rates of adequate screening increased to 98% in the pediatric practice and 88% in the family practice; only 22 of 400 children did not get adequate developmental surveillance.

Screening for social-emotional problems was lower in both practices at baseline than it had been for general developmental problems, with adequate screening for 65% in the pediatric practice and 36% in the family practice. When records were reviewed after implementation

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of the model, screening rates improved to 95% in the pediatric practice and 89% in the family practice.

PERCENTAGE OF ADEQUATE SCREENS Table 1. Urban Pediatric Practice				
Domain	**Baseline**		**Post-Intervention**	
	Cases	**Percentage**	**Cases**	**Percentage**
Development	207/232	89%	245/249	98%
Social-emotional	151/232	65%	237/249	95%
Family stress	0/232	0%	201/249	81%
Parent depression	0/232	0%	133/249	53%
Table 2. Rural Family Medicine Practice				
Domain	**Baseline**		**Post-Intervention**	
	Cases	**Percentage**	**Cases**	**Percentage**
Development	118/168	70%	133/151	88%
Social-emotional	60/168	36%	135/151	89%
Family stress	0/168	0%	121/151	80%
Parent depression	0/168	0%	114/151	75%

Neither practice provided systematic screening for family stress or parental depression at baseline. Screening improved dramatically when practices were provided with a simple surveillance/screening tool for this purpose. Family stress was adequately reviewed in 80-81% of cases seen at follow-up, while risk for parent depression was reviewed in 53% of cases seen in pediatrics and 75% of cases seen in family medicine. The somewhat higher depression screening rates in family medicine were accompanied by physician report that family physicians were accustomed to interviewing and treating parents for personal problems, while pediatricians felt less comfortable raising these questions with parents during an evaluation that focused on the child.

Provider Comments

While providers recognized the potential value of including social-emotional, developmental and family risk screening and follow-up in the well-child exam, they were wary of the extra time and work the surveillance/screening model might require.

"Initially," commented one pediatrician, "I thought, 'How much time and work will this be? It's going to throw us off kilter.' Then after hearing about it, I thought it made sense. "

A family physician said, "It is more structured than before, a more organized approach. It takes a little more time, but not much." Another commented, "Many times you didn't think about those things until a child isn't doing them. Now we are being more attentive to those types of problems."

"…surveillance is a great way to begin a dialogue with parents…"

"Parents…felt they were cared about. It built rapport."

"Better be incorporating this into medical training. This is a solid framework."

Apprehension also existed about asking adult caretakers about maternal depression and other socio-emotional risk factors. These doubts generally disappeared as providers became more accustomed to doing the screening and realized how it helped children and families. "Maternal depression is an easy question to avoid because it deals with the mother or caretaker, but it is an important issue that affects children," said a pediatrician. "The screening is a great way to begin a dialogue with parents. It is a start; doing something is better than doing nothing."

A pediatric nurse commented, "Parents seemed to appreciate that we cared. As our comfort went up, so did the parent's." A family physician noted that the "physical development red flags didn't change. That is straightforward. It was the emotional support that was new."

Another pediatrician remarked, "The project has been very helpful--especially with a good team of providers in the clinic and in the community where everyone knows their role."

Providers from both practice sites agree they will continue using the model. They believe the social-emotional component is useful in drawing out concerns from parents; as one provider said, "The HMCN forms were good in identifying risk history and concerns from parents. Parents were glad to hear providers asking those kinds of questions and felt they were cared about. It built rapport." And parents commented, "No one has ever asked me about that before."

Both pilot sites made valuable suggestions about ways to improve the HMCN forms and to spread the surveillance/screening model to other Iowa primary care practices, both pediatric and family medicine.

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