

Utah Health Status Update:

Child Developmental Screening Barriers

May 2015

In the U.S., it is estimated that developmental delays affect up to 16% of children. The Centers for Disease Control and Prevention estimates the prevalence of children with Autism Spectrum Disorder (ASD) is one in 68. Despite this, the American Academy of Pediatrics (AAP) surveyed its members in 2005 and found that only 23% of pediatricians used a standardized developmental screening tool. In 2006, the AAP published a policy for use of standardized

developmental screening. This policy recommends standardized developmental screening tools be used at 9, 18, and 24–30 months during well-child visits. Use of a standardized tool objectifies the assessment, eliminating any bias on the part of the examiner. It is well established that early recognition of developmental delays is important to obtain appropriate and timely evaluations and referrals in order to optimize these outcomes.

In 2013, a Utah Department of Health Developmental Screening Tool Survey was developed through a collaborative effort between the Children With Special Health Care Needs (CSHCN) bureau and the Data Resources Program within the Maternal and Child Health (MCH) bureau. The survey was sent out statewide to pediatricians who were Utah AAP members to better understand the use of standardized screening tools and the barriers for those not using them.

There was a 37% response rate (n=150) to the survey. Nineteen percent (n=28) of those survey respondents indicated not seeing pediatric patients ages six years and under and were excluded from the analyses. The following results are therefore based on those who identified their specialty as “pediatrics” (n=117).

- 88% were aware of the AAP policy, with 48% agreeing entirely with it and 51% agreeing with some of the policy.
- 70% routinely used a standardized developmental screening tool at well-child checks.

Of the 30% who reported not using a standardized screening tool,

- 71% indicated they had developed their own non-standardized developmental screening tool.

The most common barriers given for not routinely using a standardized screening tool:

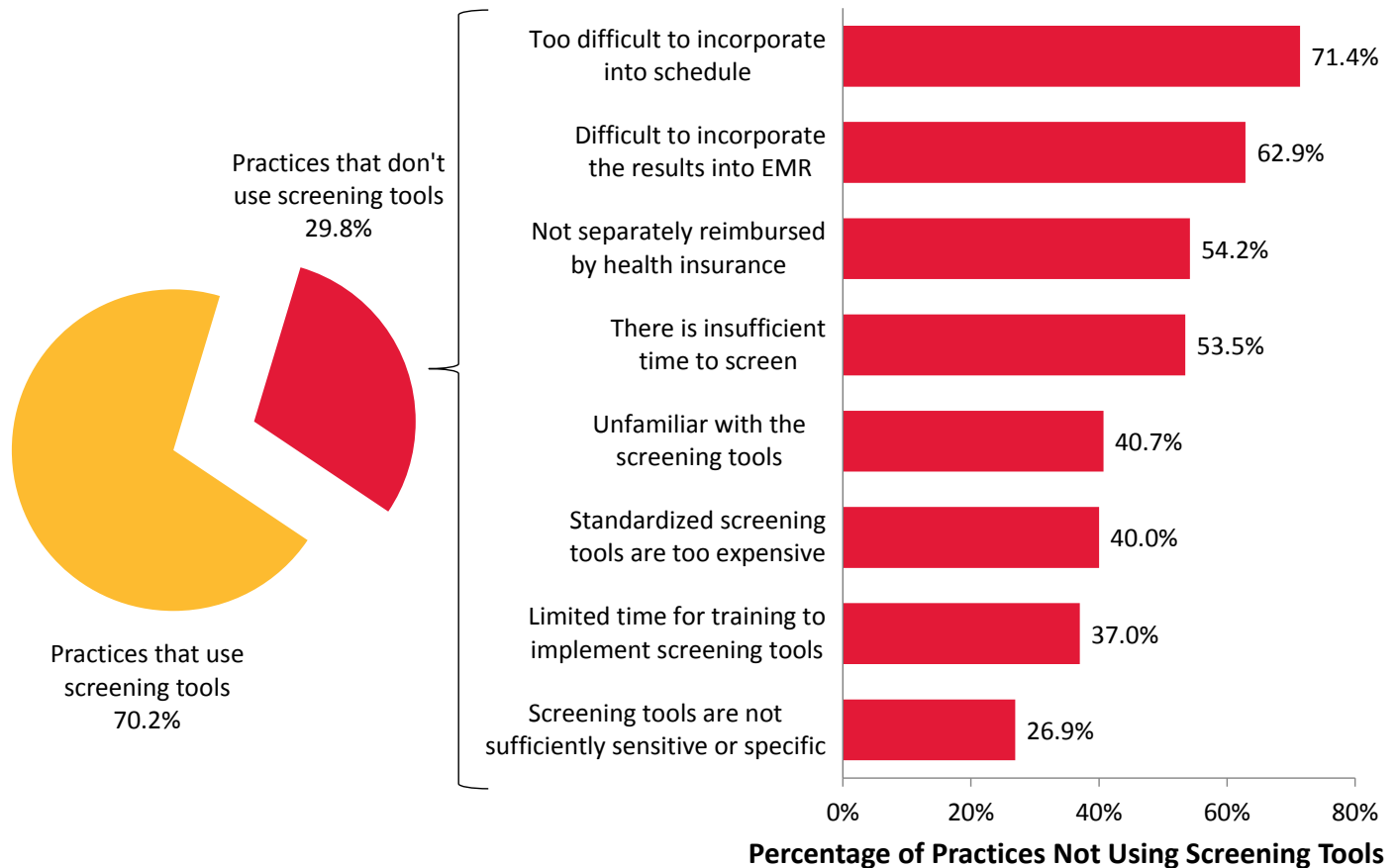
- 71% stated the tools were difficult to incorporate into their schedule of patients.
- 63% indicated it was difficult to incorporate the tool and the results in their Electronic Medical Records (EMR).
- 54% indicated that developmental screens were not separately reimbursed by most insurances.
- 54% indicated there was insufficient time to screen.
- 41% were unfamiliar with the different screening tools.

While it is encouraging that the majority of pediatricians who responded reported using standardized developmental screening tools, there are still almost 30% who are not using them in their practices. The barriers are many. In general, developmental screening tools can be complex, costly, and time-consuming to implement. Improved training in residency, education of physicians already in practice, screening tools which can be more easily incorporated into EMRs, and encouraging insurance companies/providers to unbundle the codes for well child checks and developmental screening could all improve the use of standardized developmental screening tools in pediatric practices.

- **It is well established that early recognition of developmental delays is important to obtain appropriate and timely evaluations and referrals in order to optimize outcomes.**
- **In 2013, a Developmental Screening Tool Survey was developed and sent out statewide to pediatricians to better understand the use of standardized screening tools and the barriers for not using them.**
- **Of the 30% who reported not using a standardized screening tool, 71% stated the tools were difficult to incorporate into their schedule of patients; 63% indicated it was difficult to incorporate the tool and the results in their Electronic Medical Records (EMR); 54% indicated that developmental screens were not separately reimbursed by most insurances; 54% indicated there was insufficient time to screen, and 41% were unfamiliar with the different screening tools.**
- **Improved training in residency, education of physicians already in practice, screening tools which can be more easily incorporated into EMRs, and encouraging insurance companies/providers to unbundle the codes for well-child checks and developmental screening could all improve the use of standardized developmental screening tools in pediatric practices.**

Reasons Why Standardized Screening Tools Not Used

Figure 1. Percentage of practices reporting each reason for not using the standardized developmental screening tools, Utah practices who are not using screening tools, 2013



Source: 2013 Utah Department of Health Developmental Screening Tool Survey

There are a number of resources dedicated to improving the early identification of developmental delays in Utah.

- Help Me Grow (HMG), a free parent information line, offers a standardized developmental screening tool, Ages and Stages Questionnaire (ASQ). In addition, HMG identifies community resources and provides care coordination. With parental permission, screening and referral results are sent to the child's health care provider. This coordination of screening activities lessens redundancy, affords consistency in feedback and referrals, and leads to improved care coordination for the patient and family. (www.helpmegrowutah.org, 801-691-5322)
- Early Childhood Utah, a program of the Utah Department of Health, is striving to build community-wide, coordinated early detection programs that ensure universal and periodic developmental and behav-

ioral screening for all children. Through community involvement and training focusing on child care, home visiting, and Targeted Case Manager providers and the availability of web-based screening, Utah has seen an increase in screening efforts using the Ages and Stages Questionnaire. Having the screening completed and scored before the health care visit facilitates parent-clinician communication.

- The Medical Home Portal website, medicalhomeportal.org, provides an excellent review of developmental screening.

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Breaking News, May 2015

Critical Congenital Heart Defect (CCHD) Screening Project

Congenital heart defects are problems with the heart's structure that are present at birth and change the normal flow of blood through the heart. They are the most common birth defects, affecting eight out of every 1,000 births in the U.S. The most severe types, critical congenital heart disease (CCHD), affect about one in every four babies born with a heart defect. A simple non-invasive screen called pulse oximetry can help detect CCHD in newborns. Failure to detect CCHD early puts the baby at risk for death or other serious complications within the first few days or weeks of life.

On October 1, 2014, Utah joined 35 other states by adding pulse oximetry screening to newborn screening tests (Utah Code 26-10-6). Through education and outreach, the Utah Department of Health's Birth Defects program assisted hospitals, birthing centers, and midwives to implement screening programs prior to the mandate.

In an effort to monitor screening around the state, a field was added to the newborn vital records worksheet, allowing birth certificate clerks at each birthing facility to indicate whether the baby passed, failed (oxygen saturation lower than expected), or was not screened for CCHD. All 42 birthing hospitals, birthing centers, and home births are now reporting screening results via the birth certificate. Initial results from the birth certificate record are shown in the accompanying table. Of the 26 confirmed failed cases, all had an echocardiogram performed. Final results are displayed in the accompanying graph.

For additional information about CCHD screening please visit our website at <http://www.health.utah.gov/cchd/>.

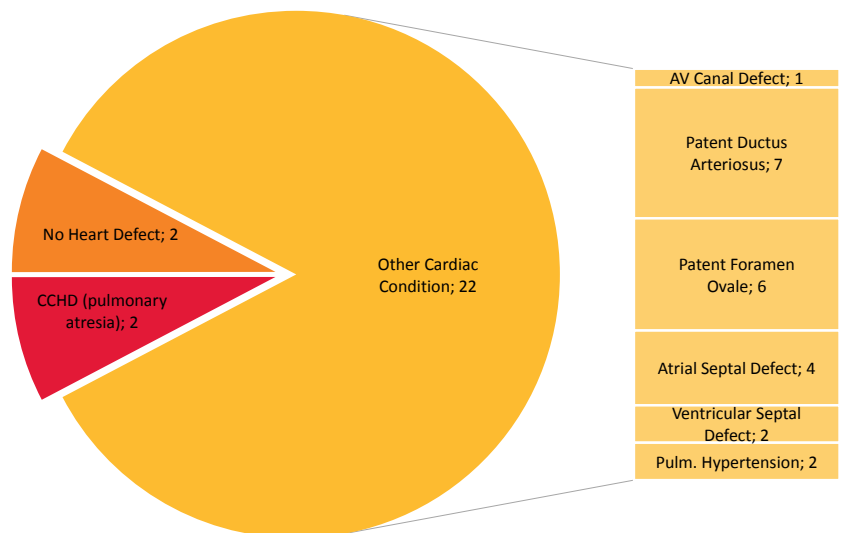
Utah CCHD (critical congenital heart defect) Screening Results, October 1, 2014 through February 28, 2015

	Hospitals		Freestanding birth centers		Home Births		Total	
	n	%	n	%	n	%	n	%
Number of babies born	19,647	100.0	185	100.0	428	100.0	20,260	100.0
Not screened^a	1,535	7.8	41	22.2	140	32.7	1,716	8.5
Babies w/ documented screening results	18,112	92.2	144	77.8	288	67.3	18,554	91.5
Passed	18,086	99.9	144	100.0	288	100.0	18,518	99.9
Failed^b	26	0.1	0	0.0	0	0.0	26	0.1

^aThis includes babies not screened at the time of completion of the birth certificate and could have been screened at a later time (e.g., babies in the neonatal intensive care unit)

^bA failed screen is when the oxygen saturation of the newborns blood is lower than expected. An echocardiogram was performed for all 26 babies failing the CCHD screening

Diagnoses for 26 Failed CCHD Screens, Utah, October 1, 2014 through February 28, 2015



Community Health Indicators Spotlight, May 2015

The Utah Cytomegalovirus (CMV) Education and Testing Initiative: A Pioneering Adventure in Public Health

Cytomegalovirus infection (CMV) is a viral infection that rarely causes obvious illness. On July 1, 2013, Utah became the first state in the nation to mandate a CMV public health initiative (UCA 26-10-10). This ground-breaking two-part legislation included a CMV public education campaign and required CMV testing for all newborns who fail their newborn hearing screenings. Why? CMV during pregnancy can be very harmful to a growing fetus. In fact, congenital CMV infection is the leading non-genetic cause of hearing loss, thought to cause up to one third of all childhood deafness. Congenital CMV causes more long-term problems and childhood deaths than Down Syndrome, Fetal Alcohol Syndrome, and neural tube defects. Women's awareness of this virus, however, is far below that of these more commonly known conditions affecting children. Approximately one child per day is born with congenital CMV infection in Utah. One in five of these children will be born with or develop significant permanent disabilities.

CMV is a very common virus and is generally passed from infected people to others through direct contact with body fluids, such as urine or saliva. CMV can also be transmitted sexually. Pregnant women who are in close contact with young children (e.g., childcare or healthcare settings, or have other children) or have multiple sexual partners are at greater risk for passing CMV on to their unborn baby. Most healthy people who contract CMV have no symptoms and face little risk of getting seriously ill. However, women who are pregnant or planning on becoming pregnant must be informed about CMV and how to prevent it.

For more information visit health.utah.gov/CMV.

Monthly Health Indicators Report

(Data Through March 2015)

Monthly Report of Notifiable Diseases, March 2015	Current Month # Cases	Current Month # Expected Cases (5-yr average)	# Cases YTD	# Expected YTD (5-yr average)	YTD Standard Morbidity Ratio (obs/exp)
Campylobacteriosis (Campylobacter)	18	33	59	82	0.7
Shiga toxin-producing Escherichia coli (E. coli)	3	4	7	9	0.8
Hepatitis A (infectious hepatitis)	0	1	0	2	0.0
Hepatitis B, acute infections (serum hepatitis)	0	0	1	3	0.3
Influenza*	Weekly updates at http://health.utah.gov/epi/diseases/influenza				
Meningococcal Disease	0	1	0	2	0.0
Pertussis (Whooping Cough)	33	72	84	215	0.4
Salmonellosis (Salmonella)	28	23	77	55	1.4
Shigellosis (Shigella)	1	3	9	8	1.2
Varicella (Chickenpox)	16	40	52	114	0.5
Quarterly Report of Notifiable Diseases, 1st Qtr 2015	Current Quarter # Cases	Current Quarter # Expected Cases (5-yr average)	# Cases YTD	# Expected YTD (5-yr average)	YTD Standard Morbidity Ratio (obs/exp)
HIV/AIDS†	28	29	28	29	1.0
Chlamydia	2,197	1,881	2,197	1,881	1.2
Gonorrhea	361	140	361	140	2.6
Syphilis	10	10	10	10	1.0
Tuberculosis	4	8	4	8	0.5
Medicaid Expenditures (in Millions) for the Month of March 2015	Current Month	Expected/Budgeted for Month	Fiscal YTD	Budgeted Fiscal YTD	Variance - over (under) budget
Capitated Mental Health	\$ 9.5	\$ 9.4	\$ 126.8	\$ 122.0	\$ 4.9
Inpatient Hospital	\$ 3.1	\$ 3.0	\$ 96.3	\$ 99.8	\$ (3.5)
Outpatient Hospital	\$ 4.1	\$ 5.0	\$ 43.3	\$ 45.9	\$ (2.6)
Long Term Care	\$ 12.5	\$ 13.6	\$ 128.0	\$ 125.3	\$ 2.6
Pharmacy	\$ 11.3	\$ 11.4	\$ 98.5	\$ 91.4	\$ 7.1
Physician/Osteo Services	\$ 4.4	\$ 5.1	\$ 45.7	\$ 47.1	\$ (1.5)
TOTAL MEDICAID	\$ 176.9	\$ 182.3	\$ 1,754.0	\$ 1,760.5	\$ (6.5)

Program Enrollment for the Month of March 2015	Current Month	Previous Month	% Change* From Previous Month	1 Year Ago	% Change* From 1 Year Ago
Medicaid	283,944	281,802	+0.8%	276,485	+2.7%
PCN (Primary Care Network)	16,760	18,208	-8.0%	12,531	+33.7%
CHIP (Children's Health Ins. Plan)	16,271	15,629	+4.1%	16,670	-2.4%
Health Care System Measures	Annual Visits			Annual Charges	
	Number of Events	Rate per 100 Population	% Change* From Previous Year	Total Charges in Millions	% Change* From Previous Year
Overall Hospitalizations (2013)	279,393	9.0%	-2.8%	\$ 6,513.8	+5.9%
Non-maternity Hospitalizations (2013)	177,191	5.6%	-2.5%	\$ 5,554.8	+6.6%
Emergency Department Encounters (2013)	683,415	22.3%	-1.5%	\$ 1,555.4	+7.1%
Outpatient Surgery (2012)	369,752	12.2%	-3.3%	\$ 1,944.7	+3.5%
Annual Community Health Measures	Current Data Year	Number Affected	Percent/Rate	% Change* From Previous Year	State Rank§ (1 is best)
Obesity (Adults 18+)	2013	483,800	24.1%	-0.5%	9 (2013)
Cigarette Smoking (Adults 18+)	2013	207,000	10.3%	-2.2%	1 (2013)
Influenza Immunization (Adults 65+)	2013	162,900	57.4%	+2.5%	39 (2013)
Health Insurance Coverage (Uninsured)	2013	336,500	11.6%	-12.1%	n/a
Motor Vehicle Traffic Crash Injury Deaths	2013	192	6.6 / 100,000	-7.8%	14 (2012)
Poisoning Deaths	2013	630	21.7 / 100,000	-6.2%	48 (2012)
Suicide Deaths	2013	570	19.6 / 100,000	+2.9%	47 (2012)
Diabetes Prevalence (Adults 18+)	2013	142,500	7.1%	-1.1%	10 (2013)
Poor Mental Health (Adults 18+)	2013	328,700	16.4%	+4.6%	21 (2013)
Coronary Heart Disease Deaths	2013	1,515	52.2 / 100,000	+1.0%	2 (2012)
All Cancer Deaths	2013	2,961	102.1 / 100,000	+1.9%	1 (2012)
Stroke Deaths	2013	831	28.6 / 100,000	+3.1%	32 (2012)
Births to Adolescents (Ages 15-17)	2013	573	8.6 / 1,000	-16.3%	10 (2012)
Early Prenatal Care	2013	38,905	76.4%	+1.2%	n/a
Infant Mortality	2013	262	5.1 / 1,000	+6.7%	9 (2012)
Childhood Immunization (4:3:1:3:3:1)	2013	40,600	80.5%	+7.5%	16 (2013)

* Influenza activity is low to moderate in Utah. Influenza-like illness activity is above baseline statewide. As of March 7, 2015, 1,223 influenza-associated hospitalizations have been reported to the UDOH since the start of the influenza season on September 28, 2014. More information can be found at <http://health.utah.gov/epi/diseases/influenza/index.html>.

† Diagnosed HIV infections, regardless of AIDS diagnosis.

‡ % Change could be due to random variation.

§ State rank based on age-adjusted rates where applicable.

Notes: Data for notifiable diseases are preliminary and subject to change upon the completion of ongoing disease investigations. Active surveillance has ended for West Nile Virus until the 2015 season.