Section 3 Healthy Kids/EPSDT Screening Components

A. HEALTH AND DEVELOPMENTAL HISTORY

Comprehensive Health History

Comprehensive health and family histories are key components of effective screening for high risk factors, as well as important tools for obtaining relevant health information and identifying health conditions that have a genetic component. At the initial Healthy Kids visit, obtain a complete medical, family, psychosocial, perinatal, immunization and developmental history. At each subsequent well child visit, update and document the child/family's health history. A standardized set of questions can improve the provider's ability to identify children/teens at risk of having significant health problems. The Maryland Healthy Kids Program provides the *Medical/Family History Questionnaire* for this purpose available in both English and Spanish languages (Refer to Section 7, Appendix I, for the *English* and *Spanish* versions). The parent, guardian, or patient may complete this form prior to review by the provider. Update the medical, family, and psychosocial histories annually.

In general, a comprehensive health history includes:

- Personal medical and mental health history: chronic and acute illnesses, allergies, surgeries, injuries, and nutritional conditions and concerns, (i.e., failure to thrive, anorexia/bulimia, etc.),
- Perinatal history: prenatal care, birth history, conditions and concerns in the neonatal period, etc.,
- Developmental history: attainment of developmental milestones, learning disorders/educational concerns,
- Family medical and mental health history: health of the immediate and extended family (through the first generation of grandparents, aunts, uncles, etc.) including chronic and acute illnesses (physical and mental), hereditary disorders, disabilities, family violence and substance abuse,
- Psychosocial history: family constellation (number of members and who is living in household) and family relationships and functioning or dynamics (any boyfriend/girlfriend of single parent, parental separation/divorce, foster care or adoption), housing, financial needs, assessment of support systems, exposure to family and community violence,
- Immunization history: record of previous immunizations and assessment of current immunization status,
- Adolescent history: menarche, sexual activity, substance abuse, mental health problems and current status, social functioning and academic concerns.

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Developmental Surveillance and Screening

Developmental surveillance is a longitudinal, continuous, and cumulative process of recognizing children who may be at risk of developmental delays. Developmental surveillance involves eliciting parents' concerns, obtaining a developmental history, making accurate and informed observations of the child, identifying the presence of risk and protective factors, and documenting the process and findings**. Developmental surveillance should be performed at all Healthy Kids preventive care visits.**

In contrast, *developmental screening* is the administration of a brief standardized, validated tool to aid the identification of children at risk of a developmental disorder. Periodic developmental screening of all children in addition to ongoing developmental surveillance can significantly increase the identification of children with developmental delays.

Based on the 2006 policy statement of the American Academy of Pediatrics (AAP), it is now **required** that general developmental screening be performed for all children at the 9-, 18-, and 24-30 month Healthy Kids preventive care visits, and whenever a concern is identified through developmental surveillance.[1] If the child is not seen at these recommended ages, screening should be conducted at the next preventive care visit. The AAP also **recommends** screening specifically for autism at the 18- and 24-month visits using a standardized tool.[2]

Both developmental surveillance and screening should address the following areas, as age-appropriate: 1) speech and language development 2) gross and fine motor development, 3) self-help and self-care skills, 4) social development, 5) cognitive development, and 6) presence of learning disabilities.

[1] AAP. (2006). Identifying Infants and Young Children with Developmental Disorders in the Medical Home: an Algorithm for Developmental Surveillance and Screening. *Pediatrics*, 118(1), 405 - 420 Retrieved on 08/08/14, from *http://pediatrics.aappublications.org/content/118/1/405.full*.

[2] AAP. (2007). Identification and Evaluation of Children with Autism Spectrum Disorders. *Pediatrics*, 120 (5),1183-1215. Retrieved on 08/08/14 from *http://pediatrics.aappublications.org/content/120/5/1183*.

Developmental Screening Tools

Healthy Kids recommends the following standardized, validated developmental screening tools for use in general developmental screening at the intervals noted above:

- *The Ages and Stages Questionnaire* (ASQ) [3]
- *Parents' Evaluation of Developmental Status* (PEDS) [4]

An additional list of standardized, validated general *Developmental Screening Tools* has been approved for use in the Healthy Kids Program to screen children through age of 5 (refer to Section 3, Addendum).

Results of the developmental surveillance and screening, and the screening tool used, should be documented in the medical record. Children identified as being at risk for developmental delays should have documented counseling and referral for additional evaluation services. (Refer to Section 3, Addendum - *Additional Evaluation and Intervention for Developmental Disorders*). Refer to *Section 6* of this Manual for coding and documentation guidelines.

Screening for Autism Spectrum Disorders (ASDs)

Autism Spectrum Disorders (ASDs) are neuro-developmental conditions characterized by:

- Impairments in social interaction,
- Impairments in communication,
- Restricted repetitive and stereotyped patterns of behavior, interests, and activities.

The Centers for Disease Control and Prevention (CDC) estimated that autism affects 1 in every 68 children aged 8 years old. The rates are higher among males, among families where another sibling has ASD, and among children with certain medical conditions (including Fragile X syndrome, fetal alcohol syndrome). The exact cause of ASDs is unknown.[5]

Early identification and early intervention services are critical to optimizing educational and functional outcomes for children with ASDs. Since 2007, the AAP recommended that primary care providers (PCPs), in addition to conducting general developmental

[3] See the ASQ website: *http://agesandstages.com/*.

[4] See the PEDS website: *http://www.pedstest.com/default.aspx*.

[5] CDC (2014). Prevalence of Autism Spectrum Disorder Among Children Aged 8 Years - Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2010. *CDC Surveillance Summaries.* 63(SS02), 1-21. Retrieved on 08/18/2014, from *http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6302a1.htm?s_cid=ss6302a1_w*.

surveillance and screening, should perform autism-specific surveillance during all well child visits.[6] Autism-specific surveillance includes:

- Ascertaining family history of ASDs, especially among older siblings,
- Eliciting parent concerns, particularly about communication, social reciprocity, and pretend play skills,
- Assessing the child's behavior and attainment of communication and social-emotional milestones.

Red flags that warrant immediate referral include:

- No babbling or pointing or other gesture by 12 months,
- No single word by 16 months,
- No 2-word spontaneous phrases (not echolalic) by 24 months,
- Loss of language or social skills at any age,
- Failed results of an autism-specific screen of any child using a structured, standardized instrument at 18 and 24 months of age.

In addition to **requiring** general developmental screening, the MD Healthy Kids Program **recommends** autism-specific surveillance at all visits and requires structured autism-specific screening at 18 and 24-30 month well child visits. The MD Healthy Kids Program recommends the *Modified Checklist for Autism in Toddlers-Revised, with Follow up* (MCHAT-R/F) screening instrument (Refer to Section 3, Addendum).[7]

As with general developmental surveillance and screening, children with findings of concern on autism-specific surveillance or screening should be simultaneously referred for medical evaluation and to the *Maryland Infants & Toddlers Program* at **1-800-535-0182** for possible early intervention services.

[6] AAP. (2007). Identification and Evaluation of Children with Autism Spectrum Disorders. *Pediatrics*, 120 (5), 1183-1215. Retrieved on 08/08/14 *from http://pediatrics.aappublications.org/content/120/5/1183*..

[7] The MCAT-R/F screening instrument can be accessed and freely downloaded at http*://www2.gsu.edu/~psydlr/M-CHAT/Official_M-CHAT_Website.html*.

Section 3 Healthy Kids/EPSDT Screening Components

The following organizations provide resources for information about general developmental screening, autism-specific screening, and early intervention:

- *AAP National Center for Medical Home Implementation*[8]
- *CDC "Learn the Signs. Act Early" campaign*[9]

Mental Health Assessment

The mental health assessment provides an overall view of the child's personality, behavior, social interactions, affect and temperament. It is the responsibility of the PCP to conduct a mental health assessment on each Healthy Kids visit, beginning at 3 years of age, to identify risks associated with behavioral or emotional problems.

The Healthy Kids Program, in collaboration with the Mental Hygiene Administration, has developed age-specific *Mental Health Questionnaires* available in English and Spanish languages (Refer to Section 7, Appendix II, for the *English* and *Spanish* versions) to assist providers in assessing for mental health problems.

Maryland Behavioral Health Integration in Pediatric Primary Care (B-HIPP) is a free service for PCPs caring for patients with mental health needs from infancy through the transition to young-adulthood. It provides support to PCP through four main components: telephone consultation, continuing education, resource and referral networking and social work co-location. For more information, refer to B-HIPP website at *www.mdbhipp.org* at or call **855-632-4477**.

Bright Futures in Practice, a series of publications from the Maternal and Child Health Bureau and the National Center for Education in Maternal & Child Health, provides additional information regarding mental health assessment for children and adolescents. Information regarding mental health assessment can be found on the ***Bright Futures*** website at *http://brightfutures.aap.org*.

Document the result of the mental health assessment in the medical record. In some cases, when a mental health problem is identified, the primary care provider can counsel the patient and note this in the record. However, when specialty mental health services are needed, refer directly to the **Maryland Public Behavioral System** by contacting **1-800-888-1965 (consumers and providers).** Access additional mental health information and resources on Beacon Health Options website at: *maryland.valueoptions.com/services*. Document the referral in the medical record.

[8] See *http://www.medicalhomeinfo.org/*.

[9] See *http://www.cdc.gov/ncbddd/actearly/hcp/index.html*.

Depression in Children

Depression is often overlooked and considered to be "mood swings" that are a normal part of childhood. This is unfortunate, because the early diagnosis and treatment of depressive disorders is paramount in the healthy development of the child. Depression is occurring earlier on the developmental continuum than in the past. Children/adolescents and their parents are less likely to identify symptoms of depression. Often the PCP is in a better position to trend the behavior and suggest that the child/adolescent should see a mental health professional.

Risk Factors for Depression:

- Family history of depression,
- A parent who experienced depression at an early age,
- Teen cigarette smoking,
- Stress,
- A loss of a parent or loved one by death or divorce or other loss,
- Attention, conduct, or learning disorder,
- Chronic illness, such as diabetes,
- Abuse or neglect,
- Other trauma, including natural disasters.

Signs That May Be Associated with Depression in Children and Adolescents:

- Frequent vague, non-specific physical complaints such as headaches, muscle aches, stomachaches or tiredness,
- Frequent absences from school or change in school performance,
- Talk of or efforts to run away,
- Outbursts of shouting, complaining, unexplained irritability or crying,
- Being bored,
- Lack of interest in playing with friends,
- Alcohol or substance abuse,
- Social isolation, poor communication,
- Fear of death,
- Extreme sensitivity to rejection or failure,
- Increased irritability, anger, or hostility,
- Reckless behavior,
- Difficulty with relationships,

- Change in sleep patterns.

Depressed children have an increased risk of suicidal ideation and gestures. Early diagnosis and treatment, accurate evaluation of suicidal ideation, and limiting access to lethal agents, including firearms and medications, may hold the greatest suicide prevention value.

Attention Deficit Hyperactive Disorder (ADHD)

ADHD is a disorder characterized by behavior and attention difficulties exhibited in multiple settings. It begins in childhood and is identified by specific attention, hyperactivity and impulsiveness criteria found in the *American Psychiatric Association's Diagnostic and Statistical Manual (DSMIVR).*[10]

A clinician with skills and knowledge in the area of mental health, developmental or behavioral pediatrics must perform the ADHD evaluation. A provider who specializes in developmental or behavioral pediatrics can become a specialty mental health provider through Maryland Medical Assistance by registering with the **Community Mental Health Unit** at the **DHMH Office of Health Care Quality**. To print the *Community Mental Health Program Application*, follow the link *http://dhmh.maryland.gov/ohcq/MH/docs/MH_Forms/mh_app.pdf*. For more information, contact the **Community Mental Health Unit** at **877-402-8220/410-402-8060** or visit their webpage at: *http://dhmh.maryland.gov/ohcq/MH/Pages/home.aspx*.

The overall approach to diagnosing a child with ADHD involves the following:

- A comprehensive interview with the child's adult caregiver,
- A mental status examination of the child,
- A medical evaluation for general health and neurological status,
- A cognitive assessment of ability and achievement,
- Use of ADHD-focused parent and teacher rating scales,
- School reports and other adjunctive evaluations separate from the school reports such as speech, language assessment, etc.

A child diagnosed with ADHD without any accompanying emotional disorders can receive care from a PCP for management of medications. However, medication is only one component in the comprehensive treatment of ADHD. Adjunctive services can significantly improve a child's response. Teaching and reinforcing organizational skills and social skills are adjunctive interventions that can significantly improve outcomes. In addition, ongoing contact and follow-up with the parents of a child with ADHD on medication is a critical component of the medication management.

[10] Diagnostic and Statistical Manual of Mental Disorders.(2013). 5th edition. Arlington, VA., *American Psychiatric Association.*

A number of psychiatric conditions frequently occur with ADHD, i.e., mood disorder, conduct disorder, oppositional defiant disorder and bipolar disorder. ADHD is classified as a specialty mental health disorder, possibly requiring multiple therapeutic approaches (Refer to Section V, *Public Mental Health System*). If the child's behavior changes significantly, reevaluation is necessary through a mental health referral by contacting **Maryland Public Mental Health System** at **1-800-888-1965** (consumers and providers). Access additional mental health information and resources online on Beacon Health Options website at: *maryland.valueoptions.com/services*.

For more information about ADHD, refer to the *AAP Clinical Practices Guidelines for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents*.[11]

Child Abuse Assessment

Provider awareness of the physical and behavioral indicators of child abuse, neglect or mental injury is critical to identification of mistreatment in children. Child abuse tends to be repetitive and usually escalates over time. In many cases, the abuse is the result of unrealistic caretaker expectations and the abuser is not intending to hurt the child. This is particularly true with shaken baby syndrome. Multiple socioeconomic or physical factors may place children at greater risk for child abuse. It is important to be aware of the child and parent risk factors that predispose children to abuse and neglect.

Child Risk Factors for Abuse:

- Emotional/behavioral difficulties
- Chronic illness
- Physical disabilities
- Developmental disabilities
- Preterm birth
- Unwanted child
- Unplanned pregnancy
- Younger than 3 years old.

[11] See AAP. (2011). ADHD: Clinical Practice Guidelines for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. *Pediatrics*. 128(5), 1007-1022. Retrieved on 10/31/20014, from *http://pediatrics.aappublications.org/content/128/5/1007.full.pdf*.

Parent Risk Factors for Child Abuse:

- Low self-esteem
- Poor impulse control
- Substance use/alcohol use
- Young maternal or paternal age
- Parent abused as a child
- Depression or other mental illness
- Poor knowledge of child development or unrealistic expectations for child
- Negative perception of normal child behavior.

Environment (Community and Society

- Social isolation
- Poverty
- Unemployment
- Low educational achievement
- Single parent
- Nonbiologically related male living in the home
- Family or intimate partner violence.

Behavioral Indicators for Possible Abuse:

- Extremes in child behavior
- Substance abuse by child
- School problems
- Depression
- Frequent runaway activity
- Suicide attempts
- Poor social interactions,
- Sudden changes in daily routines.

The *SEEK Questionnaire* (Refer to Section 7, Appendix II, for the *English* and *Spanish* versions) is designed to assist providers to identify and address potential risks for abuse and neglect for children younger than 3 years of age.

Child abuse and neglect is a serious problem that requires the involvement of professionals in the community for the purpose of prevention, identification, and treatment. The medical history is integral to the evaluation. The provider should obtain sufficient information to complete the physical and decide if local protective services or police are needed. When suspicions of inflicted injury occur, interview the parent and child separately. Past medical history, the child's social situation and the parent's response to the event are necessary components of the history. Not all child abuse occurs in high-risk families. Although the incidence is higher in high-risk families, the provider should thoroughly evaluate every child with a suspicious injury. For more instructions on the role of the pediatrician in indentifying abused children, refer to *2015 AAP Guidance on the Evaluation of Suspected Child Physical Abuse*.[12]

Red Flags that Signal Possible Abuse:

- Inconsistent history,
- No explanation for injury/bruises,
- Delay in seeking care,
- Incident inconsistent with child's developmental level,
- Severe injury not witnessed or corroborated,
- Scene of injury not consistent with history,
- High risk social situation,
- Previous suspicious and/or multiple injuries,
- Blaming of injury on sibling.

In Maryland, Subtitle 7 of the Maryland Family Law Code Annotated requires professionals, including health practitioners, police officers, educators and social workers, to report suspected child abuse or face possible professional sanctions.[13] The law requires that anyone who suspects a child has been, or is being, mistreated must report the matter to the *Department of Social Services* (Refer to Section 8) or the police. Any person who, in good faith, makes a report of abuse or neglect is immune from civil liability or criminal penalty.

Bullying and Cyber-bullying

Bullying including cyber-bullying is of increasing concern in the pediatric population. Health care providers should:

[12] See American Academy of Pediatrics. (2015). The evaluation of Suspected Child Physical Abuse. *Pediatrics*. 135(5). Retrieved on 01/14/2016, from *http://pediatrics.aappublications.org/content/135/5/e1337*.

[13] 2010 Maryland Code Family Law Title 5 - Children Subtitle 7 - Child Abuse and Neglect Section 5-704

- Ask children and adolescents about their experiences, if any, regarding bullying and cyber bullying,
- Provide information in their offices for families to educate them on this topic,
- Encourage parents to work with schools to promote awareness, prevention, and appropriate intervention.

For more information on youth violence including bullying and dating violence, review *2009 AAP Policy on the Role of Pediatrician in Youth Violence Prevention*.[14] A specific assessment tool measuring bullying victimization is the *Victimization Scale* (refer to Section 7, Appendix II for the *English* and *Spanish* versions of the tool). For other assessment tools, see *Measuring Bullying Victimization, Perpetration, and Bystander Experiences: A Compendium of Assessment Tools*, published by the Centers for Disease Control and Prevention (CDC) in 2011.[15]

Alcohol and Substance Use Disorder Assessment

Performing an assessment or screening for substance use is critical, because of the increased number of adolescents and young adults using drugs and alcohol.[16] [17] Primary care providers play an important role in identifying those who abuse substances. Completion of at least an assessment for substance use at every well child visit is required annually starting at 12 years of age. Screening for substance use should be performed by using a standardized tool such as *CRAFFT* (Refer to Section 7, Appendix II, for the *English* and *Spanish* language versions of the tool).[18] For availability of CRAFFT in other languages, refer to the ***Center for Adolescent Substance Abuse Research*** website at *http://www.ceasar-boston.org/*. For further guidance, refer to *2015 AAP Report of Binge Drinking*.[19]

[14] See AAP. (2009). Role of Pediatrician in Youth Violence Prevention. Pediatrics. 124(1), 393-402. Retrieved on 06/03/2015, from *http://pediatrics.aappublications.org/content/124/1/393.full*.

[15] See CDC (2011).Measuring Bullying Victimization, Perpetration, and Bystander Experiences: A Compendium of Assessment Tools. Retrieved on 06/03/2015, from *http://www.cdc.gov/violenceprevention/pdf/bullycompendium-a.pdf*.

[16]See AAP (2005). Tobacco, Alcohol, and Other Drugs: The Role of the Pediatrician in Prevention, Identification, and Management of Use. *Pediatrics*.115(3), 816–821. Reaffirmed March 2013. Retrieved on 08/18/2014, from *http://pediatrics.aappublications.org/content/115/3/816.full*.

[18] See AAP (2011). Policy Statement: Substance Use Screening, Brief Intervention, and Referral to Treatment for Pediatricians. *Pediatrics*. 128 (5), 1330 -1340. Retrieved on 08/18/2014, from *http://pediatrics.aappublications.org/content/128/5/e1330.full?sid=f5722c8f-0064-40c2-927f-da32a3a674ef*.

[19] See AAP(2015). Binge Drinking. *Pediatrics*. 136(3). Retrieved on 01/14/2016, from *http://pediatrics.aappublications.org/content/136/3/e718.*