Autism Screening

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Preventive Services Improvement Project
Learning Session 2

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Disclosures

I have no relevant financial relationships with the manufacturers of any commercial products and/or provider of commercial services discussed in this CME activity. I do not intend to discuss an unapproved/investigative use of a commercial product/device in their presentation.
Struggles!

- Initially M-CHAT and PEDS on paper to parents then graded and score put into record of visit
- How to find time and bodies to do the work for the rest of the project?
EHR Contents

☐ *Templates* include both PEDS and MCHAT

☐ Placed *in office visit templates* for 15, 18, 24, and 30 month visits

☐ “*Procedure*” includes coding information for billing

☐ *Parent handouts printed* from “Patient Instruction” area by Clinical Floor Staff (CFS)

☐ Parents *complete in* privacy of *exam room*

☐ *Clinician records “abnormal” data* – (default is “normal” answers)
Suggestions from AACPP:

- Do the MCHAT at 24 or 30 months only
- Include Bright Futures milestones in each checkup as checkpoints
- Do PEDS only at 9, and 18 months
How to deal with ALL those other areas?!

- **Workgroups**
  - Composed of 3-8 members
  - Clinician, CFS/Nursing, Reception
  - Others as interest is expressed

- Allow **staff to chose** which workgroup but must give **choices 1,2,3** to alleviate multiple persons choosing the same group

- **Office manager** or senior physician **put groups together** from staff choices
<table>
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<tr>
<th>Group</th>
<th>Mission</th>
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<tbody>
<tr>
<td>1</td>
<td>Growth Parameters - Metric conversions BMI / Height for Weight, Growth Charts</td>
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<td>2</td>
<td>Child Abuse Prevention Maternal Depression Screening (Connected Kids: People who care..)</td>
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<td>3</td>
<td>Development / Autism Screening, Referral, Follow-up</td>
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<td>4</td>
<td>Oral Health Risk Assessment, Education, Varnish Driver license forms completion</td>
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<td>5</td>
<td>Risk Assessments Lead/BP/Hearing/Vision/TB/dyslipidemia</td>
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<td>Parental/Family Strengths &amp; Concerns Assessment, Intervention, Utilization, Use of strength based approaches</td>
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<td>Obesity Prevention, Family Strategies</td>
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<td>8 and 9</td>
<td>Office Systems and Preventive Services Prompting</td>
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<td>Immunizations CASA Improvement Decisions re which vaccine to use</td>
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<td>11</td>
<td>CSHCN ADHD, Diabetes, Asthma, Cerebral Palsy, Spina Bifida, etc.</td>
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<td>12</td>
<td>Community Resources Eliciting and spread of information Website revision</td>
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RESULTS FROM QUIIN PROJECTS!

- 4 Lectures to full staff arranged by the groups themselves:
  - Lead, Obesity - nutrition x 2!, Child Abuse
- Metric measures 100% of the time!
- *Newborn screens followed up*
- PEDS and MCHAT implemented (now should decrease their frequency and hone in on the age specific development at each visit)

* Indicates begun in previous QuIIN projects
MORE RESULTS!

- TB procedure standardized
- Put family strengths in the problem list for easy reference at next visit
- Oral Health - Risk Assessment, Education, Varnish + toothbrushes to all office visitors
- Vision performed on Titmus with back up to wall charts
- Beginning to think about how better to do driver license paperwork
AND EVEN MORE RESULTS!

- Maternal Depression Screening always at 2, 4, 8 week visits (several referrals made!)*
- Open scheduling implemented 09/01/2011
- Referral tracking implemented for specialist referrals, working on labs
- Using Pediarix, Menactra, and Rotateq
- CASA data is improving
- Website parent resources revised and reorganized
We’re All About Children!