

**MedStar Health**  
**Pediatric Ambulatory Best Practice Group**  
**Recommended Pediatric Screening Guidelines 2024**

The Pediatric Ambulatory Best Practice Group is composed of experts in pediatrics, primary care, and pharmacy from across our system. This multidisciplinary group of health professionals meets on a regular basis to evaluate the quality of care delivered across the system while staying abreast of trends in healthcare that will impact ambulatory practice and care outcomes. This Group is a subcommittee of the Pediatric Clinical Council (PCC).

During the preparation of these screening guidelines, the Pediatric Ambulatory Quality Best Practices Group reviews multiple sources of information including current literature, community practice standards, expert opinion from subject matter experts from within our system, national recommendations from clinical specialty organizations and information available regarding recommendations for health and prevention screening guidelines.

This reference is intended for all providers who serve as primary care practitioners for pediatric **ambulatory** patients in the MedStar Health system primary and urgent care settings. This document is a summary of our recommendations for the appropriate screening of pediatric ambulatory patients in MedStar Health.

Successful implementation of the screening guidelines is at least in part related to a successful education process for providers, patients, and families. To that end, we have included information that is available free of charge through specific Internet sites.

These recommendations are provided to assist physicians and other clinicians making decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's primary care provider and in collaboration with the patient. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication but should be used with the clear understanding that continued research may result in new knowledge and recommendations.

Federal and state law, particularly laws and regulations relative to provision of care under governmental programs such as Medicare/Medicaid, may mandate the provision of certain screening and preventive care. Any questions regarding these requirements should be reviewed with legal counsel or a member of our committee. Member names and phone numbers are listed on the next page of this document.

The Pediatric Ambulatory Best Practice Group reviews guidelines on an annual/biannual basis for additions, deletions or clarifications and distribute as appropriate.

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## Pediatric Populations

Preventive Service	GUIDELINE	
	1-18 MONTHS	18 MONTHS - 21 YEARS
Well Child Care WCC) Visit Schedule <sup>1,2</sup>	Newborn, 3-5 days, by 1 mo., 2 mo., 4 mo., 6 mo., 9 mo., 12 mo., 15 mo., 18 mo.	2 yrs., 30 months, and annually from age 3 years to 21 years
Review of History: Past Medical and Family History <sup>2</sup>	Every visit	Every visit
Physical Exam <sup>1,2</sup>	Every visit	Every visit (use of chaperone when appropriate) <sup>1</sup>
Length, Height, and Weight with percentile <sup>1,2</sup>	Every visit	Every visit.
Head Circumference with percentile <sup>1,2</sup>	Every visit through 24 months	Continue if abnormal head size is detected
Weight for Length <sup>1</sup>	Every visit through 18 months	
BMI with percentile <sup>1,2</sup>		24 months, 30 months and then annually from age 3 years to 21 years <sup>10,11,39</sup>
Blood Pressure Screening <sup>1,2</sup>	Risk Assessment every visit through 30 months	Every visit beginning at 3 years to 21 years
Developmental Surveillance <sup>1,2</sup>	Surveillance every visit. Formal screening with standardized tool at 9, 18, and 24 <sup>2</sup> -30 <sup>1</sup> months.	
Developmental Screening by Standardized Tool <sup>1,2</sup>	Developmental screening should be administered regularly at the 9, 18, and 24 <sup>2</sup> -30 <sup>1</sup> -month well visits using a valid and standardized screening tool such as Ages and Stages Questionnaire (ASQ), Parent Evaluation of Developmental Status (PEDS) or Child Development Inventories (CDI).	
Psychosocial/Behavioral Screening <sup>1,2</sup>	Every WCC visit: using validated and standardized tools such as Strength and Difficulties Questionnaire (SDQ), Pediatric Symptom Checklist (PSC), Ages and Stages Questionnaire – Social/Emotional (ASQ-SE), Early Childhood Screening Assessment (ECSA)	
Maternal Depression Screening <sup>1,2</sup>	Use a validated screening tool like the Edinburgh Post-Partum Depression Screen (EPDS) at WCC 2 weeks to 6 months age. <sup>3</sup>	
Family Wellbeing/Social Determinants of Health <sup>4</sup>	At each visit, screen Social Determinants of Health (such as in the MedConnect Well Child power form). There are many tools available through the AAP. <sup>4</sup>	

<p>Anticipatory Guidance<sup>1,2</sup></p> <p>Counseling / Education / Screening for high-risk factors<sup>1</sup></p>	<p>Safe sleep for infants.<sup>5</sup> Age-appropriate counseling should be discussed during WCC (e.g., providing information regarding development, diet and exercise, injury prevention, dental health, appropriate screen time.). Evaluate strengths and protective factors (family relationships and support, childcare). Ask about use of alternative and complementary medicines.</p> <p>Additional screening and intervention may be necessary for individuals at high-risk. Review risks such as insecure living situation and food insecurity; exposure or use of tobacco, alcohol, and drugs; exposure and risk of interpersonal violence, sexuality and sexual activity, parental depression, high-risk of exposure to infectious diseases (HIV, Hep A, Hep B, Hep C).</p>	
<p>Autism<sup>1,2</sup></p>	<p>Screen all children at 18-month and 24-month WCC with autism (ASD) specific screening tool such as MCHAT-R/F (Modified Checklist for Autism in Toddlers, Revised with Follow-Up)<sup>6</sup></p>	
<p>Depression Screening<sup>1,2</sup></p>		<p>Depression screening at all WCC from ages 11-21 years old and when appropriate. Use validated and standardized tools such as Strength and Difficulties Questionnaire (SDQ), Pediatric Symptom Checklist (PSC), Patient Health Questionnaire 2 (PHQ-2), Patient Health Questionnaire (PHQ-9, PHQ-9A)<sup>7,8</sup> Patients should be screened for suicidal/homicidal ideation. A validated tool is the ASQ (Ask Suicide Screening Questions).<sup>9</sup></p>
<p>Anxiety Screening</p>		<p>Anxiety screening intervals have not been established. Available anxiety screening tools include the Screen for Child Anxiety Related Disorders (SCARED)(age 4-18) and the GAD-7 (age 12+).<sup>12</sup></p>
<p>Substance Use Assessment<sup>1,2</sup></p>		<p>Screen yearly at WCC from age 11-21 and when appropriate. There are standardized screenings such as the CRAFFT to use.<sup>13</sup></p>
<p>Cervical Cancer Screening<sup>14</sup></p>		<p>Cervical cancer screening may begin at age 21 years (regardless of sexual history). <i>Routine screening before age 21 should be avoided because women less than 21 years old are at very low risk of cancer. Screening these women may lead to unnecessary and harmful evaluation and treatment.</i> For at-risk patients (patients with an immunodeficiency such patients who are HIV positive or status renal transplant), screening may start earlier.</p>
<p>Nutritional Status/Physical Activity Status<sup>10</sup></p>	<p>Every visit: Assess nutritional status and physical activity; counsel as appropriate.</p>	
<p>Hearing<sup>1,2</sup></p>	<p>Subjective screening (validated): Newborn – 18 months. Objective Screening (validated): Newborn (confirm hearing test passed in hospital)</p>	<p>Subjective per EPSDT<sup>2</sup>: 24 months, 30 months, at years 7, 9, 11, 13, 14, 16, 17, 19, 20 Objective testing<sup>2</sup>: at years 3, 4, 5, 6, 8, 10, 12, 15, 18. *refer to hearing screening if not performed elsewhere</p>
<p>Vision<sup>2</sup></p>	<p>Subjective screening: newborn-18 months<sup>2</sup></p>	<p>Subjective per EPSDT<sup>2</sup>: 24 months, 30 months, at years 7, 9, 11, 13, 14, 16, 17, 19, 20 Objective testing<sup>2</sup>: at years 3, 4, 5, 6, 8, 10, 12, 15, 18.</p>

Dental Health <sup>15</sup>	Oral Health assessment at birth; dental assessment begins at tooth eruption. Dental provider assessment at age 12 months and 18 months	Dental provider assessment every 6 months
Fluoride <sup>2,16</sup>	Starting at tooth emergence, fluoride varnish may be applied to all children every 3–6 months in the primary care or dental office.	Fluoride varnish can be applied every 3-6 months through age 5 <sup>2</sup> . Fluoride supplementation as needed at least through age 16. <sup>16</sup>
Hepatitis C <sup>17</sup>		Screening for hepatitis C virus infection should be completed at least once between the ages of 18 and 79.
HIV Testing and Sexually Transmitted Infection (STI) Risk Assessment and Screening <sup>1,2,18-21</sup>	Recommended testing in pregnancy: syphilis, chlamydia, gonorrhea (when indicated), Hepatitis B, HIV. <sup>18</sup> Infants born to mothers whose HIV status is unknown should be tested for HIV. <sup>19</sup>	Yearly risk assessment starting at age 11. <sup>1,2</sup> Universal testing for HIV once between the ages of 15-21 years. <sup>20</sup> Screening for all sexually active adolescents for STIs (includes gonorrhea, chlamydia, HIV, and syphilis) based on risk/behavior. <sup>21</sup>
Cyanotic Congenital Heart Defect Screening <sup>27</sup>	All newborns are to be screened in the hospital. If screening is not able to be verified it should be performed in the outpatient setting.	
Neonatal Bilirubin <sup>28</sup>	Confirm initial screening was accomplished, verify results, and follow up.	
Hereditary/Newborn Metabolic Screening (NMS) <sup>1,2</sup>	NMS should be done after completing 24 hours of feeding, therefore between 24-48 hours after birth and before discharge from the hospital. <sup>29,30</sup> Maryland requires a second NMS after 7 days old, ideally between 10-14 days. <sup>29</sup> Results should be reviewed with appropriate follow up. NMS recommendations vary between states.	Sickle cell screen if not already completed if status unknown or risk factors.
Tuberculosis Screening/Risk Assessment <sup>31</sup>	Perform TB screening /risk assessment by age 1 month; again at 6,12, and 24 months.	Annually, ages 3-21. High risk patients should be tested for TB. High risk patients can be defined as those that are immunocompromised, are or have been in close contact with active TB cases, have medical risk factors, are immigrants from high prevalence areas, or have recently traveled to high-risk areas, and other disparate populations.
Lead Risk Assessment <sup>1,2</sup>	6 mo., 9 mo., 12 mo., 15 mo., 18 mo.	24 months, 30 months and then annually from age 3 years to 6 years
Anemia Risk Assessment	4 mo,15 mo., 18 mo. <sup>1</sup>	24 mo., 30 mo., 3 yrs. and annually until age 21 years <sup>1</sup> ;(11-21yo) <sup>2</sup>

Blood Lead Testing <sup>1,2</sup>	Blood lead test at 9 to 12 months <b>or sooner</b> if at high risk.	Blood lead test on or after 2 years age as required by state and repeated for anyone at high risk Screening is recommended for previously untested children aged ≤6 years and required by most school districts for entry. <sup>23</sup> <b>Any blood lead screen ≥ 3.5 mcg/dL should have a follow up blood test per state.</b> <sup>22</sup> <a href="#">Maryland Lead Recommendations,</a> <sup>24</sup> <a href="#">DC Lead Recommendations,</a> <sup>25</sup> <a href="#">VA Lead Recommendations,</a> <sup>26</sup> <a href="#">CDC Lead Recommendations</a> <sup>22</sup>
Hematocrit /Hemoglobin Screening	Hematocrit or Hemoglobin testing at 9 to 12 months <sup>1,2</sup> or if at high risk.	Test on or after 2 years age <sup>2</sup> and for anyone at high risk  Higher risk factors for iron deficiency can be defined as low socioeconomic status; history of low birth weight; exclusive breast feeding beyond 4 months old without supplemental iron; early weaning to whole milk and complementary foods not iron-fortified or naturally rich in iron; feeding problems, poor growth; inadequate nutrition typically seen in infants with special health care needs; child of Mexican American descent. <sup>42</sup>  Females should be screened at least once after regular menstruation <sup>32</sup> .
Cholesterol Risk Assessment		2-21 years old <sup>2</sup>
BloodLipid Testing (non-HDL cholesterol or fasting lipid profile) <sup>1,2,36</sup>		screening once between 9 -11 <sup>1,2</sup> years and once between 17 <sup>1</sup> (18) <sup>2</sup> -21 years and for high-risk patients with blood fasting lipid profile. Risk factors for premature cardiovascular disease include obesity, high blood pressure, diabetes, family history of dyslipidemia and family history of premature cardiovascular disease (males<55yrs and female <65yrs). <sup>36</sup>
Diabetes Screening <sup>37,38</sup>		Screening with fasting glucose and/or HbA1c every two years is recommended for overweight individual (BMI> 85 <sup>th</sup> percentile) and should also be based on other risk factors such as lifestyle and/or family history
Urinalysis Screening <sup>39,40</sup>		Routine urinalysis to screen for kidney disease is not required.
Contraception <sup>41</sup>		Screening pelvic exams are not recommended. Age-appropriate contraceptive management should be offered as part of preventive health maintenance. <b>App for mobile phone:</b> CDC – Contraception
<b>IMMUNIZATIONS</b>	<b>For Complete CDC recommendations for Pediatric Immunizations go to; <a href="https://www.cdc.gov/vaccines/schedules/index.html">https://www.cdc.gov/vaccines/schedules/index.html</a>.</b> <b>Apps for phone:</b> CDC – “Vaccine Schedules”; Society of Teachers of Family Medicine – “Shots Immunizations”	

**Note:** For MedStar Health providers, use of the **MedConnect Well Child powerforms** in Cerner is recommended for all well visits as these include many (but not all) of the above preventative screening recommendations.

## Notes & Resources

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