

Executive Summary

The Commonwealth Fund funded a three year state-focused initiative, Assuring Better Child Health and Development (ABCD), as part of its Child Health and Development Program. The goal of the Commonwealth Fund is to increase and enhance child development services low-income children and their families receive. The Commonwealth Fund also funded a combination of researchers from Northwestern University, New York University and University of Kansas as the national evaluators for ABCD.

The national evaluation team adopted a case study approach, involving primarily qualitative data collection. The team conducted three rounds of site visits (N=12) and document review, coinciding with the three years of the initiative. The team collected qualitative information on each state through 3 in-depth site visits, 206 interviews with 150 key informants, review of all submitted project documents, and participation in Consortium meetings and conference calls. The national evaluation team also synthesized the primarily quantitative data collected by the four local evaluations.

- *How did states put into place a program and policies to enhance early child development?*

All four states successfully implemented most or all of the components planned in their proposals in a relatively short time frame and for a modest amount of new dollars.

- A critical point in determining the nature of the final shape of the ABCD programs occurred in the planning phase. All four states implemented programs very similar to what was planned in the original proposals or shortly thereafter.
- It was important to establish a balance between anticipating what would be acceptable in the specific state context and being overly cautious in terms of innovation. It was important for states to not only recognize current parameters but to anticipate changes in the state environment in terms of health care, Medicaid, and other aspects of the state government when developing and subsequently implementing their ABCD programs.
- Involving representative professionals in the initial planning process was critical to successful implementation and states that did not do so spent considerable time involving key professionals during early implementation.
- Another key to successful implementation in these four states was the ability to identify and build upon existing programs, collaborations, infrastructure, or strategies around child development that existed already in their states. Integrating the ABCD program into ongoing efforts also assisted sustainability.
- Another important feature in successful implementation was the pursuit of “pilot, refine and expand”. Not only did this type of strategy allow refinement of the programs, but it provided empirical results of the success of the programs that were important for promoting broader implementation.

- *Have low-income parents been provided with information that would improve their child-rearing practices and increase their comfort level with the health care system?*

Of all the four major goals of ABCD, providing parents with child development information was the most consistently and broadly accomplished goal.

- Home visitors in Vermont and Utah were charged with providing parents both information on child development and encouragement to make EPSDT visits. Evidence from local evaluation data supports this aspect of home visiting.
 - The states developed a number of materials incorporating child development information and strategies for disseminating them to parents, including parent books, websites, health organizers, and brochures.
 - Washington's efforts at direct parent education included parent classes and training parents to use the Ages and Stages Questionnaire.
 - Another approach worked to provide better education via training or education of health care providers.
 - It is instructive that most of the parent education activities were conducted by non-primary care providers, including nurses, early childhood specialists, home visitors, Health Promoters, WIC personnel, and hospital and office staff.
- *Have changes occurred in pediatric practice that support greater attention to early childhood development?*

Overall, ABCD was most successful in changing the behavior and practice of non-primary care providers, but had some success with primary care providers.

- North Carolina and Vermont achieved some success in changing the behavior of primary care physicians through direct training, either in using a specific developmental tool or with a more generalized orientation towards developmental milestones.
 - Washington attempted to change primary care provider through the widespread use of a revised EPSDT form, but the data do not yet support the effectiveness of this approach.
 - All four states have at least an implicit assumption that changing demand for child development services will, by educating and empowering patients' parents, slowly change physician behaviors, but the validity of this assumption remains to be seen.
- *Have more Medicaid-enrolled young children in each of the four states received health and developmental services since the projects began?*

Overall, the ABCD program was effective in delivering enhanced health and developmental services to Medicaid-enrolled children aged 0 – 3.

- The ASQ program has been highly effective in one county of North Carolina, 3 other counties in North Carolina have begun or are about to begin the ASQ screening, and there are promising signs that the program will spread in time throughout much of the state.

- Vermont's integrated approach to providing services holds great promise in ensuring that the majority of families receive the best and most appropriate child development services as identified by need.
 - Vermont further anticipates enhanced services via Touchpoints training of providers, both physicians and non-physicians, and this appears to be happening very widely.
 - Washington adopted a more indirect approach to providing services in assuming that using the revised EPSDT form would enhance child development services and that empowering parents would help them demand and receive more services.
 - Utah's home visitation program did not allow for the provision of direct services but one goal of the program is enhanced referrals to developmental services. By encouraging families to establish a "medical home", the home visitors further increased the chances that children received preventive care and child development services.
- *Have states reformed their Medicaid policies to improve payments to pediatric clinicians or refined procedures that otherwise promote the provision of child development services?*

Although policy change is a very slow process, all four states made changes in Medicaid policies, regulations, reimbursement mechanisms or procedures as a result of ABCD activities in the relatively brief time span of three years.

- Utah passed a state amendment early in the process to add TCM as a reimbursement mechanism.
 - In Washington, new Medicaid policy reimburses physicians an enhanced flat rate per visit if they use the EPSDT charting tool for children in foster care.
 - In North Carolina, the state advisory group succeeded in having the definition of "natural setting" expand to include the doctor's office for reimbursement of child services.
 - Vermont holds great promise for wide systemic change. The combination of the integrated team approach ABCD is piloting in *Healthy Babies, Kids & Families* and the unifying principles of Touchpoints is considered a model for a statewide approach to coordination of services.
- *Beyond the Research Questions*
 - NASHP and the Consortium were instrumental in helping states to achieve as much as they did. The states would probably have had successful projects without NASHP and the Consortium, but it seems clear that these two factors boosted the projects to a higher level.
 - A very significant outcome of the ABCD Initiative was the degree to which it inspired inter-agency cooperation and coordination in all four states. Over the course of the three years, inter-agency barriers were broken down and often intractable bureaucracies changed their behaviors as a result of ABCD.
 - ABCD brought attention to child development issues within Medicaid, generally at very high levels in the hierarchy, and also put Medicaid in the position of developing and

providing services or partnering with agencies that could provide services, instead of merely paying for service.

- ABCD engendered enhanced attention and focus on child development throughout the states. This attention began with and was promoted by local ownership of the ABCD projects and the projects that became associated with ABCD.
- The combination of integration and support for ABCD within Medicaid and increased attention statewide on child development bode well for the sustainability of the four state projects in some form.

National Evaluation of the ABCD Initiative

Background and Project Goals

The Commonwealth Fund funded a three year state-focused initiative, Assuring Better Child Health and Development (ABCD), as part of its Child Health and Development Program. The goal of the Commonwealth Fund is to increase and enhance child development services low-income children and their families receive. Several Commonwealth-funded studies prior to the creation of ABCD revealed that states have significant opportunities to enhance delivery of developmental services. The Fund issued a Request for Proposals titled, “Building State Medicaid Capacity to Provide Child Development Services,” in September 1999, and ultimately selected four states-North Carolina; Utah; Vermont; and Washington-for participation (see Appendix A for a description of the four states’ ABCD projects). The ABCD initiative allowed funded states the opportunity to experiment with financing and pediatric delivery models designed to improve the quantity or quality of child development services received by children enrolled in Medicaid.

The ultimate goal of an experimental initiative such as ABCD is expansion and replication beyond the pilot phase. States that consider replication of aspects of ABCD will require evidence of the feasibility of implementing these types of services through Medicaid mechanisms, including information about facilitators, challenges, and how the pilot states overcame them during the development and implementation phases of their projects. States and future funders will also need persuasive evidence that services delivered in these ways can have positive impacts, as demonstrated by measurable outcomes. The Commonwealth Fund, therefore, funded a combination of researchers from Northwestern University, New York University and University of Kansas as the national evaluators for ABCD to answer five key research questions:

- *How did states put into place a program and policies to enhance early child development?*
- *Have low-income parents been provided with information that would improve their child-rearing practices and increase their comfort level with the health care system?*
- *Have changes occurred in pediatric practice that support greater attention to early childhood development?*
- *Have more Medicaid-enrolled young children in each of the four states received health and developmental services since the projects began?*
- *Have states reformed their Medicaid policies to improve payments to pediatric clinicians or refined procedures that otherwise promote the provision of child development services?*

The national evaluation team adopted a case study approach, involving primarily qualitative data collection, to capitalize on the richness of data provided by four distinct program models. Qualitative evaluation methodology provides the best fit when the goals of the evaluation are to allow continued evolution and innovation of the programs while at the same time yielding rich, detailed information. The team conducted three rounds of site visits and document review, coinciding with the three years of the initiative. The first round, conducted in the first project year, focused on planning, development and early implementation. The second round concentrated on the “program in action”. The third round emphasized expansion/replication, effectiveness, and sustainability. The team collected qualitative information on each state through in-depth site visits, interviews with key informants, review of all submitted project documents, and participation in Consortium meetings and conference calls. The national evaluation team also synthesized the primarily quantitative data collected by the four local evaluations.

The Four State Programs

Detailed summaries of the projects undertaken by each of the four Consortium states are included in *ABCD: Lessons from a Four-State Consortium*. This document is available on the NASHP website at www.nashp.org.

Methods

Process Evaluation

The process evaluation focused on assessment of the development, implementation, and refinement of each of the state’s programs (Research Question #1). This part of the evaluation established the feasibility of the programs and provided information for replication purposes by documenting the steps state took that culminated in successful implementation. The process evaluation included three primary methods of data collection: 1) document collection and review; 2) key informant interviews and site visits; and 3) observation of state Consortium meetings and monthly conference calls. The evaluators used documents and interviews with key informants to understand what services were discussed, planned and implemented, as well as perspectives on how the state environment affected plans and implementation.

The evaluation team conducted three site visits to each of the four states (N=12). Site visits included 206 semi-structured, qualitative interviews with 150 unique key informants over the three years of the evaluation. Key informants included the state Medicaid director; key personnel from partner agencies; front-line staff involved in the program; medical and nursing directors; and participating families and providers. In the first year, interviewers focused on the respondents’ perceptions of the child development needs and issues in their states; barriers faced and overcome in initiating program activities; and plans for implementation. In the second year, interviews focused on the midstream implementation of the programs and early accomplishments. The third year interviews emphasized program expansion or replication with the states, program effectiveness, dissemination, and sustainability.

The evaluators have also documented program implementation through a review of program materials. These include documents used for staff recruitment and training, including provider education; information provided for education of program participants; agendas and minutes from meetings; quarterly reports; and materials used for advertising and marketing-related activities.

Coordination, Support and Synthesis of Local Evaluations

The national evaluators worked with the local evaluators in the development and implementation of their local evaluations. The local evaluations focused on quantifiable aspects of program outputs, such as the numbers of children screened and referred or the numbers of providers trained (Research Questions #2, 3 & 4). Some of the local evaluation activities moved beyond program outputs to immediate outcomes, such as knowledge gained by providers or family satisfaction.

The national evaluation included a synthesis of the outcome or program output measures resulting from the local evaluations in the four states. This synthesis assessed the overall effectiveness of ABCD as a strategy, as well as the state-specific approaches. The national evaluators were responsible for tying together the findings from the four local evaluations and addressing Research Questions 2, 3 & 4 for the entire Initiative.

Qualitative Assessment of ABCD Outcomes

In addition to the quantitative data local evaluations gathered to address research Questions 2, 3 & 4, the national evaluators investigated these questions qualitatively through the integrated case study approach. This qualitative information not only confirmed the quantitative findings, but provided greater richness and depth to the numbers. Furthermore the qualitative approach included a variety of perspectives on these questions of what the Initiative has provided children, parents and providers. For example, by observing home visits and talking to families the evaluators gained a better understanding of what receiving specific services meant to participants. Finally, this part of the evaluation was the only component that addressed Research Question #5, the effect of ABCD on Medicaid policies, rules, and regulations.

Results

- *How did states put into place a program and policies to enhance early child development?*

All four states successfully planned, developed and implemented programs that addressed their stated goals. It is clear from the ABCD experience that it is entirely feasible for states to put programs in place to enhance child development, and that Medicaid is a viable home for such programs. All four states successfully implemented most or all of the components planned in

their proposals in a relatively short time frame and for a modest amount of new dollars. Although the four states shared similar broad goals in terms enhancing the delivery of child development services to children enrolled in Medicaid, their specific objectives and means to accomplish those objectives differed greatly. The legislative and political climates of the four states differed quite a bit as well, and the experiences from the first year suggest that state climates mattered to a certain extent in terms of planning, but were not definitive in shaping implementation.

There were both unique challenges in implementation as well as challenges shared by some states, including longstanding impediments that preceded ABCD such as inadequate reimbursement rates for Medicaid, prescriptive reimbursement mechanisms, problems with access to adequate primary care, and geography. The states grappled with these issues and largely overcame or circumvented them in the second year, although the evaluators concluded that sufficient access to primary care providers is a necessary precursor for successful implementation of an enhanced program in Medicaid.

Planning and development. A critical point in determining the nature of the final shape of the ABCD programs occurred in the planning phase. All four states implemented programs very similar to what was planned in the original proposals or shortly thereafter. In Utah, staff discovered shortly after receiving funding that its proposed mechanism for delivering services had become untenable due to changes in funding sources. Staff identified a different funding mechanism, which changed the direction of the program permanently from the outset. Early plans very much set the stage for what ABCD was to become in each state – no state changed their course of action after the beginning phase, even with considerable interaction with other states, NASHP and the Fund, and exposure to other innovative ways to deliver child development services over the first two years of the project. When considering programs in the future, it is very important that the early planning reflect and embrace the specific underlying goals of the initiative, as it is unlikely that those goals will develop over time if they are not part of the original plan.

The national evaluation team also found that in developing these new, innovative programs it was important to establish a balance between anticipating what would be acceptable in the specific state context and being overly cautious in terms of innovation. These states were able to work within the broad parameters of their states but stretch beyond those boundaries to a certain extent. At the same time, it was important for states to not only recognize current parameters but to anticipate changes in the state environment in terms of health care, Medicaid, and other aspects of the state government when developing and subsequently implementing their ABCD programs.

Implementation. Not surprisingly, the states benefited from their ability to engender high level support for their projects both within Medicaid and key partner agencies, such as the Department of Health or Public Health. This type of high level support was important in the actual implementation and also for sustainability. States also found that involving representative professionals in the initial planning process was also critical to successful implementation.

States that did not do this during planning had to devote considerable time and resources during implementation to soliciting support for these projects from the professionals who ultimately were responsible for key services.

Another key to successful implementation in these four states was the ability to identify and build upon existing programs, collaborations, infrastructure, or strategies around child development that existed already in their states. Not one state built its program “from scratch”. For example, Utah and Vermont used their existing home visiting programs as the basis for their ABCD programs. Washington very effectively integrated developmental information into the well established ChildProfile mailings. North Carolina built its screening programs onto the Access II/III system in the state. Building on existing programs, relationships and structures shortened start-up time and allowed resources to spread further, in part by minimizing the necessity to create new positions. Integrating the ABCD program into ongoing efforts also assisted sustainability.

Finally, another important feature in the successful implementation of these four projects was the pursuit of “pilot, refine and expand” strategy, either by original intention or not. Two states, North Carolina and Washington, planned to pilot one or more projects or elements of products, refine them after pilot results, and then gradually expand to other interested sites. The other two states initially planned state-wide rollout of their programs or components of their programs, but moved to a pilot, refine and expand approach in implementation. Not only did this type of strategy allow refinement of the programs, but it provided empirical results of the success of the programs that were important for promoting broader implementation. This strategy proved hugely successful in all four states. Accordingly, the evaluation team concludes that a circumscribed initial implementation is the most prudent approach to implementing innovative new services into Medicaid

- *Have low-income parents been provided with information that would improve their child-rearing practices and increase their comfort level with the health care system?*

Of all the four major goals of ABCD, providing parents with child development information was the most consistently and broadly accomplished goal. Improving parental knowledge through direct services was a cornerstone of all four programs, and the states found multiple ways to provide parent education. Home visitors in Vermont and Utah were charged with providing parents both information on child development and encouragement to make EPSDT visits, as were Health Promoters in Whatcom County of Washington. Evidence from local evaluation data supports this aspect of home visiting. For example, the vast majority of parents surveyed in Utah who received home visits indicated that the visiting public health nurses had encouraged them to make well-child visits.¹

¹ 95% of 290 parents surveyed (22% response rate). Utah local evaluation report

The states developed a number of materials incorporating child development information and strategies for disseminating them to parents. Vermont created an award winning, colorful and user-friendly parent book that it distributed to 7,500 parents in the first edition with 10,000 printed for the second wave of distribution². Vermont has also created a website for parent education (<http://www.healthyvermonters.info/cph/hbkf/hbkf.shtml>). North Carolina created colorful brochures on child development that were available to parents in participating clinics, although only a little over half of surveyed parents in 2001 and 2002 indicated they had received written information on how children develop.³ A tool developed by Washington for use by Health Promoters in encouraging and enhancing EPSDT visits, the Health Organizer, was rated as the most useful of all Bright Futures materials⁴ and has spread throughout the state. Washington also incorporated child development information into materials the state already provided all parents.

A more recent effort in Whatcom County trained Health Promoters to introduce families to the ASQ, and about half of families surveyed indicated they used the ASQ to monitor their children's development.⁵ In another Washington county WIC developed and implemented a class on child development as part of its parent education requirement, a class now provided approximately seven times each quarter to WIC clients.⁶

Another approach worked to provide better education via health care providers, either through developmentally oriented provider training as in Vermont or through the use of a charting tool that includes tear-off sheets for parents in Washington. Physicians in North Carolina were encouraged to use the ASQ as a springboard for discussions with parents about their children's development, although this happened less often than anticipated. Only 1 of 10 family practice physicians surveyed in one practice (26% response rate) indicated that he/she "definitely" used the ASQ as a guide in speaking with parents about child development, and the comments associated with the 6 of those who said they used it "somewhat" suggest that they use it primarily when the ASQ indicates problems or deficits.⁷ However 74% of parents surveyed in 2001 (N=58) and 90% of those surveyed in 2002 (N=126) reported that someone had discussed their children's development at the well-child visit targeted by the survey.⁸ Without a pre-intervention baseline or comparison group it is not possible to attribute these results to ABCD, but the increase from 2001 to 2002 is suggestive that longer use and perhaps greater saturation of the ASQ is correlated with more discussions with parents about development.

It is instructive that most of the parent education activities were conducted by non-primary care providers. Nurses, early childhood specialists, home visitors, Health Promoters, WIC personnel,

² Vermont local evaluation report

³ 53% of those surveyed in 2001 (N=58) and in 2002 (N=129). A Parent Survey/"ABCD" Program 2002.

⁴ 144 parents (30% response rate) and 44 Health Promoters (79% response rate) Washington local evaluation report

⁵ Washington local evaluation report

⁶ Washington local evaluation report

⁷ A Practice Survey 2002/Family Practice.

⁸ A Parent Survey/"ABCD" Program 2002

and hospital and office staff distributed most of the materials and were responsible for the direct education of parents.

- *Have changes occurred in pediatric practice that support greater attention to early childhood development?*

Primary care providers. Gauging the success of the ABCD Initiative in reaching its goal of changing pediatric practice depends somewhat on what is included in the term “pediatric practice”. As originally conceived, it is fair to say that the Commonwealth Fund was most interested in changing the practice of primary care pediatric practitioners, specifically pediatricians, family practitioners, and nurse practitioners who act as primary care providers to young children. When defined in this way, the Initiative achieved some success.

For example, the North Carolina project changed primary care provider behavior to the extent that pediatricians and family care practitioners in participating practices routinely used the ASQ for screening. As noted earlier, the project has been less successful in getting providers to use the ASQ as a vehicle to discuss and theoretically provide enhanced child development services to families. Changing provider practice via Touchpoints training became a major theme for Vermont, but engaging physicians in the training was initially challenging, although Year 3 saw progress on this front. Vermont hopes that the Touchpoints approach will become part of the “professional culture” of physicians, much as it has become for non-primary care providers in the state.

Washington hoped that primary care provider behavior would change through the widespread use of the revised EPSDT form. To date the local evaluation has not documented either an increase in EPSDT visits or improvement in their quality over the first year of use of the revised EPSDT forms.⁹ However, widespread uptake of the forms did not occur until after the most recent point of data collection and the ongoing local evaluation should reveal in the future whether charting EPSDT visits and developmental services improves after a longer period of implementation. The teaching and training provided by Washington’s developmental expert may also prove instrumental in changing providers’ practice behaviors. Utah’s project did not include primary pediatric providers directly, although staff hopes provider behavior might change through a feedback loop with the home visiting nurses.

All four states have at least an implicit assumption that changing demand for child development services will, by educating and empowering patients’ parents, slowly change physician behaviors, but the validity of this assumption remains to be seen.

Non-primary care providers. The ABCD Initiative was much more effective in changing pediatric practice if the definition is broadened to include non-primary care providers that serve young children. For example, Utah was quite successful in changing the behavior of its public health nurses in terms of delivering services via the targeted case management program. North

⁹ Washington local evaluation report

Carolina succeeded in not only changing the behavior of pediatricians and family practitioners, but whole practices in terms of providing routine developmental screening to all children. In Washington, all three local initiatives focused on enhancing services through non-primary care providers. In the Southwest counties, the WIC center has trained staff to provide educational classes on child development. In Snohomish, a task force sought to identify missed opportunities for screening, and has recently launched an effort to include ASQs in ChildProfile mailings. In Whatcom County Health Promoters are trained in Bright Futures and to use the ASQ. Health Promoters' assessments of the training they received were "overwhelmingly positive".¹⁰

Vermont succeeded most notably at changing pediatric practice, broadly defined, in a sweeping way. The influence of Touchpoints training cannot be underestimated. Since its inception in 2001, over 500 health care providers and 400 childcare providers have received training in Touchpoints.¹¹ Respondents talked repeatedly about how Touchpoints "puts everyone on the same page", "provides a common language", and focuses providers on the family and the child's development in the way they deliver services. A limited, non-representative survey conducted by the local evaluators in Vermont found that the great majority (87%) of respondents use Touchpoints principles consistently in their interactions with families and the majority (57-60%) feel better about these interactions and believe families are more responsive.¹² In conjunction with the Touchpoints approach, the increasing orientation in Vermont towards providing appropriate services and away from program membership appeared to have a dramatic and very positive effect on the way services are provided to children.

- *Have more Medicaid-enrolled young children in each of the four states received health and developmental services since the projects began?*

Overall, the ABCD program was effective in delivering enhanced health and developmental services to Medicaid-enrolled children aged 0 – 3. The extent and nature of these services as well as the reach in terms of numbers of children varied considerably, however, across the states and the four states offer very different models of how states can achieve this goal.

North Carolina and Vermont addressed this goal most directly, with North Carolina's direct provision of developmental screening (ASQ) by parents or a non-physician, followed by appropriate referrals, and Vermont's home visitation program. The ASQ program has been highly effective in one county of North Carolina, and local evaluation data indicate that many more low-income children in that county are being screened and referred for early intervention services than prior to the introduction of ABCD.¹³ By November 2002, 4,627 children had

¹⁰ Washington local evaluation report

¹¹ Vermont local evaluation report

¹² Vermont local evaluation report

¹³ *Screening rates in Guilford County improved from 12% prior to implementation of ABCD (10/1/99-3/31/00) to 70% after implementation (10/1/01-3/31/02), and there is every reason to expect similar success in expansion sites.* North Carolina final report.

received 6,097 ASQ screens and 352 referrals.¹⁴ Three other counties in North Carolina have begun or are about to begin the ASQ screening, and there are promising signs that the program will spread in time throughout much of the state. The provision of child development services other than ASQ screening has been much more limited in North Carolina.

Vermont's original plan had as its centerpiece a home visitation program to provide child development services to young children enrolled in Medicaid. The home visitation program is still a key component of Vermont's ABCD program, but the emphasis has shifted to identifying and providing the most appropriate services to Vermont's children. Vermont has piloted an integrated program in which key service providers form a team that reviews each case and decides collectively what services the family should receive and which agency is most appropriate to provide the services. This approach holds great promise in ensuring that the majority of families receive the best and most appropriate child development services as identified by need. Vermont further anticipates enhanced services via Touchpoints training of providers, both physicians and non-physicians, and this appears to be happening very widely.

Washington adopted a more indirect approach to providing services in assuming that using the revised EPSDT form would enhance child development services and that empowering parents would help them demand and receive more services. One of the Washington regions also added ASQ screenings to the tasks of its Health Promoters, with some success.¹⁵ Utah's home visitation program did not allow for the provision of direct services but one goal of the program is enhanced referrals to developmental services. By encouraging families to establish a "medical home", the home visitors further increased the chances that children received preventive care and child development services. In its third year Utah added ASQ screening to its repertoire, although the method of distribution resulted in completed ASQs from less than a quarter of the targeted population .

- *Have states reformed their Medicaid policies to improve payments to pediatric clinicians or refined procedures that otherwise promote the provision of child development services?*

Although policy change is a very slow process, all four states made changes in Medicaid policies, regulations, reimbursement mechanisms or procedures as a result of ABCD activities in the relatively brief time span of three years. Utah passed a state amendment early in the process to add TCM as a reimbursement mechanism. In Washington, new Medicaid policy reimburses physicians an enhanced flat rate per visit if they use the EPSDT charting tool for children in foster care. If they do not use the tool, they will not receive the enhanced rate, even if they see foster care children.

¹⁴ North Carolina final report

¹⁵ *Health Promoters surveyed indicated their usage of ASQs lower than Bright Future materials (Washington local evaluation report). This relatively low usage may be, however, a function of the very recent introduction of the ASQ to Health Promoters.*

In North Carolina, the ABCD project coincided with the unbundling of Medicaid codes to match CPT codes. As part of this unbundling process, the ABCD state advisory advocated that reimbursement for child services coordination be expanded to include the physician's office. Prior to this, child services coordination was reimbursed for services delivered in the child's "natural setting"; the state advisory group succeeded in having the definition of "natural setting" expand to include the doctor's office. Respondents thought it possible and even likely that developmental screening will emerge as a reimbursable code in the future. Although not a change in Medicaid policy per se, the ABCD project also inspired the North Carolina Department of Public Health to make a rather dramatic change in policy that directly affects Medicaid enrollees: all of their clinics are now required to use an approved developmental screening tool (one of which is the ASQ), and that screening tool cannot be the Denver.

Vermont holds great promise for wide systemic change. Although that promise has not yet been fully realized, there are many strong signs that Vermont will achieve much of its sweeping goals in terms of systems change. Vermont has been moving towards true coordination of services across agencies and away from "silos" for 10 years, but respondents uniformly credit the ABCD project with moving this process qualitatively forward and serving as a concrete example for how coordination can effectively occur. The combination of the integrated team approach ABCD is piloting in *Healthy Babies, Kids & Families* and the unifying principles of Touchpoints is considered a model for a statewide approach to coordination of services. There appears to be genuine willingness and enthusiasm across agencies and among top leadership to make such coordination policy. In addition to this sweeping change, Vermont has struggled with the appropriate reimbursement mechanism for coordinated services and has settled on a case management code with an agreement by agencies to manage services within a certain amount across the caseload; this code includes telephone time. Several local sites are either currently or about to pilot this mechanism.

Beyond the Research Questions

As is common in intensive qualitative evaluation, the national evaluation team learned much valuable information that did not directly address the original research questions. In this section we report on additional topics related to the achievements of the ABCD Initiative: the role of NASP and the State Consortium, increased inter-agency cooperation, and heightened awareness of and attention to child development services.

- *The role of NASHP and the State Consortium*

The National Academy of State Health Policy (NASHP) was awarded a grant from the Commonwealth Fund to provide program direction to the ABCD Initiative. NASHP was responsible for program monitoring, providing technical assistance, convening Consortium meetings twice a year and regular telephone conference calls, and serving as liaison to the Commonwealth Fund. The states were generally very positive about the support and guidance they received from NASHP, and were particularly enthusiastic about the State Consortium meetings.

The national evaluation team found that NASHP and the Consortium were instrumental in helping states to achieve as much as they did. NASHP was responsive to the states' needs and endeavored to find resources and contacts for them that proved valuable. NASHP facilitated a listserv which enables states to solicit suggestions and advice from each other easily. In the Consortium states shared practical advice and information with one another, but also discussed broader ideas, learned from one another and shared frustrations over budgetary woes, slow-moving bureaucracies, and other common obstacles. The Consortium and NASHP also helped the states to feel that they were part of something bigger than their own individual projects and that they were not toiling alone and unrecognized. The states would probably have had successful projects without NASHP and the Consortium, but it seems clear that these two factors boosted the projects to a higher level.

- *Inter-Agency Cooperation*

A very significant outcome of the ABCD Initiative was the degree to which it inspired inter-agency cooperation and coordination in all four states. Over the course of the three years, inter-agency barriers were broken down and often intractable bureaucracies changed their behaviors as a result of ABCD. A number of respondents in different states praised ABCD as a catalyst, providing proof that agencies could work together. Moreover, this cooperation was accomplished without a huge amount of money. It is interesting that the relationship between ABCD and inter-agency cooperation went both ways—it was necessary in many cases for inter-agency cooperation to occur in order to implement the ABCD projects, and ABCD itself spurred inter-agency coordination.

- *Attention to Child Development*

An exciting outcome of the ABCD Initiative was the noticeably increased attention to child development services throughout the four states. This heightened recognition of the importance of early childhood development and the need to enhance it, especially for low-income children, started within the Medicaid agencies themselves. ABCD represented a significant change for these Medicaid agencies, and one they appeared to embrace. ABCD brought attention to child development issues within Medicaid, generally at very high levels in the hierarchy, and also put Medicaid in the position of developing and providing services or partnering with agencies that could provide services, instead of merely paying for services. Respondents noted that now that child development services were visibly integrated into Medicaid, there was in effect, no going back to pre-ABCD levels of awareness.

In addition to heightened awareness within Medicaid, ABCD engendered enhanced attention and focus on child development throughout the states. This attention began with and was promoted by local ownership of the ABCD projects and the projects that became associated with ABCD. The evaluation team met with a great variety of respondents representing a broad array of agencies across the states and was consistently impressed by the degree of understanding of and enthusiasm for ABCD these respondents professed. The combination of integration and support

for ABCD within Medicaid and increased attention statewide on child development bode well for the sustainability of the four state projects in some form.

Conclusion

The first phase of the Commonwealth Fund's ABCD initiative has been successful in achieving its stated goals and some important unstated goals as well. The four states funded under this initiative have proven that it is possible for state Medicaid agencies to partner with appropriate agencies to initiate and implement innovative services to address the developmental needs of its youngest Medicaid enrollees. For modest amounts of new money, parents, providers and the children themselves received enhanced education, training and services around child development issues. In addition to the direct services rendered by the program, a very important achievement of ABCD was the heightened awareness of and attention to the need for and value of child development services in these four states. A relatively small program was able to demonstrate not only that these types of services are desirable but that states *should* provide such services. A demand has been established in the four states that is unlikely to disappear, even in fiscally tight times. In a noticeable way ABCD has influenced the culture of Medicaid and other agencies to regard delivering child development services to all children, not just those with identified or suspected developmental delays, as an imperative. Broadening attention to *developmental promotion* from a narrow focus on *developmental delays* may be ABCD's greatest legacy in the years to come.

Recommendations and Implications

- ABCD verified that state Medicaid agencies can successfully plan, develop and implement programs to enhance child development services for Medicaid enrolled children.
- State climates matter to a certain extent in terms of planning, but are not instrumental in shaping implementation of innovative programs.
- Sufficient access to primary care providers is a necessary precursor for successful implementation of an enhanced program in Medicaid.
- Early planning must reflect and embrace the specific underlying goals of the initiative, as it is unlikely that those goals will develop over time if they are not part of the original plan.
- It is important for states to establish a balance between anticipating what would be acceptable in the specific state context and being overly cautious in terms of innovation.

- States need to anticipate changes in the state environment in terms of health care, Medicaid, and other aspects of the state government when developing and subsequently implementing programs like ABCD.
- States should garner high level support for their projects both within Medicaid and key partner agencies, such as the Department of Health or Public Health.
- It is important for successful implementation to involve representative professionals in the initial planning process.
- A key to successful implementation is the ability to identify and build upon existing programs, collaborations, infrastructure, or strategies around child development that existed already in their states.
- Integrating a new innovative program into ongoing endeavors assists sustainability.
- The “pilot, refine and expand” strategy works well for implementing innovation.
- Widespread education of parents is most effective when both primary care and non-primary care providers are involved. In ABCD, nurses, early childhood specialists, home visitors, Health Promoters, WIC personnel, and hospital and office staff distributed most of the materials and were responsible for the direct education of parents.
- All four states have at least an implicit assumption that changing demand for child development services will by educating and empowering patients’ parents, slowly change physician behaviors, but the validity of this assumption remains to be seen.
- The ABCD Initiative was much more effective in changing pediatric practice when the definition included non-primary care providers that serve young children.
- The ABCD program offers four different models of how states can effectively bring more enhanced services to a Medicaid population.
- It is possible to make positive changes in Medicaid policies, regulations, reimbursement mechanisms and procedures in the relatively brief time span of three years.
- Mechanisms such as the technical assistance provided by NASHP and the Consortium appear to elevate projects to a higher level of success.
- A modest program can serve to break down inter-agency barriers and inspire intractable bureaucracies to change their behaviors in a relatively short time frame.

- The relationship between a program and inter-agency cooperation goes both ways—inter-agency cooperation is often necessary to implement a new program, and the program itself can spur inter-agency coordination.
- Medicaid agencies can embrace innovative new programs and even expand their role beyond payer. ABCD brought attention to child development issues within Medicaid, generally at very high levels in the hierarchy, and also put Medicaid in the position of developing and providing services or partnering with agencies that could provide services, instead of merely paying for services.
- In addition to heightened awareness within Medicaid, ABCD engendered enhanced attention and focus on child development throughout the states.