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Pediatric and Adolescent Preventive Healthcare Guidelines

Clinical Care Guideline

PURPOSE

To provide consistent Preventive Health-care Guidelines for Pediatric and Adolescent populations in Community Health Services (CHS), in accordance with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program requirements.

INCLUSION CRITERIA

Patient Population:

A. Inclusions: Patients from newborn through age 20 years of age

1. Preemie: < 36 weeks gestation
2. Infant: birth → 1 year
3. Toddler: 1 year → 3 years
4. Child: 4 years → 11 years
5. Adolescent: 12 years → 18 years

B. Exclusions: Patients age 21 years and older

RESPONSIBILITY

Providers (MDs and Licensed Independent Practitioners) and RNs who care for pediatric patients are expected to follow these preventive care guidelines.

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 B thru G below for additional detail.

A. **Preventive Healthcare Guidelines**

1. Well Child Care (WCC) visit Periodicity and Recommended Screening

a. Newborn visit schedule:

i. All babies discharged from the newborn nursery should be evaluated in a clinic within 48-72 hours of discharge. For babies discharged from the hospital at less than 48 hours of age, the clinic appointment should be scheduled within 48 hours of discharge whenever possible.

ii. WCC visit schedule:

• Newborn weight, feeding, and jaundice check by 5 days of age (can be a nurse visit)

• 2 weeks of age

• 6-8 weeks of age (if possible scheduled prior to 56 days of life so that infant's mother can obtain her postpartum check at same time)

• 4, 6, 9, 12, 15, 18, 24, 30 months of age, 3 years, and then annually from 4-18 years of age iii. Visits to include an age-appropriate history and physical exam per WCC smartform.

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iv. 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, and every visit ≥ 3 years of age

v. 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
    - Screen the following frequencies: 500, 1000, 2000, 4000 Hz routinely
  - At age 11 yrs and annually thereafter, additional screen at 6000 and 8000 Hz
- Vision
  - Initiate instrument-based screening method at 3 years of age (optionally as young as 12 months) and perform direct visual screen (SLOAN or SNELLEN charts) at each subsequent WCC.

vi. Preschool Development/Behavioral Screening

- The Survey for Well-being of Young Children (SWYC) should be administered at each WCC between 2 and 60 months of age. The score is documented in the Electronic Health Record, EHR.
- Adolescent Psychosocial/Behavioral Assessment
  - Use the Adolescent Health History smartform at every WCC ≥ 12 years of age
- Oral Health and Screening
  - The "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
  - Referral to Dentist by 1 year of age or first tooth eruption for all children

2. Laboratory Screening

a. Newborn Metabolic Screening

i. Obtain on every newborn in nursery

ii. Second screen at 2 weeks of age and greater

b. Anemia

i. Hct for all children at 12-15 months of age and repeat at 2 years of age

• Consider screening at 9 months of age for high risk infants (e.g., on whole milk, very low birth weight)

ii. Check CBC in older children only if there is a clinical concern for anemia

c. Lead

i. All children at 12-23 months of age WCC

ii. Obtain on children 3-6 years of age if not previously screened

d. Sexually Transmitted Infection (STI) screening

i. Annually for all adolescents 14 years of age and over

ii. Increase frequency if new partners or unprotected intercourse

iii. 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)

e. Pap/HPV screening: Cervical cytologic screening should be avoided under 25 years of age.

f. New Immigrant or refugee check/perform: (see Immigrant and Refugee lab smart sets and flow sheet for details)

i. CBC/diff on arrival (6mo -21 years)

ii. Lead on arrival (6mo-16 years)

iii. Newborn screening if <=6 mo,

iv. TSH if 7mo-3 years v. Quantiferon blood test if 2 years and up

vi. PPD if under 2 years

vii. If there are no records of prenatal screening, check; syphilis EIA, HIV, Hep B s Ag, sAb, cAb, and Hep C Ab.

3. Patient Education and Anticipatory Guidance

a. Nutrition, Physical Activity, Dental, Injury, Behavior and Development Counseling

b. Reach Out and Read: Guidance on language stimulation (with provision of new

book) at every WCC from 2 weeks of age to 5 years of age.

c. Age appropriate per WCC smartform and "Bright Futures" forms (<12 years of age)B

d. Condom instruction

i. Assess need at every adolescent visit

e. Family planning counseling

i. Pediatric visits

- Parental education as appropriate

ii. Adolescents

- Annually as appropriate, to include discussion of birth control options, efficacy and side effects, STI/HIV prevention and abstinence, documentation of Tanner stages

iii. Sexual Health education

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

iv. Substance Abuse counseling

- Annual (and as needed) counseling for all adolescents to include tobacco, alcohol and other substances of abuse

4. Social

a. Sexual Activity History

i. Annually after 11 years of age as appropriate based on development

b. Tobacco Exposure, Use and Education

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

c. Child Abuse Assessment – at clinician's discretion

d. Domestic Violence/Home Safety Assessment – at clinician's discretion

e. Mental Health Needs Assessment

i. Adolescents

- Assessment of possible school/learning, behavioral, legal, emotional, family/friends or sexual behavior concerns/problems

- Completion of self-administered "Adolescent Health History" and PHQ-4 (risk assessment) annually starting at age 12
- For high risk adolescents, administer APHQ-9 to screen for depression (all adolescents if adequate follow-up can be identified).The paper form becomes part of the medical record and the score is documented in the EHR.

5. Immunization and Tuberculin Screening

a. Immunization – administer AAP/AAFP/CDC recommended immunizations as recommended by the immunization registry.

b. Tuberculosis

i. Screen all high-risk children greater than 2 years of age born in an endemic area for TB (incidence >20/10,000) without a history of Quantiferon blood test or Tureculin Skin Test

ii. With continued exposure risks (e.g., child travel) after initial negative PPD, or Quantiferon blood test, consider testing every 1-3 years

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:

2. Screening Services

a. Comprehensive health and developmental history

b. Comprehensive unclothed physical exam (as appropriate)

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 Elevate Medicaid Choice by Denver Health Medical Plan covered benefits, but are covered by Medicaid and payable by the State's fiscal agent when medically necessary. Providers can obtain assistance with Wrap-Around services from an 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 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. DHMP Plan Members

1. 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**

2. 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. Data and Analytics Reports

c. ColoradoPAR Provider Portal Reports

EXTERNAL REFERENCES

A. American Academy of Pediatrics Bright Futures Periodicity Schedule (https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf)

B. American Academy of Pediatrics Bright Futures (http://brightfutures.aap.org)

C. AAP Committee on Infectious Diseases Red Book (http://aapredbook.aappublications.org/)

D. CDC Immigrant and Refugee Screening Guidelines (http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/domestic-guidelines.html)

DHMP/DHHA RELATED DOCUMENTS

None

This Clinical Care Guideline is intended to assist care providers in the provision of patient care. This document serves as a guide, and is not a substitute for independent medical decision-making.

Approval Signatures

Step Description	Approver	Date
Final Signatory	Christine Seals-Messersmith: Medical Director Managed Care	12/2024
Formatting	Candy Gibbons: Executive Assistant [SG]	11/2024
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Applicability

Denver Health Medical Plan (DHMP)