Diagnosis and Screening
August 20, 2008
Meeting #2 (3 sets of handouts were disseminated to the group)

In attendance: Hanes Swingle (USA), Franklin Trimm (USA), Cheris LeMay (Public Health, Bureau of Family Health), Jennifer Muller (Autism Society of Alabama), Laura Klinger by phone (U of A), Linda Lee (AL AAP), Caroline Gomez (Private Practice, Auburn), Kathy Welch (Easter Seals), Karen Dahle (UAB), Amanda Bellmeyer (Private Practice, Baldwin Co.), Mike Weeks.

Dr. Trimm has introduced Autism into the Medical School Curriculum at the University of South Alabama and General Developmental and Autism-Specific Screening into the Pediatric Residency Program. He noted that it is more difficult to introduce changes into a Medical School Curriculum than it is to make changes in a Residency Program. The amount of time medical students spend in school has not changed appreciably over the past 50 years, yet the amount of new information has grown exponentially. A medical school's curriculum is primarily geared toward competency (so that the students can pass the licensure examinations to move onto the next level of training). Competency exams lag with regard to emerging health issues, such as autism. Dr. Trimm was able to get information about autism into the curriculum at South by adding it to a lecture he gives to all 1st year medical students on pediatric development. He also added autism to lectures given to 3rd medical students when they rotate through pediatrics (every medical student rotates through pediatrics in their 3rd year). A 4th year elective in developmental pediatrics is planned for students interested in pediatrics. Dr. Trimm emphasized the importance of introducing autism into the Medical School Curriculum so that all future physicians will have had some exposure to autism. However, he noted that adding new topics to the curriculum are only rarely mandated and then through a planning process of the medical school's curriculum committee.

Historically much of Pediatric Medicine has been focused on preventative medicine. In the 80's there was a mandate to train Pediatricians in Developmental Medicine. There is a gap in what older Pediatricians have been trained to do and what they are comfortable doing.

The current AAP recommendations, i.e., general developmental screening at 9, 18, and 30 months and autism-specific screening at 18 and 24 months, are not the first set of recommendations. There is an attempt by the AAP to make screening for general developmental problems easier for physicians.

Dr. Trimm noted that introducing autism into the Residency Curriculum is a little easier, because Residency programs, although also driven by certification requirements, have more flexibility to meet evolving training needs. There is a mandate that all pediatric residents spend one month rotating in Developmental Pediatrics. Furthermore,the *residency curriculum is supposed to take into account community need*. The Pediatric Board Examination, which residents need to pass upon completion of their residency, is not up to date with regards to emerging health issues such as autism. Nonetheless,

training new physicians to identify autism is critical.   Dr. Trimm feels that this training is going to be most effective in the context of comprehensive general developmental screening.

When the current guidelines for Global Developmental Screening came out a call went out to practices to participate in an academic study. This study is not yet complete, but there are emerging themes-1) there must be a champion at each clinical sites who provides enthusiastic leadership, 2) there is a quagmire when it is time to picking out a screening instrument 3) the screens don't have to be administered by a physician, someone in a managerial or clinical level position can do the screening.

To facilitate implementation of the screening recommendations, the selection of appropriate screeners need to narrowed down based on the positive predictive value, sensitivity, specificity, etc. and the screeners must be easily administered and followed up on.

When you teach the standard of care in Medical School and in Residency Programs, it is more likely that physicians will incorporate these standards in the community where they practice. It is vital that screening not be an additional burden on the residents in training, because their time is limited.

In Alabama the state Legislature allocates money to the Medical Schools annually but the state allocation does not cover the cost of the medical education. The legislature potentially could direct incorporation of emerging health issues, like autism, into the medical school curriculum. This needs to be explored.

The sub-committee should consider those children that do not see Pediatricians. What about those children who see Family Medicine doctors or those only seen by Pediatric Nurse Practitioners, who are becoming increasingly independent from physicians' practices?

In Tuscaloosa there is a Family Practice program. Dr. Klinger gives the Autism lecture to that group. Dr. Klinger indicated she would be willing to take a proposal to the Medical School in Tuscaloosa.

What about the number of referrals from false positives screens? Are they increasing? Yes. Many physicians are using the original 23 question M-CHAT questionnaire, but they are not using the follow-up questionnaire, which substantially reduces the rate of false positives.

Is there a better level I screener than the M-CHAT? Is there a good 2nd level screening test? Who would be the best persons to administer the 2nd level screener?

The Commonwealth Fund has funded projects looking at the questions above because this is an issue nationwide. The most common approach is using a mid level person at an Autism Center to do level II screens. South Carolina is doing work to determine which

kids need to go straight to the full diagnostic evaluation and which can go for the level 2 screening. Maybe screening clinics should be part of our Regional Autism Centers.

Linda Lee reviewed the ABCD Project that has been implemented. Alice Widgeon has been the coordinator of the project. (A handout of a PowerPoint presentation was distributed to those present) The ABCD Project was funded by a Technical Assistance grant that lasted 18 months. The Commonwealth Fund wants to improve the policies that allow us to detect children with developmental delays and to increase screening rates and to facilitate access to treatment and services.

One thing that was noted was that our definitions for Developmental Delay are different between Early Intervention, Physicians and Psychologists, and School Systems.

The recommendation for screening in preschool is that it be done in that age range.

State Policy improvements that were important were getting payer codes consistent so that they can be used by Medicaid and AllKids (Developmental Screening). Many pediatricians didn't realize that they could bill under 96110 in addition to the EPSDT. The requirement is that the pediatricians use a standardized screening instrument. All Kids pays for up to 4 screens in the first 4 years. There is still work to be done with private payers on Developmental Screens and many other preventive medicine type things.

They have developed an algorithm that helps pediatricians know how to make referrals to EI. They are developing a tool kit that can be used and they are hoping to develop online resources as well. They will be conducting 2 open forums on Developmental Issues on a Saturday between now and June 09-the subsequent one will be after that. The 2nd one will be on autism specifically.

We need to address what to do with the increased referrals and the impact of the screening.

At our next meeting Dr. Dahle will discuss eligibility for for services for children with autism in the school system and what is being used. Education does not screen for autism, but attempts to identify high risk children for testingD. Dr. Swingle is also going to invite Betsy Prince to talk about eligibility for EI.

Meeting was adjourned at 11:40 a.m.
Next meeting is Wednesday, Sept. 17th at 10:00.