# Agenda

**Quarterly Community Provider Network (CPN) Meeting (East)**

**Date:** October 22, 2019  
**Time:** 12:30 PM – 2:00 PM  
**Location:** Pittsburg Health Center  
2311 Loveridge Rd.,  
Classroom B - 1st Floor  
Pittsburg, CA 94565

<table>
<thead>
<tr>
<th>I. CALL TO ORDER and INTRODUCTIONS</th>
<th>Christine Gordon, RN, BSN, PHN, DHCS-MT</th>
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<tbody>
<tr>
<td>II. REVIEW and APPROVAL of Previous Meeting Minutes</td>
<td>Christine Gordon, RN, BSN, PHN, DHCS-MT</td>
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<td>III. IHA, SHA, USPSTF</td>
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</table>
  • IHA, SHA, USPSTF  
  • 2019 DHCS: New FSR/MRR Tools | Christine Gordon, RN, BSN, PHN, DHCS-MT |
| IV. GUEST SPEAKERS |  
  • Member Grievance Process | Belkys Teutle, Member Services Manager |
| V. REGULAR REPORTS |  
  1. Legislative / CCHP Update  
  • California Advancing and Innovating Medi-Cal (Cal-AIM)  
  • DMHC/DHCS Audit highlights  
  2. CCHP Benefits update  
  • NEMT Transportation form DMHC/DHCS Audit highlights  
  • Updates to “No Auth” list  
  3. Quality  
  • NCQA – “Commendable” rating  
  • Population Health Performance Improvement Projects (PIP’s)  
  4. Pharmacy  
  • Review Care Matters  
  5. Utilization Management  
  • Q and A | Jose Yasul, MD  
  Medical Director, CCHP |
| VI. CLAIMS Q&A | Claims Unit Staff |

Our next scheduled meeting is January 28, 2020  
CPN meeting reimbursement will be prorated based on length of time attendee is present in the meeting.
CONTRA COSTA HEALTH PLAN  
East County  
Quarterly Community Provider Network (CPN)  
Meeting Minutes - October 22, 2019

Attending:
CCHP Staff: Jose Yasul, MD, Medical Director; Christine Gordon, RN, BSN, DHCS-MT; Jonel Sangalang, Clerical Support; Elisa Hernandez; Sylvia Hernandez, Claims Supervisor  
CPN Providers: C. Cave, NP; G. Del Rio, MD; B. Gharagozlou, MD; J. Sequeira, MD; C. Som, DO; U. Vallamdas, MD; X. Yang, MD  
Guest Belkys Teutle, Member Services Manager

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<tr>
<td>I.</td>
<td>Minutes were approved with no revisions.</td>
<td>Jose Yasul, MD Medical Director, CCHP</td>
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<td>II.</td>
<td>Reminders</td>
<td>Christine Gordon, RN, BSN, DHCS-MT</td>
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<td></td>
<td>• Initial Health Assessment (IHA)</td>
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<td>o Must be completed within 120 days of enrollment into the health plan or documented within the 12 months prior to Plan enrollment.</td>
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<td>o If member assigned to new PCP, IHA must be completed within 120 days of that assignment if no IHA documented within the past 12 months.</td>
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<td>o IHA includes H&amp;P, IHEBA (SHA), USPSTF screenings, ensure up-to-date immunizations per ACIP.</td>
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<tr>
<td></td>
<td>o Perinatal depression screening.</td>
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<td>o Gonococcal Ophthalmic Neonatorum screening.</td>
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<td>• USPSTF Update:</td>
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<td>o Colorectal cancer screening</td>
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<td>o Lipid screening – children only</td>
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<td>o Post-partum depression screening for new moms</td>
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<td>o Intimate partner violence screening</td>
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<td>o Folic acid supplementation</td>
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<td>o Immunization registry reporting</td>
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<td>• Facility, site and medical record review tools from DHCS</td>
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<td>o Extensive review</td>
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<td>o Spend more time at the facilities</td>
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<td>o USPSTF screenings</td>
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<td>o PowerPoint will be sent to the PCPs</td>
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<td>III.</td>
<td>Guest Speaker</td>
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<td>Member Grievance Process</td>
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<td>• Member Grievance Application (English and Spanish)</td>
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<td>• Member Consent Form (English and Spanish)</td>
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- Forms are available electronically
- Compliance with state
- Some Providers process grievances internally
- Educate the member and the parent

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<td>California Advancing and Innovating Medi-Cal (Cal-AIM)</td>
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<td>Non-Emergency Transportation form – Gurney</td>
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<td>Non-Medical Transportation form – Social visit</td>
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<td>Provider orientation packet</td>
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<td>o “No Auth” list</td>
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<td>■ 3,000 to 9,000 on list</td>
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<td>o Omron 3 blood pressure cuff</td>
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<td>■ Send prescription to pharmacy</td>
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<td>o Pharmacy and Therapeutics update</td>
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<td>■ HPV vaccine – MMR update</td>
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<td>■ Steroids – injection on No Auth list</td>
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<td>■ Apidra to Lispro</td>
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<td>■ Roxy condone back on formulary</td>
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<td>Medi-Cal carve out all drugs plan</td>
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<td>Respite care</td>
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<td>Behavioral health (Mid to moderate)</td>
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**Adjournment:**
Meeting adjourned at 1:45 P.M.

**Next meeting January 28, 2020**
In this Issue:
- International Travel Planning for the Holidays
- Immunization Updates – Back-to-School
- Influenza – 2019-2020 Season Updates
- Botulism – A Health Emergency
- Rabies – Postexposure Prophylaxis

Disease Reporting
- List of Reportable Diseases
- Confidential Morbidity Reports
- List of Laboratory Reportable Diseases

Communicable Diseases
8am – 5pm, M-F
Phone: (925) 313-6740
Fax: (925) 313-6465

Sexually Transmitted Diseases
8am – 5pm, M-F
Phone: (925) 313-6750
Fax: (925) 313-6758

Public Health Laboratory
8am – 5pm, M-F
Phone: (925) 370-5775
Fax: (925) 370-5252

After Hours Public Health
5pm – 8am, M-F and 24hrs, Sat and Sun
Call County Sheriff’s Dispatch
Phone: (925) 646-2441
Ask for Health Officer On-Call

To Our Health Partners in the Community
Please visit https://cchealth.org/providers/ to subscribe to our electronic version of this newsletter and view local health alerts and advisories. Please contact us at CoCoCD@cchealth.org with suggested newsletter topics and comments. For urgent questions or to report a communicable disease, please call us at (925) 313-6740.

International Travel Planning
The Holidays are a popular time for extended international travel to visit friends and family. Measles, typhoid fever, and vector-borne diseases are some of the conditions we see in Contra Costa County residents returning from abroad. For more information, check the CDC Travelers’ Health webpage for country travel advisories and disease specific health recommendations: https://wwwnc.cdc.gov/travel

Measles
Make sure your patients who are traveling internationally are protected from measles. There are measles outbreaks occurring in many areas of the world, including the US, Europe, Asia and Africa. The CDC recommends that all international travelers be protected against measles. Before traveling internationally,
- Infants (6-11 months): one doses of measles-mumps-rubella (MMR) vaccine.
- Children (1 year or older): 2 doses MMR vaccine. The doses can be given outside routine schedule and as close as 28 days apart.
- Adults: documentation of 2 doses of measles-containing vaccine or evidence of immunity.

For more information: https://www.cdc.gov/measles/hcp/index.html

Typhoid Fever
Typhoid fever is common worldwide except in industrialized regions such as the US, Canada, western Europe, Australia, and Japan. US travelers to typhoid-endemic regions should receive pre-travel vaccination at least 1-2 weeks before traveling. US travelers to typhoid-endemic regions should also be advised regarding safe food and water practices while abroad.

Other Routine Vaccinations
Travelers may also need routine (non-travel) vaccines or boosters before travel including: influenza, tetanus (Td or Tdap), varicella, pneumococcus, and polio.

Malaria
It is important to discuss malaria prophylaxis with ALL travelers who are going to areas with malaria transmission, regardless of previous travel or habitation in that area. All travelers going to malaria-endemic countries, which include parts of Africa, Latin America, the Caribbean, Asia, the Middle East, Eastern Europe, and the South Pacific are at risk for contracting the disease. Almost all the approximately 1,700 cases of malaria per year in the United States are imported cases of disease.

General Mosquito-Borne Disease Precautions
To decrease risk of all mosquito-borne diseases (e.g. chikungunya, dengue, yellow fever, zika, etc.) advise patients to prevent mosquito bites by using insect repellents, wearing long-sleeve shirts and pants, and sleeping under a mosquito bed net if sleeping outside or in a room that does not have screens or air conditioning.
**Immunization Updates**

**School Entry Immunizations**

Students entering childcare, preschool, transitional kindergarten and grades K-12 will need proof of vaccination for admission per California law.

*Parents must show their child’s Immunization Record as proof of immunization.*

For more information on requirements by age/grade level, visit: [https://www.shotsfor school.org/](https://www.shotsforschool.org/)

**Required Immunizations for School Admissions:**

*Guidance Changes as of July 1, 2019:*

- **NEW!**
  
  **Varicella** (Chickenpox)
  
  2 doses are now required for 7th grade

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**Influenza 2019-2020 Season Updates**

Routine annual influenza vaccination is recommended for **all persons aged 6 months and above** who do not have contraindications to vaccination. Optimally, vaccination should occur before the onset of influenza activity in the community. Health care providers should offer vaccination by the end of October, if possible. Vaccination should continue through the spring.

**Influenza Vaccine Formulation for 2019-20:**

- A/Brisbane/02/2018 (H1N1)pdm09–like virus*
- A/Kansas/14/2017 (H3N2)-like virus*
- B/Colorado/06/2017–like virus (Victoria lineage)
- B/Phuket/3073/2013-like virus (quadrivalent formulations only)

*new for this year

**Vaccination Recommendations**

*Children Aged 6 Months Through 8 Years**: For optimum protection the Advisory Committee on Immunization Practices (ACIP) recommends that children aged 6 months through 8 years who have **not** previously received ≥2 doses of trivalent or quadrivalent influenza vaccine before July 1, 2019 (these doses do not need to be administered in consecutive seasons) receive 2 doses for the 2019-20 season. The interval between the 2 doses should be at least 4 weeks.

**Pregnant Women**: Pregnant and postpartum women are at higher risk for severe illness and complications from influenza, particularly during the second and third trimesters. ACIP and the American College of Obstetricians and Gynecologists recommend that all women who are pregnant or who might be pregnant during the influenza season receive influenza vaccine. Any licensed, recommended, and age-appropriate preservative-free flu vaccine may be used. Intranasal flu vaccine (FluMist) should not be used during pregnancy. Influenza vaccine can be administered at any time during pregnancy.

**Per California law**, pregnant women and children under 3 years of age may only receive preservative-free vaccine.

**Older Adults**: Because of the vulnerability of this population to severe influenza illness, hospitalization, and death, influenza vaccination among older adults is recommended. High dose and adjuvanted flu vaccine have better effectiveness in this population, however there is no formal preference for any vaccine product by the ACIP. For persons aged ≥65 years, any age-appropriate influenza formulation (standard-dose or high-dose, trivalent or quadrivalent, unadjuvanted or adjuvanted) or recombinant inactivated influenza vaccine are acceptable options. Vaccination should not be delayed if a specific product is not readily available.

For more information, see the recent report ‘Prevention and Control of Seasonal Influenza with Vaccines’ (CDC MMWR, August 23, 2019) [https://www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm?s_cid=rr6803a1_w](https://www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm?s_cid=rr6803a1_w)

**Prevention & Control Activities**

**Outbreak Detection and Reporting**

Report to Public Health (per Title 17, California Code of Regulations (CCR) §2500 & 2505)

1. **Laboratory-Confirmed** influenza-related pediatric deaths (ages 0-17 years)

2. **Acute Respiratory Outbreaks** in **both** healthcare **and** congregate living settings, such as residential living facilities (retirement community, assisted living, board & care, skilled nursing facilities, rehabilitation centers, homeless and evacuation shelters, camps, jails, etc.)

An outbreak is defined as:

- One lab-confirmed influenza case in a healthcare or congregate living setting.
- 2 or more cases of new onset respiratory illness within 72 hours (3 days) in a healthcare or congregate living setting.
- Any influenza illness associated with animal exposure (pigs, poultry, and other animals that can be infected with variant influenza viruses).
Botulism
Reporting, Antitoxin Release, Lab Testing & Public Health Investigation
Botulism is a neuroparalytic illness caused by Clostridium botulinum neurotoxins. Early symptoms may include double/blurred vision, drooping eyelids, slurred speech, difficulty swallowing, dry mouth, and muscle weakness. Neurologic symptoms generally begin 12 to 36 hours after ingestion of toxin and can progress to a symmetric, descending flaccid paralysis that begins in the cranial nerves.

Untreated, botulism can progress to respiratory paralysis and death. If administered early in the course of illness, botulism antitoxin can stop the progression of, but cannot reverse, paralysis. Antitoxin is available exclusively from public health authorities.

How to Obtain Antitoxin
As soon as botulism is suspected, call the Public Health Communicable Disease (CD) to start the process of obtaining antitoxin. CD staff can be reached at 925-313-6740 or, after-hours (M-F 5pm to 8am and 24hrs Sat. & Sun.), call County Sheriff’s dispatch at 925-646-2441 and ask for the Health Officer on-call.

If infant botulism is suspected, contact the California Infant Botulism Program directly to obtain infant antitoxin (BabyBIG)
http://www.infantbotulism.org/physician/obtain.php

Serum samples along with stool specimens should be collected prior to antitoxin administration for botulism testing, but do not wait for the results of testing before administering antitoxin. Patients should be given antitoxin as soon as it is available. Laboratory info: www.cdph.ca.gov/Programs/CID/DCDC/Pages/TestOrderAdultBot.aspx

Three Main Types of Botulism
- **Foodborne botulism** – acquired by eating food contaminated with botulinum toxin. Common food sources include: home-canned, preserved or fermented foods. Commercial foods that are improperly prepared or stored can also be a source of toxin.
- **Wound botulism** – wounds can become infected with C. botulinum bacteria. Persons who inject drugs are at increased risk of becoming infected with wound botulism.
- **Infant botulism** – spores get into intestines where they grow and produce toxin and subsequent illness.

Timely Public Health Investigation
Although foodborne botulism remains a rare occurrence in California, each case represents a medical and public health emergency. The CD Programs conduct a thorough investigation of every botulism case to determine the source. If foodborne botulism is suspected, the CD Programs work with the Contra Costa Environmental Health Program to identify the food item and remove it from distribution as quickly as possible.

Rabies
Timely Reporting to Animal Services & Administration of Postexposure Prophylaxis
Rabies virus is transmitted when a rabid animal bites a human or another mammal and virus-laden saliva enters the wound, incubating in the muscle tissue before making its way through the nervous system to the brain. Although rabies is almost always fatal, rabies postexposure prophylaxis (PEP) is extremely effective at preventing disease. Rabies PEP consists of infusing rabies immunoglobulin directly around the wound and administering the rabies vaccine series.

In California, rabies can be found in certain wildlife species and has the potential to spread to pets, farm animals, and people. Bats are most commonly found to be infected with rabies, but rabies has also been detected in other wild animals such as skunks and foxes. Rabies is rarely identified in domestic animals such as dogs and cats due to routine vaccination, but unvaccinated domestic animals who have had contact with wildlife can become infected.

Postexposure Prophylaxis (PEP): Urgency of RIG and Rabies Vaccine Administration
Rabies PEP, administered after a possible exposure, is highly effective at preventing the progression to rabies disease. However, once an infected person develops symptoms of rabies there is no effective treatment and the infected person will likely die within a few days.

Download a copy of this poster:

Bite Report: Initiation of Animal Services Investigation & Quarantine of Implicated Animal
Submit a ‘Bite Report’ form to Contra Costa Animal Services. The form can be found at:

More resources at cchealth.org/providers/
Contra Costa Health Services
Twitter: @CoCoHealth

September 2019 • Issue 3
New Revisions of USPSTF Recommendations

**BRCA risk assessment**

The USPSTF recommends that primary care clinicians assess women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA1/2) gene mutations with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, genetic testing.

The USPSTF recommends screening for asymptomatic bacteriuria using urine culture in pregnant persons.

**Breast cancer preventive medications**

The USPSTF recommends that clinicians offer to prescribe risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, to women who are at increased risk for breast cancer and at low risk for adverse medication effects.

In 2005 and 2013, the USPSTF recommended that women whose family history is associated with an increased risk for potentially harmful mutations in the BRCA1/2 genes be referred for genetic counseling and evaluation for BRCA1/2 testing. It also recommended against routine referral for genetic counseling or routine BRCA1/2 mutation testing for women whose family history is not associated with an increased risk for potentially harmful mutations in the BRCA1/2 genes. This Recommendation Statement is consistent with the USPSTF’s previous recommendation.

Since 2013, the validity of genetic testing for BRCA1/2 mutations has been established and the potential benefits and harms of previously reviewed interventions, such as risk-reducing medications and surgery, have been studied for longer follow-up periods. In addition, there have been more studies of newer imaging techniques (breast MRI), surgical procedures (salpingo-oophorectomy rather than oophorectomy alone), and medications (aromatase inhibitors). The updated recommendation expands the population eligible for screening to include women with a previous breast, ovarian, tubal, or peritoneal cancer diagnosis who have completed treatment and are considered cancer free and more explicitly includes ancestry associated with BRCA1/2 mutations (ie, founder mutations) as a risk factor.
In this update, the USPSTF continues to recommend screening for asymptomatic bacteriuria in pregnant persons with urine culture and recommends against screening in nonpregnant adults. The USPSTF changed the grade for pregnant persons from an “A” to a “B” based on the reduced applicability of the previous evidence that included outdated antibiotic treatment regimens and newer evidence that shows a significantly lower risk of pyelonephritis than found in previous reviews. In addition, there are newer concerns about antibiotic use, such as antimicrobial resistance and adverse changes to the microbiome (not addressed in current studies), leading to an increase in the magnitude of potential harms. These factors led the USPSTF to reduce assessments of certainty and magnitude of benefit, resulting in the change of grade.

Since 1996, the USPSTF has maintained an “A” recommendation for 1-time screening for asymptomatic bacteriuria with urine culture in pregnant persons between 12 and 16 weeks of gestation. The original 1996 recommendation was reaffirmed in 2004 and again in 2008. In 1996, the USPSTF found that there was insufficient evidence to recommend for or against screening in older adult women or women with diabetes and, in a separate recommendation, that screening was not recommended in other asymptomatic adults or older adults who reside in an institution. In 2004, these recommendations were combined into a single recommendation against screening, which was subsequently reaffirmed in 2008.

This recommendations is consistent with the 2013 USPSTF recommendation. As before, the USPSTF recommends offering risk-reducing medications to women at increased risk for breast cancer and at low risk for adverse medication effects (B recommendation) and recommends against routine use of risk-reducing medications in women not at increased risk (D recommendation). The current recommendation now includes aromatase inhibitors among medications that can reduce risk of breast cancer.
Contra Costa Health Plan

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Star Results

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Overall Health Plan Accreditation

This plan is NCQA Commendable

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These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

See "Screening and Management of High Blood Pressure in Children and Adolescents" (http://pediatrics.aappublications.org/content/108/3/554.full) and "Assessment and Management of Childhood Hypertension" (http://pediatrics.aappublications.org/content/124/4/1227.full).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.
25. For children at risk of lead exposure, see “Prevention of Childhood Lead Toxicity”.

24. Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP Red Book Report of the Committee on Infectious Diseases.

23. Schedules, per the AAP Committee on Infectious Diseases, are available at http://pediatrics.aappublications.org/content/55/Supplemental_Schedules. Every state has an opportunity to update and complete a state schedule.

22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per “Endorsement of Health and Human Services Recommendations for Fetal Anomaly Screening for Critical Congenital Heart Disease” (http://pediatrics.aappublications.org/content/126/1/106). Schedule also available at http://pedbord.solutions.aap.org/55/Immunization_Schedules.

21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See “Footnote 25 has been updated to read as follows: “For children at risk of lead exposure, see “Prevention of Childhood Lead Toxicity”.

20. Verify results as soon as possible, and follow up, as appropriate.

19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. See “Footnote 25 has been updated to read as follows: “For children at risk of lead exposure, see “Prevention of Childhood Lead Toxicity”.

18. Confirm initial screening was accomplished, verify results, and follow up, as appropriate.

17. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases should occur per recommendations of the current edition of the AAP Red Book Report of the Committee on Infectious Diseases shall be performed on recognition of High Risk factors.

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

15. If primary water source is fluoridated, consider replacing fluoride supplements. See: Fluoride Use in Caries Prevention in the Primary Care Setting (http://pediatrics.aappublications.org/content/134/6/1224).

14. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/usp usteducation.htm) for recommendations for pelvic examinations prior to age 21 are noted in “Screening for gynecologic examination in adolescents in the pediatric office setting” (http://pediatrics.aappublications.org/content/134/5/1224).

13. Perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to “Maintaining and Improving the Oral Health of Young Children” (http://pediatrics.aappublications.org/content/134/5/1224).


11. Perform risk assessment or screening, as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.

10. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP Red Book Report of the Committee on Infectious Diseases.

9. Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/usp usteducation.htm). For adolescents who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.


7. See “Fluoride Use in Caries Prevention in the Primary Care Setting” (http://pediatrics.aappublications.org/content/134/3/626).

6. Indications for pelvic examinations prior to age 21 are noted in “Screening for Gynecologic Examination for Adolescents in the Pediatric Office Setting” (http://pediatrics.aappublications.org/content/134/5/1224). For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

5. For children at risk of lead exposure, see “Prevention of Childhood Lead Toxicity” (http://pediatrics.aappublications.org/content/134/3/626)

4. See “Footnote 6 has been updated to read as follows: “Screening should occur per Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents” (http://pediatrics.aappublications.org/content/129/5/s1/20171904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.”

3. Perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to “Maintaining and Improving the Oral Health of Young Children” (http://pediatrics.aappublications.org/content/134/5/1224).

2. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/usp usteducation.htm) for recommendations for pelvic examinations prior to age 21 are noted in “Screening for Gynecologic Examination for Adolescents in the Pediatric Office Setting” (http://pediatrics.aappublications.org/content/134/5/1224).