

Clinical Guidance and Best Practices on Screening and Diagnostic Services for CAA Section 5121 Eligible Youth

Background¹

Authorities: The Consolidated Appropriations Act (CAA) of 2023, Section 5121 requires that any screenings and diagnostic services that meet reasonable standards of medical and dental practice, as determined by the state, or as otherwise indicated as medically necessary, in accordance with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements (including a behavioral health screening or diagnostic service) be provided to post-adjudication eligible juveniles in public institutions (i.e., youth or adult carceral facility) in the 30 days prior to their release (or not later than one week, or as soon as practicable, after release from the public institution). CAA Section 5121 also requires targeted case management services be provided to post-adjudication eligible juveniles 30 days pre-release and for at least 30 days post-release.

Throughout this document, the term “youth” is used to refer to eligible juveniles under CAA Section 5121. Clinical guidance provided in this document is intended to support providers delivering screening services to eligible youth, in accordance with MassHealth requirements. The requirements in this document begin at age 12 since that is the minimum age of juvenile court jurisdiction in Massachusetts and therefore the youngest age that a youth would be in DYS care and/or custody².

MassHealth Requirements: MassHealth screening and diagnostic services required under CAA Section 5121 align with existing standards defined by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements that apply to all MassHealth-enrolled individuals under age 21 who are eligible for the EPSDT program. MassHealth EPSDT requirements are derived from Bright Futures/American Academy of Pediatrics (AAP) recommendations for pediatric preventive care. Accordingly, CAA Section 5121 screening requirements include age-appropriate components of MassHealth EPSDT requirements (e.g., a comprehensive health history, a comprehensive unclothed physical examination, appropriate vision and hearing tests, appropriate laboratory tests, and dental screenings). Under CAA Section 5121, MassHealth is also requiring certain screening and diagnostic services above and beyond MassHealth EPSDT requirements (for example, components that should be performed at earlier ages or more frequently for incarcerated youth, such as testing for sexually transmitted infections). Sources used to inform the MassHealth CAA Section 5121 requirements include, but are not limited to, the following:

- United States Centers for Disease Control and Prevention (CDC) [Recommendations for Correctional and Detention Settings](#)
- [Bright Futures Guidelines/American Academy of Pediatrics Periodicity Schedule](#)
- [Massachusetts Health Quality Partners \(MHQP\) Pediatric Preventive Care Guidelines](#)
- [United States Preventive Services Taskforce \(USPSTF\)](#)
- United States Centers for Disease Control and Prevention (CDC) [Advisory Committee on Immunization Practices \(ACIP\)](#)

¹ Please note: This content may change.

² M.G.L. c. 118, s. 84 (as amended by An Act Relative to Criminal Justice Reform, 2018, c. 69, s. 79)

Each age-specific screening requirement for CAA is summarized in table form in the MassHealth CAA Screening Schedule. Each screening requirement is described in more detail below, with specific clinical guidance on best practices for several screenings. If the clinical needs of a youth justify deviation from this schedule, the provider must document this fact in the medical record, including the provider's clinical judgment and justification for that deviation. If a screening is positive or elicits a concern, CAA Section 5121 requires that the youth then receive an appropriate diagnostic evaluation. When such screenings and diagnostics result in the identification of medically necessary subsequent treatment, the provision of that treatment is the responsibility of the carceral institution.

Timing of Services: For youth in the community, EPSDT preventive services should be provided annually. Similar preventive care services are typically provided to youth upon intake to an institution, and periodically thereafter. Therefore, screening and diagnostic services provided within 12 months prior to a youth's scheduled release date may be used to fulfill CAA Section 5121 requirements, whether they occurred in the community or institution. For any services delivered prior to 30 days pre-release period to count toward fulfilling CAA requirements, they must be documented in the institutional medical record with a date of service. Some screening and diagnostic services may be repeated more frequently than annually, as clinically appropriate. Institutions must not delay an individual's release for the purpose of meeting CAA Section 5121 requirements. Any requirements not met due to the individual's release date or an inability to provide the screening(s) at the institution should be arranged to be provided in the community as soon as practicable after release. Arrangements and/or referrals to obtain required services after release should be recorded in the institutional medical record with an accompanying brief explanation for why the screening or diagnostic service was not performed prior to release.

Components of Screening Requirements for CAA-Eligible Youth

A. History

Health histories should be taken at each preventive healthcare visit. Typically, an initial health history taken at a youth's first visit with a provider (e.g., during intake to a correctional facility) is more comprehensive than health histories taken during later preventive healthcare visits.

History that is relevant to the age-specific preventive healthcare visit is gathered to assess strengths, accomplish surveillance, and enhance the provider's understanding of the youth and their family/home environment. Past medical history and pertinent family history are important elements of the initial and interval history. Visits also include relevant social history questions.

Health histories should include age-appropriate history about the youth, including but not limited to:

- family history;
- birth, growth, nutrition, and developmental history;
- immunization history;
- current and past medications, including any alternative or complementary medicine;
- medication allergies and other allergies;
- medical history, including previous diagnoses, surgeries, and hospitalizations;
- review of systems;
- risk-taking behaviors, including alcohol, marijuana, tobacco, opiate, and other substance use;
- sexual health and development, including sexual activity; and

- other medical, psychosocial, and behavioral health concerns.

If a youth is unable to answer questions related to their health history, pertinent elements may be obtained from other sources, such as previous medical records, providers, or family, when available.

The health history of adolescents ages 12 years and older should also include a screening for their risk of sudden cardiac arrest or sudden cardiac death at a minimum of every 3 years, or more frequently as appropriate. The [following 4 questions are recommended for use by the American Academy of Pediatrics](#) and if any question is answered “yes” then a cardiac evaluation should be initiated:

- Have you ever fainted, passed out, or had an unexplained seizure suddenly and without warning, especially during exercise or in response to sudden loud noises, such as doorbells, alarm clocks, and ringing telephones?
- Have you ever had exercise-related chest pain or shortness of breath?
- Has anyone in your immediate family (parents, grandparents, siblings) or other, more distant relatives (aunts, uncles, cousins) died of heart problems or had an unexpected sudden death before age 50? This would include unexpected drownings, unexplained auto crashes in which the relative was driving, or sudden infant death syndrome (SIDS).
- Are you related to anyone with hypertrophic cardiomyopathy or hypertrophic obstructive cardiomyopathy, Marfan syndrome, Arrhythmogenic cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia or anyone younger than 50 years with a pacemaker or implantable defibrillator?

B. Measurements

1. **Height and Weight.** Providers should obtain height and weight measurements for youth at every preventive healthcare visit and plot those for youth under 21 years using appropriate, standard growth charts, such as those available [through the CDC](#).
2. **Body Mass Index (BMI) Screen for Obesity.** BMI should be calculated at every preventive healthcare visit, and may be plotted using appropriate, standard growth charts for youth under 21, such as those available [through the CDC](#). For older adolescents and those over 21, adult BMI categories may be more appropriate than a growth chart for assessing obesity risk.
3. **Blood Pressure.** Blood pressure should be measured at every preventive visit.

C. Sensory Screening

- 1. Vision Screening.** Visual acuity testing should be performed at ages 12, 15, and 18 years. Document in the medical record if the test was performed in another setting, such as a school or by a community provider. For all other ages, perform a risk assessment by asking the youth if they have any problems with or changes in their vision. For any youth with a positive risk assessment, proceed to visual acuity testing or referral, as appropriate.
- 2. Hearing Screening.** Whenever available, objective hearing screening should be performed with pure tone audiometry, including 6,000 Hz and 8,000 Hz high frequencies, or evoked otoacoustic emissions. Objective hearing screening should occur at least once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. For all other ages, perform a risk assessment by asking the youth if they have any problems with or changes in their hearing. For any youth with a positive risk assessment, proceed to objective hearing screening or referral, as appropriate.

D. Developmental/Behavioral Health

Developmental and behavioral health assessments should occur for youth and include topics specific to adolescents and young adults. The 4 main components of developmental and behavioral assessments are: 1) developmental surveillance (only for youth under age 21); 2) behavioral/social/emotional screening (only for youth under age 21); 3) tobacco, alcohol, or drug use assessment; and 4) depression and suicide risk screening. Each component may be met by incorporating the use of one or more validated and age-appropriate screening tools, as described further in each corresponding section below. As stated previously in the “Timing of Services” section, required components may also be met through the screenings and assessments completed during a youth’s intake and through preventive healthcare provided by the institution, if this occurred less than 12 months prior to the youth’s scheduled released date.

In addition to developmental and behavioral health assessments, youth should be screened for health-related social needs – such as food insecurity, exposure to caregiver, intimate partner(s), or community violence, caregiver substance use, housing instability, and other matters that may impact the youth – at several touchpoints and by different staff during their involvement in the justice system, including by their healthcare providers. Each screening opportunity increases the likelihood of identifying and providing support for any concerns. Age-appropriate screening tools for youth, in addition to examples provided below, may be found through the American Academy of Pediatrics/Bright Futures toolkit.

1. Developmental Surveillance

Developmental surveillance should occur for all youth under age 21 to determine if the youth is developing in an appropriate fashion and to provide information, intervention, or referrals, as needed. Developmental surveillance may be done by asking specific questions, through the medical examination, by observation, and through general discussion. The use of a validated screening tool is not required. Appropriate developmental milestones for most youth is the ability to do the following:

- Form caring and supportive relationships with family members, other adults, and peers
- Engage in a positive way with their community

- Engage in healthy behaviors, such as choosing healthy foods, engaging in physical activity, wearing a seat belt in the car, etc.)
- Demonstrate physical, cognitive, emotional, social, and moral competencies (including self-regulation)
- Exhibit compassion and empathy
- Exhibit resiliency when confronted with stressors
- Use independent decision-making skills (including problem-solving skills)
- Display a sense of self-confidence, hopefulness, and well-being

The medical record must include documentation of the provider's assessment of the youth's developmental status. If concerns are elicited during surveillance, then they must be documented and formal screenings or referrals should be initiated, as clinically appropriate.

2. Psychosocial/Behavioral Assessment

Screening for behavioral and social-emotional problems should occur for all youth under age 21 and may include asking questions about emotional and mental health concerns, social determinants of health, experiences of racism, poverty, and relational health. Although a validated screening tool is not required to elicit behavioral/social/emotional concerns, many screening tools are available. Administering one or more of the following validated screening tools, as clinically appropriate, is recommended:

- Massachusetts Youth Screening Instrument – Second Version (MAYSI-2)
- Youth Assessment and Screening Instrument (YASI)
- Youth Level of Service/Case Management Inventory (YLS/CMI)
- Pediatric Symptom Checklist (PSC) (if under age 17)
- Strengths & Difficulties Questionnaires (SDQ) (if under age 18)
- Screen for Child Anxiety Disorders (SCARED)
- Vanderbilt ADHD Diagnostic Rating Scales
- Screening, Brief Intervention, and Referral to Treatment for Eating Disorders (SBIRT-ED)

Former foster youth ages 21 and older should receive behavioral health screenings in accordance with institutional practices.

3. Tobacco, Alcohol, or Drug Use Assessment

Risk assessments for tobacco, alcohol, or drug use should be performed for all youth. It is recommended that providers use a validated substance screening tool such as:

- CRAFFT 2.1+N
- Screening to Brief Intervention (S2BI).

Risk assessments for tobacco, alcohol, and drug use may also be accomplished through screenings that occur in accordance with institutional practices.

If concerns are identified, providers may contact the Massachusetts Child Psychiatry Access Program (www.mcpap.com) to be connected to the Adolescent Substance and Addiction Program (ASAP), a program of MCPAP that provides pediatric primary care providers with

pediatric substance use disorder consultation. If a referral to treatment is needed, providers may contact the Massachusetts Substance Use Helpline (helplinema.org) or the Office of Youth & Young Adult Services at the Massachusetts Department of Public Health Bureau of Substance Addiction Services at (617) 624-5111.

4. Depression and Suicide Risk Screening

Screening for depression and suicide risk should occur for all youth using a validated depression screening tool, such as:

- Patient Health Questionnaire Modified for Adolescents (PHQ- A) (if under age 18)
- Patient Health Questionnaire-9 (PHQ-9) (if 18 and older)
- Patient Health Questionnaire-2 (PHQ-2) (if 18 and older), with completion of PHQ-9 if positive

Providers who identify a concern may contact the Massachusetts Child Psychiatry Access Program (www.mcpap.com) for pediatric psychiatric consultation and referral for ongoing behavioral health care after release.

E. Physical Exam

A physical exam should be performed for all youth at every preventive healthcare visit. Youth should be undressed, draped and/or gowned, and chaperoned, as indicated. The use of a chaperone should be a shared decision among the youth and provider.

F. Procedures

1. Immunization Assessment and Administration

Immunize all youth according to the Massachusetts Department of Public Health's Immunization Program. Immunization status should be assessed prior to release to ensure the youth is up to date with all recommended immunizations. The [Massachusetts Immunization Information System \(MIIS\)](#) may be accessed to help determine a youth's immunization status. It is mandated by law that all providers who administer immunizations in Massachusetts report the immunization data to the MIIS. The MIIS Help Desk for providers may be reached at MIISHelpDesk@mass.gov.

2. Anemia Screening

Conduct a risk assessment for anemia on all youth, or screening if clinically indicated by the presence of risk factors. Screen all non-pregnant female adolescents for anemia every five to 10 years during preventive healthcare visits starting at age 12. Screen those with known risk factors (i.e., excessive menstrual blood loss, low iron intake, or previous diagnosis of iron deficiency anemia) annually.

3. Tuberculosis Assessment and Testing

Conduct a risk assessment for tuberculosis on all youth annually. Testing should be performed as indicated by the results of the risk assessment.

4. Dyslipidemia Assessment and Testing

Assess youth for dyslipidemia risk factors annually from ages 12 to 16, and annually after age 21. Screen for dyslipidemia at least once between ages 17 and 21.

5. Sexually Transmitted Infections (STIs) Assessment and Testing

Screen all youth for STIs annually, including chlamydia, gonorrhea, and syphilis. Reassess risk and rescreen as clinically indicated.

6. Human Immunodeficiency Virus (HIV) Assessment and Testing

Screen all youth for HIV annually. Reassess risk and rescreen as clinically indicated.

7. Hepatitis B

Screen for Hepatitis B at least once after incarceration and reassess risk annually or as clinically indicated.

8. Hepatitis C

Screen all youth for Hepatitis C at least once after turning age 18. Reassess risk annually or as clinically indicated.

9. Cervical Dysplasia Screening

Cytology screening for cervical cancer should occur every 3 years for women ages 21 to 29 years. In compliance with [guidance](#) from the U.S. Preventive Services Task Force, human papillomavirus (HPV) testing is not recommended until age 21.

G. Oral Health – Fluoride Supplementation

Assess youth for the need for dietary fluoride supplementation through age 16 years. Dietary fluoride supplements should be considered for youth under 17 years of age if their primary water source (e.g., drinking water provided by the institution) is lacking in fluoride.

H. Anticipatory Guidance

Anticipatory guidance should be provided to all youth annually, with a focus on topics most pertinent to the individual youth's circumstances and risks. Discussion topics may include, but are not limited to, the following:

- behavioral risks, such as avoidance of the use of alcohol, drugs, tobacco, e-cigarettes (also known as vaping), opiates, cannabis, and other substances;
- safe environments at home, in school, and in the community, which are free of violence, toxic stress, bullying, and ostracism;
- mental health, including depression and anxiety, based on risk factors and individual patient presentation in adolescence;
- academic or behavioral problems that may be signs of attention deficit hyperactivity disorder (ADHD);
- safe and healthy sexual behaviors, including STI prevention, contraception, pregnancy planning (i.e., need for folic acid), and pre-exposure prophylaxis, with sensitivity to sexual orientation and gender identity;

- benefits and components of a healthy diet and safe weight management, ways to maintain adequate calcium and vitamin D, and counseling against sugar-sweetened and caffeinated drinks;
- benefits of daily physical activity, opportunities for daily physical activity;
- healthy sleep habits and encouraging proper sleep amounts,
- safety related to online activity, social networking, and use of smartphones and other handheld devices;
- chronic and communicable disease prevention;
- basic oral health education, including the benefits of daily oral hygiene and establishing a dental home;
- safety measures and injury prevention, including seat belts, bike and motorcycle helmets, poison prevention, firearm safety, and other age-appropriate counseling;
- skin protection, including using sunscreen, reducing exposure to the sun, and discouraging use of indoor tanning;
- potential risks of body piercing and tattooing; and
- nutrition, which primary care providers may assess and promote by doing the following:
 - ask about dietary habits;
 - starting in middle childhood, screen annually for eating disorders and ask about body image and dieting patterns

I. Dental Screening

Dental screening is required for all youth. Dental screening consists of procedures based on the *Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents* from the [American Academy of Pediatric Dentistry \(AAPD\) Reference Manual 2023-2024](#). If the clinical needs of a youth justify deviation from these screening services (e.g., due to the youth's age or risk factors), the provider must document this fact in the member's dental record, including the provider's clinical judgment and justification for that deviation.

The components of dental screening are listed and described below:

1. Clinical oral examination: Clinical exams should take place every six months or as indicated by the youth's risk status and susceptibility to disease. The clinical exam includes assessment of all hard and soft tissues, as well as pathology and injuries.
2. Assess oral growth and development: Oral growth and development are assessed by clinical exam.
3. Caries risk assessment: Caries risk review should be performed to prevent disease by identifying youths at high risk for caries and developing individualized preventive measures and caries management, as well as determining appropriate periodicity of services. Because a youth's risk for developing dental disease can change over time due to changes in habits (e.g., diet, oral hygiene), oral microflora, or physical condition, risk assessment must be documented and repeated regularly and frequently to maximize effectiveness.
4. Radiographic assessment: Radiographic reviews are an important component of the clinical assessment. Timing, selection, and frequency are determined by youth's history, clinical findings, and susceptibility to oral disease and in compliance with ADA/FDA guidelines (www.fda.gov/radiation-emitting-products/medical-x-ray-imaging/selection-patients-dental-radiographic-examinations). Every effort must be made to minimize the youth's radiation exposure by applying best radiological practices and minimizing radiographs only to those necessary to obtain essential diagnostic information and achieve satisfactory diagnosis. Variations

from the ADA/FDA clinical guidelines must be documented in the patient record.

5. Prophylaxis and topical fluoride: Prophylaxis and topical fluoride treatments are important preventive measures that should be a regular part of the periodic exam and assessment process. The interval for frequency of professional preventive services is based upon assessed risk for caries and periodontal disease.
6. Fluoride supplementation: Consider fluoride supplementation for youth up to at least 16 years of age when systemic fluoride exposure is suboptimal or as otherwise indicated by guidance of the American Academy of Pediatric Dentistry and the Bright Futures Periodicity schedule. See list of Massachusetts fluoridated communities at <https://www.mass.gov/info-details/community-water-fluoridation-status> -.
7. Anticipatory guidance/counseling: Anticipatory guidance is the process of providing practical and developmentally appropriate information to prepare youth for significant milestones in oral development, oral hygiene, eating practices, fluoride, and injury prevention. Individualized discussion and counseling are integral components of each visit.
8. Oral hygiene counseling: The effectiveness of home care should be monitored at every visit and includes a discussion on the consistency of daily oral hygiene preventative activities, including adequate fluoride exposure.
9. Dietary counseling: Dietary counseling is an integral part of every visit.
10. Counseling on nonnutritive habits: Counseling should include any existing habits such as fingernail biting, clenching, or bruxism.
11. Injury prevention and safety counseling: Injury prevention counseling should include use of protective equipment (e.g., athletic mouthguards, helmets with face shields) for contact sports and high-speed activities.
12. Assessment for developing occlusion: Abnormalities in occlusal development should be recognized, diagnosed, and managed or referred in a timely manner.
13. Assessment for pit and fissure sealants: For caries-susceptible permanent molars, premolars, and anterior teeth with deep pits and fissures; dental sealants should be placed as soon as possible after eruption. Sealants are a crucial part of preventive dental care and can minimize the progression of non-cavitated occlusal caries lesions.
14. Periodontal risk assessment: Periodontal risk assessment identifies individuals at increased risk of developing gingival and periodontal diseases and pathologies and should be repeated during each clinical examination to monitor changes in risk status and to maximize effectiveness. Periodontal probing should be added to the risk-assessment process.
15. Counseling for tobacco, vaping, and substance misuse: Education regarding prevention of tobacco use, vaping, and substance misuse should be provided. When tobacco or substance use has been identified, brief interventions should encourage, support, and positively reinforce avoiding substance use. If indicated, appropriate referrals should be made for assessment and/or treatment of substance use disorders.
16. Counseling on HPV virus/vaccine: Human papilloma virus (HPV) is associated with several types of cancers, including oral and oropharyngeal cancers. As adolescent patients tend to see the dentist twice yearly and more often than their medical care provider, this is a window of opportunity for the dental professional to counsel youth about HPV's link to oral cancer and the potential benefits of receiving the HPV vaccine.
17. Counseling on intraoral/perioral piercings: The oral health consequences of intraoral/perioral piercings should be initiated.
18. Assess third molars: During late adolescence, assess the presence, position, and development of

third molars, giving consideration to removal when there is a high probability of disease or pathology, or the risks associated with early removal are less than the risks of later removal.

19. Transition to adult dental care: For older adolescents, educating on the value of transitioning to a dentist who is experienced in adult oral health can help minimize disruption of high-quality, developmentally appropriate health care