CONTRA COSTA HEALTH PLAN
A Division of Contra Costa Health Services

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

I.	**CALL TO ORDER and INTRODUCTIONS**	Christine Gordon, RN, BSN, PHN, DHCS-MT
II.	**REVIEW and APPROVAL of Previous Meeting Minutes**	Christine Gordon, RN, BSN, PHN, DHCS-MT
III.	**IHA, SHA, USPSTF**	
	• **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 Heath 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

Discussion		Action	Accountable
	Meeting called to order at 12:18 P.M.		Christine Gordon, RN, BSN, DHCS-MT
I.	Minutes were approved with no revisions.		Jose Yasul, MD Medical Director, CCHP
II.	**Reminders** • Initial Health Assessment (IHA) o Must be completed within 120 days of enrollment into the health plan or documented within the 12 months prior to Plan enrollment. 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. o IHA includes H&P, IHEBA (SHA), USPSTF screenings, ensure up-to-date immunizations per ACIP. o Perinatal depression screening. o Gonococcal Ophthalmic Neonatorum screening. • USPSTF Update: o Colorectal cancer screening o Lipid screening – children only o Post-partum depression screening for new moms o Intimate partner violence screening o Folic acid supplementation o Immunization registry reporting • Facility, site and medical record review tools from DHCS o Extensive review o Spend more time at the facilities o USPSTF screenings o PowerPoint will be sent to the PCPs		Christine Gordon, RN, BSN, DHCS-MT
III.	**Guest Speaker** **Member Grievance Process** • Member Grievance Application (English and Spanish) • Member Consent Form (English and Spanish)		Belkys Teutle, Member Services Manager

	• Forms are available electronically • Compliance with state • Some Providers process grievances internally • Educate the member and the parent		

IV	**Regular Reports - CCHP Updates**
	
	• California Advancing and Innovating Medi-Cal (Cal-AIM)
	  o Waiver program
	  o Five categories
	• Non-Emergency Transportation form – Gurney
	• Non-Medical Transportation form – Social visit
	• Provider orientation packet
	• Provider Manual
	  o "No Auth" list
	  ▪ 3,000 to 9,000 on list
	  o Omron 3 blood pressure cuff
	  ▪ Send prescription to pharmacy
	  o Pharmacy and Therapeutics update
	  ▪ HPV vaccine – MMR update
	  ▪ Steroids – injection on No Auth list
	  ▪ Apidra to Lispro
	  ▪ Roxy condone back on formulary
	• Medi-Cal carve out all drugs plan
	• Respite care
	  o Secure housing
	• Behavioral health (Mid to moderate)
	  o Integrated health plan system
			Jose Yasul, MD Medical Director, CCHP

Adjournment: Meeting adjourned at 1:45 P.M.			
Next meeting January 28, 2020			

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA PUBLIC HEALTH
COMMUNICABLE DISEASE PROGRAMS
597 CENTER AVENUE, SUITE 200-A
MARTINEZ, CALIFORNIA 94553
PHONE: (925) 313-6740
FAX: (925) 313-6465

COMMUNICABLE DISEASE NEWSLETTER

September 2019 • Issue 3

NEWSLETTER FOR HEALTH PARTNERS IN CONTRA COSTA COUNTY, CALIFORNIA

In this Issue:

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.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

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

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 settings.
   - 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

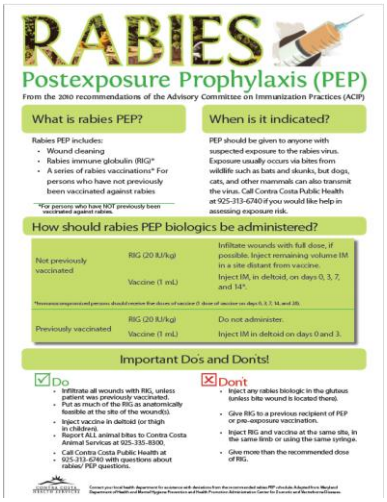
Timely Reporting to Animal Services & Administration of Postexposure Prophylaxis

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:
https://cchealth.org/rabies/pdf/bites-from-wildlife.pdf

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: https://cchealth.org/rabies/pdf/bite-report.pdf

More resources at cchealth.org/providers/

Contra Costa Health Services

@CoCoHealth

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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.	B	August 2019*
(Asymptomatic) Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria using urine culture in pregnant persons.	B	September 2019*
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.	B	September 2019*

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.[14, 147] 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.[14-16] 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.[14] 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.88 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

INSURANCE TYPE	Medicaid
PRODUCT TYPE	HMO
WEBSITE	http://www.cchealth.org
STATE(S) SERVED	California
MEMBERS ENROLLED	178547
OTHER NAMES	Medi-Cal

Star Results

ACCREDITATION CATEGORIES	RESULTS
Access and Service Access to needed care, offer good customer service.	★★★☆
Qualified Providers Ensuring doctors are licensed and patients are satisfied with their care.	★★★★
Staying Healthy Helping people maintain good health.	★★★☆
Getting Better Activities that help people get well.	★★★☆
Living with Illness Activities that help people live well while being sick.	★★☆☆

Overall Health Plan Accreditation

YES

This plan is NCQA Commendable

INSURANCE TYPE	Medicaid
PRODUCT TYPE	HMO
ACCREDITATION STATUS	Commendable
EVALUATION PRODUCT	Renewal Survey
STATUS MODIFIER	None
EXPIRATION DATE	02/24/20
NEXT REVIEW DATE	12/03/19
SCORED ON	Standards, HEDIS, CAHPS

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

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 manifestations of any important 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 continues to emphasize 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 standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	**Prenatal**[2]	**Newborn**[3]	**3-5 d**[4]	**By 1 mo**	**2 mo**	**4 mo**	**6 mo**	**9 mo**	**12 mo**	**15 mo**	**18 mo**	**24 mo**	**30 mo**	**3 y**	**4 y**	**5 y**	**6 y**	**7 y**	**8 y**	**9 y**	**10 y**	**11 y**	**12 y**	**13 y**	**14 y**	**15 y**	**16 y**	**17 y**	**18 y**	**19 y**	**20 y**	**21 y**
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																			
Weight for Length		●	●	●	●	●	●	●	●	●	●																				
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																															
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★
Hearing		●[8]	●[9] →			★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	←		●[10]	→	←	●	→	←		●	→
DEVELOPMENTAL/BEHAVIORAL HEALTH																															
Developmental Screening[11]								●			●		●																		
Autism Spectrum Disorder Screening[12]											●	●																			
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[14]																					★	★	★	★	★	★	★	★	★	★	★
Depression Screening[15]																						●	●	●	●	●	●	●	●	●	●
Maternal Depression Screening[16]				●	●	●	●																								
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																															
Newborn Blood		●[19]	●[20] →																												
Newborn Bilirubin[21]		●																													
Critical Congenital Heart Defect[22]		●																													
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★															
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	←	● →	★	★	★	★	★	←			●	→	
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	←		●	→	★	★
Cervical Dysplasia[31]																															●
ORAL HEALTH[32]							●[33]	●[33]	★		★	★	★	★	★	★	★														
Fluoride Varnish[34]							←				●		→																		
Fluoride Supplementation[35]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★				
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point 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 benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns 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 newborns 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/e827.full). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (http://pediatrics.aappublications.org/content/140/3/e20171904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
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 System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext).
11. See "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
12. Screening should occur per "Identification and Evaluation of Children With Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
13. 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/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).
14. A recommended assessment tool is available at http://crafft.org.
15. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
16. Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice" (http://pediatrics.aappublications.org/content/126/5/1032).
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/127/5/991.full).
18. These may be modified, depending on entry point into schedule and individual need.

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ← ● → = range during which a service may be provided

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19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Screening Panel (https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/home) establish the criteria for and coverage of newborn screening procedures and programs.
20. Verify results as soon as possible, and follow up, as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" (http://pediatrics.aappublications.org/content/124/4/1193).
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 Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at http://redbook.solutions.aap.org/SS/Immunization_Schedules.aspx. Every visit should be an opportunity to update and complete a child's immunizations.
24. 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).
25. For children at risk of lead exposure, see "Prevention of Childhood Lead Toxicity" (http://pediatrics.aappublications.org/content/138/1/e20161493) and "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
29. 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*.
30. Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
31. See USPSTF recommendations (https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening2). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
32. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Oral-Health/Pages/Oral-Health-Practice-Tools.aspx) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
33. Perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf). See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
34. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.htm). Once teeth are present, fluoride varnish may be applied to all children every 3–6 months in the primary care or dental office. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).
35. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care

(Periodicity Schedule)

This schedule reflects changes approved in December 2018 and published in March 2019.
For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

CHANGES MADE IN DECEMBER 2018

BLOOD PRESSURE

- 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/140/3/e20171904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years."

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' (http://pediatrics.aappublications.org/content/138/1/e20161493) and 'Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention' (https://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf)."

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