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 (head circumference) 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 20d
         • Screen the following frequencies: 500, 1000, 2000, 4000 Hz routinely

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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

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")

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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, 12 months 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:

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

### Cognitive, Language, and Social Development:

<table>
<thead>
<tr>
<th>0-1 Years (Infancy)</th>
<th>1-4 Years (Early Childhood)</th>
<th>5-10 Years (Middle Childhood)</th>
<th>11-21 Years (Adolescence)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ages and Stages Questionnaire (ASQ)</td>
<td>• ASQ should be administered at each WCC</td>
<td>• Counsel that unstructured play is</td>
<td>• Complete an adolescent psychosocial/behavioral assessment</td>
</tr>
</tbody>
</table>

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should be administered at each WCC between 9-48 months of age:
- 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

between 9-48 months of age: Goals for ASQ completion
- 1 completed by 15 months
- 2 completed by 24 months
- 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

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

Tobacco:

<table>
<thead>
<tr>
<th>0-4 Years</th>
<th>5-10 Years</th>
<th>11-21 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 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</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 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</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 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</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 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:

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**CLINICAL PREVENTIVE GUIDELINE**

**Guideline Number:** DHMP_DHMC_PG1006  
**Effective Date:** 11/1/2021  
**Guideline Subject:** Well Child and Adolescent Health  
**Revision Date:** 11/1/2022  
**Pages:** 7 of 14

<table>
<thead>
<tr>
<th>0-4 Years</th>
<th>5-10 Years</th>
<th>11-21 Years</th>
</tr>
</thead>
</table>
| • 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:**

<table>
<thead>
<tr>
<th>0-10 Years (Early Childhood-Middle Childhood)</th>
<th>11-21 Years (Adolescence-Young Adult)</th>
</tr>
</thead>
</table>
| • 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  
• 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 |
| • 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 |

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### Motor Vehicle Injury Prevention:


<table>
<thead>
<tr>
<th>Age Range</th>
<th>0-1 Years</th>
<th>1-10 Years</th>
<th>11-21 Years</th>
</tr>
</thead>
</table>
|           | • Ask about use of safety belts and child safety seats  
|           | • Counsel that children should remain in rear-facing child safety seats until at least 3 years of age or until their 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:

<table>
<thead>
<tr>
<th>0-1 Years (Infancy)</th>
<th>1-4 Years (Early Childhood)</th>
<th>5-21 Years (Middle Childhood-Young Adult)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discourage screen time except supervised video chats</td>
<td>Discourage screen time for children less than 2 years, and limit screen time to 1 hour per day for 2-4 year olds</td>
<td>Ask about frequency of age-appropriate screen time, including TV, computer, and mobile electronic devices (handheld video games, cell phones, etc.) being viewed</td>
</tr>
<tr>
<td>Ask about frequency of age-appropriate screen time, including TV, computer, and mobile electronic devices (handheld video games, cell phones, etc.) being viewed</td>
<td>Counsel on impact of screen time as a risk factor for becoming overweight, low school performance, and violent behavior</td>
<td>Ask about frequency of age-appropriate screen time, including TV, computer, and mobile electronic devices (handheld video games, cell phones, etc.) being viewed</td>
</tr>
<tr>
<td>Discourage placement of computer and TV in bedroom</td>
<td>Counsel on monitoring material being viewed</td>
<td>Counsel on impact of screen time as a risk factor for low school performance, overweight, and violent behavior</td>
</tr>
<tr>
<td>Counsel on impact of screen time as a risk factor for becoming overweight, low school performance, and violent behavior</td>
<td>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</td>
<td>Counsel on monitoring material being viewed</td>
</tr>
<tr>
<td></td>
<td>Designate media-free times together, such as dinner or driving, as well as media-free locations at home, such as bedrooms</td>
<td>Encourage discussions on internet safety (behavior or social media, cyber bullying, etc.)</td>
</tr>
<tr>
<td></td>
<td>Discourage placement of computer and TV in bedroom</td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>Discuss limits on text messaging and cell phone use, such as, no phone in bedroom near bedtime</td>
<td>Counsel on monitoring material being viewed</td>
</tr>
<tr>
<td></td>
<td>Encourage shutting down electronic devices before bedtime</td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>Discourage listening to loud-frequency sound on earphones</td>
<td>Designate media-free times together, such as dinner or driving, as well as media-free locations at home, such as bedrooms</td>
</tr>
</tbody>
</table>

Diet/Nutrition:

<table>
<thead>
<tr>
<th>0-1 Years</th>
<th>1-10 Years</th>
<th>11-21 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask about dietary habits including food</td>
<td>Ask about dietary habits,</td>
<td>Ask annually about dietary habits,</td>
</tr>
</tbody>
</table>

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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 milk 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

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

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

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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

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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.

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

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

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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 manifest or significant health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP appreciates 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 the Bright Futures Guidelines (Hagan JF, Shaw JS, Duncan PM, eds. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.


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TABLE 1

<table>
<thead>
<tr>
<th>ANTICIPATORY GUIDELINES</th>
<th>INFANCY</th>
<th>EARLY CHILDHOOD</th>
<th>MIDDLE CHILDHOOD</th>
<th>ADOLESCENCE</th>
</tr>
</thead>
</table>
| 1. If a child comes under care for the first time at any age 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 the benefits of breastfeeding and planned method of delivery, per “The Prenatal Visit” (http://pediatrics.aappublications.org/content/129/2/348).

3. Neonates should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).

4. Neonates 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 neonates should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in “Breastfeeding and the Use of Human Milk” (http://pediatrics.aappublications.org/content/129/3/827).


6. Screening should occur per “Clinical Practice Guidelines for Screening and Management of High Blood Pressure in Children and Adolescents” (http://pediatrics.aappublications.org/content/140/5/1079). Blood pressure measurement in infants and children with specific risk conditions should be performed at the next age-appropriate visit.

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 “Visual Acuity Assessment in Infants, Children, and Young Adults by Pedometrics” (http://pediatrics.aappublications.org/content/137/1/139560 and “Procedures for the Examination of the Visual System by Pediatrics” [http://pediatrics.aappublications.org/content/137/1/139560]).

8. Hearing screening at 1 year is appropriate for children with specific risk conditions. A recommended test is available at http://coch.net.

9. This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See “Promoting Optimal Development: Screening for Behavioral and Emotional Problems” (http://pediatrics.aappublications.org/content/137/2/99).


12. Screening should occur per “Identification and Evaluation of Children With Autism Spectrum Disorder” (http://pediatrics.aappublications.org/content/138/1/185).


14. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.

15. A recommended assessment tool is available at http://coch.net.

16. This should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See “Promoting Optimal Development: Screening for Behavioral and Emotional Problems” (http://pediatrics.aappublications.org/content/137/2/99).

17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See “Use of Chaperones During the Physical Examination of the Pediatric Patient” (http://pediatrics.aappublications.org/content/137/2/345).


19. Anticipatory guidance should be provided at visits at ages 12 to 15, 15 to 17, and 18 to 21 years. See “The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies” (https://www.sciencedirect.com/science/article/pii/S1054139X16000483).


21. This statement does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

22. No part of this statement may be reproduced in any form or by any means without prior written permission from the American Academy of Pediatrics except for one copy for personal use.

(continued)
Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This schedule reflects changes approved in October 2019 and published in March 2020. For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

CHANGES MADE IN OCTOBER 2019

MATERNAL DEPRESSION

• Footnote 16 has been updated to read as follows: “Screening should be performed at each well-child visit and used to identify women who may benefit from counseling and treatment.”

BLOOD PRESSURE

• Footnote 6 has been updated to read as follows: “Screening should be performed at each well-child visit and used to identify children who may benefit from counseling and treatment.”

ANEMIA

• Footnote 24 has been updated to read as follows: “Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP Pediatric Nutrition: Policy of the American Academy of Pediatrics (Iron chapter).”

LEAD

• Footnote 25 has been updated to read as follows: “For children at risk of lead exposure, see ‘Prevention of Childhood Lead Toxicity’.”

CHANGES MADE IN DECEMBER 2018

BLOOD PRESSURE

• Footnote 6 has been updated to read as follows: “Screening should be performed at each well-child visit and used to identify children who may benefit from counseling and treatment.”

ANEMIA

• Footnote 24 has been updated to read as follows: “Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP Pediatric Nutrition: Policy of the American Academy of Pediatrics (Iron chapter).”

LEAD

• Footnote 25 has been updated to read as follows: “For children at risk of lead exposure, see ‘Prevention of Childhood Lead Toxicity’.”