New York Medicaid

Child/Teen Health Program

(C/THP)

Provider Manual

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS

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EPSDT/CTHP Provider Manual

Partnering to Improve the Health of New York's Children and Adolescents:

- **Federal - Early and Periodic Screening, Diagnosis, and Treatment (EPSDT);**
- **New York State - Child Teen Health Program (CTHP);**
- **Providers enrolled in New York State Medicaid;**
- **and Medicaid Managed Care Organizations**

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Introduction

The Federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit is at the heart of New York State's Medicaid program for children and adolescents. EPSDT began in 1967 under President Lyndon B. Johnson, and was further defined in law as part of the Omnibus Budget Reconciliation Act of 1989. It affords a comprehensive array of preventive health care and treatments for Medicaid recipients from birth up until age 21 years.

New York State's Medicaid program, implements EPSDT via the Child Teen Health Program (CTHP). In line with the federal EPSDT mandate, CTHP promotes the provision of early and periodic screening services and well care examinations, with diagnosis and treatment of any health or mental health problems identified during these exams. The CTHP care standards and periodicity schedule in this manual are provided to you by the New York State Department of Health. They generally follow the recommendations of the Committee on Standards of Child Health, American Academy of Pediatrics. This manual also emphasizes recommendations such as those described in *Bright Futures* in order to guide your practice and improve health outcomes to the Medicaid population.

The Medicaid child is, more often than not, a child-at-risk and most in need of a medical home. This reality presents many challenges to you, as the child's primary medical caregiver. *Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents*[1] eloquently articulates Medicaid's vision for all covered children:

Every child deserves to be born well, to be physically fit, and to achieve self-responsibility for good health habits.

Every child and adolescent deserves ready access to coordinated and comprehensive, preventive, health-promoting, therapeutic, and rehabilitative medical, mental health and dental care. Such care is best provided through a continuing relationship with a primary health professional or team, and ready access to secondary and tertiary levels of care.

The Medicaid program invites you to share this vision for New York State's children, and to join us in turning this vision into a reality.

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[1] *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents* (2nd ed., rev.) developed by The National Center for Maternal and Child Health and Georgetown University, 2002. Hereinafter referred to as *Bright Futures: Guidelines for Health Supervision.*

EPSDT/CTHP SUMMARY

Federal EPSDT/New York State CTHP Requirements

- Summary of EPSDT/CTHP Requirements

Periodicity for Routine/Preventive Pediatric and Dental Care

- *Recommendations for Preventive Pediatric Health Care* – American Academy of Pediatrics (AAP) Periodicity Schedule
- Oral Health Supervision – American Academy of Pediatrics and Bright Futures Recommendations for Routine Preventive Dental Care

Important New York State Public Health Programs and Information

- The State Newborn Screening Program
- The State Newborn Hearing Screening Program
- The Immunization Program
- The Lead Poisoning Prevention Program

Summary of EPSDT/CTHP Requirements

SCREENING, DIAGNOSIS and TREATMENT SERVICES required for the Medicaid under 21-year-old population under federally-mandated EPSDT/CTHP include:

SCREENING SERVICES (CTHP requirement: Providers must follow the most current version of the American Academy of Pediatrics (AAP): Recommendations for Preventive Pediatric Health Care – Bright Futures/American Academy of Pediatrics. The Bright Futures/AAP Periodicity Schedule is available at the AAP website - https://www.aap.org/en-us/Documents/periodicity_schedule.pdf or type Preventive Pediatric Health Care in web search function.)

- Comprehensive health and developmental history – (including assessment of both physical and mental health development)
- Immunizations in accordance with the most current New York State or New York City Recommended Childhood Immunization Schedule, as appropriate. (Resource for updates: NYS DOH Immunization Program.)
- Comprehensive unclothed physical exam
- Laboratory tests as specified

    1. Follow the most current laboratory testing recommendations of the American Academy of Pediatrics – *Recommendations for Preventive Pediatric Health Care*.
    2. **Screening for lead poisoning. Federal Medicaid standards and New York State law require that all children be screened with a blood lead test at 1- and 2-years of age. The federal Medicaid rules require that children between 3- and 6-years of age be tested if they have not previously been tested.** In addition to universal blood lead testing of all 1- and 2-year old children, primary health care providers should assess each child, who is at least 6 months of age but under 6 years of age, for high dose lead exposure using a risk assessment tool based on currently accepted public health guidelines. Each child found to be at risk for high dose lead exposure should be screened or referred for blood lead screening. Providers must keep current with lead screening updates. (Resource for updates: New York State Department of Health (NYS DOH) Medicaid Updates on the NYS DOH website; Federal and NYS DOH Regulations.)

- Health Education
- Vision services
- Hearing services
- Dental services – See “Oral Health Supervision” within this summary documents section for guidance based upon an AAP Policy Statement (Resource for updates: AAP Policy Statements on dental at AAP website.)

DIAGNOSIS

When a screening examination indicates the need for further evaluation of an individual’s health, provide diagnostic services or refer when appropriate. Any necessary referrals and follow-up should be made without delay to make sure that the Medicaid member receives a complete diagnostic evaluation.

TREATMENT

Provide treatment or other measures (or refer when appropriate) to correct or ameliorate defects and physical and mental illness or conditions discovered by the screening services.

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in *Bright Futures* guidelines (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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	INFANCY								EARLY CHILDHOOD						
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●			
Weight for Length		●	●	●	●	●	●	●	●	●	●				
Body Mass Index[5]												●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●
SENSORY SCREENING															
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●
Hearing		●[8]	★	★	★	★	★	★	★	★	★	★	★	★	●
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT															
Developmental Screening[9]								●			●		●		
Autism Screening[10]											●	●			
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●
Psychosocial/Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment[11]															
Depression Screening[12]															
PHYSICAL EXAMINATION[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[14]															
Newborn Blood Screening[15]		←	●	→	→										
Critical Congenital Heart Defect Screening[16]		●													
Immunization[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[18]						★			●	★	★	★	★	★	★
Lead Screening[19]							★	★	● or ★[20]		★	● or ★[20]		★	★
Tuberculosis Testing[21]				★			★		★			★		★	★
Dyslipidemia Screening[22]												★			★
STI/HIV Screening[23]															
Cervical Dysplasia Screening[24]															
ORAL HEALTH[25]							★	★	● or ★		● or ★	● or ★	● or ★	●	
Fluoride Varnish[26]							←	—	—	—	●	—	—	—	—
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

	MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																	
Length/Height and Weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference																	
Weight for Length																	
Body Mass Index[5]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																	
Vision[7]	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing	●	●	★	●	★	●	★	★	★	★	★	★	★	★	★	★	★
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																	
Developmental Screening[9]																	
Autism Screening[10]																	
Developmental Surveillance	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment[11]							★	★	★	★	★	★	★	★	★	★	★
Depression Screening[12]							●	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[13]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[14]																	
Newborn Blood Screening[15]																	
Critical Congenital Heart Defect Screening[16]																	
Immunization[17]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[18]	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead Screening[19]	★	★															
Tuberculosis Testing[21]	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia Screening[22]		★		★	←	●	→	★	★	★	★	★	★	←	—	●	→
STI/HIV Screening[23]							★	★	★	★	★	←	●	→	★	★	★
Cervical Dysplasia Screening[24]																	●
ORAL HEALTH[25]		●															
Fluoride Varnish[26]	→																
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per the 2009 AAP statement "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Every infant should have a newborn evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in the 2012 AAP statement "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborn infants discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per the 2010 AAP statement "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per the 2007 AAP statement "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3 year olds. Instrument based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See 2016 AAP statement, "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/1.51) and "Procedures for Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/1.52).
8. All newborns should be screened, per the AAP statement "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. See 2006 AAP statement "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
10. Screening should occur per the 2007 AAP statement "Identification and Evaluation of Children with Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
11. A recommended screening tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.
12. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
13. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See 2011 AAP statement "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
14. These may be modified, depending on entry point into schedule and individual need.
15. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf), establish the criteria for and coverage of newborn screening procedures and programs. Follow-up must be provided, as appropriate, by the pediatrician.
16. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).
17. Schedules, per the AAP Committee on Infectious Diseases, are available at: http://aapredbook.aappublications.org/site/resources/izschedules.xhtml. Every visit should be an opportunity to update and complete a child's immunizations.
18. See 2010 AAP statement "Diagnosis and Prevention of Iron Deficiency and Iron Deficiency Anemia in Infants and Young Children (0-3 Years of Age)" (http://pediatrics.aappublications.org/content/126/5/1040.full).
19. For children at risk of lead exposure, see the 2012 CDC Advisory Committee on Childhood Lead Poisoning Prevention statement "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
20. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
21. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *AAP Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
22. See AAP-endorsed 2011 guidelines from the National Heart Blood and Lung Institute, "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
23. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the *AAP Red Book: Report of the Committee on Infectious Diseases*. Additionally, all adolescents should be screened for HIV according to the AAP statement (http://pediatrics.aappublications.org/content/128/5/1023.full) once between the ages of 16 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
24. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm). Indications for pelvic examinations prior to age 21 are noted in the 2010 AAP statement "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
25. Assess if the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. If primary water source is deficient in fluoride, consider oral fluoride supplementation. Recommend brushing with fluoride toothpaste in the proper dosage for age. See 2009 AAP statement "Oral Health Risk Assessment Timing and Establishment of the Dental Home" (http://pediatrics.aappublications.org/content/111/5/1113.full), 2014 clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626), and 2014 AAP statement "Maintaining and Improving the Oral Health of Young Children (http://pediatrics.aappublications.org/content/134/6/1224.full)."
26. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.htm). Once teeth are present, fluoride varnish may be applied to all children every 3-6 months in the primary care or dental office. Indications for fluoride use are noted in the 2014 AAP clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

KEY ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ←——●——→ = range during which a service may be provided

Oral Health Supervision

The first oral examination by a dentist should occur within 6 months of the eruption of the first primary tooth, and no later than age 12 months.[1] Thereafter the child or adolescent should receive routine preventive dental care every 6 months, and additional visits should be based upon the dentist's assessment of the child's or adolescent's individual needs and susceptibility to disease. (Note: This American Academy of Pediatrics (AAP) dental guidance updates and enhances that provided in the version of the AAP Periodicity Schedule: *Recommendations for Preventive Pediatric Health Care* that was current when the EPSDT/CTHP Provider Manual was initially published (2005).)

When oral examination of an **infant** by a dentist is not possible, the infant should begin to receive oral health risk assessments by age 6 months by a qualified health care professional. Risk assessment is a process that attempts to identify those children who are at greater risk for a high level of caries, periodontal disease, malocclusion and oral injury. Risk groups are as follows:

- Infants with special health care needs
- Infants of mothers with a high rate of tooth decay
- Infants with demonstrable tooth decay, plaque, demineralization, and/or staining
- Infants who sleep with a bottle
- Late order offspring
- Infants from families of low socioeconomic status

Health professionals can reinforce oral health supervision within the context of the regular health supervision visits. Fluoride supplements should be prescribed where indicated. Further discussion about Oral Health Supervision can be found in *Bright Futures In Practice: Oral Health*.

[1] AAP Policy Statement, Oral Health Risk Assessment Timing and Establishment of the Dental Home, PEDIATRICS: Vol. 111 No. 5 May 2003, pp. 1113-1114. (Available at: http://aappolicy.aappublications.org)

Bright Futures in Practice: Oral Health Supervision – Optimal Components infancy through adolescence [1]:

Provided both by Oral Health Professionals, and Other Health Professionals

- Family preparation
- Interview questions
- Risk assessment
- Screening, including recognizing and reporting of suspected child abuse/neglect
- Preventive procedures (application of dental sealants or topical fluoride varnishes, gels, foams) as approved by state practice acts or regulations
- Anticipatory guidance
- Measurable outcomes
- Referrals, as needed

Provided by Oral Health Professionals

- Examination, including periodontal assessment and treatment for oral disease and injury

[1] Casamassino, P. 1996. *Bright Futures in Practice: Oral Health*, Arlington, VA: National Center for Education in Maternal and Child Health.

Important New York State Public Health Programs and Information

The State Newborn Screening Program

The New York State newborn screening law requires testing at birth for over 30 inherited metabolic conditions, congenital hypothyroidism, and hemoglobinopathies including sickle cell disease. In 1996, the Public Health Law was amended to require that all newborns also be tested for HIV. Further information, including the most current listing of required newborn screening tests can be found at http://www.wadsworth.org/programs/newborn/screening.

The State Newborn Hearing Screening Program

The New York State hearing screening law requires hospital administrators to implement their own newborn screening programs or in some cases to provide newborns with a referral for hearing screening once they leave the hospital. Most hospitals in the state provide an inpatient hospital screening and have mechanisms in place to follow-up with newborns who need further testing. A few hospitals provide parents with a prescription to have their babies screened in the community following discharge from the hospital. Primary care providers should be aware of newborn hearing screening and follow-up programs conducted by facilities in their area. Infants who fail screening tests must be referred for audiological evaluation as soon as possible. Further information about the newborn hearing screening program can be found by typing newborn hearing screening into the search function at http://www.health.ny.gov/.

The Immunization Program

New York State and New York City Department of Health Recommended Childhood Immunization Schedules can be found at
http://www.health.ny.gov/nysdoh/immun/immunization.htm.

New York State law related to meningococcal meningitis and vaccine informing requires colleges, universities, and secondary residential schools specified in this law (and in some cases camps) to distribute information about meningococcal meningitis and vaccine to students, parents and guardians. The law additionally requires documentation that either the vaccine was administered, or that the child or parent/guardian if the child is a minor) refuses the vaccine with an understanding of risks and benefits. Further information can be found by typing meningococcal vaccine into the search function at http://www.health.ny.gov/.

The Lead Poisoning Prevention Program

Federal Medicaid standards and New York State law require that all children be screened with a blood lead test at 1- and 2-years of age. The federal Medicaid rules require that children between 3- and 6-years of age should be tested if they have not previously been tested. In addition to universal blood lead testing of all 1- and 2-year old children, primary health care providers should assess each child, who is at least 6 months of age but under 6 years of age, for high dose lead exposure using a risk assessment tool based on currently accepted public health guidelines. Each child found to be at risk for high dose lead exposure should be screened or referred for blood lead screening. (NYS DOH Rules and Regulations) Lead poisoning prevention resources can be found on the New York State Department of Health website (http://www.health.ny.gov/).

S E C T I O N 1

Section

1

Section 1 - Overview and Basic Concepts

The EPSDT/CTHP Provider Manual describes the Medicaid benefit package and the service delivery systems, both for fee-for-service and managed care, that provide access to covered services for children. More importantly, the manual communicates EPSDT/CTHP requirements to New York State Medicaid-enrolled providers. It additionally presents recommendations to help guide your practice in serving Medicaid children and adolescents. Please note in particular the recommendations cited in Section 4 related to emotional and behavioral problems, and in Section 5 related to HIV, asthma, and diabetes. Section 5 also includes both recommendations and some state requirements specific to Medicaid children and adolescents who are in foster care.

The roles of state and county governments in administering Medicaid are also described. Lastly, a comprehensive resource section is included to assist you in making appropriate referrals or in obtaining more in-depth or up-to-date information on special services available for New York State's children.

One of the overarching themes of the manual is that children are deemed at-risk for a variety of health and mental health problems that can be dealt with most effectively by looking at the child as a whole in his or her social context: the family, the school and the community. Another important theme is that of the value of a medical home for children. A medical home can do much to improve the continuity and, thus, quality of care a child receives. This is especially true for children. A medical home promotes the integration of health and mental health services for children through information-sharing, consultation, and collaboration among families and the health professionals that care for them.

For questions about procedure codes and/or billing Medicaid for the services you provide, please refer to relevant directives in the eMedNY Provider Manuals (e.g. Physician Manual, Clinic Manual), and the eMedNY Provider Manual section titled "Information for All Providers" on the eMedNY website (http://www.emedny.org), as well as updates to these policy documents in the monthly Medicaid Updates on the department's website (http://www.health.ny.gov.)

Medicaid Children Are Children at Risk

Low income is often associated with a higher childhood incidence of inadequate nutrition, exposure to environmental toxins, poor-quality childcare, dangerous living conditions, chronic stress, substance abuse, and physical abuse. The impact of any one of these factors on the physical, emotional and social well-being of a child can be overcome to a great degree by your provision of health services that are accessible, continuous, comprehensive, family-centered, coordinated and compassionate. All of these factors define a medical home.

The Medical Home

A medical home is defined as primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective. A medical home is not a building or hospital, but rather an approach to providing comprehensive primary care.

In a medical home, a pediatric clinician works in partnership with the family/patient to assure that all of the medical and non-medical needs of the patient are met. Through this partnership, the pediatric clinician can help the family/patient access and coordinate specialty care, educational services, out-of-home care, family support, and other public and private community services that are important to the overall health of the child/youth and family.

Primary health care providers should seek to improve the effectiveness and efficiency of health care for all children and strive to attain a medical home for all children in their community.[1] (http://www.medicalhomeinfo.org)

Primary care providers (PCP) include physicians (such as pediatricians, family practitioners and internists), nurse practitioners, and physician's assistants. The partnership between the PCP, other providers, and the child and family--whether birth parents or adoptive parents, foster parents or guardians--is central to the medical home concept. Therefore, health providers other than the PCP, and other relevant service providers (e.g. social service, school) should consult as necessary with the PCP, and obtain permission of the legally responsible adult (or youth where applicable) to share a copy of their findings with the PCP, in order to facilitate comprehensive, coordinated care. This will promote maintenance of a central record containing all pertinent information at the medical home. This is particularly important when the PCP refers youth to subspecialists for diagnostic evaluations and/or treatment (e.g. mental and developmental health care professionals, neurologists, audiologists), and when the PCP orders services that will be performed in other settings (e.g. home health care; physical, occupational and/or speech-language pathology therapy).

[1] American Academy of Pediatrics, Committee on Community Health Services. The pediatrician's role in community pediatrics. *Pediatrics.* 1999; 103:1304-1306

New York State Medicaid Health Care Delivery Systems

New York State Medicaid serves the public through two different health care delivery systems—managed care (through managed care organizations) and traditional fee-for-service arrangements. Clinicians may encounter children from either system. Sometimes, children move from one health care delivery system to another. It is advisable to check both Medicaid eligibility and the child's managed care enrollment status at each visit. Follow Medicaid eligibility verification system (MEVS) instructions and managed care enrollment status verification instructions located in the eMedNY Provider Manual section titled "Information for All Providers" on the eMedNY website.

Whether the child is in Medicaid managed care or fee-for-service, the EPSDT benefit and the entire array of New York State Medicaid services is available to him/her from birth up until age 21 years.

For information about Medicaid waivers or special programs available to children who meet additional eligibility criteria and have special needs, please see the Resource Section of this manual.

Medicaid Managed Care

In most New York State counties, most Medicaid families are required, or may choose to enroll in Medicaid managed care plans.

For policy governing EPSDT covered services, health care referrals, orders and prescriptions, you must follow the child's managed care plan's procedures and use plan network providers. Not all Medicaid services are covered by the managed care benefit package; some services remain available on a fee-for-service basis. Medicaid clients must use their Medicaid ID card in order to obtain such services from an enrolled Medicaid provider.

Medicaid Traditional Fee-For-Service System

A significant number of Medicaid children are served in the fee-for-service system by Medicaid enrolled providers. Medicaid clients must use their Medicaid ID card in order to obtain such services from an enrolled Medicaid provider. To obtain information regarding current Medicaid providers, specialists, and services in your community, you should contact the Medicaid Helpline at 800-541-2831.

New York State Medicaid Scope of Services

Please note that there may be limitations or requirements associated with some of the Medicaid services listed below (e.g., prior approval, prior authorization, physician prescription or written order prior to rendering service; specific providers or facilities that must render care in order for services to qualify for reimbursement). Utilization thresholds (UT's) apply to some services. **Medical records must reflect that the services are medically necessary in order to qualify them for Medicaid reimbursement. Services must be rendered by qualified practitioners within the scope of their practices as defined in State Law.**

Providers must enroll in New York State Medicaid in order to participate and bill. Medicaid recipient co-payments do **NOT** apply to children's Medicaid services. Please refer to relevant directives in the eMedNY Provider Manuals, and the Provider Manual section titled “Information for All Providers” on the eMedNY website, as well as updates to these policy documents in the monthly Medicaid Updates, for specific details on billing; prior approval, prior authorization, utilization thresholds, and other limitations and requirements.

Many services covered by **Medicaid managed care plans** must be provided by plan providers. Many services require primary care physician referral or plan authorization. Please refer to the Medicaid managed care model contract on the department’s website for the list of managed care covered services. Contact the Medicaid managed care plan for specific details concerning approval and authorization procedures.

The New York State Medicaid general scope of services includes but is not limited to the following: (For more details, please see the eMedNY Provider Manuals at http://www.emedny.org.)

- EPSDT/CTHP health services for screening, diagnosis and treatment
- Inpatient hospital care
- Outpatient hospital and free-standing clinics
- Emergency room visits
- Skilled nursing facility (SNF) care
- Urgent care center visits

New York State Medicaid Scope of Services (cont.)

- Physician and physician assistant services
- Services of nurse practitioners and midwives
- Laboratory and radiology services
- Prescription and physician ordered non-prescription drugs and medical supplies
- Durable medical equipment
- Prosthetics and orthotics
- Home health care
- Private duty nursing
- Hospice care
- Dental services, restricted to periodic oral evaluations and preventive, restorative and emergency dental care
- Orthodontia, limited to the treatment of physically handicapping malocclusions
- Eye and low vision services, and provision of necessary treatment, including but not limited to eyeglasses
- Audiology services, and provision of necessary treatment, including but not limited to hearing aids
- Speech-language pathology therapy
- Physical and occupational therapy
- Psychiatry and psychology services
- In-patient care for youth who are mentally ill and/or developmentally disabled
- Community-based clinics that serve youth who are mentally ill and/or developmentally disabled

New York State Medicaid Scope of Services (cont.)

- Other special day and residential services for youth who are mentally ill and/or developmentally disabled, such as partial hospitalization, day treatment, and family-based treatment services; and community residences such as group homes

- Alcohol and substance abuse/chemical dependence services, including inpatient detoxification and outpatient treatment services

- Family planning and reproductive health care services and supplies

- Comprehensive Medicaid case management (CMCM) services, such as AIDS case management, intensive case management for the seriously emotionally disturbed (ICM program), Medicaid services coordination (case management) for the developmentally disabled (MSC program), and other CMCM service programs

- Early Intervention services[1]

- Preschool and School Supportive Health Services[1]

- Several Medicaid Home and Community-based Services (HCBS) Waivers serving children with special health care needs (See Resource Section for details related to: (1.) Waiver programs that serve youth: Long Term Home Health Care, OPWDD, OMH, Care-at-Home, and (2.) the Traumatic Brain Injury Waiver (that serves those age 18 years and over))

- Transportation, if needed and requested, to/from Medicaid covered services

[1]These services are available to those children who meet program criteria and will be provided regardless of Medicaid coverage.

EPSDT Roles and Responsibilities

The New York State Department of Health

- Oversees local departments of social services (LDSS) to insure that each LDSS is performing consumer outreach and education, offering assistance in scheduling EPSDT appointments and providing transportation, if requested, and maintaining lists of enrolled Medicaid providers.

- Provides oversight and assistance to each LDSS in their administration of the EPSDT program.

- Provides the systems capability to produce reports on children's utilization of services, as the LDSS deem necessary.

- Produces the monthly **Medicaid Update** in order to inform enrolled Medicaid providers about existing and new Medicaid policy. This publication is posted on the Internet at the NYS DOH website, http://www.health.ny.gov, and there is also a link to it from the department's eMedNY website, http://www.emedny.org.

- Develops standards of care and consumer service to be utilized by the managed care organizations (MCOs). Monitors managed care plans by comprehensive annual operational reviews, on-site reviews and surveys, consumer satisfaction surveys, quality assurance reporting requirements (QARR) and encounter data.

- Provides the federal government, Centers for Medicare and Medicaid Services (CMS), with an annual report including the number of EPSDT health screenings, dental services, and blood lead level tests and other measures performed in the previous federal fiscal year.

The Local Departments of Social Services

- Administer the EPSDT benefit.
- Conduct outreach and inform families with children about EPSDT benefits, whether fee-for-service or managed care, and the advantages of preventive health care.
- Offer assistance in locating Medicaid providers, arranging transportation, or scheduling appointments, if such assistance is requested.
- Network with other local agencies serving children such as WIC and HEADSTART to coordinate services and benefits offered by each.

Medicaid Managed Care Plans

- Provide consumer and provider outreach and education to assure access to health care services. Managed care plans educate pregnant women, families with children, and young adults up until age 21 about EPSDT and its importance to their health.
- Provide members with information about services covered, patient costs, how to obtain referrals, and how to file complaints and appeals.
- Educate network providers about the program and their responsibilities under EPSDT.
- Maintain a list of participating Medicaid providers and provide assistance with scheduling appointments for EPSDT services, if requested.
- Provide access to medical services to their members through the plan's network of primary care providers and obstetricians/gynecologists on a 24-hour-a-day, 7-days-a-week basis.
- Follow-up to see that all appropriate diagnostic and treatment services, including referrals, are furnished pursuant to findings from an EPSDT screening examination.

S E C T I O N 2

Section
2

Section 2 – RECOMMENDATIONS FOR PREVENTIVE HEALTH CARE

Primary care providers must follow the **most current** American Academy of Pediatrics (AAP) guidelines, *Recommendations for Preventive Pediatric Health Care*, for all Medicaid children.[1]

AAP recommendations are designed to meet the health supervision needs of children who are at average risk for health problems. The AAP recognizes that some children and youth require more frequent visits.

Children who qualify for Medicaid should be considered children at high risk for health problems and should be screened and treated accordingly. These children are at risk for family instability, growth or developmental delay, and have a higher incidence of some health problems (e.g., asthma, lead exposure).

The AAP has also produced a number of policy statements on various pediatric issues that could be helpful to your practice. On the important issue of parental consent, please consult the AAP Policy Statement, *Informed Consent, Parental Permission, and Assent in Pediatric Practice*, available on the AAP website. (See the Resource Section for information on how to obtain *Teenagers, Health Care & The Law, A Guide to the Law On Minors' Rights In New York State,* and *Minors and Mental Health Care*. These two New York Civil Liberties Union (NYCLU) publications are also available at: http://www.nyclu.org/. They address minors' ability to consent for their own health care under specific circumstances.)

[1] American Academy of Pediatrics Policy Statement, Recommendations for Preventive Pediatric Health Care, Pediatrics Volume 105, No. 3, March 2000, Page 645; updated periodically.

Summary of EPSDT/CTHP Requirements

SCREENING, DIAGNOSIS and TREATMENT SERVICES required for the Medicaid population under federally-mandated EPSDT/CTHP include:

Screening Services (CTHP requirement: providers must follow the most current version of the Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care. The Bright Futures/AAP Periodicity Schedule is available at the AAP website - https://www.aap.org/en-us/Documents/periodicity_schedule.pdf)

- Comprehensive health and developmental history – (including assessment of both physical and mental health development)
- Immunizations in accordance with the most current New York State or New York City Recommended Immunization Schedule, as appropriate. (Resource for updates: NYS DOH Immunization Program)
- Comprehensive unclothed physical exam
- Laboratory tests as specified

  1. Follow the most current laboratory testing recommendations of the Bright Futures/American Academy of Pediatrics – *Recommendations for Preventive Pediatric Health Care*.
  2. Screening for lead poisoning. **Federal Medicaid standards and New York State law require that all children be screened with a blood lead test at 1- and 2-years of age. The federal Medicaid rules require that children between 3- and 6-years of age be tested if they have not previously been tested.** In addition to universal blood lead testing of all 1- and 2-year old children, primary health care providers should assess each child, who is at least 6 months of age but under 6 years of age, for high dose lead exposure using a risk assessment tool based on currently accepted public health guidelines. Each child found to be at risk for high dose lead exposure should be screened or referred for blood lead screening. Providers must keep current with lead screening updates. (Resource for updates: NYS DOH Medicaid Updates on NYS DOH website; Federal and NYS DOH Regulations)

- Health Education
- Vision Services
- Hearing Services
- Dental services – See "Oral Health Supervision" in Section 2 of this Manual for guidance based upon an AAP Policy Statement (Resource for updates: AAP Policy Statements on dental at AAP website.)

Diagnosis

When a screening examination indicates the need for further evaluation of an individual's health, provide diagnostic services or refer when appropriate. Any necessary referrals and follow-up should be made without delay to make sure that the Medicaid child/adolescent receives a complete diagnostic evaluation.

Treatment

Provide treatment or other measures (or refer when appropriate) to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services.

Summary Periodicity Schedule and American Academy of Pediatrics (AAP) Periodicity Schedule

Recommendations for Preventive Pediatric Health Care

The Bright Futures/AAP Periodicity Guidelines appear on the next page and also in the *EPSDT/CTHP Summary* document that immediately follows the Introduction page in this Manual. Please check the AAP website for the most current information: https://www.aap.org/

Medicaid covers all health supervision visits according to this periodicity schedule. Each developmental period includes several key health supervision visits during which age-specific screening, testing, immunizations, and health education content must be provided. The *Summary of Pediatric Visit Schedule for Pediatric Health Supervision* that follows here reflects the Bright Futures/AAP periodicity of visits.

Summary of Periodic Visit Schedule for Pediatric Health Supervision	
Newborn	2 - 4 days, 2 - 4 weeks
Infancy	2 months, 4 months, 6 months, 9 months
Early childhood	12 months, 15 months, 18 months, 24 months, 30 months, 3 years, 4 years
Middle childhood	5 years, 6 years, 7 years, 8 years, 9 years, 10 years
Adolescence	Annually up to 21 years

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in *Bright Futures* guidelines (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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	INFANCY								EARLY CHILDHOOD						
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●			
Weight for Length		●	●	●	●	●	●	●	●	●	●				
Body Mass Index[5]												●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●
SENSORY SCREENING															
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●
Hearing		●[8]	★	★	★	★	★	★	★	★	★	★	★	★	●
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT															
Developmental Screening[9]								●			●		●		
Autism Screening[10]											●	●			
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●
Psychosocial/Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment[11]															
Depression Screening[12]															
PHYSICAL EXAMINATION[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[14]															
Newborn Blood Screening[15]		←	●	→											
Critical Congenital Heart Defect Screening[16]		●													
Immunization[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[18]						★			●	★	★	★	★	★	★
Lead Screening[19]							★	★	● or ★[20]		★	● or ★[20]		★	★
Tuberculosis Testing[21]				★			★		★			★		★	★
Dyslipidemia Screening[22]												★			★
STI/HIV Screening[23]															
Cervical Dysplasia Screening[24]															
ORAL HEALTH[25]							★	★	● or ★		● or ★	● or ★	● or ★	●	
Fluoride Varnish[26]							←				●				
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

	MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																	
Length/Height and Weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference																	
Weight for Length																	
Body Mass Index[5]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																	
Vision[7]	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing	●	●	★	●	★	●	★	★	★	★	★	★	★	★	★	★	★
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																	
Developmental Screening[9]																	
Autism Screening[10]																	
Developmental Surveillance	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment[11]							★	★	★	★	★	★	★	★	★	★	★
Depression Screening[12]							●	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[13]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[14]																	
Newborn Blood Screening[15]																	
Critical Congenital Heart Defect Screening[16]																	
Immunization[17]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[18]	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead Screening[19]	★	★															
Tuberculosis Testing[21]	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia Screening[22]		★		★	←	●	→	★	★	★	★	★	★	←		●	→
STI/HIV Screening[23]							★	★	★	★	★	←	●	→	★	★	★
Cervical Dysplasia Screening[24]																	●
ORAL HEALTH[25]		●															
Fluoride Varnish[26]	→																
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per the 2009 AAP statement "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Every infant should have a newborn evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in the 2012 AAP statement "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborn infants discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per the 2010 AAP statement "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per the 2007 AAP statement "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3 year olds. Instrument based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See 2016 AAP statement, "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/1.51) and "Procedures for Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/1.52).
8. All newborns should be screened, per the AAP statement "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. See 2006 AAP statement "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
10. Screening should occur per the 2007 AAP statement "Identification and Evaluation of Children with Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
11. A recommended screening tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.
12. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
13. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See 2011 AAP statement "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
14. These may be modified, depending on entry point into schedule and individual need.
15. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf), establish the criteria for and coverage of newborn screening procedures and programs. Follow-up must be provided, as appropriate, by the pediatrician.
16. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).
17. Schedules, per the AAP Committee on Infectious Diseases, are available at: http://aapredbook.aappublications.org/site/resources/izschedules.xhtml. Every visit should be an opportunity to update and complete a child's immunizations.
18. See 2010 AAP statement "Diagnosis and Prevention of Iron Deficiency and Iron Deficiency Anemia in Infants and Young Children (0-3 Years of Age)" (http://pediatrics.aappublications.org/content/126/5/1040.full).
19. For children at risk of lead exposure, see the 2012 CDC Advisory Committee on Childhood Lead Poisoning Prevention statement "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
20. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
21. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *AAP Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
22. See AAP-endorsed 2011 guidelines from the National Heart Blood and Lung Institute, "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
23. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the *AAP Red Book: Report of the Committee on Infectious Diseases*. Additionally, all adolescents should be screened for HIV according to the AAP statement (http://pediatrics.aappublications.org/content/128/5/1023.full) once between the ages of 16 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
24. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm). Indications for pelvic examinations prior to age 21 are noted in the 2010 AAP statement "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
25. Assess if the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. If primary water source is deficient in fluoride, consider oral fluoride supplementation. Recommend brushing with fluoride toothpaste in the proper dosage for age. See 2009 AAP statement "Oral Health Risk Assessment Timing and Establishment of the Dental Home" (http://pediatrics.aappublications.org/content/111/5/1113.full), 2014 clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626), and 2014 AAP statement "Maintaining and Improving the Oral Health of Young Children (http://pediatrics.aappublications.org/content/134/6/1224.full)."
26. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.htm). Once teeth are present, fluoride varnish may be applied to all children every 3-6 months in the primary care or dental office. Indications for fluoride use are noted in the 2014 AAP clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

KEY ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ← ● → = range during which a service may be provided

Evaluations that May Vary from the Periodicity Schedule

If, in your judgment, more frequent visits are medically necessary, they should be provided.

If a child or adolescent who has missed health supervision visit(s) presents for health supervision at an age that does not appear on the periodicity schedule, perform a comprehensive well-child exam following the guidelines for the most recently missed exam. Please note that an undocumented visit should be considered a missed visit, as if it had not occurred.

While the Medicaid expectation is that practitioners will comply with these recommendations, it is likely that some children and families may have trouble adhering to providers' recommendations for preventive care visits. Some families face a variety of difficulties that prevent them from accessing the care they need when they need it. If families do not adhere to your recommendations, you should document reasonable efforts at outreach and education to promote parental compliance. Primary care providers will not be held responsible for the parent(s) or child's failure to comply due to family difficulties or other problems outside the physician's control.

Health Supervision (Well-Child) Visits

Required Content

The content of care is specified in the chart and footnotes of the Bright Futures/American Academy of Pediatrics *Recommendations for Preventive Pediatric Health Care*. See www.aap.org. Please be sure to check the website regularly for the most up-to-date recommendations.

Visit Components

Every periodic health supervision (well-child) visit must include:

1. A comprehensive health, psycho-social and developmental history.

2. An unclothed comprehensive physical examination.

3. Assessment of growth and nutritional status.

4. Assessment of immunization status and provision of appropriate immunizations. Upstate: Use the Advisory Committee on Immunization Practices (ACIP) schedules, New York State Department of Health, Recommended Childhood Immunization Schedule.
   New York City: Use the City of New York Department of Health and Mental Hygiene, Recommended Childhood Immunization Schedule.

5. Screening for vision, hearing, and development, as per AAP guidance.

6. Laboratory testing where appropriate to age and exam findings, and in line with AAP guidance. Compliance with Federal and New York State requirements (e.g. lead testing).

7. Oral health screening, preventive counseling, and referral to a dentist for ongoing dental care.

8. Screening for, and, if suspected, reporting of, child abuse and neglect.

9. Health education, sometimes known as anticipatory guidance.

10. Referrals where appropriate based on history and exam findings. Timely follow-up to incorporate outcomes into the health record.

(NOTE: Health education materials for all age groups are available from Bright Futures at www.brightfutures.org.)

Documentation

Both federal Medicaid regulations and New York State law require documentation of all visits in the medical record. Without documentation of the nature of the visit, and the components of the visit in the medical record, Medicaid will deem the visit incomplete or not having taken place.

Charting must include:

- An updated problem list.
- Plans for diagnosis, treatment, referral and follow-up.

Detailed descriptions of the components of health supervision visits are described in the following sections.

Comprehensive Health History

For new patients, a complete family history, past medical history and review of systems must be recorded. For children five years of age or younger, the history must include details of the mother's pregnancy, and the delivery and neonatal period. For known patients, the history may be confined to the interval since the previous evaluation.

Patient and family histories may be obtained with the assistance of patient screening questionnaires, or by your medical or nursing assistants. You must review and supplement these histories at the time of the patient's examination. Include age appropriate questions to elicit history of risk-taking behavior.

You are encouraged to use screening/trigger questionnaires with all your patients, especially your adolescent patients, to improve the reliability of history taking, and your documentation of screening and counseling.

History taking includes:

Prenatal to 5th Birthday

- Details of mother’s pregnancy
- Delivery
- Birth weight
- The neonatal period

Age 11 to 21st Birthday

- Health risk behavior discussion
- Psychosocial assessment
- Tobacco, alcohol and other substance use
- Interpersonal violence (physical & sexual, victim, witness or perpetration)
- Sexual activity and use of contraception
- For girls, menstrual history

Comprehensive Physical Examination

The examination must be performed by a licensed physician or other qualified licensed clinician. The physical examination must consist of an unclothed (federal Medicaid EPSDT requirement) systematic examination of all parts of the body, including appropriate fundoscopic, otoscopic and oral cavity exams, genital and neurological exam, and observation of the back for scoliosis. Blood pressure measurements should be taken for all children 3 years of age and older.

Every adolescent should also have a private, one-on-one opportunity to confidentially discuss his/her health with you.

Adolescents' pubertal development must be assessed, and adolescent males should receive a testicular exam. All sexually active females should receive a pelvic examination; females over age 18 should also be offered routine pelvic examination.

Be alert for conditions that may be more prevalent:

- Oral health problems
- Sexually transmitted diseases
- Signs of abuse or violence
- Developmental delays

Assessment of Physical Growth and Nutritional Status

Measure and record height and weight at each visit. Measure and record head circumference at each visit during the first year, and at 2 years of age. Plot growth on standard charts, which should be part of the medical record. Growth charts can be accessed at http://www.cdc.gov/growthcharts.Use Body Mass Index (BMI=weight in kg/height in meters squared) to assess weight status for children 2 years of age and older. Because BMI varies normally by age and sex, it is necessary to use sex-specific BMI-for-age percentiles to correctly classify weight status in children and adolescents. The BMI-for-age charts released by CDC in 2000 are intended to replace the use of weight-for-age and weight-for-stature charts for children and adolescents aged 2-20 years. (See CDC's website for information related to growth charts and BMI. Also see: BMI for Children and Teens at: http://www.cdc.gov/healthyweight/assessing/bmi/index.html

Screen all children and youth for nutritional risk at each visit. Screening for this risk (e.g., overweight, underweight, failure to thrive, iron deficiency, hyperlipidemia, or inappropriate feeding practices) should include evaluation of growth, dietary practices, a general health history, the physical exam, and laboratory tests.

Along with attention to family, socioeconomic and community factors, and attention to the quality and quantity of individual diets, screen your adolescent patients annually for eating disorders and obesity by determining weight, stature and BMI, and asking about body image and dieting patterns.

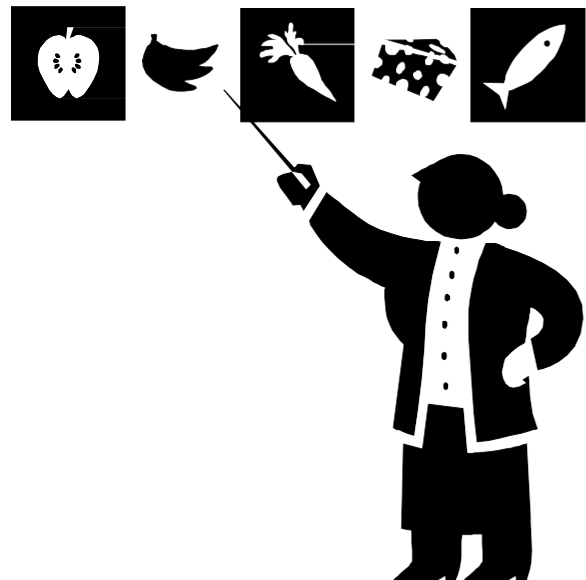
Children and adolescents with asthma, diabetes, or other chronic health conditions who are also obese or overweight should be counseled about healthy dietary regimens, or referred to a physician who specializes in nutritional issues. These children may benefit from intense nutritional counseling in combination with mental health and family counseling support.

Be alert for nutrition problems in low-income children:

- Obesity - and its complications - e.g., Type 2 diabetes and hyperlipidemia
- Malnutrition
- Pica
- Iron-deficiency anemia

Special Nutrition Program for Women, Infants and Children (WIC)

Refer all infants, children under age 5 years, pregnant, breast-feeding, and post-partum women on Medicaid to the Special Nutrition Program for Women, Infants and Children (WIC). WIC will then assess them for eligibility. WIC is free to eligible mothers and children, and provides them with nutritious food such as infant formula, juice, cheese, eggs, cereal, dried beans/peas, and peanut butter. WIC also gives mothers and children nutrition and health education, and refers them to other health services. To learn the nearest location where application assistance is available in your area, call the Growing Up Healthy Hotline at 1-800-522-5006 or visit online at: https://www.health.ny.gov/community/pregnancy/health_care/prenatal/guh.htm.



Assessment of Immunization Status and Required Immunizations

Persons under 19 years of age must be immunized in accordance with the most current New York State Department of Health or, in New York City, the New York City Department of Health and Mental Hygiene "Recommended Childhood Immunization Schedule." http://www.health.ny.gov/prevention/immunization/. This website also includes immunization requirements for school entrance and attendance.

Medicaid providers who have any questions regarding immunizations should contact the New York State Department of Health Immunization Program at (518) 473-4437 or by email at immunize@health.ny.gov.

Record all prior immunizations. If the dates of the child's previous immunizations are available, include them in the child's medical record. If the immunization history is based on parent reports, verify this information, if possible, and record. Provide each patient with a completed immunization card.

Simultaneous administration of all routinely recommended vaccines appropriate to the age and previous vaccination status is recommended. Most of the widely used vaccines can generally be safely and effectively administered simultaneously. This is particularly important in scheduling children with missed immunizations.

If live viral vaccines are not administered on the same day, there must be a waiting period of four weeks before subsequent administration of another live vaccine.

If an interruption in the schedule occurs, resume where it was left, appropriate for age. If multiple doses of DTaP/DT or IPV vaccine are needed for school or day care attendance, these may be spaced as described in ACIP recommendations. Detailed information on this and other issues can be accessed at www.health.ny.gov at *Family and Community Health/Immunization,* or under *General Recommendations on Immunizations (MMWR)* at www.cdc.gov/mmwr/preview/mmwrhtml/rr5102A1.HTM.

Unknown or Uncertain Vaccination Status

If there is any uncertainty regarding immunization status, the child should be considered susceptible. With the exception of pneumococcal polysaccharide vaccine, you should not accept self-reported immunizations without written documentation. Do not, however, postpone vaccinations if you are unable to locate missing records. Start the child in question on the age-appropriate immunization schedule. Detailed information on this issue can be found at http://www.health.ny.gov/ "Family and Community Health/Immunization," or under General Recommendations on Immunizations (MMWR) at www.cdc.gov/mmwr/preview/mmwrhtml/rr5102A1.HTM.

Altered Immunocompetence

ACIP immunization protocols for children who have, or who are living with others who have altered immunocompetence, can be obtained from the CDC MMWR website at www.cdc.gov/mmwr/preview/mmwrhtml/00023141.htm.

Immunization Registries

It is important that you register with, and participate in, the current New York State or New York City Immunization Registries. For New York City based providers, participation in the Citywide Immunization Registry is mandatory. These registries are an excellent resource for you and can assist you in the provision of timely immunizations.

The New York State Immunization Information System (NYSIIS) and the New York City Citywide Immunization Registry (CIR) collect, maintain, and transfer accurate and complete immunization information in a secure environment. NYSIIS and the CIR may eventually be linked to allow for exchange of data between the two systems. For more information on NYSIIS, call (518) 473-4437. For information on the CIR, call (212) 676-2323.

The CIR is a comprehensive database system containing demographic and immunization information on children residing in New York City (NYC). All NYC-based immunization providers are mandated by the NYC Health Code to report immunizations to the CIR within two weeks of administration.

The New York State Immunization Information System (NYSIIS) is a voluntary registry that is operational in most county health departments and many public and private providers in upstate New York. The intent of NYSIIS is to make immunization information available to the child's health care providers, including physicians and hospitals, their parents and legal guardians. You must obtain parent or guardian consent before entering a child's immunization and demographic information into the NYSIIS registry.

Other Sources of Past Immunization Records

Regardless of whether you utilize immunization registries to obtain past records, you must continue the practice of obtaining parental consents to solicit health records, including past immunization records, from all prior sources of health care. This practice ensures that you get immunization records from providers who may not have participated with immunization registries. It also ensures that updated records are obtained for Medicaid recipients. Schools and day care centers may also serve as good sources of immunization records, since children are mandated to receive specified immunizations prior to enrollment.

The Federal Vaccines for Children Program (VFC)

All physicians must participate in the VFC program if they administer vaccines to Medicaid children under the age of 19 years. Vaccines for Children is a program intended to improve childhood immunization levels nationwide. New York State's Vaccines for Children program (New York State VFC) is administered by the state and local departments of health. New York State provides VFC registered public and private providers with free routine childhood vaccines to be used to immunize Medicaid recipients and other eligible children under nineteen (19) years of age. Medicaid pays enrolled fee-for-service physicians the administration fee for vaccines available through the New York State VFC program. In order to bill Medicaid for the administration fee, you must be an enrolled Medicaid provider and must also be a registered New York State VFC provider. To register, call New York State VFC at 1-800-KID SHOTS (1-800-543-7468).

Under New York's program, if your patients are enrolled in **Medicaid managed care**, you are reimbursed in accordance with the managed care contract for your administration of the vaccine.

Vision Testing

For children from birth to three years of age, evaluation includes:

- Eyelids and orbits;
- External examination;
- Motility;
- Pupils; and
- Red reflex.

For children three years and older:

Test visual acuity at age intervals specified by the American Academy of Pediatrics (AAP) in the most current version of AAP's *Recommendations for Preventive Pediatric Health Care* (AAP Periodicity Schedule). Standardized testing should additionally be performed when subjective history and/or health exam findings suggest the need. To test visual acuity, use the Snellen letter or Symbol E chart. The use of alternative tests (HOTV or Matching Symbol, Faye Symbol, Allen Pictures) should be considered for preschoolers.

If a child wears eyeglasses, assessment regarding the need for referral for optometric reevaluation must be made based on screening with eyeglasses, and the length of time since the last evaluation.

Additional information on vision screening can be found in *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents*, Appendix E: Vision Screening. To locate this information at http://www.brightfutures.org select *Bright Futures Guidelines for Health Supervision* under "Publications."

Hearing Screening

Permanent sensorineural hearing loss is found in approximately 2-4 of every 1,000 newborns. About 30 percent of babies born with hearing loss have no signs of a potential problem, such as serious illness or family history of deafness. Universal newborn hearing screening is essential to identify hearing loss as early as possible and ensure that parents and babies have access to early services to promote language development and learning.

In New York State, newborn hearing screening is mandated. - All newborns born in maternity hospitals and birthing centers in New York State must be screened. Regulations (10 NYCRR Section 69-8) require most facilities to provide inpatient screening for newborn hearing loss using physiologic testing by evoked otoacoustic emissions (EOAE) and auditory brainstem response (ABR) before discharge. Primary care providers should be aware of newborn screening and follow-up programs conducted by facilities in their area. Infants who fail screening tests must be referred for audiological evaluation as soon as possible.

Timely follow-up is important, both for those infants who do not pass their initial hearing screening and for those infants who fail two newborn hearing screenings. Referral to the Early Intervention Program in the infant's county of residence can take place at two main junctures in the newborn hearing process:

1. After an infant fails two hearing screenings, they may be referred to early intervention for a confirmatory (diagnostic) hearing test; and,
2. If an infant who has failed their initial screening does not receive a follow-up screening within 75 days post-discharge, the facility responsible for reporting data to the Department (usually the birth facility) may refer the family to early intervention for the purpose of facilitating a second hearing screening.

Hearing screening for children less than three years of age – For children less than age 3 years, follow the most current version of American Academy of Pediatrics' (AAP's) *Recommendations for Preventive Pediatric Health Care* (AAP Periodicity Schedule) for age-specific intervals at which subjective history and/or routine standardized hearing testing should be performed. Children less than age three years who have test findings indicative of hearing loss, or are deemed to be at increased risk for hearing problems based upon subjective history and/or individualized health exam findings need to be referred for age-appropriate hearing testing. It is recommended that providers refer the child to a speech and hearing center approved to provide services under the Physically Handicapped Children's Program (PHCP). Otherwise appropriately licensed and credentialed providers may be utilized. Increased risk exists when parents or caregivers have concern regarding hearing, speech, language and/or developmental delay. In addition, there may be a history of neonatal events associated with hearing loss, such as head trauma, ototoxic medications, neurodegenerative disorders, and bacterial meningitis or other diseases associated with hearing loss.

Children older than three years of age – Perform pure tone screening at ages specified in the most current version of AAP's *Recommendations for Preventive Pediatric Health Care* (AAP Periodicity Schedule). If you suspect a hearing impairment or hearing loss in your patient at any age, refer the child for age-appropriate hearing testing. It is recommended that providers refer the child to a speech and hearing center approved to provide services under the Physically Handicapped Children's Program. Otherwise appropriately licensed and credentialed providers may be utilized. For a list of approved centers, contact your county health department.

Early Intervention Guidance Memorandum 2003-03 on Newborn Hearing Screening is available on the Department of Health website at http://www.health.ny.gov/nysdoh/eip/memo03-3.htm.

Hearing impairment can contribute to developmental delays. See *Monitoring Child Development* in Section 2, as well as the EPSDT/CTHP Manual Resource Section for further information related to referrals to the Early Intervention Program, and to Preschool and School Committees on Special Education. The New York State Growing Up Healthy 24-hour hotline (1-800-522-5006; for New York City, 1-800-577-2229) can help providers link youth to early intervention programs and services.

Additional information on hearing screening can be found in *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents*, Second Edition (2000) – Appendix D: Hearing Screening. To locate this information at http://www.brightfutures.org select *Bright Futures Guidelines for Health Supervision* under "Publications."

Overview of Developmental Screening Tools (National Academy for State Health Policy©-October 2002)

	ASQ[4]	BINS[5]	DDST[6]	PEDS[7]	CDI[8]	BRIGANCE[9]	PSC[10]	GAPS[11]
Type/Ages	Parent questionnaire (2 mos. - 5 yrs.)	Direct elicitation (3-24 mos.)	Direct elicitation	Parent questionnaire (0-8 yrs.)	Parent questionnaire (3 mos.-6 yrs.)	Direct elicitation (21 mos.-7.5 yrs.)	Parent questionnaire	Child & parent questionnaire (11-21 yrs.)
Staff Required	Para-professional	MA or equivalent	3.5 hrs. of training	Para-professional	Para-professional	Profesional	Para-professional	No scoring
Time to score	5 minutes	10-15 minutes	20-30 minutes	5 minutes	10 minutes	10-15 minutes	7 minutes	20 minutes
Cost (per kit)	$190	$195	$91 kit, $185 training materials	$39	$41	$249	Free download	Free download from AMA
Refills	OK to copy	Needed	$26-$100	$30-$50			OK to copy	OK to copy
Languages	English and Spanish	English	English	English and Spanish	English and Spanish	English and Spanish	English	English and Spanish
Reading Level	4th-6th Grade	NA	NA	5th Grade	NA	NA	NA	NA

From *Reasons and Strategies for Strengthening Childhood Development Services in the Healthcare System*, by the National Academy for State Health Policy, Portland, ME, October 2002. The full publication is available at no charge at www.nashp.org.

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4 Ages and Stages Questionnaire. Paul Brooks Publishing Co., P. O. Box 10624, Baltimore, MD 21285-3775. 1-800-638-3775. www.pbrookes.com

5 Bayley Infant Neurodevelopmental Screen. The Psychological Corp., 555 Academic Court, San Antonio, TX 78204. 1-800-228-0752. www.psychocorp.com

6 Denver Developmental Screening Test. Denver Developmental Materials, Inc., P. O. Box 371075, Denver, CO 80206-0919. 1-800-419-4729

7 Parents Evaluation Developmental Status. Ellsworth & Vandermeer press, P. O. Box 68164, Nashville, TN 37206. 1-888-729-1697. www.pedstest.com

8 Child Development Inventory. Behavior Science Systems, Inc., P. O. Box 580274, Minneapolis, MN 55458

9 Brigance Diagnostic Inventory of Early Development, Curriculum Associates, Inc., 153 Rangeway Road, North Billerica, MA 01862. 1-800-225-0248. www.curricassoc.com

10 Pediatric Symptom Checklist. Child Psychiatry, Bulfinch 351, Massachusetts General Hospital, Boston, MA 02114. 617-724-3163

11 Guidelines for Adolescent Preventive Services, American Medical Association. www.ama-assn.org

Routine Laboratory and Diagnostic Testing

Newborn Screening for HIV, Metabolic and Genetic Disease

If a newborn screening test was **not** performed at 48-72 hours after birth, an appropriate filter paper specimen must be obtained at the first well-child exam (at age two weeks) and submitted to the New York State laboratory.

Since 1997, all infants born in New York have been screened for HIV exposure through the Newborn Screening Program. In August 1999 expedited HIV testing was implemented, so that the HIV exposure status of all infants is known at discharge from the birth facility.

Document newborn screening results in the medical record. Newborn screening test results may be obtained from the NYS DOH Newborn Screening Program. For children born 1990 and earlier, call (518) 473-7552, for children born 1991 and later, call 1-800-535-3079.

Sickle Cell Screening

All children born in hospitals within New York State after 1975 are tested for sickle cell disease as part of routine newborn testing. If children are at risk of sickle cell disease and there is any doubt about previous testing, test them.

Anemia Testing

The prevalence of iron-deficiency is higher among children living at or below poverty level and among African-American and Latino children.

Perform testing for anemia on all children in accordance with the most current AAP Guidelines. Rapid growth and inadequate dietary iron intake places children less than age 24 months at the highest risk of any age group for iron deficiency. In infants and preschool children, iron-deficiency anemia may result in developmental delays and behavioral disturbances. As many as nine percent of children aged 12-36 months in the United States have iron deficiency.

Pre-term and low-birth weight infants' iron stores are often depleted by age 2-3 months, and these children are at greater risk for iron deficiency. For children older than 36 months, risks for iron deficiency include low family income, migrant or refugee status, and medical conditions that affect iron status.

Childhood Lead Poisoning Prevention

Childhood lead poisoning is a serious health problem that can have a devastating effect on a child, and has serious repercussions for society as a whole. Human interaction with lead in the environment is most dangerous for children under age six. Exposure to even small amounts of lead can contribute to behavior problems, learning disabilities, and lowered intelligence. Screening and prompt and effective intervention have been shown to prevent some of the more advanced effects of lead poisoning, such as seizures and severe kidney and nervous system damage. Childhood lead poisoning remains a significant problem in New York State although the prevalence of childhood lead poisoning has been declining. [12]

Federal Medicaid standards and New York State law require that all children be screened with a blood lead test at 1- and 2-years of age. The federal Medicaid rules require that children between 3- and 6-years of age be tested if they have not previously been tested.

Risk Assessment

In addition to universal blood lead testing of all 1- and 2-year old children, primary health care providers should assess each child, who is at least 6 months of age but under 6 years of age, for high dose lead exposure using a risk assessment tool based on currently accepted public health guidelines. Each child found to be at risk for high dose lead exposure should be screened or referred for blood lead screening. (NYS DOH Rules and Regulations)

[12] Protecting Our Children from Lead: The Success of New York's Efforts to Prevent Childhood Lead Poisoning. New York State Department of Health Publication 2002.

The Department of Health / American Academy of Pediatrics District II Task Force has recommended the use of five risk assessment questions developed by the Centers for Disease Control, and has added a sixth.

- Does your child live in or regularly visit a house with peeling or chipping paint built before 1960? This could include a day care center, preschool, and the home of a babysitter or a relative.
- Does your child live in or regularly visit a house built before 1960 with recent, ongoing or planned renovation or remodeling?
- Does your child have a brother or sister, housemate or playmate being followed or treated for lead poisoning?
- Does your child frequently come in contact with an adult whose job or hobby involves exposure to lead? Occupational examples are house painting, renovations, construction, welding or pottery making. Hobby examples are making stained glass or pottery, fishing, making firearms and collecting lead figurines.
- Does your child live near an active lead smelter, battery recycling plant or other industry likely to release lead?
- Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?

If the answer to any of these questions is yes, then the child is considered to be at risk for high-dose lead exposure. Screen with a blood lead test when such risk is identified. The need for sibling screenings should also be considered.

Further information on childhood lead poisoning prevention can be found online at: https://www.health.ny.gov/environmental/lead/.

Targeted Tuberculin Skin Testing in Children and Adolescents

Targeted skin testing in children and adolescents focuses on pediatric populations at high risk for Latent Tuberculosis Infection (LTBI) in addition to those patients at risk of progression to TB disease. Risk factors for LTBI/TB include: birth in, or travel to Africa, Asia, Latin America, or Eastern Europe; exposure to anyone with TB disease; and, close contact with a person who has a positive TB skin test. "Routine" or "mandated" LTBI testing policies for pediatric patients without risk factors are strongly discouraged by the Pediatric Tuberculosis Collaborative Group. [1]

The Pediatric Tuberculosis Collaborative Group recommends that health care providers follow these steps:

- Assess an individual child or adolescent for LTBI or TB disease using a risk-factor questionnaire. (See questionnaire on the next page.)
- If any risk factors are present, test for LTBI/TB with a Tuberculin Skin Test (TST). The Tuberculin Skin Test is the intradermal injection of 5 tuberculin units of purified protein derivative from M Tuberculosis administered via the Mantoux technique.
- Perform risk assessment once a year to assess acquisition of any new risk factors since the last assessment.

Health Professionals may judge the need for TB risk assessment at more frequent intervals based upon individualized health assessment and patient circumstances. Specific information on updated TB risk factors, interpretation of the TB skin test, further evaluation of the child/adolescent, and treatment recommendations can be found in the most current edition of the *Red Book: Report of the Committee on Infectious Diseases.*

[1] Targeted Tuberculin Skin Testing and Treatment of Latent Tuberculosis Infection in Children and Adolescents. Pediatric Tuberculosis Collaborative Group. PEDIATRICS Vol. 114 No. 4 October 2004, pp.1175-1201.

Targeted Tuberculin Skin Testing[1]

Risk-Assessment Questionnaire*

Questions

1. Was your child born outside the United States?
   If yes, this question would be followed by: Where was your child born? If the child was born in Africa, Asia, Latin America, or Eastern Europe, a TST should be placed.

2. Has your child traveled outside the United States?
   If yes, this question would be followed by: Where did the child travel, with whom did the child stay, and how long did the child travel? If the child stayed with friends or family members in Africa, Asia, Latin America, or Eastern Europe for greater than or equal to 1 week cumulatively, a TST should be placed.

3. Has your child been exposed to anyone with TB disease?
   If yes, this question should be followed by questions to determine if the person had TB disease or LTBI, when the exposure occurred, and what the nature of the contact was. If confirmed that the child has been exposed to someone with suspected or known TB disease, a TST should be placed.
   If it is determined that a child had contact with a person with TB disease, notify the local health department per local reporting guidelines.

4. Does your child have close contact with a person who has a positive TB skin test?
   If yes, see question 3 (above) for follow-up questions.

Risk-assessment questionnaires can include the following questions based on local epidemiology and priorities

1. Does your child spend time with anyone who has been in jail (or prison) or a shelter, uses illegal drugs, or has HIV?

2. Has your child drank raw milk or eaten unpasteurized cheese?

3. Does your child have a household member who was born outside the United States?

4. Does your child have a household member who has traveled outside the United States?

*Adolescents can be asked these questions directly.

[1] Targeted Tuberculin Skin Testing and Treatment of Latent Tuberculosis Infection in Children and Adolescents. Pediatric Tuberculosis Collaborative Group. PEDIATRICS Vol. 114 No. 4 October 2004, pp.1175-1201.

Hyperlipidemia Screening

Recent evidence suggests that atherosclerosis and coronary heart disease (CHD) involve processes that begin in childhood or adolescence. The AAP policy statement, Cholesterol in Childhood (1998), recommends that depending on family history, children at risk for hyperlipidemia should be selectively screened beginning at age 2 years.

The following table lists major risk factors and recommended screening procedures for hyperlipidemia.

Major Risk Factor	Recommended Screening Procedure
Parent or grandparent (less than or equal to age 55 years) diagnosed with coronary atherosclerosis (based on coronary arteriography), including those who have had balloon angioplasty or coronary artery bypass surgery.	➢ Screen with fasting lipoprotein analysis (12-hour fast). ➢ Repeat lipoprotein analysis to calculate the average LDL-C, based on the two measurements.
Parent or grandparent (less than or equal to age 55 years) with documented myocardial infarction, angina pectoris, peripheral vascular disease, cerebrovascular disease, or sudden cardiac death.	➢ Screen with fasting lipoprotein analysis (12-hour fast). ➢ Repeat lipoprotein analysis to calculate the average LDL-C, based on the two measurements.
➢ Parent with high cholesterol level (greater than or equal to 240mg/dl) ➢ Family history unknown	➢ Measure TC

Follow-up information can be found in Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents, Second Edition (2000) - Appendix H: Hyperlipidemia Screening.

Papanicolau Smear

All sexually active adolescent females should have a Pap smear at least annually. For your female patients age 18 and over who are not sexually active, you should offer a Pap smear as part of a routine pelvic examination.

Sexually Transmitted Disease and Pregnancy Screening

According to a 2001 study conducted by the CDC's National Center for Chronic Disease Prevention and Health Promotion on Adolescent Sexual Behaviors, 46 percent of high school students engaged in sexual intercourse, and 42 percent of sexually active high school students did not use a barrier contraceptive at most recent sexual intercourse, placing them at increased risk for contracting sexually transmitted diseases and unintended pregnancy.

Counsel sexually active patients (and those contemplating sexual activity) about prevention of pregnancy, HIV infection and other sexually transmitted diseases. Sexually active patients must be offered confidential pregnancy and STD testing, including tests for HIV, gonorrhea and chlamydia, and, as appropriate, serological screening for syphilis. For all sexually active females, provide a routine gynecologic examination and a Pap smear.

Sexually transmitted disease treatment guidelines are available in the May 3, 2002 CDC Morbidity and Mortality Weekly Report (MMWR), available at: http://www.cdc.gov/std. These 2002 guidelines address antibiotic therapies for the common STD's. CDC updates these guidelines periodically. Please reference the most current guidelines.

If you, as primary care provider, are unable to perform these services to your sexually active patients, you should refer them to a confidential source of reproductive health care, and your follow-up must be documented in the medical record.

Oral Health Supervision

The first oral examination by a dentist should occur within 6 months of the eruption of the first primary tooth, and no later than age 12 months.[1] Thereafter the child or adolescent should receive routine preventive dental care every 6 months, and additional visits should be based upon the dentist's assessment of the child's or adolescent's individual needs and susceptibility to disease.

When oral examination of an infant by a dentist is not possible, the infant should begin to receive oral health risk assessments by age 6 months by a qualified health care professional. Risk assessment is a process that attempts to identify those children who are at greater risk for a high level of caries, periodontal disease, malocclusion and oral injury. Risk groups are as follows:

- Infants with special health care needs
- Infants of mothers with a high rate of tooth decay
- Infants with demonstrable tooth decay, plaque, demineralization, and/or staining
- Infants who sleep with a bottle
- Late order offspring
- Infants from families of low socioeconomic status

Health professionals can reinforce oral health supervision within the context of the regular health supervision visits. Fluoride supplements should be prescribed where indicated. Further discussion about Oral Health Supervision can be found in *Bright Futures In Practice: Oral Health*.

[1] AAP Policy Statement, Oral Health Risk Assessment Timing and Establishment of the Dental Home, PEDIATRICS: Vol. 111 No. 5 May 2003, pp. 1113-1114.

Bright Futures in Practice: Oral Health Supervision – Optimal Components infancy through adolescence [1]:

Provided both by Oral Health Professionals, and Other Health Professionals

- Family preparation
- Interview questions
- Risk assessment
- Screening, including recognizing and reporting of suspected child abuse/neglect
- Preventive procedures (application of dental sealants or topical fluoride varnishes, gels, foams) as approved by state practice acts or regulations
- Anticipatory guidance
- Measurable outcomes
- Referrals, as needed

Provided by Oral Health Professionals

- Examination, including periodontal assessment and treatment for oral disease and injury

[1] Casamassino, P. 1996. Bright Futures in Practice: Oral Health, Arlington, VA: National Center for Education in Maternal and Child Health.

Monitoring Child Development

Birth to Age 6

All infants and young children should be monitored for developmental delays.

The components of comprehensive child development monitoring include:

- Eliciting and attending to parental concerns;
- Obtaining a relevant developmental history;
- Making accurate and informative observations of children's developmental strengths and challenges; and
- Sharing opinions and concerns with other relevant professionals.

Child development monitoring can be strengthened by utilizing high quality, developmental screening tools at some visits. The use of a developmental screening tool is particularly important and recommended for children who receive inconsistent health care supervision. Those children at risk for delay, including all who were born prematurely, those born to mothers with alcohol or substance abuse problems, and all HIV-infected children, should have formal developmental assessments every 6 months, in order to identify developmental delays as early as possible.

Numerous child development and behavioral assessment tools are available for developmental screening. However, no single universally accepted tool currently exists. Developmental screening tools that use parent report are increasingly being used in health care settings because they allow for more efficient use of the health care provider's time.

For more information on developmental screening instruments, please visit the Early Intervention Program page on the New York State Department of Health website, www.health.ny.gov (Select: "Community, Family & Minority Health" or "Topics A-Z"; then select: "Early Intervention").

The Early Intervention Program has developed clinical practice guidelines that include recommendations regarding screening and assessment tools for children with specific conditions. The National Academy for State Health Policy has produced an Overview of Developmental Screening Tools. (See *Overview of Developmental Screening Tools (National Academy of State Health Policy – October 2002)* in Section 2 of this Manual.)

Referral to Early Intervention Program (EIP) - Children under 3 who have a suspected or established developmental delay or disability likely to cause developmental delays (such as Down syndrome or cerebral palsy) are required to be referred to the Early Intervention Program in their county of residence for a multidisciplinary evaluation to determine their eligibility for early intervention services. Children with certain medical-biological risk factors associated with disability are also required to be referred to the Early Intervention Program child find system for tracking to ensure children are engaged in primary health care and receiving developmental screening and surveillance by their health care providers or other available community resources. Each county and New York City have designated Early Intervention officials responsible for receiving early intervention referrals and for educating health care providers about referral criteria and procedures. Most Early Intervention Officials (EIOs) are directors or commissioners of county health departments; however, this differs in some counties. For information about EIOs in your area, call the NYS Department of Health Growing Up Healthy Hotline at 1-800-522-5006.

For referred children under 3 years of age - Children under 3 years of age referred to the Early Intervention Program will have a comprehensive evaluation. If the child is found eligible, an Individualized Family Service Plan (IFSP) will be developed. The IFSP clearly delineates all early intervention services planned for the infant/toddler and the frequency and location of the services. The Early Intervention Program and/or family may ask you to provide input into the development of the IFSP and request that you participate in the IFSP development meeting. The family may also request that you receive copies of the initial and all subsequent IFSPs and periodic progress notes on the infant/toddler.

For Preschool Children

If you identify children age 3 to 5 as having a suspected or established developmental delay or disability that may affect their school performance, you should refer them to the child's school district for an evaluation by the school Committee on Preschool Special Education (CPSE). Children whom you refer for special education evaluation may have an Individualized Education Program (IEP). You may be asked to provide input.

For School Age Children

For all school-aged children, assessment of developmental status and psychosocial adjustment needs to include a discussion of school performance, peer and family relationships, and evaluation of physical development. If you identify a child as having a suspected or established developmental delay or disability that may affect school performance, you should refer them to the child's school district's Committee on Special Education (CSE) for an evaluation.

For Adolescents

Your assessment of developmental status and psychosocial adjustment needs to include a confidential discussion of peer and family relationships, school/job performance, injury and violence prevention, use of tobacco, alcohol and other drugs, sexual development and activity, HIV, STD and pregnancy prevention, depression/risk for suicide, eating disorders, physical, sexual and emotional abuse, and an evaluation of physical development, including sexual maturity rating (Tanner staging).

Anticipatory Guidance

Anticipatory guidance helps families understand what to expect regarding their child's or adolescent's stage of development. Note: Anticipatory guidance relevant to each age group is available from the Bright Futures guidelines at www.brightfutures.org.

Infancy

Focus on parenting issues including crying, sleep patterns, caring for the child, parental interactions with the child (holding, cuddling, vocalization, etc.), and nutrition (breast/bottle feeding, vitamin supplements, fluoride, table food, etc.).

Provide tips to parents on how to sooth a crying baby: rocking, singing, taking the baby for a walk, and gently rubbing the baby's stomach. Remind parents that – No matter how impatient or angry you feel, never hit or shake your baby.

Advise parents and caregivers to place healthy infants on their backs when putting them to sleep. Encourage mothers to breastfeed and provide appropriate instruction. Early injury prevention should stress the use of child safety car seats, prevention of lead exposure, and the importance of not leaving a child unattended.

As the child crawls and then begins to walk, your instructions in injury prevention should be extended to include protection from falls, burns from hot liquids or food (especially if heated in a microwave oven), electrical outlets, machinery, and poisoning. Emphasize the importance of water safety, providing safe toys, and avoiding infant walkers.

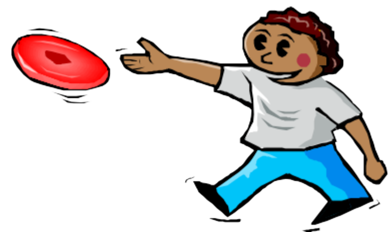
Early Childhood (1-4 years)

As the child becomes a toddler and enters the pre-school years, injury prevention should include such topics as safety stair gates, window guards, burns and scalds, supervised play, strangers and strange dogs, bicycle safety (including proper use of a bicycle helmet), and car safety. Use of child safety seats and, subsequently, seat belts, should be promoted at each visit.

Middle Childhood (5-10 years)

Anticipatory guidance should be addressed to parents or guardians and to children. Discussion of the appropriateness of confidential screening and counseling during adolescence should be introduced.

Anticipatory guidance includes good health habits and hygiene, pedestrian safety and other injury prevention, substance abuse prevention, social interactions and physical activity. Topics such as puberty development, sexuality, prevention of substance abuse (including practicing refusal skills), and academic progress should be discussed.



Adolescence (11-21 years)

Provide confidential screening and counseling to all your adolescent patients. Their parents or guardians should also receive health education at least once during early, mid- and late-adolescence about adolescent growth and development, about parenting style, and about the influence of their setting expectations, monitoring behaviors, and the importance of acting as positive role models.

Adolescent Alcohol and Substance Use and Abuse

The American Academy of Pediatrics has issued policy statements addressing the escalating problems of alcohol and drug use and abuse by children and adolescents. In Alcohol Use and Abuse: A Pediatric Concern: http://pediatrics.aappublications.org/content/108/1/185 AAP recommends the use of the "CRAFFT" substance abuse screening instrument, which is developmentally appropriate for the adolescent and teen-age patient, and which provides a practical means of quickly identifying patients in this age group who will need more comprehensive assessment or referral to substance abuse treatment specialists.

In Indications for Management and Referral of Patients involved in Substance Abuse: https://www.ncbi.nlm.nih.gov/pubmed/10878166, the AAP addresses the patterns of adolescent nicotine, alcohol and drug use, the states of substance abuse, and the criteria for assessment, diagnosis, and referral for evaluation or treatment (Tables 1-4 on this AAP website).

If a youth screens positive for a potential problem for alcohol or drug abuse, they should be referred to a New York State Office of Alcoholism and Substance Abuse Services (OASAS) certified program for a comprehensive assessment.

Please refer to the Resource Section for the OASAS website, which contains reference and referral sites, and OASAS Field Offices.

Other Risks for Adolescents

During adolescence, motor vehicle crashes are a major cause of injury and death. You should stress responsible behavior, both as vehicle driver and passenger. You should provide confidential discussion of behaviors and their medical and psychosocial consequences. You should also provide appropriate counseling including discussion of school performance, growth and sexual development, diet and physical activity, sexual activity, need for contraception, sexually transmitted disease and HIV prevention, pregnancy prevention, tobacco, alcohol and other drug use and abuse, eating disorders, depression and suicide, abuse, and interpersonal violence.

Instruction in testicular self-examination should be provided to adolescent males. Although breast self-examination is not an effective screening test during adolescence, you may choose to provide BSE instruction in order to help adolescent females develop comfort with their bodies or to promote BSE as a preventive habit when they become adults.

Materials from the AMA Guidelines for Adolescent Preventive Services (GAPS) may be helpful in providing adolescents with preventive care strategies.

SECTION 3

Section

3

Section 3 - Suspected Child Abuse and Neglect

Physicians and nurses are among those designated by New York State Law as mandated reporters for suspected maltreatment (neglect) or abuse of a child involving a parent, guardian or someone with formal responsibility for the child. Mandated reporters, which include all health care professionals, should call the **Central Register for Child Abuse and Maltreatment at 1-800-635-1522**. Reports from all other sources should use the following number, **1-800-342-3720**. Reports may also be made to the police.

Mandated reporters must file a signed, written report (DSS-2221A). Forms are available on the New York State Office of Children and Family Services (OCFS) website, http://ocfs.ny.gov/main/cps/default.asp.

For further information regarding identification and reporting of suspected child abuse and maltreatment, please refer to the New York State Office of Children and Family Services website, http://ocfs.ny.gov/main/cps/default.asp. For a *Guide to New York's Child Protective Services System*, check the New York State Assembly website at http://www.assembly.state.ny.us/comm/?sec=post&id=5.

SECTION 4

Section

4

Section 4 - Children and Adolescents with Emotional and Behavioral (Mental Health) Problems

Incidents of tragic adolescent and teen violence, such as at Columbine High School in April 1999, subsequent school shootings, the escalation of teenage drug use, gang violence, and the alarming increase in adolescent and teen suicides (the third leading cause of death for adolescents to 19 years old) [13] have galvanized the medical and psychiatric community as few events have done in the past. The American Academy of Pediatrics (AAP) is leading a coalition of eight provider and family groups, formed in 2000, to explore solutions to inadequate access to mental health care, and also is leading the call for more child mental health resources. The AAP has upgraded their 2001 policy statement: A Renewed Commitment to the Psychosocial Aspects of Pediatric Care to bring newer modalities to the attention of pediatric practitioners.[14]

The information provided in this section has been prepared by a child psychiatrist especially for the busy pediatrician or family practitioner to help you better understand and integrate basic mental health care into your practice, in referring children and adolescents to appropriate mental health practitioners and in coordinating care with those practitioners, if circumstances warrant it.[15]

[13] Monitor on Psychiatry, Volume 31 No. 10, November 2000.

[14] AAP Policy Statement: The New Morbidity Revisited: A Renewed Commitment to the Psychosocial Aspects of Pediatric Care.

[15] James MacIntyre, M.D., Former Clinical Director—Chief of Psychiatry, Bureau of Children and Families, New York State Office of Mental Health

It is important to note that:

- Psychiatric and mental disorders are not uncommon in children and adolescents.
- Children and adolescents with emotional, behavioral and mental health problems are frequently brought to primary care settings for evaluation by their parent(s).
- Some psychiatric disorders in children and adolescents (e.g., anxiety, depression, etc.) can present with physical complaints or vague somatic symptoms.

Role of the Primary Care Physician

Primary care physicians are in an important position to identify emotional, behavioral and psychiatric problems in children and adolescents. Earlier identification of these problems can result in appropriate and effective treatment being provided sooner in the life of the child or teen.

Screening for Emotional and Behavioral Problems in Office Setting

- Numerous tools have been developed for busy office practitioners to screen for emotional and behavioral problems in children and adolescents. These screening tools can save time by focusing the practitioner's areas of inquiry and assist in making a diagnosis and assessment.
- *Bright Futures in Practice: Mental Health Volume 2* (Tool Kit) contains several screening tools (e.g., Pediatric Symptom Checklist), which can be copied and used in the office.

Clinical Considerations when Evaluating Children and Adolescents with Emotional and Behavioral Problems

Note: The following information is based on "Practice Parameters for the Psychiatric Assessment of Children and Adolescents," Journal of the American Academy of Child and Adolescent Psychiatry, 1997, 36:10.

- **Physical/somatic symptoms** - Some psychiatric disorders in children and adolescents (e.g., anxiety, depression, etc.) can present with physical complaints or vague somatic symptoms. For example, sleep and appetite changes, fatigue, decreased energy, pain, headaches, dizziness, palpitations and shortness of breath. It is important that the primary care physician consider emotional problems in the differential when evaluating these physical complaints or symptoms.

- **Working with parents/families** - It is essential that parents be included as part of the evaluation. They are a critical source of information and their perspective on the child's day-to-day life and functioning is vital to your assessment.

- **Evaluating for abuse (all types)** - Any child or adolescent presenting with emotional or behavioral problems should also be carefully evaluated for possible abuse (i.e., emotional, sexual, and physical). Children who are currently suffering abuse as well as children who have been victims in the past frequently have emotional and behavioral problems.

- **Integrating physical health and mental health care** - Children and adolescents with emotional, psychological and behavioral problems also need on-going well-child health care and careful assessment and treatment of any physical illnesses or diseases that develop. Primary care physicians serve a critical role insuring that the child's total healthcare (both physical and mental) is coordinated and integrated.

- **Coordination with other child serving systems and practitioners** - Children and adolescents with emotional and behavioral problems have contact with and often receive services from multiple child serving systems (e.g., child welfare, Family Court, school, etc.) and different practitioners. It is important that primary care physicians are aware of and communicate with these systems and individuals to coordinate the child's overall healthcare.

Components of Psychiatric Evaluation in the Primary Care Office Setting

Office practitioners should conduct their own psychiatric evaluation of a child or adolescent who presents with emotional, psychological or behavioral problems. The following are some "tips" for conducting the psychiatric evaluation:

- Schedule sufficient time to conduct the evaluation.
- Use a framework or structure (see outlines below) to facilitate gathering and organizing relevant information.
- Take time to establish rapport and lessen anxiety or defensiveness with the child, teen and parents.
- Meet with child/teen and parents together to gather information and understand the problem(s).
- Meet with child/teen alone to explore problem areas and assess their mental status - note any differences (information provided, behavior, etc.) from when parent(s) were present.
- Obtain information from other relevant sources (e.g., school, case worker, etc.).
- When the assessment is completed, meet with the child/teen and parents together to discuss the formulation of the problem and any recommendations for intervention, treatment and/or referral.

The following is an outline of the components that should be included in the psychiatric evaluation conducted by a primary care physician:

Psychiatric history

- Identifying data
- Presenting problem
- Past psychiatric history
- Early development
- School performance
- Family history
- Social history
- Medical history
- Drug/alcohol history

Mental status exam

- Appearance
- Behavior
- Doctor-patient relationship
- Mood and affect
- Perceptual processes
- Thought content
- Thought processes
- Orientation
- Intellectual function (estimate)
- Insight and judgment
- Impulse control and frustration tolerance

Assessment/formulation

- Strengths/assets of child and family
- Problems/needs of child and family
- Probable psychiatric diagnoses (DSM-IV)
- Recommendations (e.g., referral, treatment, etc.)

Treating Psychiatric Disorders in Children and Adolescents

Evidence-based outpatient treatments (excluding medications) - The following is a brief summary of the scientific evidence-base (1998) related to outpatient treatments for emotional and behavioral problems:

Well-established/effective treatments:

- **Attention Deficit Hyperactivity Disorder (ADHD)** - Behavioral parent training; Behavioral interventions in classroom
- **Specific Phobia** - Participant modeling; Reinforced practice
- **Disruptive Behavior (Conduct Disorder (CD)/Oppositional Defiant Disorder (ODD))** - Living with children; Videotape modeling

Probably efficacious treatments:

- **Depression** - Self-control (children); Coping with depression (adolescents); Interpersonal psychotherapy (adolescents)
- **Attention Deficit Hyperactivity Disorder (ADHD)** - Behavioral management training; Behavioral modification in classroom
- **Anxiety** - Cognitive-behavioral treatment (CBT)
- **Specific phobia** - Imaginal and in-vivo desensitization; Live and filmed modeling.
- **Disruptive behavior (Conduct Disorder (CD)/Oppositional Defiant Disorder (ODD))**
  - **Preschool-age:** Delinquency prevention program; Parent-child interaction therapy; Parent training program; Time-out plus signal seat treatment
  - **School age:** Anger coping therapy; Problem solving skills training
  - **Adolescent:** Anger control training; Assertiveness training; Multisystemic therapy (MST); Rational-emotive therapy

Types of Therapies

The following is a listing of some of the different types of psychotherapy which are used with children and adolescents:

- Cognitive-behavioral therapy(CBT)
- Dialectical behavior therapy(DBT)
- Family therapy
- Group therapy
- Interpersonal therapy (IPT)
- Play therapy
- Psychodynamic therapy
- Behavior therapy

Psychiatric Medication

Research continues to be published which supports the careful use of psychiatric medications in children and adolescents for specific disorders and target symptoms (see below). Psychiatric medication should be used along with other mental health services as appropriate.

Using psychiatric medications for children and adolescents:

Role of the primary care physician - Primary care physicians may prescribe psychiatric medication(s) for children and adolescents with emotional and behavioral problems. It is important that the primary care provider coordinate this treatment with appropriate mental health professionals as needed.

Medication evidence-base - The following is a brief summary of the scientific evidence-base (2002) related to medications for emotional and behavioral problems:

Strong support

- Stimulants for Attention Deficit Hyperactivity Disorder (ADHD)

Moderate support

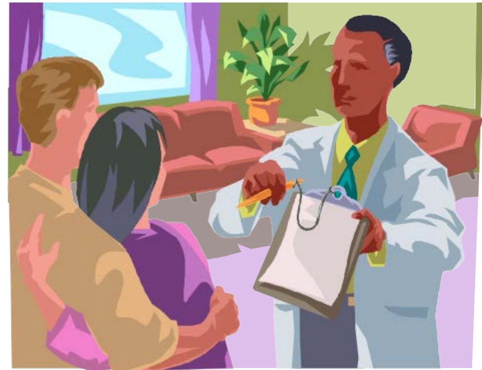
- Selective Serotonin Re-uptake Inhibitors (SSRI) antidepressants for Depression, Anxiety, and Obsessive-Compulsive Disorder (OCD)
- Antipsychotics for autism/Pervasive Developmental Disorder (PDD)
- Antipsychotics, mood stabilizers, stimulants for Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD)

Weak support

- Lithium for Bipolar Disorder
- Antipsychotics for Tourette's Disorder

Informed Consent

Primary care physicians must always obtain fully informed consent from the parent(s) when prescribing any psychiatric medication. This process should include a discussion with the parent and child/teen as well as providing them with printed information about the medication. Physicians should also obtain assent (agreement) from any adolescent about taking the medication(s).



Cautions

1. Physicians should not prescribe any psychiatric medication until they have completed their own clinical assessment.

2. Patients should be followed regularly.

3. Physicians should regularly monitor the clinical effectiveness of the medication(s).

4. Physicians should regularly check for side effects and/or adverse reactions or effects related to the medications(s).

Coordination of care - Primary care physicians who are prescribing psychiatric medication(s) must maintain regular communication with the child/teen's treating mental health professional to assure coordination of care.

Accessing Mental Health System and Practitioners (Referrals)

Making Referrals

Successful referrals of a child, adolescent, family to a mental health practitioner by a primary care physician require thought and planning. The following outline should be used as a guide:

a. Conduct psychiatric evaluation of child/teen.

b. Option - Discuss case with mental health colleague.

c. Option - Counsel the patient and/or parent(s) yourself.

d. Anticipate the child, adolescent and parents' concerns (worries, resistance, etc.) about the referral.

e. Present the referral to the patient and parent(s) and discuss their concerns.

f. Do not make the first appointment with the mental health professional - it is very important that the parent(s) are responsible and make the appointment.

g. Discuss the mental health referral and treatment at future visits or by phone.

Referral Options/Resources

- **Types of mental health practitioners in office practice** - There is a variety of mental health practitioners. Communities across New York have differing numbers of the following licensed practitioners: child and adolescent psychiatrists; psychiatrists; psychologists; and social workers. All of these types of practitioners conduct comprehensive psychiatric evaluations and all provide one or more types of psychiatric treatment referred to previously. However, only physicians (child and adolescent psychiatrists, psychiatrists) can prescribe medications.

- **Releases of information/confidentiality** - In view of the importance of privacy and confidentiality for patients and families, mental health practitioners require that the parent(s) give permission for the exchange of information with the primary care physician.

- **Adolescents** - In order to engage teens in psychiatric treatment it is vital that the mental health practitioner respects their privacy and the confidentiality of all discussions with the teen. However, this must be balanced with a duty to keep the parents involved and reasonably informed about the treatment.

Helpful Tools and Resources

The AAP has taken another major step in building partnerships to improve children's mental health by sponsoring and promoting the *Bright Futures Mental Health Guide*, a two-volume set. Volume 1 contains developmental chapters and bridge topics. Volume 2 is a tool kit containing screening measures and questionnaires, resource lists and interactive handouts, all of which can be copied for use in your practice, www.brightfutures.org. The Bright Futures Mental Health Guide is also strongly endorsed by the National Institute for Health Care Management (NICHM).

There is an abundance of other resources to assist you and your practice clinicians as you work to foster optimum psychosocial aspects of pediatric care for your patients. Please check the Resources Section of the Manual.

S E C T I O N 5

Section

5

Section 5 - Special Populations

The following special populations have been singled out as having conditions or circumstances deserving special attention, due to prevalence of the condition or to availability of specific treatment guidelines for the condition.

Children Infected with HIV

Since the mid-1990s, significant changes have occurred in the pediatric HIV epidemic in New York, including a dramatic reduction in the number of infants born with HIV infection and a shift from an acute, terminal illness to a chronic illness model. These changes are the result of early identification of HIV infection in pregnant women and newborns, antiretroviral therapy to prevent perinatal transmission and new drug regimens to treat children living with HIV infection.

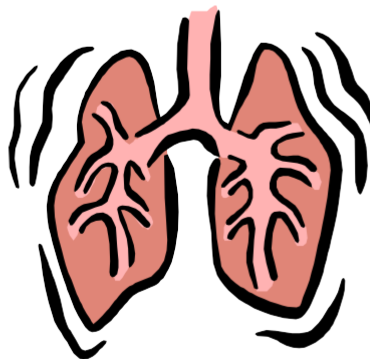
Since the identification of HIV-exposed infants and the documentation of HIV infection are critical priorities in the care of HIV-positive children, HIV screening of all infants born in New York began in 1997 through the Newborn Screening Program. The earlier the diagnosis of HIV infection, the better the prognosis. Provision of appropriate care in the early stages will improve the child's chances of a longer and better quality life. Most children living with HIV in New York are school age, and encounter many of the issues other chronically ill children encounter. Rapid changes in recommendations for HIV therapy require that you refer to, and coordinate the care of your HIV-positive patients with, appropriate Pediatric HIV Specialists.

Questions about HIV screening, testing, diagnosis and treatment are addressed by the New York State Department of Health AIDS Institute's Pediatric & Adolescent HIV Guidelines, www.hivguidelines.org, click on Clinical Guidelines.

Children with Asthma

Asthma is a serious public health problem in New York and the nation. Here are some compelling statistics:

- Asthma affects over 250,000 children in New York.[16]
- Asthma caused an average of 358 deaths per year in New York during 1998- 2000, including 12 deaths in children 0-14 years of age.[17]
- New York residents had an average of 42,725 asthma hospitalizations per year during 1998-2000.[18] Asthma hospitalizations for children between ages 0-17 averaged 16,539 per year for a rate of 35.3 per 10,000.[3] In the 0-4 age group, hospitalization rates were 72.1 per 10,000.[3] Asthma hospitalization rates are higher among poor inner city populations.
- Total Medicaid health care expenditures for recipients with asthma in New York State exceeded $1 billion in fiscal year 2000.[19]
- Asthma takes its toll in many ways. Asthma is the leading cause of school absenteeism. Asthma results in many lost nights of sleep and disruption of activities for the child, as well as his or her family. Parents frequently miss days from work as a result of their child's asthma.



[16] New York State extrapolated dated based on national CDC asthma attack rates for children under 18
[17] New York State Department of Health, Bureau of Biometrics, Vital Statistics
[18] New York State Department of Health, Statewide Planning and Research Cooperative System (SPARCS)
[19] Claim Detail/Special Reporting System, New York State Department of Health, Office of Medicaid Management

The good news is that asthma can be controlled. Good control means that patients with asthma have:

- Minimal or no chronic symptoms.
- Minimal or no exacerbations.
- No emergency room visits or hospitalizations.
- Minimal or no need for $Beta_2$ Agonist.
- No limitations on activities, including exercise.
- No school or work missed.
- PEF circadian variation of less than 20%.
- Near normal PEF (greater than or equal to 80% of personal best).
- Minimal or no adverse effects from medications.

Role of primary care physicians - Primary care physicians, their staff and their links to community organizations play a crucial front line role in controlling asthma. Establishing effective partnerships between physicians/providers and families, and utilizing evidence-based interventions produces better patient outcomes.

Asthma Guidelines

New York State Department of Health Clinical Guidelines for the Diagnosis, Evaluation, and Management of Adults and Children with Asthma-2003 can be accessed at the NYS DOH website: www.health.ny.gov under asthma. Health care professionals in the New York City area can also access the New York City Department of Health and Mental Hygiene New York City Asthma Partnership (NYCAP) at https://www1.nyc.gov/site/doh/providers/health-topics/asthma-provider-partners.page

The following areas of emphasis for long term control of asthma care and management are based on the 1997 National Asthma Education Prevention Program (NAEPP) Second Expert Panel Report (EPR2), Guidelines for the Diagnosis and Management of Asthma, and subsequently, the NAEPP Expert Panel Report Update (EPR-Update 2002) which updates recommendations for clinical practice on selected topics.

In addition, to improve the implementation of these guidelines, a working group of the Professional Education Subcommittee of the NAEPP extracted key clinical activities that should be considered as essential for preventive, long term asthma care and management, http://www.cdc.gov/mmwr/PDF/rr/rr5206.pdf, in accordance with the EPR-2 guidelines and the EPR-Update 2002.

In the Resource section of this manual, you will find other asthma resources, particularly those that your patients and asthma caregivers will find useful in asthma control and management.

Four Key Components for Long Term Control of Asthma

1. Assessment and monitoring

- Assess and document asthma severity.
- Identify triggers and precipitating factors.
- Assess medication use, knowledge and skill.
- Perform physical exam of upper and lower airways.
- Monitor every six months.
- Consult asthma specialist per recommendations.
- Link to community organizations for patient education, support and care coordinator services.

2. Pharmacological therapy

- Follow Stepwise approach to asthma management.

3. Control factors contributing to asthma severity

- Assess exposure to and clinical significance of irritants and allergens.
- Provide education to reduce exposure and prevent infections.
- Advise to quit smoking and avoid second-hand smoke.

4. Patient education

- Provide basic education on facts about asthma, roles of medications and techniques for using medications, environmental control measures at home, school and work, and personal self-management plan.

- Complete a written Asthma Action Plan. Spanish and English versions are available free at www.health.ny.gov under asthma.

- Link to community agencies that may be able to support patient education as well as home remediation.

Children in Foster Care

Children in foster care are a uniquely disadvantaged and vulnerable group because of the multiple and cumulative adverse events in their lives. Prior to foster care, many of these children lived in poverty with families devastated by substance abuse, mental health disorders, poor education, unemployment, violence, lack of parenting skills, and, sometimes, involvement with the criminal justice system. High rates of premature birth, prenatal drug and alcohol exposure, and postnatal abuse and neglect, as well as inadequate health care, contribute to the poor health status of children in foster care.

Medical providers will be able to achieve more for their patients who are in foster care when they are familiar with the mandates, obligations, and intricacies of the foster care system. Quality, accessible, comprehensive and culturally sensitive health care must be effectively woven into the child welfare system's individual treatment plans for each child placed in foster care, in order to assure his or her future well-being and to support effective permanency planning.

What is Foster Care?

Children are placed into foster care by an order of the Family Court. The Family Court may place children in foster care for a variety of reasons: child abuse, child neglect, or orphaned. Placement may also be initiated voluntarily by the parents. The Family Court can also place persons in need of supervision (PINS, e.g., youth who are beyond parental control) and juvenile delinquents into foster care.

Who Has Custody of the Child?

The Family Court places the child in the custody of the County Commissioner of Social Services for placement in an appropriate foster care setting. The local department of social services (LDSS) appoints a caseworker who is responsible for all aspects of the child's case planning and coordination of care. The LDSS caseworker can be a resource for health care providers who need information about a foster child brought to them for care and treatment.

The State Office of Children and Family Services (OCFS) has primary oversight of children in foster care. OCFS regulations pertaining to foster care contain numerous health requirements, which local departments of social services (LDSS) and voluntary agencies must fulfill. The local social services district or agency with which the child is placed is responsible for explaining to physicians why a child is brought for care and the needs and expectations of the agency or district.

The Foster Home

Children in foster care may be placed in a variety of types of living situations, including homes of relatives, foster boarding homes, group homes, group residences and institutions. Sometimes the LDSS will place a foster child with a voluntary agency that operates its own foster care programs. When a child is placed with a voluntary agency, the LDSS contracts with the voluntary agency to provide needed services to the child. The voluntary agency will often have its own caseworker who is directly responsible for the child's case planning and coordination of services.

Unmet Health Needs

Children entering foster care have multiple unmet health care needs, far exceeding even those of other poor children. Studies of children entering foster care demonstrate high rates of acute and chronic medical problems, including sub-optimal growth, vision and hearing problems, dental caries, developmental delays, education disorders, and mental health problems.

Special Health Care Requirements

New York State regulations require agencies responsible for children in foster care to obtain a comprehensive medical examination within 30 days of admission into care. Ideally this would include a medical history and physical examination, screening tests appropriate for age and background of the child, formal developmental assessment, mental health assessment and examination by a dentist. For children age 10 years and older (younger when specifically indicated), also assess for use of alcohol, tobacco, and other harmful drugs. (As is the case for the non-foster care population, the first routine preventive oral examination by a dentist should occur within 6 months of the eruption of the first primary tooth, and no later than age 12 months. See Section 2 – *Oral Health Supervision* for further guidance related to routine preventive dental care.)

Due to multiple factors previously described, foster care children have higher incidence of, and are at increased risk for various health problems. Therefore, the primary care provider for a foster child should go beyond the basic requirements of the AAP Guidelines and periodicity schedule. Appropriate referrals should be made, in order that children in foster care obtain necessary developmental, mental health, dental, and substance abuse assessments.

Establishment of a medical home for each foster care child is another important goal which can serve to assure continuity of care and follow-through on referrals for evaluation and treatment recommendations.

Consent for Care

It is important for medical providers who care for children in foster care, to understand the delegation of responsibility for medical consents for these children. **Foster parents and kinship foster parents are *not* legally authorized to sign consents for medical care.** Generally, the birth parent/legal guardian retains the right to consent for their child's care and, if at all possible, it is important for the parent/legal guardian to be involved in all medical decisions related to the child. The following points are an overview of consent issues:

- Voluntary agencies and local departments of social services must make an attempt within 10 days of placement to obtain parental/legal guardian consent for routine and urgent care. A copy of this consent should be provided to emergency rooms (as needed) and the child's primary care physician.

- If the birth parents are not available, cannot be found, or have had their parental rights terminated, the local Commissioner of Social Services has the right to sign consents for routine and urgent care (New York State Social Services Law 383- b).

- For pre-planned medical care that is neither routine nor urgent, the birth parent or legal guardian should provide consent after consultation with the practitioner. Some counties may require consent of the County Commissioner of Social Services as well as the parent.

- If the birth parents/legal guardians are not available, cannot be found, or have had their parental rights terminated, the County Social Services Commissioner has the right to consent for pre-planned care.

- If the birth parents/legal guardians refuse to sign consents for pre-planned care that is necessary for the wellbeing of the child, the County Commissioner of Social Services may consent for the care.

Consent for Care (cont.)

Exceptions to the aforementioned medical consent guidelines: Under some specific circumstances, foster care minors may provide consent for their own health care, and for that of their children. (This also applies to minors *not* in foster care.) See the Resource Section of this manual for information on how to obtain a resource related to minors' ability to consent for health care titled: *Teenagers, Health Care & The Law, A Guide to the Law On Minors' Rights In New York State*. This NYCLU publication is also available at: http://www.nyclu.org/files/thl.pdf .

AAP Manual: Fostering Health – Health Care for Children in Foster Care

The Task Force on Health Care for Children in Foster Care of the American Academy of Pediatrics, District II (New York State) has developed a manual, *Fostering Health: Health Care for Children in Foster Care*, which provides detailed guidelines for the care of foster children. Copies of this manual may be ordered via the AAP Bookstore located on the AAP website, https://www.aap.org/en-us/Pages/Default.aspx, or by phoning 800-433-9016.

NYS OCFS Manual: Working Together – Health Services for Children in Foster Care

OCFS has also prepared a manual intended to assist and advise foster care and health services staff in the local departments of social services and in child care agencies that care for many foster care children. This manual is entitled *Working Together: Health Services for Children in Foster Care.* You can access it on the OCFS website: http://ocfs.ny.gov/main/ by typing *Working Together* into the website search function. It contains a wealth of information that could be helpful to you if you service children in foster care. For example, this resource further expands upon the overview of foster care related consent issues presented earlier. Additionally, it includes a section on minors' ability to provide consent for health care under specific circumstances.

Children with Diabetes

Presently, type 1 diabetes is the second leading childhood chronic disease affecting at least 13,000 children in New York. The majority of children with diabetes have type 1, but the incidence of type 2 diabetes is increasing. Currently, there are no reliable estimates of the prevalence of type 2 diabetes among children in New York State. Pediatric endocrinologists are reporting more type 2 diabetes in children and adolescents.

Upwards of 15% of U.S. children are now overweight and recently the U.S. Surgeon General declared obesity an epidemic in children. The medical community agrees – the more overweight children become, the greater the chance they have of developing type 2 diabetes. Those most at risk include children of Native American, African American, Hispanic, and Asian/Pacific Islander origins.

Primary care providers should encourage lifestyle modifications that might delay or prevent the onset of type 2 diabetes, particularly in those children at high risk for developing this endocrine disease.

Focus on:

- weight management
- increasing physical activity

The above information was excerpted from New York State Strategic Plan for the Prevention and Control of Diabetes.

The American Diabetes Association's Consensus Panel, which included representation from the American Academy of Pediatrics recommended the following screening protocol for youth deemed at high risk for type 2 diabetes. [1]

Testing for Type 2 Diabetes in Children[1]

- Criteria *

Overweight (BMI greater than 85th percentile for age and sex, weight for height greater than 85th percentile, or weight greater than 120% of ideal for height)

PLUS any two of the following risk factors:

- Family history of type 2 diabetes in first- or second-degree relative.
- Race/ethnicity (American Indian, African-American, Hispanic, Asian/Pacific Islander).
- Signs of insulin resistance or conditions associated with insulin resistance (acanthosis nigricans, hypertension, dyslipidemia, PCOS).

Age of initiation: age 10 years or at onset of puberty if puberty occurs at a younger age.
Frequency: every 2 years.
Test: FBG preferred.

*Clinical judgment should be used to test for diabetes in high-risk patients who do not meet these criteria.

Diabetes Resources

- Further information for families can be found online at: http://www.health.ny.gov/diseases/conditions/diabetes/index.htm
- Additional diabetes information is available at: http://www.niddk.nih.gov/ and http://www.diabetes.org.

[1] PEDIATRICS Vol. 105 No. 3 March 2000, pp. 671-680

S E C T I O N 6

Section

6

Section 6 - Resources for Practitioners and Families

PLEASE NOTE: Links to other internet sites are provided here and throughout the manual, only for the convenience of our users. The New York State Department of Health (NYS DOH) is not responsible for the availability or content of these external sites, nor does the NYS DOH endorse warrant or guarantee the products, services or information provided at the other internet sites.

Every effort has been made to verify the accuracy of web sites and phone numbers as of the date of printing. We regret any errors.

Special Health Care Programs and Resources

Medicaid Home and Community-Based Services (HCBS) Waivers for Children

For eligible children and adolescents, Medicaid waiver programs allow Medicaid to pay for some services not normally provided in the New York State Medicaid benefit package in order to facilitate keeping children in their local community and out of institutional placement. All waiver program children are eligible for Medicaid services. Additional eligibility requirements may apply. (NYS DOH, http://www.health.ny.gov, NYS OMH, https://www.omh.ny.gov/, and NYS OPWDD, https://opwdd.ny.gov/, websites have additional information on Medicaid HCBS Waivers.)

HCBS/Office for People with Developmental Disabilities (OPWDD)

- **Waiver Eligibles:** any age, developmentally disabled, meet Intermediate Care Facility (ICF)/MR level of care, may or may not be eligible for Medicaid.
- **Waiver Services:** all Medicaid services plus care planning, pre-vocational services, supported employment, adaptive devices, environmental modifications, respite care, family education and training.
- **Contact:** nearest local Developmental Disabilities Services Office (DDSO).

HCBS/Office of Mental Health (OMH)

- **Waiver Eligibles:** age 5-17 years, serious emotional disturbance, multiple/complex health care needs, otherwise eligible for institutional level of care, can be cared for in home or community, need services from multiple agencies, may or may not be eligible for Medicaid.
- **Waiver Services:** all Medicaid services plus individualized care coordination, family support, crisis response, skill building, intensive in- home care, respite care.
- **Contact:** local county department of mental health.

HCBS/Traumatic Brain Injury (TBI)/Department of Health (DOH)

- **Waiver Eligibles:** age 18-64 years, diagnosed with TBI or related condition, injury/condition occurred after age 18 years, eligible for nursing facility placement, able to be served under TBI Waiver in living arrangement meeting individual's needs outside institutional setting, enrolled in Medicaid.
- **Waiver Services:** all Medicaid services, service coordination, independent living skills and development, structured day programs, substance abuse programs, intensive behavioral programs. Eligible for housing subsidy under certain conditions.
- **Contact:** DOH TBI Regional Resource Centers.

Care at Home (CAH) I and II/Department of Health (DOH)

- **Waiver Eligibles:** under age 18 years, meet SSI criteria for physical disability, had a 30-day hospital stay, require skilled nursing care, *ineligible for Medicaid* due to their parents' income and resources.
- **Waiver Services:** all Medicaid services, as well as: case management, respite, home and vehicle modifications.
- **Contact:** Care at Home Coordinator at local department of social services, in NYC - (212) 360-5444.

Care at Home III, IV and VI/Office for People with Developmental Disabilities (OPWDD)

- **Waiver Eligible:** under age 18 years, meet SSI criteria for disability, have a developmental disability, have complex healthcare needs, ineligible for Medicaid due to their parents' income and resources.
- **Waiver Services:** all Medicaid services, as well as: case management, respite, assistive technology.
- **Contact:** Care At Home Coordinator at nearest local Developmental Disabilities Services Office (DDSO).

Long Term Home Health Care (LTHHC)/Local Certified Home Health Agencies (CHHAs)/ Department of Health (DOH)

- **Waiver Eligibles:** any age, meet criteria for care in Residential Health Care Facility (RHCF), choose to receive services at home, meet local and regional income and resource allowances, eligible for and in receipt of Medicaid.

- **Waiver Services:** all Medicaid services, case management by RNs, home-delivered meals, housing improvements, respiratory therapy, medical social services, nutrition and dietary services, respite care, social day care, moving assistance, social transportation, congregate meals.

- **Contact:** local county health department for information and referral.

Children with Special Health Care Needs Program (CSHCN) Including Physically Handicapped Children's Program (PHCP)

- **Program Goal -** To achieve a statewide system of care for CSHCN and their families that links them to appropriate health and related services, identifies gaps and barriers and assists in their resolution, and assures access to quality health care.

- **Eligibility –** CSHCN are children 0-21 years who have or are suspected of having a serious or chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. Eligibility is determined by the county health units.

- **Description –** The Children with Special Health Care Needs (CSHCN) Program is a state public health program that provides information and referral services for health and related services for families of CSHCN. Most, but not all, counties administer a CSHCN program. In addition some of the local CSHCN programs offer case management.

- **For Information –** Call the New York State Health Department's Growing Up Healthy Hotline, 1-800-522-5006; or contact your local county health department.

NYS web site: Resource Directory for Children with Special Health Care Needs
http://www.health.ny.gov/nysdoh/child/special_needs/resource_directory.htm

Early Intervention (EI)

- For contact information on referral for EI services in your locality, you can call:
    - NYS Growing Up Healthy 24-hour hotline at 1-800-522-5006
    - New York City, call 311 and say that you want to refer a child to the EIP
    - NYS contacts for EI Program, (518) 473-7016

- **State web sites:**
    - Clinical Practice Guidelines: *Autism/Pervasive Developmental Disorders, Assessment and Intervention for Young Children (age 0-3)*:
        - Report of the Recommendations (available on DOH website) http://www.health.ny.gov/nysdoh/eip/index.htm.
        - Quick Reference Guide for Parents and Professionals
        - The Guideline Technical Report

    - Clinical Practice Guidelines: *Communication Disorders: Assessment and Intervention for Young Children (Age 0-3)*:
        - Report of Recommendations (available on DOH website) http://www.health.ny.gov/nysdoh/eip/index.htm
        - Quick Reference Guide for Parents and Professionals
        - The Guideline Technical Report

To order hardcopy of all of the above Clinical Practice Guidelines, as well as other useful early intervention publications (free of charge): http://www.health.ny.gov/community/infants_children/early_intervention/memoranda.htm.

Committees on Special Education (CSE) and Related Preschool and School Supportive Health and Special Education Services

See *Monitoring Child Development* in Section 2 of this EPSDT/CTHP Provider Manual for discussion on referring youth to the early intervention program, and to committees on preschool and school special education, when there is a suspected or established developmental delay or disability.

- For more detailed information on CSE processes, related services, and transitioning from the Early Intervention Program to the Preschool Special Education Program, see *Special Education in New York State for Children Ages 3-21, A Parent's Guide May 2002*, http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm.

Mental Health

Local mental hygiene directors can provide you with information on mental health treatment and support services that are available in each locality. This includes contact information related to Single Point of Access (SPOA), and a related (and in some counties overlapping) initiative, Coordinated Children's Services Initiative (CCSI).

New York State Office of Mental Health (NYS OMH) asked each locality in New York State to designate a SPOA for Children and Families. The purpose of the SPOA is to identify those children with the highest risk of placement in out-of-home settings and to develop appropriate strategies to manage those children in their home communities. See the NYS OMH website https://www.omh.ny.gov/ for further information about SPOA. CCSI processes have a cross-systems focus, and CCSI was initiated to better serve children with special emotional and behavioral service needs who also have complex needs that span other service delivery systems, such as physical health, education, mental retardation/developmental disability, chemical dependency, foster care, and juvenile justice service systems. For further information about CCSI see: http://ccf.ny.gov/council-initiatives/council-archives/coordinated-childrens-services-initiative-ccsi/. Primary care providers and relevant subspecialty providers can improve coordination of health care by actively participating in SPOA and CCSI processes.

You can contact the local government unit/county mental health director for information on mental health services and supports. (Some services/supports may vary by county.) For a complete listing of contacts, visit the New York State Office of Mental Health's (OMH) web site at: http://www.clmhd.org/contact_local_mental_hygiene_departments/

- **New York State OMH web site:**
  - https://www.omh.ny.gov/
  - School Violence Prevention/State and National Resources, Community Programs, https://www.omh.ny.gov/omhweb/sv/SchlViol.htm

- **Private web sites:**
  - American Academy of Child and Adolescent Psychiatry, http://www.aacap.org
  - Bright Futures, http://www.brightfutures.org
  - American Psychological Association, www.apa.org
  - American Academy of Pediatrics (AAP), www.aap.org

- The Pediatric Development and Behavior homepage (endorsed by the AAP, MCHB and HRSA), including a downloadable Pediatric Symptom Checklist (PSC),https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/sodbp/Pages/default.aspx

- **Federal web site:**
  - Mental Health services locator, www.mentalhealth.org/databases/default.asp

Chemical Dependency

For chemical dependency services (alcohol and substance abuse services) information in your locality, call:

- The New York State (NYS) Office of Alcohol and Substance Abuse (OASAS) hotline, 1-800-522-5353;
- NYS OASAS General Information, (518) 473-3460;
- NYS OASAS Client Advocacy Line, 1-800-553-5790; or
- Call the OASAS Regional Field Offices listed on the next page.
- NYS OASAS web site, https://www.oasas.ny.gov/
- Federal web site: Substance Abuse and Mental Health Services Administration (SAMHSA):
    - Substance abuse facility locator, https://findtreatment.samhsa.gov/locator/home

OASAS Regional Field Offices

Upstate Field Operations: 1450 Western Ave., Albany, NY 12203-3526, (518) 485-1660
Downstate Field Operations: 501 7th Ave., New York, NY 10018, (646) 728-4533

Upstate Directory	Address/Phone	Counties Served
Western:	1021 Main Street Buffalo, New York 14203-1016 (716) 885-0701	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming
Finger Lakes	109 South Union Street, Suite 400 Rochester, New York 14607-1893 (585) 454-4320	Broome, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Yates
Central	J.H. Hughes State Office Building, Room 546 333 East Washington Street Syracuse, New York 13202-1422 (315) 428-4113	Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence
Northeastern	1450 Western Avenue Albany, New York 12203-3526 (518) 485-1660	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington
Mid-Hudson	1450 Western Avenue Albany, New York 12203-3526 (518) 485-1484	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester
Downstate Directory		
Bronx	501 7th Avenue New York, New York 10018 (646) 728-4539	Bronx
Upper Manhattan	501 7th Avenue New York, New York 10018 (646) 728-4566	Upper Manhattan
Lower Manhattan	510 7th Avenue New York, New York 10018 (646) 728-4561	Lower Manhattan
Brooklyn	501 7th Avenue New York, New York 10018 (646) 728-4546	Brooklyn
Queens/Staten Island	501 7th Avenue New York, New York 10018 (646) 728-4595	Queens, Staten Island
Long Island	Pilgrim Psychiatric Center NYS OASAS Field Office 998 Crooked Hill Road West Brentwood, New York 11717 (631) 434-7263	Nassau, Suffolk

Developmental Disabilities

NYS Office of Mental Retardation and Developmental Disabilities web site: http://www.omr.state.ny.us

Local Developmental Disabilities Services Offices (DDSO) can provide you with information on local services to developmentally disabled individuals.

Bernard Fineson DDSO	80-45 Winchester Blvd. Building 12 Queens Village, NY 11427	P (718) 217-4242 F (718) 217-4724	Queens
Brooklyn DDSO	888 Fountain Avenue Brooklyn, NY 11208	P (718) 642-6000 F (718) 642-6282	Kings
Broome DDSO	249 Glenwood Road Binghamton, NY 13905	P (607) 770-0211 F (607) 770-8037	Broome, Chenango, Delaware, Otsego, Tioga & Tompkins
Capital District DDSO	Oswald D. Heck Developmental Center Balltown & Consaul Roads Schenectady, NY 12304	P (518) 370-7370 F (518) 370-7401	Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren & Washington
Central NY DDSO	101 West Liberty Street Rome, NY 13442	P (315) 336-2300 F (315) 339-5456	Cayuga, Cortland, Herkimer, Lewis, Madison, Onondaga, Oneida & Oswego
Finger Lakes DDSO	620 Westfall Road Rochester, NY 14620	P (585) 461-8500 F (585) 461-0618	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Wyoming & Yates
Hudson Valley DDSO	Administration Building 2 Ridge Road P. O. Box 470 Thiells, NY 10984	P (845) 947-6000 F (845) 947-6004	Westchester, Orange, Rockland & Sullivan
Long Island DDSO	45 Mall Road Commack, NY 11725	P (631) 493-1700 F (631) 493-1803	Nassau & Suffolk
Metro NY DDSO	75 Morton Street New York, NY 10014	P (212) 229-3000 F (212) 924-0580	Bronx & Manhattan
Staten Island DDSO	1150 Forest Hill Road Staten Island, NY 10314	P (718) 983-5200 F (718) 983-9768	Richmond
Sunmount DDSO	2445 State Route 30 Tupper Lake, NY 12986-2502	P (518) 359-3311 F (518) 359-2276	Clinton, Essex, Franklin, Hamilton, Jefferson & St. Lawrence
Taconic DDSO	26 Center Circle Wassaic, NY 12592	P (845) 877-6821 F (845) 877-9177	Columbia, Dutchess, Greene, Putnam & Ulster
Valley Ridge DDSO	Serving individuals with intensive needs statewide.	P (607) 337-7000	
Western NY DDSO	1200 East & West Road West Seneca, NY 14224	P (716) 674-6300 F (716) 674-7488	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara & Orleans
Institute for Basic Research in Developmental Disabilities	1050 Forest Hill Rd Staten Island, NY 10314	P (718) 494-0600 F (718) 698-3803	

HIV/AIDS

For contact information for HIV/AIDS treatment and immunizations protocols and linkage to HIV/AIDS specialists to manage or co-manage HIV/AIDS treatment, you can call:

- NYS AIDS General Information Hotline, 800-541-AIDS
- NYS AIDS, Spanish-speaking, Hotline, 800-233-7432
- NYS website: http://www.hivguidelines.org

For information on testing and local services for persons living with HIV/AIDS and their families, and counseling on HIV/AIDS epidemiology and prevention:

Roswell Park,

- information on HIV/AIDS testing and local services,800-541-2437
- counseling on HIV/AIDS epidemiology and prevention, 800-872-2777

Lead Poisoning Prevention

- NYS (518) 473-4602
- NYC Hotline, (212) BAN-LEAD
- NYS web sites:
  - Lead Poisoning Curriculum for Preschool Children and their Families, http://www.health.ny.gov/nysdoh/environ/lead.htm

Regional Lead Centers:

- **Erie County Medical Center:** WNY Regional Lead Resource Center, 462 Grider Street, Buffalo, New York 14215. Telephone: (716) 898-3363
- **Long Island Regional Poison Control Center at Winthrop University Hospital:** 259 First Street, Mineola, New York 11501. Telephone (516) 542-2323

- **Montefiore Medical Center:** Division of Environmental Sciences, Lead Program, Albert Einstein College of Medicine, 111 East 210th Street, Bronx, New York 10467. Telephone (718) 547-2789
- **Pediatric Medical Services at State University of New York/Health Science Center:** Department of Pediatrics, 750 East Adams Street, Syracuse, New York 13210. Telephone: (315) 464-5450
- **University of Rochester:** Rochester General Hospital, Department of Pediatrics/MOB, 1425 Portland Avenue, Suite 300, Rochester, New York 14621- 3095. Telephone: (585) 922-4028
- **Albany Medical College:** Regional Lead Resource Center, 43 New Scotland Avenue, Suite MC88, Albany, New York 12208. Telephone: (518) 262-5952
- **Children's and Women's Physicians of Westchester, LLP, New York Medical College:** Division of Endocrine and Metabolic Medicine, Munger Pavilion, Subbasement Room B42, Valhalla, New York 10595. Telephone: (914) 594-3838.

Diabetes

NYS DOH web sites:

- Diabetes Control Program publications - 1) Children with Diabetes, A Resource Guide for Families of Children with Diabetes and 2) Children with Diabetes, A Resource Guide for Schools, http://www.health.ny.gov/diseases/communicable/
- Diabetes in New York State – Department of Health Diabetes Program http://www.health.ny.gov/nysdoh/consumer/diabetes/condiab.htm

Smoking Cessation

New York State Tobacco Use Prevention and Control Program

- Deaf/Hearing Impaired Quit line, 800-280-1213
- New York State Smoker's Quit line, 866-697-8487
- NYS Smoker's Quit site: http://www.nysmokefree.com

Asthma

NYS web sites:

- Department of Health Clinical Guidelines for the Diagnosis, Evaluation, and Management of Adults and Children with Asthma-2003, http://www.health.ny.gov/nysdoh/asthma/index.htm.
- Regional Asthma Coalitions, http://www.health.ny.gov/nysdoh/asthma/contact.htm
- Free Asthma Action Plan and Informational Materials, http://www.health.ny.gov/nysdoh/asthma/brochures.htm

Federal Government web site:

- MMWR Recommendations and Reports, April 12, 2002: "Prevention and Control of Influenza, Recommendations of the Advisory Committee on Immunization Practices (ACIP)" (includes asthma-related guidelines), http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5103a1.htm

Private web sites:

- National Heart, Lung and Blood Institute (NIH), Division of Lung Diseases, Two Rockledge Center, Suite 10122, 6701 Rockledge Drive MSC 7952, Bethesda, Maryland 20892-7952; http://www.nhlbi.nih.gov
- **Guidelines for the Diagnosis and Management of Asthma** (includes 1997 National Asthma Education and Prevention Program (NAEPP) Expert Panel Report 2; with 2002 Update); http://www.nhlbi.nih.gov/guidelines/asthma/index.htm
- Global Initiatives for Asthma (project conducted in collaboration with NIH); http://www.ginasthma.com
- Asthma-NYC.org (New York City Asthma Information Outreach Project), http://www.asthma-nyc.org
- National Jewish Medical and Research Center-Ranked #1 Respiratory Hospital in America; 1400 Jackson Street, Denver, Colorado 80206; Lung- line: 800-222-LUNG; www.njc.org
- Mothers of Asthmatics (Allergy and Asthma Network Mothers of Asthmatics) (AANMA); 2751 Prosperity Avenue, Suite 150, Fairfax, Virginia 22031; phone, 1-800-878-4403; fax, (703) 573-7794; http://www.aanma.org
- American Lung Association, National Office; 61 Broadway, 6th Floor, New York, New York 10006; phone, (212) 315-8700; http://www.lungusa.org
- American Lung Association of New York State; http://www.alanys.org
- American Academy of Allergy, Asthma and Immunology (AAAAI), 611 East Wells Street, Milwaukee, Wisconsin 53202; phone, (414) 272-6071. Patient information and Physician Referral Line: 800-822-2762; http://www.aaaai.org

- American College of Allergy, Asthma and Immunology; http://www.acaai.org
- American Thoracic Society; http://www.thoracic.org
- American College of Chest Physicians; http://www.chestjournal.org

Immunization Program

New York State Vaccines for Children (VFC) Hotline, 800-KID-SHOTS

- Upstate Immunization Registries, NYS contact, (518) 473-4437
- NYC Citywide Immunization Registry (CIR), NYC contact, (212) 676-2323

FIELD OFFICES	COUNTIES	
Capital District Regional Office 1 Fulton Street Troy, New York 12180 (518) 408-5278 fax (518) 402-0422	Albany Clinton Columbia Delaware Essex Franklin Fulton Greene Hamilton	Montgomery Otsego Rensselaer Saratoga Schenectady Schoharie Warren Washington
Central New York Regional Office, NYSDOH 217 S. Salina Street, 3rd Floor Syracuse, NY 13202 (315) 477-8164 fax (315) 477-8581	Broome Cayuga Chenango Cortland Herkimer Jefferson Lewis	Madison Oneida Onondaga Oswego St. Lawrence Tioga Tompkins
Rochester Field Office Triangle Building, 335 East Main Street Rochester, NY 14604-2127 (585) 423-8014 fax (585) 423-8108	Chemung Livingston Monroe Ontario Schuyler	Seneca Steuben Wayne Yates
Western Regional Office, Buffalo 584 Delaware Avenue, 2nd Floor Buffalo, NY 14202-1202 (716) 847-4385 fax (716) 847-4333	Allegany Cattaraugus Chautauqua Erie	Genesee Niagara Orleans Wyoming
New Rochelle Field Office 145 Huguenot Street New Rochelle, NY 10801-5228 (914) 654-8236, (914) 654-7194 fax (914) 654-8249 **Monticello Field Office** 50 North Street, Suite 2 Monticello, NY 12701-1711 (845) 794-2045, fax (845) 794-3165	Dutchess Orange Putnam Rockland	Sullivan Ulster Westchester
Central Islip Office Courthouse Corporate Center 320 Carleton Avenue, Suite 5000 Central Islip, NY 11722 (631) 851-3081, (631) 851-4315 fax (631) 851-4319	Nassau Suffolk	
Metropolitan Area Regional Office (MARO) 90 Church Street, 13th floor New York, NY 10007 (212) 417-4918, (212) 417-4917 fax (212) 417-4909	New York Bronx Kings Queens Richmond	

Dental

Private web sites:

- American Academy of Pediatric Dentistry (AAPD) Caries risk-Assessment Tool (CAT) - http://www.aapd.org/members/referencemanual/pdfs/02-03/Caries%20Risk%20Assess.pdf
- The American Academy of Pediatrics (AAP) statement: *Oral Health Risk Assessment Timing and Establishment of the Dental Home* - http://www.aap.org/policy/s040137.html

Local Departments of Social Services (LDSS)

(See the County Government Section of your local telephone directory, or go to the New York Public Welfare Association (NYPWA) web site, http://www.nypwa.com/General/ssdistricts.htm)

- For participating Medicaid providers (e.g., fee-for-service physicians, specialists or dentists) and assistance with scheduling appointments, please ask for the Director of Medical Assistance.
- For information on the Medicaid managed care program and participating providers, contact the LDSS Managed Care Coordinator or call: 800-505-5678 (NYC only).
- For information on services to **PREVENT** child abuse and neglect, ask for the Director of Services. (See New York State Government Resources – Office of Children and Family Services (OCFS) for Child Abuse Hotline numbers **to report child abuse**.)
- Medicaid-reimbursed transportation services, ask for the Transportation Coordinator.

Local Departments of Health (LDOH)

(See the County Government Section of your local telephone directory, **OR** go to the New York State Association of County Health Officials (NYSACHO) web site, http://www.nysacho.org (Click on directory to access map-based listings of staff in each county and NYC Health Department.))

- Reporting and treatment protocols for communicable diseases (e.g., sexually transmitted diseases (STDs), tuberculosis (TB), rabies).
- Public health services for the uninsured (e.g., tuberculosis and other public health services).
- Environmental lead investigations for children with elevated blood levels.
- Referral services for children with special health care needs (CSHCN) who have one or more conditions that are physically disabling or chronic to impede normal growth and development.
- Consumer outreach and education.
- Available home health care services (nursing; physical, occupational and speech-language pathology therapy).

New York State Government Resources

Department of Health (DOH)

Homepage - http://www.health.ny.gov

EPSDT (also known as the CTHP) Program, and comments on this Manual
Bureau of Maternal and Child Health,
Office of Medicaid Management (518) 486-6562

Growing Up Healthy

- 24-hour hotline 800-522-5006
- New York City 800-577-2229

Judicious Use of Antibiotics - Otitis Media
Otitis Media and Antibiotic Resistance: Otitis media is a common childhood infection leading to many physicians' office and emergency room visits. Helpful resources describing evaluation and treatment guidelines for otitis media are the NYS DOH Capital Region Otitis Project report at www.health.ny.gov/nysdoh/antibiotic/antibiotic.htm and the CDC website at https://www.cdc.gov/getsmart/community/for-patients/common-illnesses/ear-infection.html

Medicaid HelpLine (518) 486-9057

Medicaid Update –
http://www.health.ny.gov/health_care/medicaid/program/update/main.htm
(Note: There are links to the NYS DOH website (http://www.health.ny.gov) and directly to the web page for the Medicaid Update from the department's eMedNY website (http://www.emedny.org).

Physician Profiles - www.nydoctorprofile.com or 888-338-6999 (Identifies NYS providers by county and indicates participation in State/Federal health insurance programs.)

Department of Health (DOH) Office of Managed Care

How to Reach Us

You can contact us by sending e-mail to: omcmail@health.ny.gov or call the number listed below for your area of concern. You may also write to:

NYSDOH Office of Managed Care
Empire State Plaza
Corning Tower, Room 2001
Albany, New York 12237-0094

Important Phone Numbers

Issue/Concern	Phone
Benefit Package/Scope of Benefits	(518) 473-7467
Clinical Guidelines and Standards of Care	(518) 486-6865
Managed Care Complaint Helpline/Quality of Care	800-206-8125
External Appeals (State Insurance Department)	800-400-8882
Disenrollment/Enrollment Policies	(518) 473-1134
Prompt Payment Complaints (State Insurance Department)	800-358-9260

Office of Children and Family Services (OCFS)

Homepage – http://ocfs.ny.gov/main/
OCFS Regional Offices: http://ocfs.ny.gov/main/regionaloffices_main.asp

CHILD PROTECTIVE SERVICES/CHILD ABUSE HOTLINE INFORMATION:
http://ocfs.ny.gov/main/cps/

- Child Abuse Hotline – **MANDATED REPORTERS** 800-635-1522
- Child Abuse Hotline - General Public 800-342-3720

Child Day Care (518) 474-9454
Foster Care and Adoption 800-345-KIDS

- *Working Together, Health Services for Children in Foster Care (*Type: *Working Together* at OCFS website search function)
- See also American Academy of Pediatrics resource: *Fostering Health, Health Care for Children in Foster Care;* order via https://www.aap.org at the AAP Bookstore, or phone 1-800-433-9016 to get a copy

Juvenile Justice (518) 402- 3149

Office of Advocate for Persons with Disabilities

Information about services, legal rights, and protections for disabled persons and their families 800-522-4369

Office of Temporary & Disability Assistance (OTDA)

Homepage - http://otda.ny.gov

Information on Home Energy Assistance program (HEAP), Food Stamps, WIC, School Meals Program, Home-Delivered Meals Program, and Federal Disability Benefit Program. 800-342-3009

Office for the Prevention of Domestic Violence (OPDV)

Homepage – http://opdv.ny.gov/

New York State Adult Domestic Violence Hotline 800-942-6906

Federal Government Resources

Centers for Disease Control and Prevention (CDC)

http://www.cdc.gov/about

Healthy People 2010

Leading health indicators to measure the health of the Nation through the year 2010
https://health.gov/our-work/healthy-people

National Health Information Center (NHIC)

Health information referral services, Federal Clearinghouses, toll-free numbers for health information. https://health.gov/NHIC/

Office of Minority Health

Information on health conditions with greater prevalence in particular populations and information to assist providers in rendering culturally sensitive health care.
https://minorityhealth.hhs.gov/

- 14 national culturally and linguistically appropriate services (CLAS) standards – https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

Substance Abuse and Mental Health Services Administration (SAMHSA)

http://www.samhsa.gov
Mental health services locator - http://www.mentalhealth.org/get-help
Substance abuse facility locator – https://findtreatment.samhsa.gov/locator/home

The Virtual Office of the Surgeon General, Reports of Surgeon General, U.S. Public Health Services

http://www.surgeongeneral.gov/library/reports/index.html

Private/Non-Government Resources

American Academy of Pediatrics (AAP)

Homepage - https://www.aap.org/en-us/Pages/Default

- AAP Policy Statements - https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Policy-Statements.aspx
- **AAP PERIODICITY SCHEDULE:** *Recommendations for Preventive Pediatric Health Care* – http://www.aap.org (Type: *Preventive Pediatric Health Care* at AAP web site search function to locate the most current AAP guidelines.)
- AAP Immunization Recommendations https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/immunization/Pages/Immunization-Schedule.aspx

American Academy of Family Physicians (AAFP)

Homepage – https://www.aap.org

American College of Obstetricians and Gynecologists (ACOG)

Homepage – http://www.acog.org http://www.acog.org

American Academy of Child and Adolescent Psychiatry (AACAP)

Homepage - http://www.aacap.org

American Academy of Pediatric Dentistry (AAPD)

Homepage - http://www.aapd.org

Bright Futures

Resource to assist providers with rendering age-appropriate anticipatory guidance for children and adolescents. References related to health promotion, nutrition, physical activity, mental health and other topics. http://www.brightfutures.org

Journal of Pediatrics and Adolescent Medicine

Homepage - http://jamanetwork.com/journals/jamapediatrics

National Organization for Rare Diseases

Information on rare diseases and agencies that support affected families.
http://www.rarediseases.org

NYS Coalition Against Domestic Violence

A private agency providing information and referrals to battered women's shelters, safe homes, counseling, support groups, social services, legal assistance.

English	800-942-6906
Spanish	800-942-6908

National Child Safety Council Child watch

Answers questions about safety, household dangers, and drug abuse. Distributes written material

800-222-1464

Early Childhood Direction Center

Information on services for children birth through age 5 with special needs, and referral to local Early Childhood Direction Centers (e.g., services for developmentally disabled children, physically disabled, technologically dependent children)

800-462-7653

Prevention Information Resource Center (PIRC)/ (Prevent Child Abuse New York, NYS Chapter of Prevent Child Abuse America)

Information on child abuse/neglect. Referrals to local parent programs and services. Distributes pamphlets and other materials.

800-342-7472

Lamaze International

Distributes lists of local childbirth educators. 800-368-4404

Planned Parenthood Federation of America, Inc.

Information on family planning, referral to local Planned Parenthood services.

800-230-PLAN

- http://www.plannedparenthood.org/pp2/portal/ - Information and links to information on State laws related to teens' access to abortion and birth control. Click on "health info" and then "FAQs" to access a **ZIP CODE LOCATOR FOR PLANNED PARENTHOOD LOCATIONS** by region.

New York Civil Liberties Union (NYCLU)

NYCLU booklets and reference cards.

(212) 344-3005, extension 239

Teenagers, Health Care & The Law, A Guide to the Law On Minors' Rights in New York State

- http://www.nyclu.org/node/1048 - NYCLU Reproductive Rights Project / 2002 NYCLU booklet addresses minors' rights to provide consent for their own health care, without parental consent, under specific circumstances.

Minors and Mental Health Care

- http://www.nyclu.org/node/1337 - NYCLU Reproductive Rights Project / 2005. NYCLU reference card covers issues of confidentiality and consent when treating minors, addressing differences between outpatient and inpatient mental health services; and discusses circumstances under which the law limits parental access to their minor children's mental health records.