DENVER HEALTH MEDICAL PLAN INC.™

DENVER HEALTH MEDICAID CHOICE

CLINICAL PREVENTIVE GUIDELINE

Guideline Number: DHMP_DHMC_PG1006	**Effective Date: 11/1/2020**
Guideline Subject: Well Child and Adolescent Health	**Revision Date: 11/1/2021**
Pages: 1 of 14	

Craig Kaman 11-1-2020

Quality Management Committee Chair **Date**

I. PURPOSE:

To define the expected standards of outpatient care for well children, from infancy to young adulthood, who are covered by any of the Denver Health Medical Plans (DHMP).

This guideline encompasses adolescent preventive health as a component of the well child care visits to promote continuity of care and to meet national preventive care standards. Regular (at least annual) contact with a health care provider not only manages physical health but provides an opportunity for education, risk assessment, and promotion/reinforcement of healthy choices. Early, periodic, screening, diagnostic and treatment (EPSDT) is key to ensuring that children and youth receive appropriate preventive, dental, mental health, developmental and specialty services. The well child visit and adolescent preventive health is most effective when a team approach is used to develop optimum physical, emotional and developmental health/needs of the member. Providers should utilize clinical judgment based on the needs of the individual patient.

II. POPULATION:

2 weeks of life through 21 years of age. To align with Denver Health Ambulatory Care Services (ACS), this guideline includes patients from newborn through 20 years of age.

III. GUIDELINE:

The information and recommendations for pediatric and adolescent preventive healthcare contained herein align with the Colorado Department of Health Care Policy and Financing (HCPF) program requirements for EPSDT. See sections below for additional detail.

A. Well Child Care (WCC) visit Periodicity:
Periodic Health Evaluation and Recommended Screening: *[See Visit Schedule immediately below, page 2]*

1. Initial/Interval History and Physical Exam
    a. Visits to include an age-appropriate history and physical exam.
    b. WCC measurements:
        - Height and weight every WCC, and every visit ≥ 3 years of age
        - OFC every WCC ≤ 2 years of age
        - Blood pressure every WCC ≥ 3 years of age (at younger ages if indicated)
        - Body Mass Index every WCC ≥ 2 years of age
    c. Assessment of Medication and Herbal Remedies
    d. Sensory Screening - Hearing
        - All newborns in nursery or refer to audiology at first WCC during infancy
        - Initiate formal screening at 4 years of age and perform annually at each subsequent WCC through 10 years of age.
        - Screen at 20dB

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- Screen the following frequencies: 500, 1000, 2000, 4000 Hz routinely
- At age 11 yrs. and annually thereafter, additional screen at 6000 and 8000 Hz

Sensory Screening - Vision (see also DH Pediatric Visual Acuity Screening Guidelines)

- Attempt to initiate standard screening method at 3 years of age and perform at each subsequent WCC.

PERIODIC HEALTH EVALUATION VISIT SCHEDULE:

0-1 Years (Infancy)	1-4 Years (Early Childhood)	5-21 Years (middle Childhood-Young Adult)
Ages 1-2 weeks and 1(Breast Fed Infants), 2, 4, 6, 9, and 12 months	Ages 15, 18, and 24 months, 30 months (prn) and at 3 and 4 years	Annually

2. Age-Appropriate Developmental Assessment, Patient Education, and Anticipatory Guidance:
   a. Preschool Development/Behavioral Screening: (physical and mental)
      - Recognized questionnaire should be administered and documented in the medical record, at each WCC between 9 months of age and 48 months of age. Within Denver Health the Ages and Stages Questionnaire (ASQ) is utilized with the score documented in the Electronic Health Record, EHR.
        - ➢ Minimum expectations (see CP-23.004 Pediatric Development Screening A for details of screening and referral process) for example:
          - o One (1) ASQ by 15 months of age
          - o Two (2) ASQs by 24 months of age
          - o Three (3) ASQs by 36 months of age
   b. Physical: Gross/fine motor and sexual development *[See Physical Activity Table below, page 5]*
   c. Cognitive: Self-help and self-care skills; problem solving and reasoning abilities *[See Cognitive, Language and Social Development Table immediately below, page 6]*
   d. Language: expression, comprehension, and articulation
   e. Social: Assessment of social integration and peer relations, including school performance and family issue. Social Skills, child temperament
      - Ask about educational/day-care arrangements for infants, toddlers and preschoolers, and school and activities for older children
      - Sexual Activity History
        - ➢ Annually after 11 years of age as appropriate based on development
      - Tobacco Exposure, Use and Education *[See Tobacco Table below, page 7]*

- Assessment at every visit (patient and parent), with education at every WCC (and as needed)

- Child Abuse Assessment – at clinician's discretion *[See Family Violence/Abuse Table below, page 8]*
- Domestic Violence/Home Safety Assessment – at clinician's discretion
- Mental Health Needs Assessment
  - Adolescents
    - Assessment of possible school/learning, behavioral, legal, emotional, family/friends or sexual behavior concerns/problems
    - Completion of self-administered Risk Assessment such as "Adolescent Health History" annually
    - For high risk adolescents, administer PHQ-9 (or similar) to screen for depression (all adolescents if adequate follow-up can be identified).The score is documented in the EHR.

f. Health Education/Anticipatory Guidance Discussion: feeding/dietary, safety and injury prevention, social competence, health care *[See Sun Safety and Motor Vehicle Injury Prevention and General Counseling and Guidance – Social and Emotional Well-Being Tables below, pages 8-10]*

- Nutrition, Physical Activity, Dental, Injury, Behavior and Development Counseling *[See Diet/Nutrition Table below, page 11]*
  - Reach Out and Read: Guidance on language stimulation (with provision of new book) at every WCC from 6 months of age to 5 years of age
- Age appropriate per WCC and "Bright Futures" forms (<12 years of age)B
- Condom instruction
  - Assess need at every adolescent visit
- Behavioral Health
  - At age 0-6 months, ask about parental postpartum depression or history of prenatal depression
  - Adolescent Psychosocial/Behavioral Assessment
    - Use the Adolescent Health History at every WCC ≥ 11 years of age
    - Refer to primary care provider or mental health professional for those with a positive screening
    - Assess age-appropriate behavioral health, including aggression, depression, anxiety, and risk-taking behavior
    - Utilize behavioral health screening tools as appropriate

g. Oral Health and Screening
   - The DH "Dental Home" is a combination of oral health care provided by primary care providers and Dentists
   - Assessment of oral health and dental preventive counseling at every WCC
   - Application of fluoride varnish at every WCC from first tooth eruption up to 5 years of age
   - Referral to Dentist by 1 year of age or first tooth eruption for all children

3. Laboratory Screening
   a. Anemia
      - screen all children at 12-15 months of age and repeat if risk factors are present
      - Consider screening at 9 months of age for high risk infants (e.g., on whole milk, very low birth weight)
   b. Lead
      - Complete risk assessment at 6 months and again at 9 months
      - Perform on all children at 12-23 months of age WCC
      - Obtain on children 3-6 years of age if not previously screened
   c. Sexually Transmitted Infection (STI) screening
      - Annually for all sexually active adolescents. Consider universal urine GC/chlamydia in teens greater than or equal to 13 years at physicals.
      - Increase frequency if new partners, unprotected intercourse, or "test of cure"
      - Other screenings as indicated (HIV and RPR if GC is positive, or if two (2) or more partners in past six (6) months, history of STI; intercourse in exchange for money, drugs or housing; anal intercourse; intravenous drug abuse)
      - HIV screening recommended at 17 years of age
      - Pap/HPV screening: As long as the patient is not immunocompromised (HIV infection, etc.), cervical cytology screening should be avoided under 21 years of age
   d. New Immigrant or Refugee check/perform laboratory testing per current CDC recommendations.
4. Family planning counseling
   a. Pediatric visits
      - Parental education as appropriate
   b. Adolescents
      - Annually as appropriate, to include discussion of birth control options, efficacy and side effects, STI/HIV prevention and abstinence, documentation of Tanner stages
   c. Sexual Health education
      - Pre-Adolescence

- Developmentally appropriate discussion (consider "As Boys Grow" and "As Girls Grow")

5. Substance Abuse counseling
   a. Annual (and as needed) counseling for all adolescents to include tobacco, alcohol and other substances of abuse
6. Immunization and Tuberculin Screening
   a. Immunization – administer AAP/AAFP/CDC recommended immunizations as recommended by the DH immunization registry per the schedule recommended by the DH Medication Immunization Committee (MIMM). Refer to DH Immunization Policy for further details
      - Assessment of Immunization Status and Administration of Needed Immunizations
      - Refer to immunization schedule or immunization guideline
   b. Tuberculosis
      - Complete risk assessment by 1 month, and repeat at 6 months, 12months and 24 months with appropriate action to follow if positive
      - Screen all high-risk children (defined by tuberculosis risk questionnaire) by 15-18 months of age and at other ages as indicated using PPD (or TB blood test when available)
      - With continued exposure risks (e.g., child travel) after initial negative PPD, or Quantiferon blood test, consider testing every 1-3 years
      - Skin testing is done regardless of BCG history
      - May begin testing as early as 3 months of age in active TB exposed patients. Otherwise begin testing at 12-15 months of age.

Physical Activity:

0-1 Years	1-10 Years	5-21 Years
• Encourage opportunities for play time and other physical activity	• Ask about play time and other physical activities • Encourage opportunities for physical activity each day • Encourage parents to be role models for physical activity	• Ask about frequency, type, and duration of play time and other physical activities • Encourage daily physical activity (at least one hour a day) • Counsel on the importance of regular moderate-to-vigorous physical activity as a way to prevent illness in adult life • Encourage parents to be role models for physical activity

Cognitive, Language, and Social Development:

0-1 Years (Infancy)	1-4 Years (Early Childhood)	5-10 Years (Middle Childhood)	11-21 Years (Adolescence)

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• Ages and Stages Questionnaire (ASQ) should be administered at each WCC between 9 -48 months of age: o Complete at least 1 ASQ by 15 months of age • Review opportunities for cognitive growth and language development through talking, singing, and reading aloud and developing baby's fine (e.g. play with toys or food) and gross (e.g. tummy time, practice walking) motor skills • Counsel on avoiding background TV or related media	• ASQ should be administered at each WCC between 9- 48 months of age: Goals for ASQ completion o 1 completed by 15 months o 2 completed by 24 months o 3 completed by 36 months • Counsel that unstructured play is essential to the cognitive, physical, social, and emotional well-being development of children and adolescents • Review the importance of cognitive development by exposing children to language through talking, singing, and reading aloud	• Counsel that unstructured play is essential to the cognitive, physical, social, and emotional well-being development of children and adolescents • Review that a child's participation in sports or other physical activities can reinforce positive interaction skills and help ensure a positive self-image	• Complete an adolescent psychosocial/behavioral assessment at every well child visit ≥ 11 years • Encourage adolescents to maintain a balance of participation in extracurricular activities with demands of academics and/or work • Assess and screen for school concerns, signs of learning disorders, and social-adjustment concerns • Assess possible behavioral, legal, emotional, family/friends or sexual behavior concerns or problems • For high risk adolescents, administer PHQ-4 to screen for depression (all adolescents if appropriate follow-up can be identified) • Screen those age 11 years and older for sexual activity history as appropriate based on development

Tobacco:

0-4 Years	5-10 Years	11-21 Years
• Counsel parents who smoke on the potentially harmful effects of smoking on fetal and child health and on maintaining a smoke-free home. Refer parents to their PCP, QuitLine or to another smoking cessation program for help quitting	• Counsel parents who smoke on the potentially harmful effects of smoking on fetal and child health and on maintaining a smoke-free home. Refer parents to their PCP, QuitLine or to another smoking cessation program for help • Counsel patients not to begin using tobacco products, including e-cigarettes • Provide interventions, such as education and brief counseling to prevent initiation	• Counsel parents who smoke on the potentially harmful effects of smoking on fetal and child health and on maintaining a smoke-free home. Refer parents to their PCP, QuitLine or to another smoking cessation program for help quitting • Counsel patients not to begin using tobacco or any other substances such as e-cigarettes, smokeless tobacco, cigars, herbal substances

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0-4 Years	5-10 Years	11-21 Years
	of smoking	• Advise tobacco users to quit, especially patients who are pregnant • Assess readiness to quit • Assist tobacco users in quitting, especially patients who are pregnant. Provide brief counseling and refer to QuitLine or a smoking cessation program (patients under 18 will need consent from guardian to enroll) • Arrange follow-up

Family Violence/Abuse:

0-21 Years
• Screen for signs of family violence, including: facial/body bruising; depression; anxiety; failure to keep medical appointments; reluctance to answer questions about discipline in the home; or frequent office visits for complaints not supported by medical evaluation of the child • Screen for signs of child physical and/or sexual abuse • Counsel about safe relationships with adults, including no secrets, touching private parts or being asked to touch others private parts • For adolescents, counsel on safe and appropriate dating and relationships as well as strategies for avoiding or resolving conflicts with friends and peers • Ask about relationships with peers and bullying • Assessment at every visit (patient and parent) with education at every well child check (and as needed) regarding: child abuse assessment and domestic violence/home safety assessment

Sun Safety:

0-10 Years (Early Childhood-Middle Childhood)	11-21 Years (Adolescence-Young Adult)
• Advise that infants 6 months of age and younger should be kept out of direct sunlight • Encourage limiting time in the sun during peak hours • Encourage use of sunscreen, clothing, and hats to prevent sun exposure	• Encourage limiting time in the sun during peak hours and use of sunscreen, clothing, and hats to prevent sun exposure • Educate about skin cancer • Discourage use of indoor tanning • ≥20 years, perform skin exams
• Risk Factors: Repeated sunburns early in life; family history; certain types and a large number of moles; light skin/hair/eye color; sun-sensitive skin; and chronic exposure to the sun	

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Motor Vehicle Injury Prevention:

Resource: http://www.dmv.org/co-colorado/safety-laws.php

0-1 Years	1-10 Years	11-21 Years
• Ask about use of safety belts and child safety seats • Counsel that children should remain in rear-facing safety seats until at least 3 years of age or until either the height or weight limit of their rear-facing child safety seat has been reached • Counsel that rear facing car seat should be installed in the back seat only • Inform about the danger of front-seat airbags for children ≤ 12 years of age • Counsel parents against driving under the influence of alcohol/drugs	• Ask about use of safety belts and child safety seats • Counsel that children should remain in rear-facing child safety seats until they are at least 3 years old or until they reach the height/weight limit of their rear-facing seat. Children must be in an appropriate child passenger safety restraint; forward-facing safety seat until ≥40lbs; booster seat until 4ft9in tall or at least 8 years recommended • Inform about danger of front-seat airbags for children ≤12 years • Counsel parents against driving under the influence of alcohol/drugs	• Counsel parents that children <12 years who have outgrown their booster seats should always use a seat belt and ride in the back seat • Ask about the use of safety belts and motorcycle helmets • Inform about danger of front-seat airbags for children aged 12 and under • Counsel that seat belts are mandatory for drivers and all front-seat passengers in Colorado • Counsel that Colorado law requires motorcycle riders under 18 years to wear a DOT approved helmet, and riders and passengers must wear eye protection regardless of age • Counsel against driving under the influence of alcohol/drugs or getting in a car with someone under the influence of alcohol/drugs • Counsel against excessive speed and other risk-taking behaviors while driving, such as cell phone use • Inform that cell phone use (including texting) while driving is prohibited for those under age 18 in the state of Colorado

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GENERAL COUNSELING AND GUIDANCE- SOCIAL AND EMOTIONAL WELL-BEING

Electronic Media Exposure:

0-1 Years (Infancy)	1-4 Years (Early Childhood)	5-21 Years (Middle Childhood-Young Adult)
• Discourage screen time except supervised video chats	• Discourage screen time for children less than 2 years, and limit screen time to 1 hour per day for 2-4 year olds • Ask about frequency of age-appropriate screen time, including TV, computer, and mobile electronic devices (handheld video games, cell phones, etc.) being viewed • Counsel on monitoring material being viewed • Discourage placement of computer and TV in bedroom • Counsel on impact of screen time as a risk factor for becoming overweight, low school performance, and violent behavior	• Ask about frequency of age-appropriate screen time, including TV, computer, and mobile electronic devices (handheld video games, cell phones, etc.) being viewed • Counsel on impact of screen time as a risk factor for low school performance, overweight, and violent behavior • Counsel on monitoring material being viewed • Encourage discussions on internet safety (behavior or social media, cyber bullying, etc.) • Place consistent limits on time spent using media, and they types of media. Ensure that media does not take the place of adequate sleep, physical activity, and other behaviors essential to health • Designate media-free times together, such as dinner or driving, as well as media-free locations at home, such as bedrooms • Discourage placement of computer and TV in bedroom • Discuss limits on text messaging and cell phone use, such as, no phone in bedroom near bedtime • Encourage shutting down electronic devices before bedtime • Discourage listening to loud-frequency sound on earphones

Diet/Nutrition:

0-1 Years	1-10 Years	11-21 Years

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• Ask about dietary habits including food insecurity • Promote breastfeeding as best form of infant nutrition for first 4-6 months • Recommend breastfeeding for at least 1 year if possible and counsel breast mild as sole source of nutrition • Counsel for breastfed infants to receive 400 IU of oral vitamin D drops daily beginning soon after birth and continuing until the daily consumption of fortified formula or milk is 500mL (16oz/2cups) • Infants weaned before 12 months should receive iron fortified infant formula • Cow's milk can be given to children at 1 year of age • Counsel not to restrict fat or cholesterol • Refer eligible families to WIC or SNAP programs for help with supplemental nutritional or other needs	• Ask about dietary habits, including food insecurity • Counsel about the benefits of a healthy diet, ways to achieve a healthy diet, and safe weight management • A healthy diet: o Emphasizes fruits and vegetables; whole grains; low-fat dairy; lean proteins, nuts and legumes o Limits red meat, saturated and trans fat, and food and beverages with added sugar o Follows appropriate portion size • Refer eligible families to WIC or SNAP programs for help with supplemental nutritional or other needs	• Ask annually about dietary habits, including food insecurity • Counsel about the benefits of a healthy diet, ways to achieve a healthy diet, and safe weight management • A healthy diet: o Emphasizes fruits and vegetables; whole grains; low-fat dairy; lean proteins, nuts and legumes o Limits red meat, saturated and trans fat, and food and beverages with added sugar o Follows appropriate portion size • Screen for eating disorders by asking about body image and dieting patterns • Counsel to maintain adequate calcium and vitamin D intake • Counsel against sugar-sweetened and caffeinated drinks • Advise patients at risk of becoming pregnant to take a multivitamin containing 0.4mg foliate • Refer eligible families to WIC or SNAP programs for help with supplemental nutritional or other needs

B. EPSDT Services

1. EPSDT is key to ensuring that children and youth receive appropriate preventive, dental, mental health, developmental and specialty services.
    a. **Early**: Assessing and identifying problems early
    b. **Periodic**: Checking children's health at periodic, age-appropriate intervals
    c. **Screening**: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
    d. **Diagnostic**: Performing diagnostic tests to follow up when a risk is identified, and
    e. **Treatment**: Control, correct or ameliorate health problems found.

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f. EPSDT is made up of the following screening, diagnostic, and treatment services:

2. Screening Services
   a. Comprehensive health and developmental history
   b. Comprehensive unclothed physical exam
   c. Appropriate immunizations (according to the Advisory Committee on Immunization Practices)
   d. Laboratory tests (including lead toxicity testing)
   e. Health Education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention)
3. Vision Services
   a. At a minimum, diagnosis and treatment for defects in vision, including eyeglasses.
4. Dental Services
   a. At a minimum, dental services include relief of pain and infections, restoration of teeth, and maintenance of dental health, including examinations, cleanings and fluoride treatments.
5. Hearing Services
   a. At a minimum, diagnosis and treatment for defects in hearing, including hearing aids.
6. Other Necessary Health Care Services
   a. Additional health care services that are coverable under the Federal Medicaid program and found to be medically necessary to treat, correct or ameliorate illnesses and conditions discovered regardless of whether the service is covered in a state's Medicaid plan.
7. Diagnostic Services
   a. When a screening indicates the need for further evaluation, diagnostic services must be provided.
8. Treatment
   a. Necessary health care services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.
9. Lead Screening

C. **EPSDT Wrap-Around Services**
   1. Wrap-Around Benefits are additional treatments or services that are not part of the Denver Health Medicaid Choice covered benefits, but are covered by Medicaid and payable by the State's fiscal agent when medically necessary. It is the providers' responsibility to make a referral to another provider or Healthy Communities. Providers can obtain assistance with Wrap-Around services from the ACS RN Care Coordinator and should contact them with any questions. See Section VII for tracking requirements associated with Wrap-Around benefits.
      a. Wrap-Around Benefits associated with EPSDT:
      b. Hearing devices and auditory training

c. Dental/hygienist care and treatment
d. Orthodontia for severe, handicapping malocclusions
e. Transportation for non-emergency medical, dental, or behavioral/mental health care
f. Family planning with a non DH provider such as Planned Parenthood
g. Hospice services
h. Skilled nursing facility care
i. Intestinal transplants
j. Private duty nursing
k. Expanded benefits; benefits that the state chooses to provide a child that are above and beyond the EPSDT benefit package. Examples are: chiropractic care and extraordinary home care.

D. **EPSDT Supporting Services and Programs**

1. *Healthy Communities* is a comprehensive community-based outreach program designed to assist families, children, and pregnant women to find appropriate services. Healthy Communities can help provide or arrange for the provision of screening services for all children; arrange (through referral) for corrective treatment as determined by child health screenings; missed appointment follow-up; and refer for transportation assistance. Providers can also contact Healthy Communities to obtain assistance with EPSDT related Wrap-Around services, or may refer members to Healthy Communities for any questions related to EPSDT related Wrap-Around services.

EPIC: AMB REF TO PEDIATRIC CARE COORDINATION (EPSDT) [REF430] Phone: (303) 602-6770

2. For *Denver Health Medical Plan (DHMP)* members, contact Member Services for questions regarding Care Management or to refer a child for Care Management Services. **Phone: (303) 602-2140**
3. The *EPSDT Outreach Coordinator* for the State is available to help providers and families of Medicaid children (ages 0 through 20) by helping families complete paperwork for Medicaid and CHP+; guiding families to appropriately use Medicaid benefits; assisting with finding a Medicaid dentist; assisting with coordination of transportation through the local Health and Human services department. **Contact: Gina Robinson Phone: (303) 866-6167**

E. **Medical Necessity for EPSDT Services**

1. Medical Necessity is defined as:
   a. A service that is found to be equally effective treatment among other less conservative or more costly treatment options.
   b. Meets one of the following criteria:
      i. The service is expected to prevent or diagnose the onset of an illness, condition, or disability.

ii. The service is expected to cure, correct, or reduce the physical, mental, cognitive, or developmental effects of an illness, injury, or disability.
iii. The service is expected to reduce or ameliorate the pain and suffering caused by an illness, injury, or disability.
iv. The service is expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living.

c. May be a course of treatment that includes observation or no treatment at all.

2. Medical Necessity does **not** include:
   a. Experimental or investigational treatments;
   b. Services or items not generally accepted as effective; and/or not within the normal course and duration of treatment; or
   c. Services for caregiver or providers convenience.

F. **EPSDT Provider Responsibility**

1. Provide health screening services, including immunizations; according to EPSDT guidelines and periodicity schedule (see Section I above).
2. Promptly diagnose, treat or provide referral for problems identified during the screening process.
   a. If a provider is not licensed or equipped to render necessary treatment, the provider is responsible to make a referral to another provider, make a referral to Healthy Communities, and/or make a referral to the UM case managers to assist with a referral (see Section IV above).
3. Utilize the ColoradoPAR Provider Portal for wrap-around services available through Colorado Health First for delivery of medically necessary services to EPSDT-eligible members.

G. **Tracking of EPSDT-required Services**

1. Initiation of treatment, if required, must occur within an outer limit of six months after a referral has been placed. To ensure the delivery of EPSDT-required services, the following tools should be utilized as needed:
   a. EPIC Reports
   b. ACS Data and Analytics Reports
   c. ColoradoPAR Provider Portal Reports

IV. EXTERNAL REFERENCES/TOOLS:

American Academy of Pediatrics Bright Futures Guidelines: http://brightfutures.aap.org
AAP Committee on Infectious Diseases Red Book: http://aapredbook.aappublications.org/
CDC Immigrant and Refugee Screening Guidelines:
http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/domestic-guidelines.html

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Colorado Department of Health Care Policy and Financing: colorado.gov/pacific/hcpf/early-and-periodic-screening-diagnostic-and-treatment-epsdt

V. ATTACHMENTS:

American Academy of Pediatrics: Bright Futures/AAP periodicity schedule 2020

VI. REFERENCES:

American Academy of Pediatrics. (2020). Bright Futures: Prevention and Health Promotion for Infants, Children, Adolescents and their Families. Elk Grove Village, Illinois, United States.
American Academy of Pediatrics: Bright Futures/AAP periodicity schedule 2020
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

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