Primary Care Behavioral Health Screening Toolkit for the MassHealth Children's Behavioral Health Initiative (CBHI)

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Behavioral Health Screening

MassHealth requires primary care providers, as part of the Children's Behavioral Health Initiative (CBHI), to offer to complete the behavioral health screening component during well child visits for MassHealth members under the age of 21. The screening must use an age-appropriate, standardized behavioral-health screening tool selected from a menu of tools approved by MassHealth.

Experience has shown that behavioral health (or developmental) screening in primary care settings involves office staff members at every stage of the visit, from the person who greets families when they arrive, to the person submitting insurance claims after the visit.

This toolkit provides:

- Suggestions for how to get started using standardized behavioral health screening tools in your office

- Guidance on clinical issues related to the screening, such as how to manage the screening within the well-child visit and how to respond to an identified risk of a behavioral health concern

- Information on several of the most commonly used MassHealth-approved screening tools

Table of Contents

SECTION 1: OVERVIEW

A. Implementation of Behavioral Health Screening

Components of the screening process for office staff members

Conducting behavioral health screening in primary care involves nearly every function of the office, whether your office is staffed by two people or is a part of a large, multidepartment medical center. Below is a bulleted list of the required actions for the successful screening of a patient.

- Parents/guardians or older youths should be offered a screen and informed that participation is voluntary.

- One screening form per patient must be completed, either by a parent/guardian or the youth him/herself.

- The screening form must be scored, and the primary care provider must interpret and respond to the screening form and document the encounter as would be done for any clinical procedure.

- A staff member must submit a claim for the screening process.

Additional resources

The toolkit information that follows is applicable to nearly all settings, small and large, free-standing and institutional. If you encounter circumstances within your setting that this toolkit does not address, you may find the following web sites helpful:

- www.mass.gov/masshealth/childbehavioralhealth: This MassHealth Children's Behavioral Health Initiative (CBHI) web site provides information for members (patients), primary care providers, behavioral health providers, and billing staff regarding behavioral health screening in the primary care setting as well as behavioral health services.

- www.developmentalscreening.org: This web site, which often refers to developmental screening, explains applicable implementation principles for behavioral health screening.

Implementation steps for office staff: a summary

The implementation steps listed below are described on the pages that follow.

This guidance is based on the "Plan, Do, Study, Act" model of process improvement from the *Institute for Healthcare Improvement: Quality Resources"* found at www.ihi.org (specifically, www.ihi.org/iHi/Topics/Improvement/ImprovementMethods/Tools), and briefly described in the box below.

- *Step #1: **Identify*** two office "screening champions"
    - ✓ **Clinician** (e.g., physician, nurse practitioner)

- ✓ **Administrator** (e.g., office manager)
- *Step #2: Meet* as an entire office group to plan implementation
- *Step #3: Prepare* for implementation
  - ✓ **Assess** current screening practices
  - ✓ **Identify** who is involved with each operational step
  - ✓ **Select** which standardized tools the office will use
  - ✓ **Decide** how to distribute the screening forms to respondents
  - ✓ **Plan** introduction of screening tools
  - ✓ **Agree on** measures for tracking progress
  - ✓ **Set date** for the group to review progress
  - ✓ **Plan responses** to the identification of risks for behavioral health concerns
- *Step #4: Launch* screening
  - ✓ **Inform families/patients** via poster or other form of notification
  - ✓ **Implement** screening based on decisions in step #3
  - ✓ **Track** measures on a sample of patients to monitor progress
  - ✓ **Address** obstacles as they emerge
- *Step #5: Review* progress periodically as a group
  - ✓ **Present** results based on tracking of measures
  - ✓ **Acknowledge** achievements
  - ✓ **Discuss** obstacles, resolved and ongoing
  - ✓ **Develop** modifications, as needed
  - ✓ **Plan** next date for group review of progress

"Plan, Do, Study, Act" model of the *Institute for Healthcare Improvement Quality Resources (www.ihi.org)*, specifically www.ihi.org/iHi/Topics/Improvement/ImprovementMethods/Tools

- **Plan** improvement changes
- **Do** what is planned
- **Study** the results and identify improvement modifications
- **Act** upon the indicated modifications

Step #1: Identify two office "screening champions"

A champion is someone who is well respected within the office and can be an advocate of the proposed change. The champion should be one that is willing to work hard on a matter at hand, whether it is screening for a health issue, fundraising for a cause, or advocating for those with a disadvantage. With behavioral (or developmental) screening in primary care, experience has shown it is best to have **both a clinical champion and an administrative champion**, no matter how big or small the office setting.

➢ **The clinical champion** can be a physician, nurse practitioner, physician assistant, nurse, medical assistant, or other who routinely interacts with parents/guardians and youth at some time during clinical encounters.

- This champion must be a part of the "clinical side" of the practice.

➢ **The administrative champion** can be the office manager, billing manager, receptionist, filing clerk, or other. A clinical staff person could be appropriate for this role if he/she has significant administrative responsibility.

- This champion must be a part of the "business side" of the practice.

Step #2: Meet as an entire office group to plan implementation

Implementing behavioral (or developmental) screening is not a one-person job, nor is it solely the responsibility of the two "screening champions" unless they are the only staff. **Everyone in the office (or key personnel from the different functions of an institutional practice) should attend an initial meeting with the "screening champions," in which implementation is introduced and discussed.**

The "screening champions" should gather implementation-related information in advance of the initial meeting, as listed in "Step #3: Prepare for Implementation."

Step #3: Prepare for implementation

In order to prepare for implementation, decide on the following operational steps.

> A weekly or monthly staff meeting is the ideal setting for the initial group meeting to discuss behavioral health screening.

Operational steps

3a. Assess current screening practices

Before "throwing out the old way," identify your current screening operations. Recognizing what operations are already in place helps to identify what changes need to be made to support widespread, routine screening.

3b. Identify who is involved with each operational step

Example steps:

- Who will stock forms and order/print more when the supply is low?

- Who will hand out forms to parents/guardians/youth?

- Who will make completed screens available to the clinicians seeing the patients?

- Who will refer patients to behavioral health providers, when needed?

- Who will track progress regarding the screening implementation?

Guidelines are available that list the various operational steps that can facilitate the identification of necessary staff persons. They can be found at:

1. http://www.dbpeds.org/articles/detail.cfm?TextID=343

2. www.developmentalscreening.org/how_to_implement/implementation_checklist.htm

3. http://www.commonwealthfund.org/usr_doc/Integrating_Developmental_Screening_Worksheet.pdf?section=4225

3c. Select which standardized tools the office will use

Following is the list of current MassHealth-approved behavioral health screens. This list is subject to change. Go to the MassHealth Children's Behavioral Health Initiative web site, www.mass.gov/masshealth/childbehavioralhealth, scroll to "Training for Providers," then select to find the most up-to-date list.

- Ages and Stages Questionnaires: Social Emotional (ASQ:SE)

- Brief Infant-Toddler Social-Emotional Assessment (BITSEA)

- Modified Checklist for Autism in Toddlers (M-CHAT) (autism risk)

- Parents' Evaluation of Developmental Status (PEDS)

- Strengths and Difficulties Questionnaires (SDQ)

- Pediatric Symptom Checklist (PSC; Y-PSC)

- CRAFFT (substance abuse risk)

- Patient Health Questionnaire (PHQ-9) (depression risk)

A practice **does not** have to use all eight tools. The age of the patient must be considered in selecting an appropriate tool. No one tool can be used for all ages. Some tools are free; others must be purchased. This toolkit features the tools most commonly used from the currently approved list.

Information on each of the tools is available in attachment A on page 25. This toolkit covers additional help on the PEDS, PSC (Y-PSC), M-CHAT, SDQ, and PHQ-9. A separate toolkit for the CRAFFT is available at the MassHealth Children's Behavioral Health Initiative web site, www.mass.gov/masshealth/childbehavioralhealth. To find the CRAFFT toolkit, scroll to "Training for Providers," and then scroll to "Training on Using Behavioral-Health Screening Tools for Children Under the Age of 21 in the Primary-Care Setting." From there, scroll to "Using the MassHealth-Approved Screening Tools: Screening Tool Toolkits," and then select the CRAFFT.

3d. Decide how to distribute screening forms to respondents. There are several options for distributing the form to the parent/guardian or older youth respondent:

- Mail in advance of the appointment

- Give at the time of arrival at the front desk (preferred because produces highest rate of completion and least disruption to office flow)

- Give at the time the patient enters the examination room

3e. Plan introduction of screening tools

- Most practices choose to test the implementation of behavioral health screening tools on a small scale, rather than starting to screen all ages at all well child visits by all providers at one time. Once the initial screening process is working with relative ease, add another age group/tool/provider. Below are common starting points for screening, which can be combined:

  o Tool: Start with one tool; then add other tools over time.

  o Provider: Start with one or two providers, and add other providers over time.

  o Day of the week: Start with using tools on one particular day of the week, and add the other days over time.

- o Sites: Some practices have more than one site. Start with one site, and add additional sites as staff become familiar with the screening process.

- Pick a launch date. See "Step #4: Launch screening," for details on preparing to start the screening process.

- Identify a target date for full implementation of behavioral health screening in your practice.

3f. Agree on measures for tracking progress

There are several ways that changes in screening can be tracked over time as the practice implements behavioral health screening. Examples are:

- Tracking claims data for the CPT code for behavioral health screening, 96110.

- Giving the completed screening forms to someone to tally before they are scanned into an electronic medical record or filed in the patients' charts.

- The number of completed screens should be compared to the number of well-child visits. The goal is that every well child visit includes a behavioral health screen. Remember that this includes all well child visits through age 20.

3g. Set date for group review of progress

Before ending the first meeting of the entire office staff, agree upon a date for the next meeting to discuss successes, challenges, and the data collected from the tracking of the identified measures. Generally a monthly review works well.

- In addition to a presentation of progress and concerns, recognition of the efforts and successes of individuals and teams can build commitment to further improvement.

3h. Plan response to the identification of a risk for a behavioral health concern

This is a two-part step, clinical and administrative. Guidance on clinical responses is provided in the next section.

Regarding the administrative response, if the primary care provider believes a behavioral health referral is needed to a provider outside of the office, a process should be developed to expedite the referral.

- Each office must identify how the primary care clinician will communicate the need for that referral to the appropriate administrative staff person within the office.

- The office must decide how the referral is going to be made. Is the parent going to make the appointment? Or, will the office staff help the parent to call or make the phone call for the parent?

- A written communication should go to the behavioral health provider from your office either by mail or taken by the family. (See sample form on attachment C page 27).

Step #4: Launch screening

4a. Inform families/patients

Prepare your patients and their parents/guardians for routine behavioral health screening by providing an introduction. Suggestions for how to do so are:

- Posters on your waiting room and/or examination room walls

- Written notice or letter, mailed in advance, perhaps with an appointment reminder

- Include an update in a practice newsletter, if available

- Providing the handout "How's Your Child's Mental Health?", available at www.masspartnership.com/provider (click "Reports and Support Materials" in the left sidebar, scroll down to the brochure title to see the text, or click on "here" under the "Member Health Education Materials" section to place an order). Note that this handout is available to all practices and for all youth courtesy of the Massachusetts Child Psychiatry Access Project.

- Providing the brochure "Worried About the Way Your Child is Acting or Feeling?" available for MassHealth PCC Plan-enrolled providers though the PCC Plan Catalog or at www.masspartnership.com/pcc (click "Support Materials" in the left sidebar). This brochure is also available to MassHealth primary care providers not enrolled in the PCC Plan through the MassHealth Children's Behavioral Health Initiative web site, www.mass.gov/masshealth/childbehavioralhealth (click on "CBHI Related Materials" in the left sidebar, and scroll down to "CBHI Brochure and Companion Guide" to order). This brochure provides parents/guardians with an overview of behavioral health services for children and youth under 21 covered by MassHealth.

Suggested elements of the notification are:

- Behavioral health screening is now a routine part of care.

- Why behavioral health screening is an important part of a well child visit.

- Parents/guardians have the option to decline.

- Translations are available (as appropriate to your patient population).

- Staff can assist by reading the screening form, as needed.

4b. Track measures on a sample of patients, to monitor progress when you first get started.

This information should be given to one or both champions to make them aware of problems as soon as they arise.

4c. Address obstacles when they emerge

This will facilitate rapid problem resolution. If problems are allowed to continue unaddressed, staff will become frustrated or discouraged, which could lead to failure instead of success.

- Champions should be involved or kept informed.

Step #5: Review progress periodically as a group

Scheduling periodic reviews of the screening process with the entire office staff was advised in Step 3g, "Set date for group review of progress." Generally, monthly reviews work well. This step, broken down into components, below, can complete the requirements for a quality improvement project The *Institute for Healthcare Improvement* offers guidance on managing improvement projects as well as information on how to use the "Plan, Do, Study, Act" model. Additional information on implementing quality improvement efforts within your practice can be found at www.ihi.org (specifically, www.ihi.org/iHi/Topics/Improvement/ImprovementMethods/Tools); see box below. Other tools are available, as well.

5a. Present results based on tracking of measures

Objective information can make a powerful difference. The office staff will benefit from hearing how the screening is progressing. Potential measures are:

- Number of screening forms distributed per day (e.g., tally one day per week)
- Number (or rate) of positive screens
- Frequency (or rate) of submission of CPT code 96110 to insurers

5b. Acknowledge achievements

At the meeting, acknowledge people who prevent or solve problems. Rewards and/or public recognition of achievements often generate further commitment to the cause at hand, in this case behavioral health screening process.

5c. Discuss ongoing challenges

Having a group discussion about ongoing challenges can result in creative problem-solving. It may also offer insight for staff not directly involved in a challenge into why their circumstances are what they are.

5d. Develop modifications, as needed

This step involves identification of practical solutions (action steps) to be taken to address challenges, in contrast to 5c., "Discuss ongoing challenges," which identifies the challenges.

$\rightarrow$ Often the results of the action steps selected become good measures to track and report on at the next follow-up meeting.

5e. Plan the next date for group review of progress

If the group did not set up multiple dates for reviewing progress, be sure to agree on a date when the screening process will be discussed again before the end of the meeting. Clear milestones, such as acknowledgement of achievements and participation in problem-solving, can motivate people to engage in and promote a process.

B. Clinical Issues Related to Behavioral Health Screening

Behavioral health screening is voluntary for parents/guardians and older youths.

Parents/guardians and older youths should be informed that behavioral health screening can be declined. To put this into context, it is suggested they be simultaneously informed of the following:

- ✓ Behavioral health screening is becoming a routine part of well-child care nationwide, as supported by the American Academy of Pediatrics.

- ✓ Early identification and intervention of behavioral health risks and concerns can result in better outcomes for children and youth, and therefore their families.

- ✓ Behavioral health screening is voluntary.

Approved, standardized tools must be used.

To comply with MassHealth Children's Behavioral Health Initiative, only the MassHealth-approved screening tools may be used. **All of the approved tools are standardized questionnaires that are completed by a parent/guardian or the youth/adolescent.**

"Standardized tools" have been shown to be measurably superior to clinical impression (clinical judgment) alone. Well known examples are vision screening and mammography. The following two references demonstrate the disadvantage of relying on clinical impression alone when assessing the risk of a behavioral health concern.

1. Brugman E, et. al. *Identification and management of psychosocial problems by preventive child health care*. Arch Pediatr Adolesc Med. 2001;155(4):462-469

2. Lavigne JV, et. al. *Behavioral and emotional problems among preschool children in pediatric primary care: prevalence and pediatricians' recognition*. Pediatrics. 1993;91(3):649-655

The "standardizing process" for questionnaires involves asking research volunteers several proposed screening questions related to the condition of interest. The volunteers are then given a diagnostic ("gold standard") test for the presence, or absence, of the condition and the researchers compare the gold standard test results against the proposed screening questions to identify the best questions. The researchers also develop a scoring system for the best screening questions that establishes a scoring threshold, beyond which most individuals with the condition fall ("sensitivity" of the screen), and within which most of those without the condition fall ("specificity" of the screen).

Good screens are inexpensive, tolerable to the person being screened as well as the person administering the screen, reliable (results are the same no matter who administers the screen), valid (screen for the condition of interest), and screen for a condition for which there is treatment. They have other characteristics as well. All of these characteristics are considered during the standardization process.

Clinicians should use the screens as designed.

Providers should not modify a screening tool, nor alter the formal scoring process. Doing so will very likely reduce its usefulness, and does not fulfill the MassHealth Children's Behavioral Health Initiative requirement.

The clinical impression (clinical judgment)

Basis: Three sources of information

The behavioral health screen is only one of four sources of information on which the primary care provider should develop a clinical impression/judgment as to whether or not there is a risk of a behavioral health concern. The four sources of information are:

→ The behavioral health screen

→ The patient's or parent's statement of concern about behavioral or emotional issues

→ History of the patient

→ Observation/examination of the patient

Communicating about the clinical impression

Regarding the clinical impression/judgment, the primary care provider must:

✓ Inform the parent/guardian or youth

✓ Document it in the clinical record

✓ Inform the office billing person, for the purpose of submitting the appropriate MassHealth-specific modifier as part of the billing claim (see "Billing for Behavioral Health Screening")

✓ Inform the behavioral health provider to whom the patient is referred, if referral is indicated

The basic behavioral health screening encounter

Ask if the patient is receiving counseling

This is helpful information that may be considered when deciding whether or not there is an identified risk for a behavioral health concern.

- Asking this question of each patient, when the parent/guardian or youth receives the form to complete, or before the screen is reviewed, normalizes the idea of counseling.

Identifying parental/personal concern

A pre-existing parent/guardian or youth concern about a behavioral health issue may aid the selection of an appropriate screening tool and may augment the tool's results. Questions about parental/personal concern can include:

- Are you currently concerned about your child's (your) behavioral or emotional health?

- Are you interested in speaking with a counselor about these issues?

Review and score any screening form that is given to the parent/guardian or youth

The completed screening form should be scored, either by a staff member before being given to the primary care provider, or by the primary care provider. Interpret the score as either "within normal limits" (negative) or "at risk" (positive).

Responding to an incomplete form

If a form is not completed, there may be a cultural, language, or literacy problem, or the parent/guardian or youth may have difficulty comprehending. Someone may offer to read the questions to them (see "Addressing a language or literacy problem," if applicable). Each of the MassHealth-approved screens can be administered as an interview. The interviewer should read the items as written and not reword them or offer explanations or examples.

Verbally acknowledge the screening and its results with parent/guardian or youth

Acknowledge to the parent/guardian or youth that you have looked at the form and its score.

Informing the parent/guardian or youth

When informing the parent/guardian or youth of the results, adhere to the following:

- If the score on the screening form is reassuring ("negative"), acknowledge as such to the parent/guardian and youth. For example, "Things seem to be going well; that's terrific."

  - Ask if any questions came up while the form was being completed; this can help to build the provider-patient relationship.

- If the score on the screening form is concerning ("positive"), state that the result is telling you there could be an issue for which more information is needed. See "Initiating a discussion about a concerning ("positive") screen," below.

Initiating discussion about a concerning ("positive") screen

Before initiating a discussion about a concerning screen, the primary care provider must decide how much time he/she has in that screening visit. If there is insufficient time to explore "positive" items, schedule a return visit, arrange a telephone follow-up, or refer to a mental health colleague in your practice, if you have one. Referring to a mental health provider without further exploration of the "positive" items may be appropriate for patients with additional evidence of significant mental/behavioral concerns, such as a parental concern or clinical interaction with the youth.

Discussion:

→ Always: Inform parents/guardians and youth that the screen does not make a diagnosis; it only indicates there may be an issue.

→ Ask open-ended questions. For example, "It seems your child has a lot going on. Can you tell me about the situation? How is life at home?"

> ➢ Add, "Are you worried about these behaviors?"

- Explore "positive" items with the parents/guardians and youth, to better understand their responses.

  ⇨ This discussion might clarify misunderstanding of the question, disagreement, disproportionate concern, or other reasons to suggest the item may not actually be failed.

  ⇨ Keep in mind that the erroneous response may be an indication of a different, but genuine, concern.

  ⇨ Rescore positive items and the entire screening form, as indicated.

- Determine whether these symptoms are affecting the child's functioning.

- Ask how the parent/guardian is dealing with the symptoms.

If after this discussion, the clinical impression is that there is a risk of a behavioral health concern, move on to the next section "Responding to an identified risk of a behavioral concern."

Responding to an identified risk of a behavioral health concern

The primary care provider must decide what is clinically indicated for the patient. The decision may be to manage the patient him/herself; refer "internally" to a co-located behavioral health provider; or refer "externally" to an outside behavioral health provider. Parent/guardian input in where to receive services should also contribute to the decision on how to manage the patient.

If the decision is to refer to a behavioral health provider, take the following steps:

- Inform the parent/guardian or youth, and provide an explanation.

- Describe what the referral process may entail (e.g., parent will be given a phone number, and they will speak to an intake worker, other).

- Some patients and/or families may benefit from a brief description of the likely clinical experience (e.g., "You will talk with someone alone sometimes and as a family other times.").

- Determine what behavioral health resources are available for the child.

- Consider providing the brochure "Worried About the Way Your Child is Acting or Feeling?" available for MassHealth PCC Plan-enrolled providers through the PCC Plan Catalog or at www.masspartnership.com/pcc (click "Support Materials" in the left sidebar). This brochure is also available to MassHealth primary care providers not enrolled in the PCC Plan through the MassHealth Children's Behavioral Health Initiative web site, www.mass.gov/masshealth/childbehavioralhealth (click on "CBHI Related Materials" in the left sidebar, and scroll down to "CBHI Brochure and Companion Guide" to order). This brochure provides parents/guardians with an overview of behavioral health services for children and youth under 21 covered by MassHealth. A companion guide for providers who work with families entitled, "Helping Families Access MassHealth Home and Community Behavioral Health Services for Children and Youth under Age 21: A Guide for Staff Who Work with Children and Families," is also available in downloadable format at www.mass.gov/mashealth/childbehavioralhealth (follow the directions for the brochure above).

- Utilize the Massachusetts Child Psychiatry Access Project (MCPAP) to assist with making the referral (see "Referring externally," next page).

Primary care management or referral for behavioral health management

Managing behavioral health issues in the primary care setting

There are several general resources available for assisting primary care providers with managing a behavioral health concern in the primary care office, such as:

- www.aap.org/mentalhealth

- www.massgeneral.org/schoolpsychiatry

- www.mcpap.com

Here in Massachusetts, the Massachusetts Child Psychiatry Access Project (MCPAP) is available for telephonic consultation and, if necessary, a face-to-face consultation, Monday through Friday from 9 a.m. to 5 p.m. If you are not currently enrolled in MCPAP, please read attachment B.

Referring internally

A practice may have one or more behavioral health providers who are responsible for following up on a risk of a behavioral health concern identified at a well-child visit.

Referring externally

Resources are available for finding help from behavioral health providers in the community. Examples are:

- Massachusetts Child Psychiatry Access Project (www.mcpap.com)
  - Western MA/Baystate Medical Center: (413) 794-3342
  - Central MA/UMass Medical Center: (508) 334-3240
  - Northeast Region/North Shore Medical Center: (888) 627-2767
  - Boston-Metro Region I/Mass General Hospital: (617) 724-8282
  - Boston-Metro Region II/Tufts-Children's: (617) 636-5723
  - Southeast Region/McLean-Brockton: (508) 894-8484
- MassHealth Children's Behavioral Health Initiative (CBHI) (www.mass.gov/masshealth/childbehavioralhealth)
- MassHealth-contracted Managed Care Entity (MCE) Customer Service Hotlines
- MassHealth Customer Service at 1-800-841-2900

For external referrals, a communication should go to the behavioral health provider explaining the reason for the referral. This communication should include the results of the screening. Consider using the MCE approved communication form designed to be used between a primary care provider and a behavioral health provider which is included in this toolkit (attachment C).

Children and their families often do not follow through with keeping a behavioral health referral. If you have significant concerns about a child's mental health, consider setting up a tickler system with someone in the office, following up with a family to ascertain whether the referral has been kept; and if not, the child and family should return to your office for further discussion.

Screening a patient with a known behavioral (mental) health problem

All MassHealth enrolled members must be offered an age-appropriate, standardized behavioral health screening tool from the menu of approved screening tools at each well-child visit at which a behavioral health screen is required, even those members with known behavioral, or mental, health problems.

- If the screen is "positive," the primary care provider should discuss whether failed items are new, or worsened, symptoms of the known condition, or related to a new concern. Also, the primary care provider should determine whether the current treatment plan is being followed or needs to be reevaluated.

- If the screen is "negative," the primary care provider should ask whether there are any new concerns. For example, say "Your screen results indicate there is no concern. That tells me your (depression/anxiety/substance abuse) is better. Is that right?" If right, say "Excellent!" Then ask, "Are there any new concerns?" If so, say "Tell me more." (See "Managing the behavioral health screening visit," above.)

C. Billing for Behavioral Health Screening

CPT Code

Once a MassHealth-approved screening tool has been completed, interpreted, and the outcome documented, your office may bill MassHealth or the appropriate MassHealth-contracted MCE for the screening using CPT code 96110.

Modifier

MassHealth and the MassHealth-contracted MCEs require the use of a unique MassHealth-specific modifier, consisting of the letter U combined with a single digit, 1-8. The selection of the appropriate U-modifier is based on the servicing provider (MD, NP, PA, nurse midwife) and the clinical decision regarding the presence, or absence, of a behavioral health need (see table below).

NOTE: Providers should not base their choice of digit for the modifier based only on whether the screen is "negative" (no behavioral health need identified) or positive (behavioral health need identified). The selection should be based on the combination of screen results, history, and observation/examination of the patient.

Modifiers for Use with Service Code 96110

Servicing Provider	Modifier for Use When No Behavioral Health Need Identified*	Modifier for Use When Behavioral Health Need Identified*
Physician, Independent Nurse Midwife, Independent Nurse Practitioner, Community Health Center (CHC), Outpatient Hospital Department (OPD)	U1	U2
Nurse Midwife employed by Physician or CHC	U3	U4
Nurse Practitioner employed by Physician or CHC	U5	U6
Physician Assistant employed by Physician or CHC	U7	U8

*"Behavioral health need identified" means the provider administering the screening tool, in her or his professional judgment, identifies a child with a potential behavioral health services need.

If you have questions for MassHealth about the CPT code, modifiers, or billing issues, contact the Customer Service Representative for your MassHealth-contracted MCE or the MassHealth Customer Service Center at 1-800-841-2900.

ATTACHMENT A - MASSHEALTH SCREENING TOOLS

MassHealth-Approved Standardized Behavioral Health Screening Tools
For Children Under the Age of 21

Screening Tool	Full Name	Age Group	Administered By	Initial Cost	Ongoing Costs	Link
ASQ:SE	Ages and Stages Questionnaires: Social-Emotional	6 to 60 months	Parent	Complete starter kit (CD) with 8 color coded sheets - $194.95	No cost for photocopying forms after purchase of the starter kit	http://www.brookespublishing.com/tools/asqse/index.htm
BITSEA	Brief Infant - Toddler Social and Emotional Assessment	12 to 36 months	Parent	Complete kit (manual, 25 Parent forms, 25 Childcare provider forms) - $105	Parent forms - $39 for pkg. of 25; Childcare provider forms - $39 for pkg. of 25. $1.56 per form	http://www.pearsonassessments.com/haiweb/cultures/en-us/productdetail.htm?pid=015-8007-352
M-CHAT	Modified Checklist for Autism in Toddlers	16 to 30 months	Parent	Copyright by Diana Robins, Deborah Fein, and Marianne Barton. No charge.	No charge.	http://www2.osu.edu/~psydir
PEDS	Parents' Evaluation of Developmental Status	Birth to 8 yrs.	Parent	Complete starter kit (guide, set of 50 forms) -$30	Pad of 50 forms - $15. $.30 per form (bulk ordering and discounts available)	http://www.pedstest.com
PSC	Pediatric Symptom Checklist	4 thru 16 yrs.	Parent	Public domain. No charge.	No charge.	http://www2.massgeneral.org/allpsych/psc/psc_home.htm
YPSC	Pediatric Symptom Checklist – Youth Report	11+ yrs.	Youth	Public domain. No charge.	No charge.	http://www2.massgeneral.org/allpsych/psc/psc_home.htm
SDQ	Strengths and Difficulties Questionnaire	3 thru 16 yrs	Parent	Public domain. No charge.	No charge.	http://www.sdqinfo.com
SDQ	Self-rated SDQ	11 thru 16	Youth	Public domain. No charge.	No charge.	http://www.sdqinfo.com
CRAFFT	An acronym for: Car, Relax, Alone, Forget, Friends, Trouble; screening for substance abuse	11 to 21 yrs.	Youth	Copyright by Children's Hospital Boston. No charge.	No charge.	http://www.ceasar-boston.org/clinicians/crafft.php
PHQ-9	Patient Health Questionnaire-9; screening for depression	18+ yrs.	Young Adult	Copyright by Pfizer. No charge.	No charge.	http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/

Information, including prices, is current as of 11/24/09.

ATTACHMENT B - MCPAP INFORMATION

Massachusetts Child Psychiatry Access Project (MCPAP)

The Massachusetts Child Psychiatry Access Project (MCPAP) is available to assist any primary care provider (PCP) that sees children or adolescents. Currently, more than 95 percent of PCPs in the Commonwealth are enrolled. MCPAP encourages any PCP not yet enrolled to call one of the teams listed below. MCPAP is supported by the Department of Mental Health and is free to all PCPs.

The goal of MCPAP is to make child psychiatry services accessible to PCPs throughout the Commonwealth. MCPAP provides PCPs with timely access to child psychiatry consultation and, when indicated, transitional services into ongoing behavioral health care.

MCPAP is available to all children and families, regardless of insurance status, as long as the point of entry is through their PCP. MCPAP operates from 9 a.m. to 5 p.m., Monday thru Friday, and is not meant to replace necessary emergency services. Through MCPAP, teams of child psychiatrists, social workers, and care coordinators provide assistance to PCPs in accessing psychiatric services. MCPAP is regionalized to facilitate an ongoing relationship between the MCPAP team and the PCP.

The state is divided into six (6) regional teams. A regional team consists of 1 FTE of child psychiatrist, 1.5 FTE of a licensed social worker, 1 FTE of a care coordinator, and appropriate administrative support. Each team builds relationships with the PCPs in their region to provide psychiatric telephone consultation, often immediately, but at least within 30 minutes. The consultation will result in one of the following outcomes, depending upon the needs of the child and family:

1. an answer to the PCP's question;

2. referral to the team care coordinator to assist the family in accessing routine, local behavioral health services, with the understanding that there may be a 4-6 week wait;

3. referral to the team social worker to provide transitional face-to-face care or telephonic support to the child and family until the family can access routine, local behavioral health services; or

4. referral to team child psychiatrist for an acute psychopharmacologic or diagnostic consultation.

The regional MCPAP team also provides PCPs with training and behavioral health continuing education. Although much of this education will occur during telephone consultations around specific members, the team is available for "brown bag" or other types of learning sessions at the PCP office.

Satisfaction data shows that PCPs participating in MCPAP now report that ***because of MCPAP, they are able to meet the psychiatric needs of children and adolescents in their practices.***

Primary care practices that care for children and adolescents may call one of the programs below to sign up. For additional, please contact Irene Tanzman, Massachusetts Behavioral Health Partnership, at (617) 350-1990 or Irene.Tanzman@valueoptions.com.

MCPAP Regional Teams

Western Mass.	Baystate Medical Center	(413) 794-3342
Central Mass.	U Mass. Medical Center	(508) 334-3240
Northeast Region	North Shore Medical Center	(888) 627-2767
Boston/Metro Region I	Mass. General Hospital	(617) 724-8282
Boston/Metro Region II	Tufts/Children's	(617) 636-5723
Southeast Region	McLean-Brockton	(508) 894-8484

ATTACHMENT C - COMMUNICATION FORM

Combined MCE Behavioral Health Provider/Primary Care Provider Communication Form

Health Plan: Boston Medical Center HealthNet Plan   Network Health   Fallon Community Health Plan   Neighborhood Health Plan   PCC Plan

The member below is currently receiving services and has consented to share the following information between their PCP and BH provider.

In an effort to increase communication and promote care coordination between providers, we ask that you review and/or complete the following health information.

Member Name: _____   DOB: _____   Member ID#:_____

A signed copy of the release of information (ROI) must be attached to this form. Indicate date of expiration of ROI: _____

Section A: *(completed by BH Provider)*

1. The patient is being treated for the following behavioral health problem(s) and/or diagnoses: (list all)

_____   _____
_____   _____

2. The patient is taking the following medication(s): (list all prescribed and OTC medications, with dosage and frequency as applicable)

_____   _____
_____   _____
_____   _____

Prescriber: _____

3. The patient has the following Substance Abuse problem(s) (if applicable):

_____
_____
_____

4. Please describe any special concerns:

_____
_____
_____
_____

Behavioral Health Clinician: _____
Behavioral Health Clinician Signature: _____
Provider Name/Site Name: _____
Address: _____
_____
_____
Phone: _____
Fax: _____
Date this form completed:

Section B: *(completed by Primary Care Provider)*

1. The patient is being treated for the following medical problem(s) and/or diagnoses: (list all)

_____   _____
_____   _____

2. The patient is taking the following medication(s): (list all prescribed and OTC medications, with dosage and frequency as applicable)

_____   _____
_____   _____
_____   _____

3. The patient has the following BH (MH/SA) problem(s) (if applicable):

_____
_____
_____

4. Please describe any special concerns (i.e., include abnormal lab results):

_____
_____
_____
_____
_____

Primary Care Provider: _____
Primary Care Provider Signature: _____
Provider Name/Site Name: _____
Address: _____
_____
_____
Phone: _____
Fax: _____
Date this form completed:

To make a referral to Case Management, please call the members' plan at:

Boston Medical Center HealthNet Plan: (866) 444-5155 • Network Health: (888) 257-1986 • Fallon Community Health Plan: (781) 994-7500
Neighborhood Health Plan: (781) 994-7500 • Primary Care Clinician Plan: (617) 790-5633

(Updated 11/07/2008)

SECTION 2: PARENTS' EVALUATION OF DEVELOPMENTAL STATUS (PEDS)

A. An Overview of the PEDS

The PEDS is a parent-completed questionnaire that is a validated screening tool used to facilitate the early identification of developmental and behavioral needs. Children with "positive" PEDS have increased likelihood of needing Early Intervention Program (EIP) services or specialized educational services. The American Academy of Pediatrics recommends use of a validated developmental screening tool at the 9 months, 18 months, and 24 or 30 months well-child visits. The PEDS is validated for children 0 to 9 years of age and is approved by MassHealth for behavioral health screening at well-child visits.

What does the PEDS do?

The PEDS identifies children with high probability for undiagnosed developmental disabilities requiring further evaluation. Parent report of concerns is reviewed and categorized into specific areas of development, with certain concerns considered "predictive" at certain ages. These predictive concerns are statistically derived; more than 700 children had formal evaluations after the parent completed a PEDS. The PEDS forms were analyzed, and "predictive" concerns are those associated with formal evaluation results below 1 to 2 standard deviations of the mean (approximating prediction of EIP or specialized educational service needs). Therefore, predictive concerns are not necessarily intuitive. One predictive concern means the child is eight times more likely of having a disability that indicates a need for services, and two predictive concerns means the child is 20 times more likely to have a disability that indicates a need for services. The PEDS, therefore, is not a diagnosis-specific tool.

B. Tools and Scoring

The PEDS consists of 10 items to be completed by a parent.
- The first and last items elicit general concerns.
- The remaining eight items seek parent concerns about distinct streams of development:
  - ✓ Receptive language
  - ✓ Expressive language
  - ✓ Fine motor skills
  - ✓ Gross motor skills
  - ✓ Behavior
  - ✓ Social interactions

- ✓ Self-help skills
- ✓ Academic development

- For items 2-9, parents are asked if they have concerns and may select one of the following:
  - ○ No
  - ○ Yes
  - ○ A little

  "Yes" and "A little" are scored the same.

- Some items at each age are "predictive."
  - ○ Predictive concerns increase the likelihood that the child will have a need for disability-based services.
  - ○ Referring to the scoring algorithm is essential: it is nearly impossible to memorize which items are predictive at each age.
  - ○ "Global cognitive concerns" are predictive at every age; a child who is "behind his peers" or "does everything more slowly" is more likely to have a need for services.
  - ○ Behavior and self-help concerns are not predictive at any age; temper tantrums or toilet training trouble themselves are never predictive of a developmental disability that will indicate a need for services.

- Some electronic records incorporate the scoring so that the provider is flagged when a parent concern on the PEDS is predictive.

- Parent concerns do not always match the developmental stream queried, which means that concerns written on the response survey do not always correspond to the same number on the score form. Discussion is necessary to score the parent concern accurately.

C. Languages

The PEDS is currently translated into many languages: English, Spanish, and Vietnamese – and licensed in the following: Thai, Indonesian, French, Swahili, Arabic, Somali, Taiwanese, Chinese, Hmong, Malaysian, Russian, Haitian-Creole, and Galician. The publisher will work with you on translations needed and can license use of many translations.

D. Accuracy

The PEDS will correctly identify 74 – 80 percent of children with developmental disabilities, and 70 – 80 percent of children developing typically. Given concerns with

under-detection, providers are encouraged to use clinical judgment when parents do not endorse concerns. Children over-referred on the PEDS (not meeting eligibility criteria for IEP or EIP services) almost always perform in the lower limits of the average range and may benefit from special attention.

E. Implementation of the PEDS

- After the parent completes the response form, a clinician must review the information before scoring.

    o Some responses are not categorized within the accurate developmental stream; when scored, these items should be included in the developmental stream that the parent *meant* and not necessarily in the category where they answered the question.

    o Parents with literacy or language needs may underreport concerns, and so the PEDS questions may be read directly to the parent in review.

    o Translations in languages other than English and Spanish have not been validated, and questions may be misunderstood.

- To score the parent responses, the clinician must access the score form or a computer version that identifies which concerns are "predictive" at each age.

- One predictive concern leads to the recommendation for "Second Stage Screen," which may not be feasible in the typical primary care practice. Clinician judgment may be necessary in determining whether further referral is indicated.

F. PEDS Frequently Asked Questions

1. **Does a clinician have to score the PEDS?**

   Yes, a clinician has to score the PEDS. Parents may endorse a concern, but with further discussion, the concern may need re-categorization. For example, when asked, "Do you have any concerns about how your child understands what you say?" many parents report, "Doesn't listen." Often, this is a behavioral and not a receptive language concern and should be endorsed as behavior.

2. **Can I ignore parent concerns that are clearly developmentally inappropriate?**

   No; no parent concerns can be ignored. The premise of the PEDS is that parents are knowledgeable about their children's current skills, and can detect differences between their child and same-aged peers. In some cases, the child will not be found eligible for services when referred, indicating a "false positive." However, the group of children whose parents report predictive concerns yet were found not eligible for services tend to have lower than average performance on expressive language, reading, motor, and cognitive testing, and may benefit from enrichment opportunities.

3. **What should I do about anxious parents who are worried about everything?**

Parents who appear to over-endorse concerns may contribute to the "false positives," but their PEDS should be scored in the routine manner. Most providers find it helpful to have this list of worries available at the start of the visit, rather than leaving this discussion until the visit's end. Providers should document why they are not referring a child for further evaluation when the screen was "positive."

4. **Will the PEDS be accurate for less-educated, younger, first-time parents?**

Previous studies indicate that, in general, all parents are accurate reporters of what their children can and cannot currently do. It is possible that less-experienced parents will contribute to the "false negative" rate of PEDS. However, in standardization and validity studies of the PEDS, neither parent age, education , income status, first-born status, nor marital status were associated with a difference in report accuracy. Parents of first-born children were more likely to report behavior concerns. As in all screening, results should be interpreted in the context of clinical observations and further discussion.

5. **What is the appropriate second stage screen to perform in the office?**

For one predictive concern, the PEDS algorithm indicates the need for a second stage screen to further refine the child's risk for a disability. The PEDS author suggests using the Brigance Screening tools, however tools that directly elicit the child's skills may be too time consuming to be practical in the primary care setting. Some providers opt to refer all children with one or more predictive concerns for further evaluation, while others use clinical judgment in managing those with only one predictive concern.

6. **Why do I have to purchase the PEDS?**

The author of the PEDS maintains a copyright, so the tool cannot be photocopied legally. Buying in bulk and arranging integration with electronic medical records may decrease the cost.

7. **How do I score the concern if a parent changes his or her report after our discussion?**

Discussion is necessary to understand the nature of each parent concern. The item should be endorsed in the category the parent concern best fits. However, the provider response to the overall score may be impacted by the discussion, including modifications made by the parent and interpretation of the concern in light of typical developmental expectations. These discussion results should be documented.

8. **Is the PEDS validated in Spanish? In other languages? If not, should I still use it?**

Of the 771 children participating in PEDS validation studies, 25 parent-child dyads (3%) were primarily Spanish speaking. They were exclusively tested in Spanish using standardized Spanish directions for their tests. In the non-English speaking group, there were significantly more parents who under-reported when their children had findings than parents who accurately reported or over-reported. Based on only 12

cases, it appears that this under-reporting reflected difficulty in responding to the PEDS, both in writing and orally. Other languages are less well documented. Since learning and language disorders in children who speak English as a second language are easily missed, translated PEDS should still be considered, but findings must be interpreted with caution; parent interview and clinical judgment are particularly important in these cases.

9. **Should I use the PEDS for children whose developmental disorders have already been identified?**

   Many families whose children's needs have been identified already and are being addressed fail to endorse current concerns about these developmental and behavioral areas. In some cases, particularly complex children whose *physical health* is stable are not reported as having developmental concerns. MassHealth regulation necessitates use of a screening tool at every well-child visit at which a behavioral health screen is required. Therefore, members with previously identified disorders should still be offered a screen, but results must be interpreted in light of ongoing services and progress.

G. What to do with a "Positive" Screen

Children with two or more predictive concerns

- ✓ All children with two or more predictive concerns should be seriously considered for further evaluation.

- ✓ In general, children under 2 years, 9 months should be referred to Early Intervention, and older children can be referred to the local public schools for specialized educational service evaluations.

- ✓ Most children will also benefit from a hearing evaluation, particularly with concerns in language development.

- ✓ Some children may require specialty evaluation by a developmental pediatrician, pediatric psychologist, neurologist, or psychiatrist.

Children with one predictive concern

- ✓ For children with one predictive concern, the PEDS algorithm indicates the need for a second stage screen to further refine the child's risk for a disability.

- ✓ The PEDS author suggests using the Brigance Screening tools, however tools that directly elicit the child's skills may be too time consuming to be practical in the primary care setting.

- ✓ Some providers opt to refer all children with one or more predictive concerns for further evaluation, while others use clinical judgment in managing those with only one predictive concern.

Children with nonpredictive concerns

✓ Nonpredictive concerns need to be addressed, even if they don't increase the risk of need for developmental services.

✓ The most common concerns endorsed for children over 1 year of age are behavior problems; 31.8 percent of parents report behavior concerns. Office-based counseling and guidance is usually the first step.

✓ Peer-reviewed or consensus-developed parental education can be helpful, such as the AAP booklets and Bright Futures handouts described on page 35 .

Concerns endorsed	1 or more nonpredictive concerns	0 predictive concerns	1 predictive concern	2 or more predictive concerns
Next steps	Office counseling	Rescreen at routine intervals	Second Stage Screen, clinical judgment	Seriously consider further evaluation, hearing test
Important facts		Check language and literacy of parent or caregiver	8 times increased likelihood of being at risk of need for developmental services	20 times increased likelihood of need for developmental services

How to determine clinical concerns

Like any screener, the PEDS has "false positives" (screens that include predictive concerns for a child who is developing typically) and "false negatives" (screens without any predictive concerns for a child with true delays). Therefore, in every case, the clinician's impressions should be incorporated into decisions about referral plans. The final decision should take into account:

1. risk as indicated by the PEDS;

2. parent concerns elicited during conversation; and

3. clinical observation and judgment.

These hints may help guide you in formulating the extent of your own clinical concerns regarding the need for further evaluation of the child:

• Are there multiple areas of concern reported by the parent? Many concerns may indicate:

  o a global developmental issue;

  o parent anxiety; or

  o behavior problems interfering with several skill domains.

- What first made the parent concerned?

  o When parents compare their children to other same-aged peers, they can detect subtle differences in what different children are saying, learning, and doing independently.

  o Parents may be sharing concerns from daycare providers, teachers, or others with extensive child development experience.

  o Fears based on previous experiences, something heard on television, or imagined problems may deserve attention, even when the child's development is, in fact, on target.

- Is there a family history of developmental or behavioral disorders?

  o Many disabilities run in families, so a positive family history may increase a child's risk for being affected.

  o Children with learning and attention needs often have parents with similar profiles, so environmental models may play a role in the child's current skills.

- How behind in any one skill does the child appear to be?

  o Even if there is only one area of concern reported, when that domain is substantially behind expectations, it should be explored.

- When you interact with the child in your office, look for the following areas of ability:

  o How the child understands simple and then more complex directions

  o Whether the child responds with intelligible words, phrases, or sentences

  o If the child can maintain a simple conversation

  o How the child climbs onto and moves around the exam table

  o If the child can turn pages of a book, holds a writing implement properly, imitates finger movements, and forms shapes and letters well

  o Whether the child makes eye contact, has a facial expression appropriate to context, looks to the parent for reassurance, follows your point, and responds to name as indications of social communication

H. Resources for Providers

- ❑ Find a detailed directory of EI programs at www.massfamilyties.org

- ❑ Attachment A - Sample release of information for early intervention

- ❑ Attachment B - Sample referral letter for general early intervention

- ❑ Free provider handouts from Bright Futures

    http://www.brightfutures.org/mentalhealth/pdf/

    Topics include:
    - Anxiety Disorders
    - Attention Deficit Hyperactivity Disorder
    - Learning Problems and Disorders
    - Oppositional and Aggressive Behaviors

I. References

Council on Children with Disabilities; Section on Developmental Behavioral Pediatrics; Bright Futures Steering Committee; Medical Home Initiatives for Children with Special Needs Project Advisory Committee. *Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening.* Pediatrics*.* 2006 Jul;118(1):405-20. Erratum in: Pediatrics*.* 2006 Oct; 118(4):1808-9.

Glascoe FP. *Parents' evaluation of developmental status: how well do parents' concerns identify children with behavioral and emotional problems?* Clin Pediatr (Phila). 2003 Mar; 42(2):133-8.

J. Resources for Families

Parent education handouts and audio files from the American Academy of Pediatrics (AAP)
http://patiented.aap.org/categoryBrowse.aspx?catID=5004

Topics include:

- ADHD

- Bed Wetting

- Growing Independence: Tips for Parents of Young Children

- Helping Shy Children

- Helping Your Child Learn to Read

- How Do Infants Learn?

- Learning Disabilities: What Parents Need to Know

- Playing is How Toddlers Learn

- Separation Anxiety and Sleeping

- Sibling Rivalry

- Speech Development

- Teaching Good Behavior: Tips on How to Discipline

- Teaching Kids to Share

- Temper Tantrums

- Toilet Training

- Your Child's Growth: Developmental Milestones

Free parent handouts from Bright Futures

http://www.brightfutures.org/tools/index.html
Infancy, Early Childhood, Middle Childhood, and Adolescence handouts focus on social and emotional development, with anticipatory guidance and suggestions of when to seek help.

Suggested reading
The Wonder Years. American Academy of Pediatrics; Edited by Tanya Remer Altmann, MD, FAAP.

K. The Principal Author's Web Site

http://www.pedstest.com/
Includes ordering information, PEDS examples, training materials, research summary, information about translations, and electronic applications

ATTACHMENT A - SAMPLE RELEASE OF INFORMATION TO EARLY INTERVENTION FORM

Practice name:
Practice address:
City, state, zip:
Phone:
Fax:

AUTHORIZATION TO REQUEST/RELEASE MEDICAL RECORDS

Patient's name:_____

DOB:_____

Medical record number:_____

Address:_____

City_____State_____Zip_____

Contact phone:_____

I give consent to [your practice name] to release of information from the medical record maintained while my child/ward was a patient at [your practice name] to [Name of the Early Intervention Program].

The specific information to be disclosed is:

☐ Office Notes
☐ Physical Exams
☐ Legal and Attorney Reports
☐ Immunization Records
☐ Developmental Notes
☐ Laboratory Reports
☐ Daycare Information
☐ Nutrition Summaries

I [insert parent/guardian name] give [insert practice name] permission to speak with and/or release information to [insert name of early intervention program].

Information ☐may ☐may not be released by telephone.

I understand that this consent is subject to revocation at any time unless action based on this release has already been taken. I understand that further disclosure of the information to be released may not be made without my written consent or as otherwise restricted by Federal Regulations (42 Code of Federal Regulations. Part 2).

UNLESS OTHERWISE INDICATED, THIS CONSENT WILL EXPIRE IN SIX (6) MONTHS.

_____   Date: _____
Signature of parent/guardian

ATTACHMENT B - SAMPLE REFERRAL LETTER TO GENERAL EARLY INTERVENTION

Practice name:
Practice address:
City, state, zip:
Practice phone:
Practice fax:

Date:

Re: [insert patient's name]

DOB: [insert date of birth of patient]

Dear [name of specialty services liaison or "To Whom It May Concern"]:

Please enroll the above-referenced patient in an early intervention program. I have made a provisional diagnosis of autism spectrum disorder (ASD) based on my clinical assessment and administration of the Modified Checklist for Autism in Toddlers (M-CHAT).

Please refer this child in a specialty services early intervention program for children with autism spectrum disorders.

Sincerely,

Referrals made:
__ General EI
__ Audiology

SECTION 3: PEDIATRIC SYMPTOM CHECKLIST (PSC)

A. Overview

The Pediatric Symptom Checklist (PSC), developed by Drs. Michael Jellinek and J. Michael Murphy, is a behavioral health screening tool for children ages 4 to 16 years. It has been widely validated nationally and internationally. The Youth Pediatric Symptom Checklist (Y-PSC) was developed for youth over age 11 to 18+.

B. Tool and Scoring

The PSC is a 35-item questionnaire used to screen children for behavioral health issues. The Y-PSC is the youth version of the tool. While parents can fill out the PSC on their children up to the age of 16 years, the Y-PSC is available for youth to fill out themselves for ages 11 to 18+. The PSC and Y-PSC are available online for no additional charge at http://www2.massgeneral.org/allpsych/psc/psc_home.htm.

Questions are directed at either parent or youth (depending on the version). Each question is scored as 0 (never), 1 (sometimes), or 2 (always). The total is summed, and if it falls above the cut-point, then the tool is considered positive. The cut-point is the score above which the screen is positive. The PSC is designed to be done by the parent or youth (Y-PSC) while they await a visit with the provider.

The cut-points for the screen are:

PSC
- ✓ **Ages 3-5: Cut-point is 23 or greater (ignore the school questions)**
- ✓ **Ages 6-18: Cut-point is 28**

Y-PSC
- ✓ **Cut-point is 30**

C. Languages

The PSC and Y-PSC are available in English, Spanish, Brazilian and European Portuguese, Chinese, Hindi, and French. The PSC is also available in Dutch, Hmong, German, and Haitian Creole.

D. Accuracy

The PSC and Y-PSC have both been validated in multiple populations in a number of studies. The PSC was validated against the Child Behavior Checklist (CBCL) and the Children's Global Assessment Scale (CGAS) ratings of impairment in a variety of pediatric and subspecialty settings representing diverse socioeconomic backgrounds. When

compared to CGAS in both middle and lower income samples, the PSC has shown high rates of overall agreement (79%; 92%), sensitivity (95%; 88%), and specificity (68%; 100%), respectively.

E. Implementation of PSC

The PSC can be given to families in the waiting room prior to their well-child appointment, given that it is a self-administered tool. It is important to determine when adolescents in your practice should receive the Y-PSC. The Y-PSC is designed for those aged 11 to 18+. In many offices this tool is used when the practice gives time alone to adolescent patients (i.e., 14 and up). Families can also receive the screen by mail prior to their appointment and be encouraged to bring the completed form to their annual appointment.

Once the family comes into the provider's office, the provider should review the questions and also ask whether the family has any concerns or whether their child is currently in counseling services.

F. PSC Frequently Asked Questions

1. **Do I need to review each question on the PSC/Y-PSC?**

   The PSC is an overall screening tool whose cut-point is predictive of mental health issues. While physicians review the tool differently with patients (some read each question, some look at the total score and review, and some highlight sub scores), it is important to review the tool with the patient regardless of the total score.

2. **Does a negative score mean there is no problem?**

   The PSC/Y-PSC are screening tools that do not diagnose problems but rather is designed to identify children at risk. The tool can act as a prompt for further discussion, and your clinical acumen is ultimately the most important tool that you have at your disposal.

3. **Where do I get the PSC?**

   The PSC and Y-PSC is free and available on the internet at the following web site*:* http://www2.massgeneral.org/allpsych/psc/psc_home.htm.

4. **What if families don't answer questions?**

   The PSC is invalid if more than three questions are left blank. However, if the total score is still above the cut-point, it should be considered reliable. If the total score is less than the cut-point, then ask the family/youth those questions directly.

   For children who are not in school, you can ignore the questions on school, and the tool is still valid.

5. **At what age should teens receive the Y-PSC?**

   The Y-PSC can be used at age 11 and older, but the PSC can be used up to age 16. You can decide how you would best like to implement these versions in your office for consistency. In many offices this tool is used when the practice gives time alone to adolescent patients (i.e., 14 and up).

G. PCC Response to Positive Screen

1. **Interpreting the scores**

If score is less than the cut-point, and the parents are not concerned	If the score is less than the cut-point, but the parents are concerned	If the score is over the cut-point, and the parents either are or are not concerned
Discuss results and re-screen at annual visit.	Use clinical judgment. Determine if a referral for further assessment is necessary.	Conduct or refer for further assessment.
Clinical judgment and parental/personal concern should always be considered in determining further referral or assessment needs.		

2. **Guidelines and resources for a positive screen**

   If the PSC or Y-PSC score falls above the cut-point, there are several options. However, it is important to recognize that the PSC/Y-PSC are screening tools and do not diagnose conditions. Rather, a positive screen will require further assessment to determine whether a mental health issue is present. All decisions for next steps will require the physician to determine the urgency of the situation and work with the child and family, as outlined below.

   - The physician can decide to assess the child and manage him/her in the practice. There are multiple standardized tools for assessment of various mental health conditions (ADHD, depression, anxiety, etc.). This screening could take place in a follow-up visit or may need to take place during the screening visit, depending on the acuity and complexity of the situation.

   - The physician may choose to work collaboratively with a mental health provider to determine next steps and either refer or manage the situation in primary care.

   - The physician can contact the MCPAP program, which offers timely psychiatric consultation.

- The physician can refer the family to a mental health provider for further assessment.

3. **Addressing parental concern**

The PSC is best used as a screening tool at the annual well-child visit. Administering the tool at an acute visit may result in an artificially increased score due to anxiety about the condition for which the family/patient is seeking help.

The questions about parental/personal concern can include:

➢ Are you currently concerned about your child's behavior or emotional health?

➢ Are you interested in speaking with a counselor about these issues?

If a parent is interested in further assessment when his/her child scores below the cut-point, use your clinical judgment to determine next steps.

H. Decision to Refer

Steps to take when a child scores above the cut-point are as follows:

1. Discuss the score with the family.

   "It seems that your child has a lot going on. Can you tell me about the situation? How is life at home? Are you worried about these behaviors?"

2. Review the areas of most concern to get clarity on the problem.

3. Determine whether these symptoms are affecting the child's functioning.

4. Ask how the parent is dealing with the symptoms.

5. Suggest further assessment with a counselor.

6. Describe in detail what can be expected during further assessment.

7. Determine what mental health resources are available for the child.

8. Utilize the MCPAP service, if necessary.

I. Resources for Families

Further information on the PSC can be found at:
http://www2.massgeneral.org/allpsych/psc/psc_home.htm

AAP web site:
http://www.aap.org/healthtopics/behavior.cfm

SAMHSA web site:
http://mentalhealth.samhsa.gov/child/childhealth.asp

NIMH web site:
http://www.nimh.nih.gov/health/topics/child-and-adolescent-mental-health/index.shtml

J. References

Stancin, T. & Palermo, T.M. *A review of behavioral screening practices in pediatric settings: Do they past the test?* J Dev Behav Pediatr. 1997; 18(3):183-194.

Jellinek, M., Patel, B.P. & Froehle, M.C. Eds. *Bright Futures in Practice: Mental Health Volume I. Practice Guide.* Arlington, VA: National Center for Education in Maternal and Child Health. 2002.

Simonian, S.J. & Tarnowski, K.J. *Utility of the Pediatric Symptom Checklist for behavioral screening of disadvantaged children.* Child Psychiatry Hum Dev. 2001; 31(4); 269-278.

Brugman, E., Reijneveld, S., Verhulst, F. & Verloove-Vanhorick, S.P. *Identification and management of psychosocial problems by preventive child health care*. Arch Pediatr Adolesc Med. 2001; 155(4):462-469.

Hacker, K., Myagmarjav, E., Harris, V., Franco Suglia, S., Weidner, D. & Link, D. *Screening for mental health in pediatric practice: Factors related to positive screens and the contribution of parental/personal concern*. Pediatrics. 2006;118(5):1896-1906.

Pediatric Symptom Checklist, Bibliography.
http://psc.partners.org/psc_bibliography.htm Accessed May 10, 2008.

Pagano, M., Cassidy, L., Little, M., Murphy, M. & Jellinek, M. *Identifying psychosocial dysfunction in school-age children: The pediatric symptom checklist as a self-report measure.* Psychology in the Schools. 2000; 37:91-106.

Jellinek, M.S., Murphy, J.M., Robinson, J., Feins, A., Lamb, S. & Fenton, T. Pediatric *Symptom Checklist; Screening school-age children for psychosocial dysfunction*. 1988, Journal of Pediatrics. 112: 201-209.

Murphy, J.M. & Jellinek, M.S. *Screening for psychosocial dysfunction in economically disadvantaged and minority group children: further validation of the Pediatric Symptom Checklist*. 1988. American Journal of Orthopsychiatry. 58: 450-456.

SECTION 4: STRENGTHS AND DIFFICULTIES QUESTIONNAIRES (SDQ)

A. Overview

The Strengths and Difficulties Questionnaires (SDQ) are designed for behavioral health screening of 3- to 16-year-olds. This copyrighted screening tool is available for free at www.sdqinfo.com. It is listed in the American Academy of Pediatrics' "Feelings Need Check Ups Too" resource, and its use was presented in the "Connecting for Children's Sake: Integrating Physical and Mental Health Care in the Medical Home" symposium at the 2005 National Conference & Exhibition. Both documents are available at the AAP's web site, www.aap.org by searching for "SDQ."

The SDQ consists of 25 questions and is estimated to take about five minutes for a respondent to complete. There are three age-group versions of the SDQ:

- 3-4 year-olds
- 5-10 year-olds
- 11-16 year-olds

There are three respondent versions of the SDQ:

- Parent (all age groups)
- Teacher (all age groups)
- Self (11-16 year-olds, only)

For each age group, the SDQ has complementary forms:

- Basic form, consisting of 25 questions
- Basic form, plus questions regarding impact of difficulties on the child and family
- Follow-up form: Parent (all age groups), Teacher (all age groups), Self (11-16 year-olds, only)

For the purpose of the behavioral health screening required for the Children's Behavioral Health Initiative (CBHI), only the parent or self (youth) <u>basic</u> form need be administered. Primary care providers may find other versions clinically useful.

The SDQ home page, www.sdqinfo.com, provides the following links (icons): "What is it?," "Questionnaires etc, view and download," "Scoring the SDQ," "Uses," "SDQ vs other Q's," "Articles," and "Norms." Primary care providers will find two links most practical:
1. "Questionnaires, etc., view and download"
2. "Scoring the SDQ"

The authors of www.sdqinfo.com are also the authors of the web site www.youthinmind.com, which is a consumer-oriented site for accessing the SDQ and identifying helpful resources. "Youth in Mind" appears on many pages of the www.sdqinfo.com web site.

B. Tool and Scoring

The tool described

The 25 items in the basic SDQ are comprised of five items in each of the following areas ("scales"):

- Emotional symptoms
- Conduct problems
- Hyperactivity
- Peer problems
- Pro-social behavior ("strengths")

The sequence of items is identical in each of the age group forms. However, the wording of some of the items varies from age group to age group. The items from the different scales are intermingled in the respondent forms, rather than being clustered by scale. Respondents are asked to rate each item as "not true," "somewhat true," or "certainly true." It is estimated it takes about five minutes for respondents to complete the basic response form.

In the process of scoring the SDQ, which is explained below, a score for each scale listed above is obtained. A "total difficulties" score is obtained by summing the scores in the first four scales (emotional symptoms, conduct problems, hyperactivity, and peer problems) only. The "pro-social behavior" scale is the "strengths" component of the SDQ.

For the purpose of screening for behavioral health problems for CBHI, the overall "total difficulties" score is all that needs to be considered in deciding whether a child is in need of a referral for further assessment. However, the primary care provider may find the profile generated by the scale scores to be useful. Also, parents/guardians, as well as older children, would likely benefit from hearing about the child's strengths, if present, in their pro-social behavior.

Finding the right versions of the tool

At www.sdqinfo.com:

- Click on the link (icon) "Questionnaires, etc., view and download." This brings you to the list of more than 60 translations.
- Click on the desired translation, such as "English (USA)."

- The next page lists the various versions, based on age group, informant, impact, and follow-up.

- Click on the yellow circle to the left of the desired versions to open and print them. **Only the "one-sided" versions (basic forms), which are the first four listed, are necessary for CBHI.** Primary care providers may find other versions of the SDQ (described in the "Overview," above) useful, as well.

Systems for scoring the SDQ

At the SDQ web site, www.sdqinfo.com:

- Hand-scoring instructions can be found at either of the following links, "Questionnaires, etc., view and download" or "Scoring the SDQ." Information on hand-scoring forms is provided in the following section.

- Computer-based instructions can only be found at "Scoring the SDQ." Information on computer-based scoring of the SDQ is provided in a following section.

Hand-scoring forms

At "Questionnaires, etc., view and download," select a translation then scroll to the bottom of the page to find the following scoring forms:

1. Scoring instructions for versions completed by parents or teachers ("Scoring the Informant-Rated Strengths and Difficulties Questionnaire")

2. Scoring instructions for self-report versions ("Scoring the Self-Report Strengths and Difficulties Questionnaire")

3. Black-and-white overlays for hand scoring

4. A record sheet for hand-scored questionnaires ("SDQ Record Sheet")

At the web page, click on the yellow circle to the left of the desired options to open and print them. Additional information about the forms follows.

Scoring instructions (#1 and #2, above):

- **Page one**, which contains the 25 items clustered by scale (emotional symptoms, conduct problems, etc.), indicates the value (0, 1, or 2) assigned to responses (not true, somewhat true, certainly true) for each item. A patient's summed score for each scale and "total difficulties" score can be tracked in a record sheet (#4, above).

- **Page two** of the scoring instructions provides interpretations (normal, borderline, abnormal) of each scale score and "total difficulties" score.

"Black-and-white overlays" (#3, above) provides five pages, one for each scale (emotional symptoms, conduct problems, etc.), each indicating the value (0, 1, or 2) assigned to responses (not true, somewhat true, certainly true) for the associated items. A patient's summed score for each scale and "total difficulties" score can be tracked in a record sheet (#4, above).

The record sheet for hand-scored questionnaires (#4, above) provides for recording the summed score for each scale and "total difficulties" score, as well as the interpretation of those scores.

Scoring the SDQ

For each item in the SDQ, responses of "not true," "somewhat true," and "certainly true," are assigned values of 0, 1, or 2. While "somewhat true" is always valued at 1, "not true" and "certainly true" can be valued at either 0 or 2, depending on the item. Knowing what value to assign to item responses can be learned from the "Scoring Informant-Rated Strengths and Difficulties Questionnaire," or "Scoring the Self-Report Strengths and Difficulties Questionnaire," described above in the "Hand-scoring forms" section.

The values of the responses for the items within each of the following scales are summed, to derive a scale score:

- Emotional symptoms scale

- Conduct problems scale

- Hyperactivity scale

- Peer problems scale

- Pro-social scale

The scale scores each have their own interpretation (normal, borderline, abnormal). See the next section.

The "total difficulties" score is created by summing the scores for the first four scales, above, and DOES NOT INCLUDE the pro-social scale. See the next section for interpreting the "total difficulties" score.

Interpreting SDQ scale scores and "total difficulties" scores

Interpretation of scale scores, as well as the "total difficulties" score, can be found in the "Scoring Informant-Rated Strengths and Difficulties Questionnaire," "Scoring the Self-Report Strengths and Difficulties Questionnaire," and the "SDQ Report Sheet," described above in the "Hand-scoring forms" section. These documents can be found at www.sdqinfo.com by clicking on the link (icon) "Questionnaires, etc., view and download." Select a translation then scroll down to the bottom of the page to "scoring instructions for versions completed by parents or teachers," "scoring instructions for self report versions," or "a record sheet for hand-scored questionnaires."

For the purpose of screening for behavioral health problems for the CBHI, the overall "total difficulties" score is all that needs to be considered in deciding whether a child is in need of a referral for further assessment. However, the primary care provider may find the profile generated by the scale scores to be useful. Also, parents/guardians, as well as older children, would likely benefit from hearing about the child's strengths, if present, in their pro-social behavior.

For the CBHI, the primary care provider should add his or her own clinical impression to the results of the SDQ in deciding whether or not there is a need for services.

Computer-based scoring

Computer-based scoring instructions, along with hand-scoring instructions, are available at the "Scoring the SDQ" web page. To assist with understanding the options at that web page, the options are noted below as either "COMPUTER" or "HAND" (for hand scoring). At the web page, click on the yellow circle to the left of the desired option to open it.

1. (COMPUTER) "www.sdqscore.net." Responses must be entered by the health care provider into a web-based scoring program. A report is generated that provides the scale scores as well as the "total difficulties" score (and impact, if completed). In addition, the "total difficulties" and scale scores are interpreted in terms of risk (low, high, etc.). Diagnostic predictions and cautions for the parent/guardian are provided, should the primary care provider wish to share the report.

2. (HAND) "Instructions in English for scoring informant-rated SDQS by hand." See "Hand-scoring forms" section, above.

3. (HAND) "Instructions in English for scoring self-rated SDQS by hand." See "Hand-scoring forms" section, above.

4. (HAND) "Black-and-white transparent overlays for hand scoring." See "Hand-scoring forms" section, above.

5. (HAND) "A record sheet in English for hand-scored questionnaires." See "Hand-scoring forms" section, above.

6. (COMPUTER) "Scoring syntax using SPSS," "Scoring syntax using STATA," Computerized algorithm," and "An 'added value' score for specialist services," are beyond the expectations of the CBHI for primary care providers. However, any provider interested in working with statistical packages may find them of interest.

7. (COMPUTER) There is also the option to use a "computerized scoring and report-writing program" using Access, which would store results on the provider's computer. This must be requested via e-mail; the e-mail address is provided at the web page. Responses must be entered by the health care provider. A report

is generated that provides the subscale scores as well as the "total difficulties" score (and impact supplement, if completed). Diagnostic predictions may be included.

C. Languages

The SDQ is available in more than 60 languages including Chinese, French, Khmer, Korean, Portuguese, Russian, and Spanish. The translations can be found at www.sdqinfo.com by clicking on "Questionnaires, etc., view and download."

English (USA) must be selected, the same as any other translation, as it is not available by default.

D. Accuracy

The SDQ was selected to be the mental health screening instrument for the 2001 Supplement of the National Health Interview Study (NHIS) cosponsored by the National Institute of Mental Health and the National Center for Health Statistics for the Center for Disease Control and Prevention, for which it was administered to the parents of 10,367 4- to 17-year-olds. The results, published in the June 2005 issue of the *Journal of the American Academy of Child and Adolescent Psychiatry*, found the SDQ to be "an effective and efficient screener for child and adolescent mental health problems in the United States"[1]. Normative data from this US study are available at www.sdqinfo.com ("Norms").

When first published, the SDQ was found to have good reliability and validity[2], which was reinforced in a Dutch study published in 2009 when it performed well against the Child Behavior Checklist (Achenbach System of Empirically Based Assessment, ASEBA)[3].

The SDQ was included in a 1999 survey by the United Kingdom Office for National Statistics of 10,438 children from child benefit records (available for 98 percent of British children). Measured against the likelihood of selected DSM-IV diagnoses based on an accepted tool (Development and Well-Being Assessment, DAWBA), the SDQ was found to have acceptable properties[4].

In that 1999 study, for parent respondents, sensitivity was fair at 47 percent, meaning 47 percent of children with DSM-IV diagnoses fell in the high-risk group (top 10%) on the SDQ. The SDQ was good at identifying children at low-risk (specificity was 94%). Positive predictive value, the percent of children scoring in the high-risk group (top 10%) who go on to have DSM-IV diagnoses, was acceptable at 46 percent. Negative predictive value was very good (96%).

For youth ("self-rated") respondents, sensitivity was not as good as for parents (23%), meaning 23 percent of children with DSM-IV diagnoses fell in the high-risk group (top 10%) on the SDQ. The SDQ was good at identifying children at low-risk (specificity was 94%). Positive predictive value, the percent of children scoring in the high-risk group (top 10%) who go on to have DSM-IV diagnoses, was 35 percent, once again lower than for parent report. Negative predictive value was good (92%).

Normative banding

Scores falling in the top 10 percent for the "total difficulties" scale for parent completed forms had a mean odds ratio of 16 that a child would be independently diagnosed with a psychiatric diagnosis (4). In that same study, the odds ratio was 15 for teacher completed forms and 6 for youth completed forms. In the 2001 NHIS, those scoring in the top 10 percent of difficulties were classified as "high difficulties," the next 10 percent "medium difficulties," and the remaining 80 percent to be "low difficulties" (1). These band scores correspond to "abnormal," "borderline," and "normal" in interpretations provided at www.sdqinfo.com.

E. Implementation of the SDQ

The SDQ response form can be given to the parent/guardian or youth (ages 11-16 years) in the waiting room after arriving for the primary care appointment. The response form can be scored by hand or by computer, as discussed in sections above, prior to the encounter with the primary care provider.

Parents/guardians, teachers, and youth can complete the SDQ online by visiting www.youthinmind.com. Reports generated at this web site could be brought to the primary care provider for review and discussion. The web site www.youthinmind.com also points parents, teachers, and youth to books and other web sites that might be of help if concerns are identified.

F. SDQ Frequently Asked Questions

1. Do I need to score each scale (emotional problems, etc.) on the SDQ?

Answer: Although only the "total difficulties" score is required by the CBHI, all the scoring systems available through www.sdqinfo.com derive the scale scores as a means to reaching the "total difficulties" score. Primary care providers could find the scale scores, including the "prosocial scale" (the "strengths" identified in the SDQ) helpful in managing patients and their families.

2. Do I need to administer any of the teacher forms?

Answer: For the CBHI, these forms are not necessary. Primary care providers may wish to have the additional observer input in deciding if a patient may have a difficulty and to monitor progress.

3. Do I need to use the "Impact" items?

Answer: For the CBHI, these items are not necessary. Primary care providers may choose to administer these items to better understand their patients and the impact of difficulties on the patient and family.

4. Do I need to administer any of the "Follow-up" forms?

Answer: For the CBHI, these forms are not necessary. Primary care providers may choose to use the SDQ to monitor progress with any behavioral health concern being managed or monitored.

G. PCC Response to a Positive Screen

1. **Responding to the "total difficulties" score**

If score is "normal" and the parent/guardian is not concerned	If the score is "borderline," or is "normal" but the parent/guardian is concerned	If the score is "abnormal" and the parent/guardian either is or is not concerned
Discuss results and re-screen at annual visit.	Use clinical judgment. Determine if a referral for further assessment is necessary.	Conduct or refer for further assessment.
Clinical judgment and parental/personal concern should always be considered in determining further referral or assessment needs.		

2. **Guidelines for a positive screen**

It is important to recognize that the SDQ is a screening tool and not diagnostic. An "abnormal," and in some cases a "borderline" score, will require further assessment to determine whether a mental health issue is present. All decisions for next steps will require the physician to determine the urgency of the situation and to work with the child and family, as outlined below.

- The primary care provider can decide to assess the child and manage him/her in the practice. One or more of the scale scores can help identify the concern(s) to be addressed.
  - Utilizing the "impact" version of the SDQ, can assist with identifying the degree to which the concern is a problem.
  - The "follow-up" version of the SDQ can be used to manage and monitor the concern, with or without intervention from a mental health provider.

- The physician may choose to work collaboratively with a mental health provider to determine next steps and either refer or manage the situation in primary care.

- The physician can contact the MCPAP program, which offers timely psychiatric consultation.

- The physician can refer the family to a mental health provider for further assessment.

3. **Addressing parental concern**

Additional questions to the parent/guardian and/or youth can also help to assess the situation. Suggested questions are:

- Are you currently concerned about your child's behavior or emotional health?

- Are you interested in speaking with a counselor about these issues?

Utilization of the SDQ "impact supplement" can help with documenting the concerns of the parent/guardian. It is part of computer-based scoring. For hand-scoring, the basic form with the "impact supplement" can be found at www.sdqinfo.com, "Questionnaires, etc., view and download," by selecting a translation and clicking on the yellow box next to the appropriate age and respondent form that contains the impact supplement.

A parent/guardian can always request further assessment or referral even when his/her child scores in the "borderline," or even "normal," range.

If the parent/guardian and/or youth is interested in additional information, see the following "Resources for Families" section.

H. Decision to Refer

When a primary care provider decides that a child who scores in the "abnormal" and in some cases the "borderline" range of the SDQ is in need of referral, steps to take are as follows:

1. Discuss the scores with the family.

   "It seems that your child has a lot going on. Can you tell me about the situation? How is life at home? Are you worried about these behaviors?"

2. Review the areas of most concern to get clarity on the problem.

3. Determine whether these symptoms are affecting the child's functioning.

4. Ask how the parent is dealing with the symptoms.

5. Suggest further assessment with a counselor.

6. Describe in detail what can be expected during further assessment.

7. Determine what mental health resources are available for the child.

8. Utilize the MCPAP service, if necessary.

Utilization of the SDQ "impact supplement" can help with documenting the concerns of the parent/guardian and/or youth (steps 1-3, above). It is part of computer-based scoring. For hand-scoring, the basic form with the "impact supplement" can be found at www.sdqinfo.com, "Questionnaires, etc., view and download," by selecting a translation and clicking on the yellow box next to the appropriate age and respondent form that contains the impact supplement.

I. Resources for Families and Providers

Many web-based resources are available to address behavioral health issues in children, adolescents, and young adults. A few are listed below, including "Youth in Mind" (www.youthinmind.com), a resource web site developed by the authors of the SDQ. Web sites listed below include information on additional resources.

- Youth in Mind (www.youthinmind.com): This is a resource web site developed by the authors of the SDQ. This web site provides book and internet resources for families, teachers, and youth that may be of help in addressing concerns they may have before or after completing the SDQ. Of note:

    - The authors of the SDQ are British; therefore some of the wording and information at this web site may be unfamiliar to American readers.

    - Families, teachers, and youth can access the SDQ questionnaires at this web site. Therefore, some families or youth may bring completed questionnaires with them to visits with their primary care providers.

- Massachusetts Child Psychiatry Access Project (MCPAP) (www.mcpap.org): This web site offers information on clinical reference and screening, diagnostic fact sheets, and more, as well as information on the MCPAP clinical service available to primary care providers in Massachusetts.

- Massachusetts General Hospital School Psychiatry Department (http://www2.massgeneral.org/schoolpsychiatry/index.asp): This web site offers information for parents, educators, and clinicians.

- American Academy of Pediatrics (AAP):
  http://www.aap.org/healthtopics/behavior.cfm

- Substance Abuse and Mental Health Services Administration (SAMHSA), a federal agency: http://mentalhealth.samhsa.gov/child/childhealth.asp

- National Institute of Mental Health:
  http://www.nimh.nih.gov/health/topics/child-and-adolescent-mental-health/index.shtml

J. References

1. Bourdon KH, Goodman R, Rae DS, et al. The strengths and difficulties questionnaire: U.S. normative data and psychometric properties. *J Am Acad Child Adolesc Psychiatry. 2005;44:557-564*

2. Goodman R. The strengths and difficulties questionnaire: A research note. *J Child Psychol Psychiatry*. 1997;38:581-586

3. Janssens A, Deboutte D. Screening for psychopathology in child welfare: the strengths and difficulties questionnaire (SDQ) compared with the Achenbach System of Empirically Based Assessment (ASEBA). *Eur Child Adolesc Psychiatry. 2009;18:691-700*

4. Goodman R. Psychometric properties of the strengths and difficulties questionnaire. *J Am Acad Child Adolesc Psychiatry*. 2001;40:1337-1345]

SECTION 5: MODIFIED CHECKLIST FOR AUTISM IN TODDLERS (M-CHAT)

A. Overview

The M-CHAT is a parent-completed questionnaire that is a validated screening tool used to facilitate the early diagnosis of autistic spectrum disorders (ASD). ASDs are a group of disorders of development, disrupting social relationships, communication, play, and academic skills. Autism can be difficult to detect in young children, but early diagnosis can improve prognosis and benefit families. The American Academy of Pediatrics (AAP) recommends specific autism screening at the 18 month and 24 month well-child visits. The M-CHAT is validated for children 16 months to 48 months of age and is approved by MassHealth for behavioral screening.

B. Tools and Scoring

The M-CHAT consists of 23 "Yes"/"No" questions to be completed by a parent. It is available free of charge. The authors of the M-CHAT maintain authorized web sites at www2.gsu.edu/~psydlr and at www.firstsigns.org. These web sites include full information about the tool and scoring options.

The 23 M-CHAT questions include six critical and 17 non-critical items. A screen is "positive," indicating increased risk of ASD, if the parent reports that the child "fails" two critical or three total items. For most items, the child "fails" when the parent answers "Yes"; however the "fail" is associated with a "No" answer for four of the items. Scoring options include a key, a transparent overlay, or an electronic scoring program.

For positive screens, the authors have published an M-CHAT interview, which consists of follow-up questions to clarify whether a particular "Yes" or "No" answer indicates that a child "fails" the item. Parents can be asked clarifying questions at the time of initial screening or in follow-up phone calls or office visits. If the M-CHAT interview changes an answer, the test is rescored accordingly.

C. Languages

The M-CHAT is available in the following languages: Arabic, Bangla, Chinese, Dutch, French, French Canadian, German, Greek, Gujarati, Icelandic, Japanese, Japanese with Illustrations, Kurdish, Portuguese (Brazil), Portuguese (Portugal), Sinhala, Somalian, Spanish (Western Hemisphere), Spanish (Spain), Tamil, Turkish, and Vietnamese. Other translations are currently in progress. Translations can be found at the author's web site.

D. Accuracy

Autism and autistic spectrum disorders affect between 2 and 8 out of 1,000 children. Of children with positive M-CHAT screens in a general population, about 1 to 3 in 10 will receive an autism diagnosis. When a positive M-CHAT is confirmed with the clarifying questions of the M-CHAT interview, 6 to 8 in 10 children who screen positive will receive a diagnosis of autism. Those children who screen positive but do not have autism may have other disorders, including language and/or global developmental delay, which benefit from early intervention.

E. Implementation of the M-CHAT

If possible, the M-CHAT should be scored before the visit, with failed items identified so that the clinician can ask clarifying questions during the visit. If it is not possible to explore the failed items at the time of the visit, consider developing a follow-up process to explore positive screens (telephone interview or a follow-up visit).

It is important to organize office resources to respond to positive screens, including parent information about autism, information about early intervention (EI) services, audiology evaluation, and potential resources for further evaluation of children who screen positive.

F. M-CHAT Frequently Asked Questions

1. **Should children who have been screened with the M-CHAT be re-screened at 24 months?**

    Children should be screened at both 18 and 24 months. Re-screening at 24 months may identify children who were not identified at an earlier time. Children who screen positive at 18 months but then have a negative further evaluation should still be rescreened at 24 months.

2. **Can the M-CHAT be used for younger or older children?**

    The M-CHAT is only validated for screening between the ages of 16 and 48 months. If there are concerns about children outside of this age group, clinicians should use other methods of evaluation. The AAP autism toolkit includes information on other validated tools that can be used for younger and older age groups.

3. **Does a negative M-CHAT mean there is no concern about autism and further evaluation is not necessary?**

   A negative M-CHAT does not mean that further evaluation is unnecessary. If a parent has concerns about autism and the M-CHAT is passed, a clinician should explore the parental concern and use clinical judgment to pursue appropriate further evaluation. Similarly, if a clinician has concerns based on clinical findings, these findings should be explored even if the M-CHAT is negative.

G. PCC Response to Positive Screens

1. **Clarifying if items are truly failed**

   While the family is in the office, consider further inquiry about each "failed" item with M-CHAT interview questions.

2. **Evaluating a child suspected of having an Autism Spectrum Disorder**

   a. **Provide peer reviewed information**

      The AAP has several booklets, including *Understanding Autistic Spectrum Disorders,* which provide good information for parents.

   b. **Refer for early intervention**

      A child at age 18 or 24 months with a positive M-CHAT, or any child at these ages suspected of having a delay or developmental disorder, should be referred for early intervention services. The early intervention referral should include a copy of the M-CHAT to facilitate evaluation and referral for specialty intervention services. If the child appears very likely to have an ASD, a simultaneous referral can be made to specialty early intervention services for children with autism with a provisional diagnosis of ASD. Although step (e) below is necessary, step (b) should not wait until the appointment before step (e) has occurred.

   c. **Refer for audiological evaluation**

      A child suspected of having ASD and all children with language delays should have an audiological evaluation, even if the newborn hearing screen is normal. If behavioral audiometry does not accomplish this task, a brainstem auditory evoked response can be ordered.

   d. Refer for further evaluation

      If a child scores positive on the M-CHAT but does not appear to the clinician to have an ASD, further evaluation is warranted. An M-CHAT interview found at http://www2.gsu.edu/~psydlr/Diana_L._Robins,_Ph.D._files/M-CHATInterview.pdf, if not previously done, would be appropriate. The child could also be referred to EI services or an appropriate specialist for further evaluation.

e. **Refer for diagnostic evaluation**

In the state of Massachusetts, children will need a definitive diagnosis in order to receive autism specialty services. Specialists that can provide a definitive diagnosis of suspected ASD may include developmental psychologists, developmental pediatricians, speech pathologists, neurologists, autism specialty clinics, and child psychiatrists. Offices should keep a listing of specialists in their area who can make a definitive diagnosis of autism.

f. **Medical evaluation of children with ASD**

There are several excellent reviews recommending the medical evaluation of a child with ASD. In children with global developmental delay, medical evaluation might include lead screening, high resolution karyotype, and DNA testing for Fragile X. Children with specific clinical findings suggested by history of physical exam such as seizure, cyclic vomiting, lethargy with mild illness, or unusual odors, or hypopigmented macules may benefit from targeted studies including EEG, metabolic studies, and MRI. Consultation with a geneticist, pediatric neurologist, or developmental pediatrician might facilitate this targeted work-up.

H. Resources for Providers

❑ M-CHAT scoring sheet (Attachment A)

❑ The M-CHAT Follow-Up Interview can be downloaded free of charge from http://www2.gsu.edu/~psydlr/Diana_L._Robins,_Ph.D._files/M-CHATInterview.pdf

❑   Checklist for child who screens positive (Attachment B)

❑ To find a detailed listing of **early intervention programs**, visit www.massfamilyties.org or call 1-800-905-TIES.

❑ Universal early intervention referral form (Attachment C)

❑ Sample release of information for early intervention (Attachment D)

❑ Sample referral letter for general early intervention (Attachment E)

❑ Department of Public Health's listing of Audiological Assessment Diagnostic Center in Massachusetts (Attachment F)

I. References

http://www2.gsu.edu/~psydlr
M-CHAT authors' web site; contains information on scoring options, MCHAT interview, translations, and other helpful information

AAP autism tool kit – Visit http://www.aap.org/publiced/autismtoolkit.cfm for more information; contains comprehensive materials including information on screening, evaluation, and treatment; also contains summary documents written for clinicians and parents

www.firstsigns.org
Web site dedicated to educating parents and professionals about early identification and intervention for children at risk for developmental delays and disorders, including autism

AAP Policy Statement: *Identification and Evaluation of Children with Autism Spectrum Disorders.* November 2007
Review of screening and evaluation processes

Myers et al. *Management of Children with Autism Spectrum Disorders*. Pediatrics 2007; 120; 1162-1182
Review of treatment options

J. Resources for Families

AAP Pamphlet: *Is your one-year-old communicating with you?*
Brochure that can be handed out at the 9 month or 1 year well-child visit

www.familyvoices.org
Web site for families with special health care needs

AAP brochure: *Autism and Autistic Spectrum Disorders - For a limited time, you can obtain one complimentary copy. To order your complimentary copy, please send an e-mail to screening@aap.org with "ASD Booklet Request" in the header and your preferred mailing address in the text. There is a limit of one copy per person. Copies are being provided through a cooperative agreement with the National Center of Birth Defects and Developmental Disabilities. Additional copies are available for purchase online at www.aap.org/bookstore.*
Booklet with comprehensive consensus-based information; serves as a good introduction for parents of children newly diagnosed with ASD

AAP autism toolkit - Visit http://www.aap.org/publiced/autismtoolkit.cfm for more information. The AAP toolkit is an excellent resource for autism. Resources include summary of treatment issues for parents and clinicians.

Local Massachusetts autism support centers
Resources for parent support, education (Attachment H)

K. Background Information on Autism Spectrum Disorders

Autistic Spectrum Disorders (ASDs) are a group of developmental disorders, disrupting social relationships, communication, play, and academic skills, which usually lead to life-long disability. The best current estimate of the prevalence of ASDs in the general population is about 6 per 1,000 in 8-year-old children. Of 1,000 children, approximately two have autism (AD), one has Asperger's Syndrome (AS) and three have Pervasive Developmental Disorder (PDD-NOS). There is a strong male predominance among children with ASDs; 2-6:1 for AD and 6-15:1 for AS.

Autism can be difficult to detect in young children, and children are often referred for evaluation later than would be optimal. Although parents generally report concerns as early as age 16 to 18 months, most children are diagnosed at age 4 years or later. The early diagnosis of ASDs is important because early intervention improves prognosis, and families can benefit from identification of etiological causes and counseling regarding recurrence risk.

ATTACHMENT A - M-CHAT SCORING SHEET
<div align="center">

M-CHAT Scoring Sheet
Instructions and Permissions for Use of the M-CHAT
</div>

The Modified Checklist for Autism in Toddlers (M-CHAT; Robins, Fein, & Barton, 1999) is available for free download for clinical, research, and educational purposes. There are two authorized web sites: the M-CHAT and supplemental materials can be downloaded from **www.firstsigns.org** or from Dr. Robins' web site, at **http://www2.gsu.edu/~wwwpsy/faculty/robins.htm.**

Users should be aware that the M-CHAT continues to be studied, and may be revised in the future. Any revisions will be posted to the two web sites noted above.

Furthermore, the M-CHAT is a copyrighted instrument, and use of the M-CHAT must follow these guidelines:

1. Reprints/reproductions of the M-CHAT must include the copyright at the bottom (© 1999 Robins, Fein, & Barton). No modifications can be made to items or instructions without permission from the authors.

2. The M-CHAT must be used in its entirety. There is no evidence that using a subset of items will be valid.

3. Parties interested in reproducing the M-CHAT in print (e.g., a book or journal article) or electronically (e.g., as part of digital medical records or software packages) must contact Diana Robins to request permission (drobins@gsu.edu).

Instructions for Use

The M-CHAT is validated for screening toddlers between 16 and 30 months of age, to assess risk for autism spectrum disorders (ASD). The M-CHAT can be administered and scored as part of a well-child check-up, and also can be used by specialists or other professionals to assess risk for ASD. The primary goal of the M-CHAT was to maximize sensitivity, meaning to detect as many cases of ASD as possible. Therefore, there is a high false-positive rate, meaning that not all children who score at risk for ASD will be diagnosed with ASD. To address this, we have developed a structured follow-up interview for use in conjunction with the M-CHAT; it is available at the two web sites listed above. Users should be aware that even with the follow-up questions, a significant number of the children who fail the M-CHAT will not be diagnosed with an ASD; however, these children are at risk for other developmental disorders or delays, and therefore, evaluation is warranted for any child who fails the screening.

The M-CHAT can be scored in less than two minutes. Scoring instructions can be downloaded from http://www2.gsu.edu/~psydlr/Diana_L._Robins,_Ph.D._files/M-CHAT_score.pdf or www.firstsigns.org. We also have developed a scoring template, which is available on these web sites; when printed on an overhead transparency and laid over the completed M-CHAT, it facilitates scoring. Please note that minor differences in printers may cause your scoring template not to line up exactly with the printed M-CHAT.

Children who fail more than three items total or two critical items (particularly if these scores remain elevated after the follow-up interview) should be referred for diagnostic evaluation by a specialist trained to evaluate ASD in very young children. In addition, children for whom there are physician, parent, or other professional's concerns about ASD should be referred for evaluation, given that it is unlikely for any screening instrument to have 100 percent sensitivity.

Modified Checklist for Autism in Toddlers (M-CHAT)*

Diana L. Robins, M.A., Deborah Fein, Ph.D., Marianne L. Barton, Ph.D., & James A. Green, Ph.D.
University of Connecticut
*The full text may be obtained through the Journal of Autism and Developmental Disorders, April 2001

PLEASE NOTE: The M-CHAT was not designed to be scored by the person taking it. In the validation sample, the authors of the M-CHAT scored all checklists. If parents are concerned, they should contact their child's physician .

Abstract

Autism, a severe disorder of development, is difficult to detect in very young children. However, children who receive early intervention have improved long-term prognoses. The Modified – Checklist for Autism in Toddlers (M–CHAT), consisting of 23 yes/no items, was used to screen 1076 children. Thirty of 44 children given a diagnostic/developmental evaluation were diagnosed with a disorder on the autism spectrum. Nine items pertaining to social relatedness and communication were found to have the best discriminability between children diagnosed with and without autism/PDD. Cutoff scores were created for the best items and the total checklist. Results indicate that the M-CHAT is a promising instrument for the early detection of autism.

Background

The M-CHAT is an expanded American version of the original CHAT from the U.K. The M-CHAT has 23 questions using the original nine from the CHAT as its basis. Its goal is to improve the sensitivity of the CHAT and position it better for an American audience. The M-CHAT has been steadily expanding its radius of usage in the state of Connecticut and surrounding New England states. Its authors are still collecting data on the initial study, awaiting final outcomes for sensitivity and specificity after the subjects return for their 3.5 year well-child visit by 2003. The authors have applied for funding of an expanded study on 33,000 children. The M-CHAT tests for autism spectrum disorders against normally developing children.

M-CHAT Scoring Instructions

A child fails the checklist when 2 or more critical items are failed OR when any three items are failed. Yes/no answers convert to pass/fail responses. Below are listed the failed responses for each item on the M-CHAT. Bold capitalized items are CRITICAL items.

Not all children who fail the checklist will meet criteria for a diagnosis on the autism spectrum. However, children who fail the checklist should be evaluated in more depth by the physician or referred for a developmental evaluation with a specialist.

1. No	6. No	11. Yes	16. No	21. No
2. NO	**7. NO**	12. No	17 No	22. Yes
3. No	8. No	**13. NO**	18. Yes	23. No
4. No	**9. NO**	**14. NO**	19. No	
5. No	10 No	**15. NO**	20. Yes	

M-CHAT

Please fill out the following about how your child usually is. Please try to answer every question. If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.

1. Does your child enjoy being swung, bounced on your knee, etc.?	Yes	No
2. Does your child take an interest in other children?	Yes	No
3. Does your child like climbing on things, such as up stairs?	Yes	No
4. Does your child enjoy playing peek-a-boo/hide-and-seek?	Yes	No
5. Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things?	Yes	No
6. Does your child ever use his/her index finger to point, to ask for something?	Yes	No
7. Does your child ever use his/her index finger to point, to indicate interest in something?	Yes	No
8. Can your child play properly with small toys (e.g., cars or blocks) without just mouthing, fiddling, or dropping them?	Yes	No
9. Does your child ever bring objects over to you (parent) to show you something?	Yes	No
10. Does your child look you in the eye for more than a second or two?	Yes	No
11. Does your child ever seem oversensitive to noise? (e.g., plugging ears)	Yes	No
12. Does your child smile in response to your face or your smile?	Yes	No
13. Does your child imitate you? (e.g., you make a face-will your child imitate it?)	Yes	No
14. Does your child respond to his/her name when you call?	Yes	No
15. If you point at a toy across the room, does your child look at it?	Yes	No
16. Does your child walk?	Yes	No
17. Does your child look at things you are looking at?	Yes	No
18. Does your child make unusual finger movements near his/her face?	Yes	No
19. Does your child try to attract your attention to his/her own activity?	Yes	No
20. Have you ever wondered if your child is deaf?	Yes	No
21. Does your child understand what people say?	Yes	No
22. Does your child sometimes stare at nothing or wander with no purpose?	Yes	No
23. Does your child look at your face to check your reaction when faced with something unfamiliar?	Yes	No

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ATTACHMENT B - CHECKLIST FOR CHILD WHO SCREENS POSITIVE

Checklist:

Patient name_____

Patient DOB_____

Recommendations for positive M-CHAT screening:

☐ Conduct M-CHAT interview if appropriate

☐ Referral to audiology to rule out hearing problems

☐ Referral to early intervention program

☐ Distribute pamphlets, if appropriate

☐ Conduct lead screening

☐ Refer for formal diagnostic testing (For information about resources for diagnostic testing, please contact your local MCPAP team.) Diagnostic tests:

       ☐ Speech/Language

       ☐ Developmental Evaluation

       ☐ Neurological Evaluation

       ☐ Occupational Therapy Evaluation

Fax to EI:

       ☐ Immunization record

       ☐ Copy of the M-CHAT screening questionnaire

       ☐ Visit note regarding developmental concerns

       ☐ Signed release of information form

       ☐ EI referral form

ATTACHMENT C - UNIVERSAL EARLY INTERVENTION REFERRAL FORM

Early Intervention Universal Referral Form

Please complete this form for referring a child to early intervention if you prefer to do so in writing. Also please indicate the feedback that you want to receive from the early intervention program in response to your referral.

CHILD CONTACT INFORMATION

Child name:_____

Date of birth:_____/_____/_____ Child age (Months):_____ Gender: _ M _ F

Home address:_____

City:_____ State:_____ Zip:_____

Parent/Guardian:_____Relationship to child:_____

Primary language:_____ Home phone:_____Other phone:_____

Signature:_____ Date:_____

REASONS FOR REFERRAL

Reason(s) for referral to early intervention (Please check all that apply.):

_ Identified condition or diagnosis (e.g., spina bifida, Down syndrome): _____

_ Suspected developmental delay or concern (Please circle areas of concern.):

  Motor/Physical   Cognitive Social/Emotional   Speech/Language   Behavior Other_____

_ At Risk (Please describe risk factors.):_____

_ Other (Please describe.):_____

FEEDBACK REQUESTED BY THE REFERRAL SOURCE

Status of initial family contact

_ Services being provided to child/family

_ Developmental evaluation results

_ Child progress report/summary

_ Other (Please describe.):_____

REFERRAL SOURCE CONTACT INFORMATION

Person making referral: _____ Date of referral: _____/_____/_____

Address: _____

Office phone: ____/____-_____ Office fax: ___/____-_____E-mail: _____

Signature:_____ Date:_____

Program name:_____

Address:_____

City:_____State:_____ Zip:_____

Telephone number:_____ Fax number:_____

E-mail address:_____

ATTACHMENT D - SAMPLE RELEASE OF INFORMATION TO EARLY INTERVENTION FORM
Practice name:
Practice address:
City, state, zip:
Phone:
Fax:

AUTHORIZATION TO REQUEST/RELEASE MEDICAL RECORDS

Patient's name:
DOB:
Medical record number:
Address:

Contact phone:

I give consent to [your practice name] to release of information from the medical record maintained while my child/ward was a patient at [your practice name] to [name of the early intervention program].

The specific information to be disclosed is:

☐ Office Notes
☐ Physical Exams
☐ Legal and Attorney Reports
☐ Immunization Records
☐ Developmental Notes
☐ Laboratory Reports
☐ Daycare Information
☐ Nutrition Summaries

I [insert parent/guardian name] give [insert practice name] permission to speak with and/or release information to [insert name of early intervention program].

Information ☐may ☐may not be released by telephone.

I understand that this consent is subject to revocation at any time unless action based on this release has already been taken. I understand that further disclosure of the information to be released may not be made without my written consent or as otherwise restricted by Federal Regulations (42 Code of Federal Regulations. Part 2).

UNLESS OTHERWISE INDICATED THIS CONSENT WITLL EXPIRE IN SIX (6) MONTHS

_____   Date: _____
Signature of parent/guardian

ATTACHMENT E - SAMPLE REFERRAL LETTER TO GENERAL EARLY INTERVENTION

Practice name:
Practice address:
City, state, zip:
Practice phone:
Practice fax:

Date:

Re: [insert patient's name]

DOB: [insert date of birth of patient]

Dear ["To Whom It May Concern"]:

Please enroll the above-referenced patient in an early intervention program. Enclosed please find an Early Intervention referral form, a record of the patient's immunizations, a copy of the M-CHAT screening questionnaire, the visit not regarding developmental concerns, and an EI referral form.

Thank you.

Sincerely,

Referrals made:
__ Audiology
__ Evaluation

ATTACHMENT F - DEPARTMENT OF PUBLIC HEALTH'S LISTING OF AUDIOLOGICAL ASSESSMENT DIAGNOSTIC CENTERS IN MASSACHUSETTS

Department of Public Health's listing of Audiological Assessment Diagnostic Centers in Massachusetts

The DPH list is a compilation of the audiological centers. These audiological centers do perform newborn hearing screening, but the DPH list also includes centers that can provide audiologic evaluations for older children. Since many children diagnosed with ASD may not respond to a behavioral audiological assessment, they would need a level one or level two diagnostic center for audiological testing.

Please verify with the patient's insurance provider that the facility is part of the patient's network, and that the audiological evaluation is a covered benefit.

For more information on audiological screening, visit the first signs web site audiological screening pages at
http://www.firstsigns.org/screening/audio.htm

Audiological Assessment/Diagnostic Centers List

Level One and Two (Serve children birth to 3)

Baystate Medical Center
Rehabilitation Services/Audiology
Wesson W&I Ground
759 Chestnut Street
Springfield, MA 01199
413-794-2222 V
413-794-2557 TTY

Berkshire Medical Center
The Center for Rehabilitation
725 North Street
Pittsfield, MA 01201
413-447-2225 V
413-447-3079 TTY

Boston Medical Center
Daniels Hearing Center
J. Joseph Moakley Bldg., Otolaryngology
830 Harrison Avenue, Suite 1400
Boston, MA 02118
617-414-4901 V
800-439-2370 TTY

Braintree Rehabilitation Hospital
Department of Audiology
250 Pond Street
Braintree, MA 02184
781-848-5353 x2209 V
781-843-9021 TTY

Charlton Memorial Hospital
Communication Disorders

363 Highland Avenue
Fall River, MA 02720
508-679-3131 V
508-679-7026 TTY

Children's Hospital Boston
Audiology Program
333 Longwood Avenue, 3rd Floor
Boston, MA 02115
617-355-6461 V
617-738-7218 TTY

Children's Hospital at Lexington
Audiology Program
482 Bedford Street
Lexington, MA 02420
781-672-2100 V
781-672-2101 TTY

Children's Hospital at Peabody
Audiology Program
Lahey Clinic North
One Essex Center Drive
Peabody, MA 01960
978-538-3600 V
978-538-8021 TTY

Children's Hospital at Waltham
Audiology Program
9 Hope Avenue
Waltham, MA 02453

781-216-2100 V
781-216-2175 TTY

Franciscan Children's Hospital
Speech/Language-Hearing Department
30 Warren Street
Boston, MA 02135
617-254-3800 x5110 V
617-254-6835 TTY

Harvard Vanguard Medical Center, Kenmore Center
Audiology
133 Brookline Avenue
Boston, MA 02215
617-421-5987 V
617-421-1190 TTY

HealthAlliance Hospital – Burbank
Speech & Hearing
275 Nichols Road
Fitchburg, MA 01420
978-343-5005 V
978-343-5005 TTY

Massachusetts Eye and Ear Infirmary
Audiology Department
243 Charles Street
Boston, MA 02114
617-573-3266 V
617-573-3290 TTY

Mercy Medical Center
Weldon Hearing Center
PO Box 9012
Springfield, MA 01102-9012
413-748-6840 V
413-788-9644 TTY

Morton Hospital and Medical Center
Speech, Hearing & Language Center
Northwoods Medical Center
2007 Bay Street, Suite B-100
Taunton, MA 02780
508-823-3050 V
508-821-4470 TTY

North Shore Children's Hospital at North Shore Medical Center
Department of Audiology
57 Highland Avenue
Salem, MA 01907
978-354-2650 V
978-740-4766 TTY

Tufts Medical Center
Department of Speech Language Pathology and Audiology
750 Washington Street
Box 823
Boston, MA 02215
617-636-5300 V
617-636-7200 TTY

U.Mass Memorial Medical Center
Department of Audiology
University Campus
55 Lake Avenue North
Worcester, MA 01655
508-856-3996 V
508-856-5998 TTY

Level Three (Serve children six months to 3 years)

Baystate Rehabilitation Care at Franklin Medical Center
48 Sanderson Street
Greenfield, MA 01301
413-773-2227 V
413-773-4566 TTY

Beverly Hospital
Center for Communication Disorders
85 Herrick Street
Beverly, MA 01915
978-922-3000 x2690 V
978-921-7007 TTY

Clarke School for the Deaf
Center for Audiological Services
45 Round Hill Road
Northampton, MA 01060
413-582-1114 V
413-582-1114 TTY

Harvard Vanguard Medical Center, Chelmsford Center
Audiology
28 Billerica Road
Chelmsford, MA 01824-3604
781-250-6040 V
978-250-6333 TTY

Harvard Vanguard Medical Center, Medford Center
Audiology
26 City Hall Mall
Medford, MA 02155-4765
781-306-5255 V
781-306-5186 TTY

Harvard Vanguard Medical Center, Quincy Center
Audiology
President's Place - South Tower
1250 Hancock Street
Quincy, MA 02169-4339
617-774-0750 V
617-774-0846 TTY

Harvard Vanguard Medical Center, Wellesley Center
Audiology
230 Worcester Street
Wellesley, MA 02181-5491
781-431-5255 V
781-431-7677 TTY

Holyoke Hospital
Speech and Hearing Center
575 Beech Street
Holyoke, MA 01040
413-534-2508 V
413-534-2508 TTY

Rehabilitation Hospital of the Cape and Islands
Audiology
311 Service Road
East Sandwich, MA 02537
508-833-4141 V

St. Luke's Hospital
Audiology
Mashpee Rehabilitation Building
49 State Road
North Dartmouth, MA 02747
508-910-3434 V

The Learning Center for the Deaf
Audiology Unit
848 Central Street
Framingham, MA 01701
508-875-4559 V
508-875-4559 TT

ATTACHMENT G - AUTISM SUPPORT CENTERS IN MASSACHUSETTS

These centers provide information and referral and education and support to families with children diagnosed with autism. These centers can provide a vital first response for support to parents with a newly diagnosed child.

Autism Alliance of Metrowest	14 East Central St. Natick, MA 01760	(508) 652-9900 Serving: Metrowest
Autism Resource Center	71 Sterling St. West Boylston, MA 01583	(508) 835-4278 Serving: Central MA
Community Resources for People with Autism	116 Pleasant St. Easthampton, MA 01027	(413) 529-2428 Serving: Western MA
Community Autism Resources	2315 GAR Highway Swansea, MA 02777	(508) 379-0371 Serving: Southeast
TILL and Boston Families for Autism	20 Eastbrook Rd. Dedham, MA 02026	(781) 302-4600, ext. 4835 Serving: Greater Boston
The Family Autism Center	789 Clapboardtree St. Westwood, MA 02090	(781) 762-4001, ext. 310 Serving: Norfolk County Area
NSARC: The Autism Support Center:	6 Southside Rd. Danvers, MA 01923	(978) 777-9135, ext. 2301 or 2302 Serving: Northeast

SECTION 6: PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

A. Overview

The PHQ-9 is a validated screening tool for risk of major or other depressive disorders and may be used to monitor depression over time. The PHQ-9 is approved by MassHealth for behavioral screening at well visits for young adults ages 18 and older. The web site for the PHQ-9 is:
www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/

B. Tool and scoring

The PHQ-9 is a brief patient-completed questionnaire. It is available without charge. The PHQ-9 is composed of nine questions about depression symptoms. If there are at least two checks in the two right columns, one of which corresponds to question #1 or #2, determine total score to assess severity. The ninth question about suicidal thinking is counted as a depression symptom if it is present at all.

The patient's total score on the PHQ-9 can also be used to measure depression severity. Score the nine items as follows:

- o   1 points for every item checked "several days;"
- o   2 points for items checked "more then half the days;" and
- o   3 points for items checked "nearly every day."

Tally the points for each question to obtain a total score. The total score, or severity score, can be used to assess depression severity and can be used to follow treatment over time.

DIAGNOSTIC CATEGORIES FOR DEPRESSION

PHQ-9 Severity	Provisional Diagnosis	Treatment Recommendations**
0-4	None	• None
5-9	Mild or minimal depression	• Reassurance and/or supportive counseling • Education to call if deteriorates
10-14	Moderate depression (minor depression)*	• Watchful waiting • Supportive counseling • If no improvement after one or more months, consider use of antidepressant or brief psychological counseling
15-19	Moderately severe major depression*	• Patient preference for antidepressant and/or psychological counseling
>20	Severe major depression	• Antidepressants alone or in combination with psychological counseling

*If symptoms present for >2 years, chronic depression, or functional impairment is severe, remission with watchful waiting is unlikely, immediate active treatment indicated for moderate depressive symptoms (minor depression).
** Referral to co-management with mental health specialty clinician if patient is a high suicide risk or has bipolar disorder, an inadequate treatment response, or complex psychosocial needs and/or other active mental disorders.

C. Languages

Current translations are available at:
www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/

Translations include Arabic, Chinese, Czech, Danish, Dutch, English, Finnish, French, German, Greek, Guajarati, Hindi, Hebrew, Hungarian, Italian, Korean, Malayalam, Malay, Mandarin, Norwegian, Oriya, Polish, Portuguese, Russian, Spanish, and Swedish.

D. Accuracy

A positive screen with a severity score of 10 has a sensitivity of 88 percent and a specificity of 88 percent for major depression. The risk of major depression increases with total score over 15. The total score has been validated to assist in following a patient over time.

E. Implementation of the PHQ-9

There are several excellent resources for the management of depression in primary care settings (see section J below). It is suggested that practices implementing PHQ-9 screening set up office systems to facilitate evaluation, management, and referral for patients with risk of depression.

F. PHQ-9 Frequently Asked Questions

1. **Is it necessary to give the full PHQ-9? Can the first two questions be asked as a screen?**

   Two questions can be given as a quick screen for depression. They are asked as follows:

   During the past month, have you often been bothered by:

   1. Little interest or pleasure in doing things?

   2. Feeling down, depressed, or hopeless?

   If the patient's response to both questions is "No," the screen is negative. If the patient's response to either question is positive, the written PHQ-9 is given.

2. **Does a positive PHQ-9 diagnose depression?**

   The PHQ-9 does not diagnose depression. The diagnosis of depression requires clinical assessment. In addition to the symptoms of depression, a diagnosis of depression requires evidence of impairment.

   Medical conditions, acute grief reaction, substance abuse, and bipolar disorder can present with symptoms of depression.

G. PCC Response to a Positive Screen

A patient who screens positive for depression must be assessed for suicide risk. The MacArthur toolkit (see section J for reference) suggests that all depressed patients may be asked the following questions:

- ✓ Have these symptoms/feelings we've been talking about led you to think you might be better off dead?

- ✓ This past week, have you had any thoughts that life is not worth living or that you'd be better off dead?

- ✓ What about thoughts about hurting or even killing yourself? If YES, what have you thought about?

Establish a safety plan, including an emergency communication mechanism should the patient deteriorate, become actively suicidal or dangerous to others, or experience an acute psychosocial stressor.

The PCC should counsel the patient/family about options for diagnosis and management. Follow up or refer the patient for further evaluation or treatment.

H. Decision to Refer

The decision to treat or refer will depend on the interests and skills of the provider, the availability of behavioral health providers, the preferences of the patient and family, and the severity and co-morbidities of the patient. Generally patients with complicating factors, including substance abuse, psychosis, or moderate to severe depression, should be seen in consultation by a mental health specialist.

I. Resources for Providers

PHQ-9 - See Attachment A

The MacArthur Initiative on Depression and Primary Care at Dartmouth and Duke: Depression Management Tool Kit, (June 7, 2004), Trustees of Dartmouth College available at
http://www.depression-primarycare.org/images/pdf/macarthur_toolkit.pdf

Visit http://www.thereachinstitute.org/guidelines-for-adolescent-depression-primary-care.html **for the following information on depression.**

❑ **Guide to Speaking with Adolescents and Parents about Depression**

What to discuss with patients and parents about depression

Frequently asked questions about depression

❑ **Guide to Treatment Information for Providers**

- Treatment choices

- Active monitoring

- Suicidality in adolescence

❑ **Treatment referrals and follow-up**

Primary Care Clinician Guide to Mental Health Referrals

Forms to facilitate the referral process

Depression resources for PCCs

The following materials were prepared to facilitate a primary care evaluation and management of depression following the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) developed by the REACH (The Resource for Advancing Children's Health) Institute. You may find the GLAD-PC Toolkit in its entirety at http://www.thereachinstitute.org/files/documents/GLAD-PCToolkit.pdf**.**

Attachment B – **Access Initiative Depression "Cheat Sheet"**
One page summary of approach to screening, evaluation, and treatment of adolescent and young adult depression

Attachment C – **Instruction Sheet: Initial Depression Visit**
Suggestions for a primary care evaluation of depression visit

Attachment D – **Adolescent Depression: Initial Visit** template
Template to use for depression evaluation visit

Attachment E – **Instruction Sheet for Depression Follow-Up Visit**
Suggestions for a primary care depression management follow up visit

Attachment F – **Adolescent Depression Follow Up Visit** template
Template to use for depression follow up visit

J. References

http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/
This web site contains PHQ-9, information on translations, and depression evaluation
and management.

www.depression-primarycare.org
This web site contains the depression management toolkit sponsored by the MacArthur
Initiative on Depression and Primary Care; it also contains comprehensive information
on primary care assessment and treatment of depression.

www.glad-pc.org
This web site contains guidelines for the management of adolescent depression in
primary care. It includes a toolkit with extensive information: flow sheets, parent and
patient handouts, and references to consensus information on evaluation and
treatment of adolescent depression.

K. Resources for Families

The Guidelines for Adolescent Depression Toolkit (www.glad-pc.org) contains many parent handouts, including the following:

Education materials for parents

- NAMI "A Family Guide"

- Family Support Action Plan

- How Can You Help with Sleep Problems?

- Depression and the Family

Education materials for adolescents and young adults

- Depression information

- Medication information

  o Antidepressant Medication and YOU (12-21)

  o Antidepressant Medication and YOU (10 to 12)

- Psychological counseling

  o Patient handout on psychological counseling

- Self-Management

  o Self-Care Success

  o Monitoring Sheet for Depression

  o Depression Medication and Side Effects

  o Mental Health and Drugs and Alcohol

  o How can you help with Sleep Problems?

  o Suicide: What Should I Know?

ATTACHMENT A- PHQ-9

PATIENT HEALTH QUESTIONNAIRE- 9

Were data collected? **No** ☐ or specify date:_____
DDMMYY

Comments:

Only the patient (subject) should enter information onto this questionnaire

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
	____+_____+_____+_____ =Total Score:_____			

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐   Somewhat difficult☐   Very difficult☐….Extremely difficult ☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

I confirm this information is accurate.	Patient's/Subject's initials:	Date:

ATTACHMENT B- ACCESS INITIATIVE DEPRESSION CHEAT SHEET

Access Initiative Depression Cheat Sheet

Well-Child Visit: Depression Screen	
positive PHQ-9 screen depression initial visit within 2 weeks	**Safety Interview**: If there are safety concerns ☎ MCPAP

Depression Initial Visit		
Diagnosis: 5 or more sx's causing distress or impairment for greater than 2 weeks, not directly due to toxic or medical condition	Severity Rating: PHQ9 >=9=Mild 10-19=Moderate >=20=Severe	
Mild depression Active Support and Monitoring Depression f/u visits: Q1-2 wks for 6-8 wks Self-Management Goals If persistent, treat as moderate	**Moderate depression** Consider MCPAP ☎ consultation Educate and discuss tx options Discuss role of pcc vs. specialists Initiate Medication and/or Therapy referral Self-Management Goals Depression f/u visits: Q1 week for the first month, then as clinically indicated	**Severe depression** (or comorbidity or suicidality) Definite MCPAP consultation ☎ Otherwise same as Moderate depression, except more specialist involvement

Depression Follow-Up Visit		
Assess symptom severity, monitor for side effects Continue education and discussion of self-management goals After 6-8 weeks, if there is…………..		
No improvement Initiate medication if applicable Add therapy referral if applicable Increase dose toward max as tolerated Change medication if already on max dose Continue f/u visits (note FDA guidelines*) Consider MCPAP ☎consultation	**Partial Improvement** Initiate medication if applicable Add therapy referral if applicable Increase dose toward max as tolerated Reinforce self-management goals Continue f/u visits (note FDA guidelines*) Consider MCPAP ☎consultation	**Significant Improvement** If on medication, Continue Rx for 1 year after full remission Continue f/u visits and coordination with specialists

*FDA SSRI Monitoring Guidelines (after initiation or dose increase): q1 week for first month, q2 weeks for second month, q4 weeks thereafter

ATTACHMENT C- INSTRUCTION SHEET FOR INITIAL DEPRESSION VISIT
Instruction Sheet: Depression Initial Visit

Schedule 30 minutes.

Use Initial Visit Template.

Begin with teenager:

1. Address limits of confidentiality

2. Discuss positive responses.

3. Review life circumstances, stressors.

4. Explore high risk behaviors.

5. Begin psychiatric and medical ROS.

6. Complete relevant mental status questions including suicidality assessment.

Invite parent into room (with teen's permission):

1. Solicit parental input regarding depressive symptoms and stressors.

2. Complete psychiatric and medical ROS.

Consider MCPAP telephone consult

Discussion/Wrap-up (with parent and teen)

1. Discuss diagnostic impression.

2. Provide education about depression.

3. Present treatment options.

4. Negotiate role of specialists and facilitate choices of treatment.

5. If prescribing medication, educate regarding side effects, risks.

6. Provide self-management counseling.

7. Discuss contingency planning if suicidal ideation emerges.

8. Provide referrals and/or prescriptions.

9. Administer baseline PHQ-9 for severity monitoring.

ATTACHMENT D- ADOLESCENT DEPRESSION INITIAL VISIT
Adolescent Depression: Initial Visit
Name: _____ DOB: _____
Date: _____

CC/History of present illness

Depressive Symptoms
❐ Depressed/irritable mood
❐ Decreased interest/pleasure
❐ Lost or increased appetite
❐ Sleep problems (increase or decrease)
❐ Psychomotor retardation or agitation
❐ Tired/low energy
❐ Worthlessness/feeling of failure or guilt
❐ Difficulty concentrating
❐ Suicidal ideation or behavior

Associated Issues
Substance abuse_____
Manic symptoms _____
ADHD _____
Anxiety/Panic _____
Eating disorder _____
Family psych. hx _____
High risk bx _____
Prior suicidal bx _____
Availability of guns _____
Conduct problems _____

Stressors/Losses:

Contributing medical factors:

Mental Status

Appearance _____
Behavior _____
Mood/Affect_____
Speech _____
Thought process _____
Thought content _____

Suicidality _____
Homicidality _____
Judgment _____
Insight _____
Cognitive _____

PHQ-9 Score_____

Adolescent Depression: Initial Visit
Name: _____ DOB: _____
Date: _____

<u>Overall Impression</u>
Diagnosis _____   Comorbidities _____
Presence of: ☐ Psychosis ☐ Suicidality
Severity: ☐ Mild ☐ Moderate ☐ Severe
MCPAP telephone consult: ☐ yes ☐ no
Additional notes/impressions:

Plan:
☐ Active monitoring (if mild depression)
☐ Education provided   Follow appointment in _____ weeks
☐ Initiate treatment
     ☐ Education provided
     ☐ Safety planning discussed
     ☐ Referrals: ☐ MCPAP consult   ☐ Psychotherapist_____
               ☐ Child Psychiatrist (for treatment)_____
     ☐ Prescription:_____
     ☐ Follow-up appt:_____weeks

Additional recommendations:

Signed _____

ATTACHMENT E - INSTRUCTION SHEET DEPRESSION VISIT FOLLOW-UP VISITS

Instruction Sheet: Depression Follow-Up Visit

Schedule 15 minutes.

Use Follow-Up Visit Template.

Begin with teenager*:*

1. Review and discuss PHQ-9 responses, compare to baseline and previous.

2. Assess side effects, safety, and suicidality.

3. Discuss and reinforce self-management goals.

4. Assess compliance and satisfaction with treatment.

5. Complete relevant mental status questions.

Invite parent into room (with teen's permission)*:*

1. Solicit parental input regarding depression severity and side effects.

2. Inquire regarding progress of outstanding referrals.

Consider MCPAP telephone consult

Discussion/Wrap-up (with parent and teen)

1. Provide feedback regarding progress.

2. Discuss any concerns or questions, provide additional education.

3. Side effect management (if applicable).

4. Update and reinforce treatment plan.

5. Update and reinforce self-management plan.

6. Provide prescriptions and arrange follow-up.

ATTACHMENT F – ADOLESCENT DEPRESSION FOLLOW-UP VISIT

Adolescent Depression: Follow-Up Visit

Name: _____ DOB: _____

Date: _____

Interval History:

Depressive Symptoms	Severity Rating
❒ Depressed/irritable mood ❒ Decreased interest/pleasure ❒ Lost or increased appetite ❒ Sleep problems (increase or decrease) ❒ Psychomotor retardation or agitation ❒ Tired/low energy ❒ Worthlessness/feeling of failure or guilt ❒ Difficulty concentrating ❒ Suicidal ideation or behavior	PHQ9_____

Severity Rating

PHQ9_____

Compliance
Psychotherapy_____(❒ N/A)
Medication_____(❒ N/A)

Side Effects

Mental Status

Appearance_____   Suicidality_____

Behavior_____   Homicidality_____

Mood/Affect_____   Judgment_____

Speech_____   Insight_____

Thought Process_____   Cognitive_____

Thought Content_____

Impression:

Status of depressive symptoms: ☐ Improving   ☐ Unchanged   ☐ Worsening

Safety Issues: _____

MCPAP Telephone Consult: ☐ Yes _____ ☐ N/A

Comments: _____

Recommendations:

❒ Additional education provided…………………………❒ Safety planning discussed

Additional referrals:

❒ Therapy _____

❒ Child psychiatry _____

❒ MCPAP consult

❒ Other _____

Medication: _____

Additional recommendations: _____

Follow-up in _____weeks

Signed _____