CARE FOR KIDS
Early & Periodic Screening, Diagnosis & Treatment
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Bright Futures Overview

Implementing Recommendations in Your Practice

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As stated in the guidelines for health supervision of infants, children, and adolescents, Bright Futures is a theory based, evidence driven, and systems oriented set of principles, strategies, and tools. They can be used to improve the health and well-being of all children through culturally appropriate interventions that address the current and emerging health promotion needs at the family, clinical practice, community, health system, and policy levels. The mission of Bright Futures is to promote and improve the health, education, and well-being of

infants, children, adolescents, families, and communities. The third and most recent version of Bright Futures was published in 2008.

The Accountable Care Act of 2010 stated that all private health plans must cover the services described in these guidelines.

The Bright Futures (BF) Guidelines start with an in-depth discussion of health promotion themes that occur through the age groups. Two of these themes are identified as significant challenges to Child and Adolescent Health: promoting healthy weight and promoting mental health. The eight additional themes include promoting the following: family support, child development, healthy nutrition, physical activity, oral health, healthy sexual development and sexuality, safety and injury prevention, and promoting community relationships and resources.

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The outline for visits in each age group follows a strength-based approach and matches the AAP's Recommendations for Preventive Pediatric Health Care (Periodicity Schedule).

A. Context

B. Priorities
   1. Attending to concerns
   2. Five additional priority topics for discussion are included at each visit

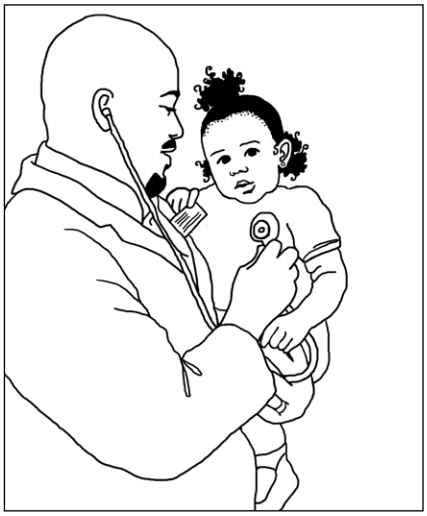
C. Health Supervision
   1. History
   2. Observation of parent-child interaction
   3. Surveillance of development
   4. Physical examination including assessment of growth and a listing of particular components of the examination that are important for the child at each age visit
   5. Screening including universal screening and selective screening using risk assessment
   6. Immunizations
   7. Other practice-based interventions

D. Anticipatory Guidance
   1. Information for the health care professional
   2. Health promotion questions for the five priorities for the visit
   3. Anticipatory guidance for the parent and child

The American Academy of Pediatrics (AAP) and the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB) are studying primary care providers' abilities to implement these recommendations into practice. Particular areas of focus of these evaluations include whether providers are addressing the following areas:

1. Eliciting and addressing parental concerns
2. Completing age-appropriate risk assessments and addressing identified risks
3. Completing appropriate measurement and plotting of growth parameters
4. Using validated developmental screening tools and follow-up of abnormal screens
5. Addressing at least three BF anticipatory guidance priorities
6. Assessing parental strengths and identifying sources of support for the family
7. Completing oral health risk assessments

At the University of Iowa, we have been fortunate to participate in some of these studies on the implementation of BF into practice. Our area of focus was on the 9 month and 2 year visits. In the process, we have



learned that standardized pre-visit questionnaires that include age-appropriate risk assessments and developmental surveillance questions are very helpful. Validated developmental screening tools such as the ASQ and M-CHAT are mandatory. These can be completed on-line or in written form. The risk assessment questions include topics such as vision, hearing, tuberculosis, dyslipidemia, anemia, and oral health. There are also questions about parental depression in appropriate age groups and an assessment of parental support. The BF tool kit has pre-visit questionnaires developed for each age visit, but these could also be developed by an individual practice. We modified ours slightly to fit our practice and to include the Iowa lead screening questions.

The pre-visit questionnaires (PVQ) dovetail with the

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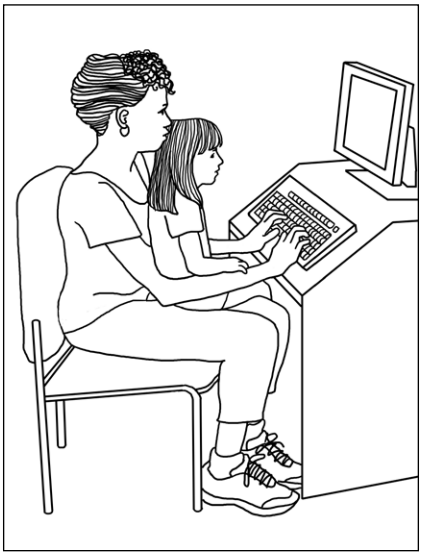
documentation forms that are in the BF toolkit. We have developed templates on our EMR for appropriate documentation of each age visit. These templates include a summary of the answers to the PVQ as well as a summary of the results from developmental screening. Using templates was mandatory in making sure that all areas of Bright Futures were addressed at each visit. This is particularly important with multiple providers in a group. Quality Improvement assessment using chart reviews can determine if the BF guidelines are being optimally implemented in a practice.

We are currently working with our Information Technology Department to put all of the pre-visit questionnaires and developmental screening tools on-line so that they can be completed by families on a computer. These will be sent out to families via e-mail so that they can complete them before the visit. If the forms are not completed ahead of time, the families can complete them at computer kiosks located in the waiting or exam room. Results of all of the questionnaires and screens will then populate in summary form into our documentation templates, saving significant physician time.



Private offices also have successfully implemented validated developmental screening in their practice. Dr. Rhonda Enserro and her colleagues are using the ASQ and M-CHAT in their office, as she explains below.

Using Bright Futures in Private Practice

The thought of introducing developmental screening and autism screening into our office was a daunting one. Like many offices, we already felt rushed during our well child exams–responding to parent concerns, performing a complete exam, providing anticipatory guidance and discussing vaccines. How possibly could we add in more steps?

Over the last two years we have been able to successfully implement this process within our clinic. We have instituted routine autism screening at 18 and 24 months using the M-CHAT. The M-CHAT is handed out to families upon check-in to the office and is typically completed by the time the provider enters the room. The M-CHAT can be quickly scored by either a provider or clinical staff person.

We have also been routinely using the ASQ (Ages and Stages Questionnaire) at 9, 18, and 24 months as our validated developmental screening tool. This tool requires approximately 10 minutes for a caregiver to complete. Our office provided families with two options for filling out the ASQ, either online or on paper at the time of the visit. The online version allows families to fill out the ASQ at their convenience prior to their child's appointment. Once it's completed, we are able to view the results and print a scoring sheet. We then share the results with the family at the office visit. The results of the ASQ are documented within our EHR, along with follow-up plans (i.e. continue with routine screening, earlier rescreening, or referral for services).

I honestly feel this is a process any office can reasonably do. The one requirement for this to be successful is a staff (front office, nursing and providers) willing to try something new and to be a part of the process.

Recommendations for Preventive Pediatric Health Care: The Periodicity Schedule

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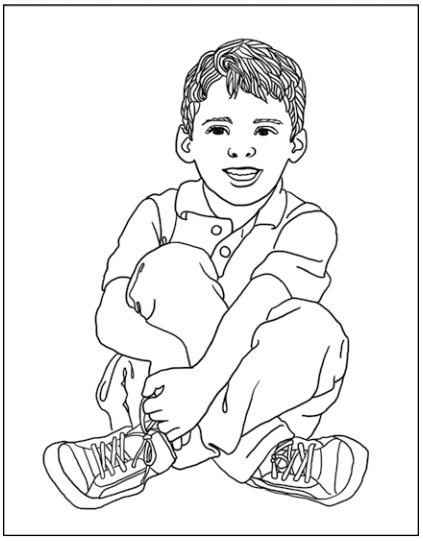
The Iowa Medicaid Health Maintenance Recommendations (Iowa EPSDT Care for Kids) provide guidance for children's health care providers as they implement well-child supervision for Medicaid recipients. Also known as the periodicity schedule, this dashboard-at-a-glance provides a single page synopsis of the health care guidelines and recommendations for children with no important health problems. These children must be growing and developing satisfactorily. The schedule indicates which health care procedures should be accomplished at specific ages for selected cohorts of children, adolescents, and young adults. This article will focus on the historical rationale for these requirements, including a review of the impact of the enabling legislation, and will provide references to the scientific evidence on which the clinical recommendations are based. This should provide a context for practitioners to utilize as they develop and implement their



personal and office approach to ensuring each portion of the guidance contained in the periodicity schedule is appropriately used, resulting in the optimum health care practice for children, their families, and the communities in which they live.

The recommendations of the periodicity schedule follow the federal Social Security Act, PL 89-97, 1965, which authorized Medicaid support to states for a variety of services required by categorically needy children and their families. This was supported in part by the "One-Third of a Nation" report published in 1964, which found one-third of the nation's youth to be medically ineligible for military service. In assessing the medical reasons for this ineligibility, it was determined the vast majority of medical problems could have been prevented by optimal child health care.

To ensure child and adolescent health services of the highest quality and incorporate contemporary scientific standards, the federal Medicaid program, in collaboration with the American Academy of Pediatrics, has developed and recommended child care health maintenance guidelines. Similarly, the Iowa Medicaid Enterprise (IME), working with the Iowa Chapter of the American Academy of Pediatrics (AAP), has selected these practices as their statewide recommendations. As the recommendations are periodically updated as new science is translated into practice, the IME's most recent update occurred in September of 2011. These recommendations can be found as an insert in this volume of the newsletter.

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The Periodicity Schedule
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The original 1965 clinical implementation recommendations follow a format that has become known as EPSDT (Early Periodic Screening, Diagnosis and Treatment). This model approach provided excellent guidance. Newer physiologic and development health science findings have indicated additional components were needed to ensure a comprehensive approach to the optimal child health and development services. These recommendations were incorporated into the 1994 first edition of Bright Futures published by the AAP. This edition emphasized the importance of the psychosocial aspects of child health while continuing the broad principle of early periodic screening, diagnosis, and treatment, which remains the foundation of the IME practice recommendations.

Subsequent editions of Bright Futures established a need for optimal practice patterns; the concept of the health home; documentation of the scientific evidence for each recommendation; keeping pace with changes occurring in families and communities; greater recognition of children with special needs and their families; recognition for how culture and ethnicity frame patient, family, and health care practitioner behavior; and the recognition that each family must have the information and decision-making capacity to choose health practices that best serve their family need. Bright Futures 2008 now serves as the primary reference for optimal child health care practices.

Each individual IME Medicaid recommendation relates to what are considered the primary components of child health including history, physical examination, measurements, nutritional/ obesity prevention, oral health, developmental and behavioral assessment, sensory screening, immunizations, and anticipatory guidance. In addition, seven procedures including lipid screening, hemoglobin/hematocrit determination, lead screening, sexually transmitted diseases screening, cervical dysplasia screening, and tuberculin testing provide necessary laboratory data. These recommendations are summarized in the periodicity schedule available at the Bright Futures website and at the IME EPSDT website.

The rapidity at which new child health science is discovered and translated into clinical practice dictates that child health care practitioners must rely on contemporary electronic communication technology to keep abreast of the latest recommendations. Monthly and sometimes weekly changes occur in the recommendations for child health maintenance and may profoundly influence the selection and/or timing of any one practice recommendation.

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The Periodicity Schedule
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The following web links to contemporary electronic sources are recommended for more detailed information on the components of EPSDT health maintenance recommendations for pediatric patients:

History:	**http://brightfutures.aap.org/ www.iowaepsdt.org**
Physical Exam	**www.iowaepsdt.org**
Developmental and Behavioral Development	**http://brightfutures.aap.org/ http://www.iowaepsdt.org/ScreeningResources/Screening.htm**
Sensory Screening (vision) (hearing)	**www.aao.org http://one.aao.org/flash/visionscreening/pediatricvisionscreening.html http://brightfutures.aap.org/**
Immunizations	**http://www2.aap.org/immunization/ http://www.cdc.gov/vaccines/schedules/ http://www.iowaepsdt.org/ScreeningResources/Screening.htm**
Lipid Screening	**http://pediatrics.aappublications.org/content/122/1/198.full www.nhlbi.nih.gov/guidelines/cvd_ped/peds_guidelines_full.pdf**
Hemoglobin/Hematocrit	**www.aap.org**
Lead Screening	**www.idph.state.ia.us/eh/lead_poisoning_prevention.asp**
Newborn Metabolic Screening	**http://www.idph.state.ia.us/genetics/default.asp**
Sexually Transmitted Infections	**http://www.cdc.gov/std/**
Cervical Dysplasia Screening	**http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm**
Tuberculin Test	**http://brightfutures.aap.org/ http://aapredbook.aappublications.org/**

Additional information, clarification, and advice regarding the recommendations can be found at:

Iowa Medicaid Enterprise EPSDT: **www.iowaepsdt.org**

Iowa Medicaid Enterprise provider information: **www.ime.state.ia.us/providers/index.html**

American Academy of Pediatrics: **www.aap.org**

American Academy of Family Physicians: **www.aafp.org**

One-Third of a Nation: A Report on Young Men Found Unqualified for Military Service: **http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/index.cfm?mdl=pubSearch&evt=view&PublicationID=35A8D671-5056-9D20-3DEFF238AEFA7071**

EPSDT: An overview **http://www.allhealth.org/briefingmaterials/01EPSDToverview-161.pdf**

Copies of **Bright Futures** can be secured through **http://brightfutures.aap.org/**, with information also at the website relating to specific components of the well-child health maintenance recommendations.

* Dr. Healy died April 19, 2012. His career was devoted to advocating for and improving the quality of care provided to the children of Iowa and the world. His obituary may be found in the ***Iowa City Press Citizen*** dated Wednesday, May 2, 2012.

Iowa **EPSDT Care for Kids** Health Maintenance Recommendations

KEY

- ● To be performed
- ● To be performed at all visits
- ✪ Screen at least once during time period indicated
- **S** Subjective, by history;
- **O** Objective, by standard testing method
- ✻ Assess risk

AGE — See below ✶

		Infancy							Early Childhood						Mid.Childhood				Adolescence				
		2-3[1] days	by 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 yr	4 yr	5 yr	6 yr	8 yr	10 yr	12 yr	14 yr	16 yr	18 yr	20+ yr
History	Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Physical exam	As part of each visit	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Measurements	Weight/length: each visit through 18 mo; BMI each visit 24 mo and older	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
	Head circumference	●	●	●	●	●	●	●	●	●	●												
	Blood pressure	✻	✻	✻	✻	✻	✻	✻	✻	✻	✻	✻	●	●	●	●	●	●	●	●	●	●	●
Nutrition/Obesity prevention	Assess/educate	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Oral health	Assessment at 6 and 9 mo and until a dental home is established. Referral to dental home by 12 mo. Ask about dental home at every visit starting at 18 mo.			✻	✻	●	●	●	✻	●	●	✻	●	✻	✻	●	✻	✻	✻	✻	✻	✻	✻
Developmental and behavioral assessment	Developmental surveillance	●	●	●	●	●		●	●			●	●	●	●	●	●	●	●	●	●	●	●
	Developmental screening: 9, 18, 24 or 30 mo						●			●	✪												
	Autism screening: 18 & 24 mo									●	●												
	Psychosocial/behavioral assessment	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
	Alcohol and drug use assessment																		✻	✻	✻	✻	✻
Sensory screening	Vision	S	S	S	S	S	S	S	S	S	S	S	O	O	O	O	O	O	O	✪		O	S
	Hearing	O	S	S	S	S	S	S	S	S	S	S	S	O	O	O	O	O	S	S	S	S	S
Immunization	Perform an immunization review at each visit; administer immunizations at recommended ages, or as needed	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anticipatory guidance	Provided at every visit	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES																							
Lipid screening											✻			✻	✻	✻	✻	✻	✻	✻	✻	✪	
Hemoglobin/ hematocrit	Perform once between 9-month and 12-month visits for children at risk; also annually for adolescents if risk factors are present				✻		✪			✻	✻	✻	✻	✻	✻	✻	✻	✻	✻	✻	✻	✻	✻
Lead Testing	Assess and test children at 12 mo. and 24 mo. of age; Assess and test high-risk children at 18 mo, 3,4, 5 and 6 y.					✻	✻	●		✻	●		✻	✻	✻								
Metabolic screening	The Iowa Newborn Screening Program tests for hypothyroidism, galactosemia, phenylketonuria, hemoglobinopathies, congenital adrenal hyperplasia, plus expanded metabolic screening.	✪																					
Sexually transmitted infections	Screen as appropriate. People with a history of, or at risk for, STIs should be tested for chlamydia and gonorrhea.																		✻	✻	✻	✻	✻
Cervical Dysplasia Screening	Pap test at age 21, unless immunosupression or HIV																		✻	✻	✻	✻	●
Tuberculin test	Annual testing is recommended for high risk groups, which include household members of persons with TB or others at risk for close contact with the disease; recent immigrants or refugees from countries where TB is common (e.g., Asia, Africa, Latin America, Pacific islands and former Soviet Union); migrant workers; residents of correctional institutions or homeless shelters; persons with certain underlying medical disorders. Children with HIV and incarcerated adolescents should be screened yearly.	✻	✻	✻	✻	✻	✻	✻	✻	✻	✻	✻	✻	✻	✻	✻	✻	✻	✻	✻	✻	✻	✻

[1] For newborns discharged within 24 hours or less after delivery.

✶ **Medicaid recommends and will reimburse for annual visits for older children and adolescents, but does not yet require them.**

11/11

CARE FOR KIDS
Early & Periodic Screening, Diagnosis & Treatment

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What's in this issue

If you have questions about **billing** related to EPSDT Care for Kids services, please call Provider Services: **1- 800-338-7909** If you have questions about **clinical issues** and EPSDT Care for Kids services, please call **1 - 800-383-3826.** Please note: Due to budget restraints, the *EPSDT Care for Kids Newsletter* is sent to offices and organizations, rather than to individuals. **The newsletter is also available on line at www.iowaepsdt.org/EPSDTNews**. Readers are welcome to photocopy or download material from the newsletter to share with others. If you wish to reproduce material from the newsletter in another publication, whether print or electronic, please obtain permission prior to publication by contacting the editor. Please include the following acknowledgment with reprinted material: Reprinted by permission of the Iowa *EPSDT Care for Kids Newsletter.*

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