POLICY AND PROCEDURE

POLICY NAME: Early and Periodic, Screening, Diagnostic and Treatment (EPSDT)	**POLICY ID:** LA.QI.20
BUSINESS UNIT: LHCC	**FUNCTIONAL AREA:** Quality Improvement
EFFECTIVE DATE: 01/12	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE: 09/11, 11/11, 09/12, 10/13, 07/13, 07/14, 06/14, 06/15, 5/16, 5/17, 5/18, 5/19, 2/20, 03/21, 05/22, 5/23, 023/24	
REGULATOR MOST RECENT APPROVAL DATE(S): n/a	

POLICY STATEMENT:
This policy outlines the plan's responsibility in providing EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) services to all members under the age of 21, in compliance with the terms of the State contract and Federal Government requirements and as defined by the required periodicity schedule.

PURPOSE:
The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is a Medicaid mandated program under the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) and section 1905(r)(5) of the Social Security Act (the Act). EPSDT includes periodic nutritional and development screening, immunizations, pediatric lead toxicity screening, and vision, dental, and hearing services. The EPSDT program has two primary objectives: (1) assuring the availability and accessibility of required healthcare resources; and (2) helping Medicaid recipients and their parents or guardians effectively use these resources. It encourages assessment of the child's health needs through initial and periodic examinations and evaluations and promotes early diagnosis and treatment of problems before they become more complex and costly.

Plan is committed to providing preventive health screenings and improving the overall health of children enrolled in its health plan. With the high proportion of children in Plan's member population, Plan's ability to impact the incidence of EPSDT screening is of vital importance to the overall health and well-being of Plan's membership.

SCOPE:
Louisiana Healthcare Connections (Plan) Quality Improvement, Provider Consultants and Member Services departments.

DEFINITIONS:
EPSDT is an acronym for Early and Periodic Screening, Diagnostic and Treatment. Defined by law, EPSDT is Medicaid's comprehensive and preventive child health program for enrollees under the age of 21.
These services must be provided at intervals that meet reasonable standards of medical practice. Centene Corporation has adopted the American Academy of Pediatrics (AAP) *Recommendations for Preventive Pediatric Health Care*. The AAP periodicity schedule should be followed by the health plan unless otherwise dictated per State contract.

POLICY:
Plan shall cover and provide all members under the age of 21 years with EPSDT services in compliance with the terms of the State contract and Federal Government and as defined by the required periodicity schedule.

The health plan will monitor EPSDT well child visits in accordance with the established EPSDT goal that 80% of eligible members under the age of twenty-one (21) are receiving EPSDT well-child visits and services in accordance with the periodicity schedule for that FFY.

Plan shall implement ongoing processes for monitoring compliance with EPSDT program requirements and initiate interventions to promote substantial and sustained improvement over time. Although monitoring and implementing interventions related to the EPSDT program is a multi-disciplinary collaborative project across the Plan, the Quality Improvement (QI) Director maintains lead responsibility for the EPSDT Management program. The key aspects of the program include control monitoring reports, employee education, provider level interventions and member level interventions.

PROCEDURE:

A. EPSDT Required Services

1. The Member's assigned Primary Care Provider (PCP) is responsible for providing or arranging for the provision of complete EPSDT services, including screening, diagnosis, and treatment. Screening services include:

    a. Comprehensive Health and development history (including assessment of both physical and mental health and development)

    b. Comprehensive unclothed physical exam

    c. Developmental and Autism Screening

    ~~c.~~d. Behavioral/Social/Emotional Health Screening

    ~~d.~~e. Assessment and provision of immunizations as appropriate for age and health history, including the Flu* vaccine. **See table 1 below*

    ~~e.~~f. Assessment of nutritional status

    ~~f.~~g. Vision Screening (subjective and objective)

    ~~g.~~h. Hearing Screening (subjective and objective)

    ~~h.~~i. Laboratory procedures appropriate for age and population groups (including appropriate neonatal, iron deficiency anemia, dyslipidemia, sexually transmitted infections, and blood lead screening)

    ~~i.~~j. Lead risk assessment questionnaire (administered at every well visit)

    ~~j.~~k. Perinatal Depression Screening administered to caregiver from birth to 1 year, must employ one of the following validated screening tools:

        - Edinburg Postnatal Depression Scale (EPDS)
        - Patient Health Questionnaire 9 (PHQ-9)
        - Patient Health Questionnaire 2 (PHQ-2) and, if positive, a full PHQ-9

    ~~k.~~l. Oral health risk assessment, including fluoride varnish application

    ~~l.~~m. Direct referral for dental services for diagnosis and treatment for a child 2 years of age and over

    ~~m.~~n. Anticipatory guidance and health education

    ~~n.~~o. Referral for additional services if indicated for further diagnosis and treatment services

2. If a child misses a regular periodic screening, that child may be screened off-schedule in order to bring the child up to date at the earliest possible time. However, all screenings performed on children who are under two years of age must be at least 30 days apart, and those performed on children aged two through six years of age must be at least six months apart.

3. Documented laboratory procedures provided less than six months prior to the medical screening must not be repeated unless medically necessary. All components, including specimen collection, must be provided on-site during the same medical screening visit. The services shall be available both on a regular basis, and whenever additional health treatment or services are needed.

4. Lead Screening: Children ages six months to 72 months should be screened in compliance with Louisiana Medicaid EPSDT requirements and in accordance with practices consistent with current Centers for Disease Control and Prevention guidelines, which include the following specifications:
    - Administer a risk assessment questionnaire at every well child visit;
    - Use a blood test to screen all children at ages 12 months and 24 months or at any time from ages 36 months to 72 months, if they have not been previously screened; and
    - Use a venous blood sample to confirm results when finger stick samples indicate blood lead levels ≥5 µg/dl (micrograms per deciliter).

- Providers must report lead cases to the Office of Public Health's Childhood Lead Poisoning Prevention Program within 24 working hours. A lead case is indicated by a blood lead test result of >5 µg/dl.

Table 1. Provisions Regarding Flu Vaccine shortages:
If a Medicaid provider does not have the VFC pediatric influenza vaccine on hand to vaccinate a high priority Medicaid-enrolled child, the provider should not turn away, refer or reschedule the enrollee for a later date if the vaccine is available from private stock. The provider should use pediatric influenza vaccine from private stock and replace the dose(s) used from private stock with dose(s) from VFC stock when the VFC vaccine becomes available.
If a Medicaid provider does not have the VFC pediatric influenza vaccine on hand to vaccinate a non-high priority or non-high risk Medicaid-enrolled child, the enrollee can: • *Wait for the VFC influenza vaccine to be obtained, or* • *If the enrollee chooses not to wait for the VFC influenza vaccine to be obtained, and the provider has private stock of the vaccine on hand, the MCO shall reimburse only the administration of the private stock vaccine.*   ○ *If the provider intends to charge the enrollee for the vaccine, then prior to the injection, the provider shall inform the enrollee/guardian that the actual vaccine does not come from the VFC program, and the enrollee will be responsible for the cost of the vaccine. In these situations, the provider shall obtain signed documentation that the enrollee is responsible for reimbursement of the vaccine only.*

Louisiana Department of Health, MCO Manual (2022)

B. Control Monitoring Reports

1. *Care Gap Report*

   a. Monthly, the predictive modeling application generates care gap alerts to include children due or past due for EPSDT screenings, immunizations, lead, and other treatment services.

   b. Care gaps are viewable to providers through the Plan's secure provider portal during the eligibility search function. Providers can view care gaps when looking up eligibility for an individual member or can filter to pull a list of members with EPSDT-related care gaps.

   c. Care gaps are viewable to customer services in the OMNI tool. When a Customer Services Representative (CSR) pulls up the member record, member-specific care gaps are viewable to the representative. CSRs are educated to notify members of existing care gaps and assist them in scheduling appointments or arranging transportation as needed.

   d. Care gaps are viewable to the Care Management (CM) staff in OMNI and the predictive modeling application. CM staff will educate and assist those CM-enrolled members who have known gaps in care in scheduling appointments and arrange transportation as needed.

C. Plan Employee Education

During New Employee Orientation, new employees are encouraged to access the general overview training materials available on Centene University, Centene's internal learning & development platform on CNET. Established employees are reminded intermittently about the availability of the training course through the CNET site and other internal Plan communication platforms. Documentation of course completion and quiz results are maintained in each employee's Centene University transcript.

D. Provider Interventions for Improvement

1. General provider education

   a. New provider orientation

   b. Provider Manual

c. Provider newsletter

d. Plan website

e. Provider-facing workshops and seminars

2. Targeted face-to-face provider education

a. Utilize practitioner EPSDT participation report to identify providers with moderate to large panels of EPSDT eligible members and low participation scores.

b. Conduct face-to-face and/or virtual EPSDT specific education with the provider to include EPSDT program requirements, documentation, billing processes, missed opportunities, etc. Plan may also conduct chart audits to assist in determining reasons for low participation. Provider Consultants are available to brainstorm with Provider and assist as needed to implement interventions for improvement.

c. Track provider participation quarterly. If no improvement is noted after six months, Plan may conduct up to three (3) additional education sessions. If the provider continues without improvement in EPSDT participation rates, case should be presented to Plan quality committee for corrective action determination to include, but not limited to: Peer Review session with Plan's Chief Medical Officer (or designated Medical Director), closure of panel to new members, change in contract from capitated reimbursement to Fee-For-Service (FFS), termination of contract, etc.

3. PCP Reports

a. Monthly provider report that shows timely status of members under age 21 who are currently due and past due are made available via Plan's secure provider portal

b. Availability of these reports are communicated during PCP Orientation and PCP EPSDT education ~~sessions~~sessions.

4. Medical Record Reviews

a. Medical record documentation standards include measuring for provision of preventive screening and services in accordance with the Plan's practice guidelines. ~~Standards are communicated through Plan's Provider Manual and Plan's website.~~ Standards are communicated through the Provider Manual posted on the Plan's provider website. When there are significant changes in the requirements, the Plan shall provide the strategy to LDH or its designee for approval as part of the Readiness Review and sixty (60) Calendar Days prior to the implementation of any updates. The revisions may be distributed through the Provider newsletter, through direct mailing and the Plan website.

b. Medical record compliance audits are conducted per associated policy (LA.QI.13)

c. ~~Preliminary results of audit reviewed with provider office at conclusion of audit. Education is offered upon audit conclusion. Audit findings are indicated via letter to the provider, and the provider is advised of the expectation that any area under 80 percent requires corrective action. Model record-keeping aids, such as standardized documentation forms are shared with provider as indicated~~. Preliminary results of the medical record review are reviewed with the designated office contact at the conclusion of the audit. Education is offered upon conclusion and any elements scoring below 80 percent are considered deficient and in need of improvement. The results are mailed or faxed to the provider within 30-45 days of the medical record review. Model record-keeping aids, such as standardized documentation forms are shared with the provider as applicable.

5. Provider Profiling/P4P

a. Plan Provider Profiling and/or Pay for Performance project is aimed at improving health outcomes by recognizing participating practitioners for meeting and/or exceeding standards for quality healthcare and services. Measures should include those that relate to EPSDT. Profiling reports are distributed quarterly.

b. Plan Quality Staff and/or Provider Consultants work with providers to identify interventions for improvement and assist with implementation as indicated.

6. Provider Recognition

a. Practitioners may be recognized for providing quality services to members according to nationally recognized standards through Plan's Pay for Performance program and/or through publication in Plan's Provider Newsletter, website, or local news press release. Plan includes measures relating to EPSDT services in its recognition program methodologies.

E. Member Interventions for Improvement

1. General member education: Members and their families are educated regarding the value of preventive health care, benefits provided as part of EPSDT services, how to access these services, their right to access these services, and their right to appeal any decisions relating to EPSDT services.

a. New Member Welcome Packet ~~(EPSDT brochure)~~

b. Member handbook

~~c. Member newsletter~~

~~d.~~c. Plan website and member educational blog articles

~~e.~~d. Member services ~~on-hold message~~Member calls are initiated throughout the year to address wellness and other care gaps

~~f.~~e. Community events ~~(Currently on hold due to COVID restrictions)~~

~~g. Annual member birthday card mailings~~

~~h.~~f. Start Smart For Your Baby pregnancy and postpartum program materials ~~mailings~~

~~i. Newborn packet mailings (may include incentive program for EPSDT visits)~~

g. Member education flyers – well-child visits and fluoride varnish

2. Targeted member education

a. Past due auto-reminder calls

b. Telephonic past due reminder calls to provide education and counseling with regard to member compliance with prescribed treatment and EPDST appointments.

c. Potential Community Health Representatives home visit if member cannot be reached via mail or phone. ~~(Currently on hold due to COVID restrictions)~~

d. Potential referral to Care Management for continued non-compliance with EPSDT services on a case-by-case basis as indicated.

3. Documentation of member outreach, education, and information gathered from providers is maintained in OMNI.

REFERENCES:

CC.QI.01 QAPI Program Description

Louisiana Periodicity Schedule:
https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf
Physician Incentive Program Proposal
Omnibus Budget Reconciliation Act of 1989
Section 1905(r)(5) of the Social Security Act
Department of Health and Human Services. Overview: Medicaid Early & Periodic Screening & Diagnostic Treatment Benefit. Centers for Medicare & Medicaid Services. https://www.medicaid.gov/medicaid/benefits/epsdt/index.html

https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html
Periodicity Schedule: Recommendations for Preventive Pediatric Health Care (2019) American Academy of Pediatrics' Website (Bright Futures) www.aap.org
Louisiana Department of Health website www.ldh.la.gov
2019 Recommendations for Preventive Pediatric Health Care. Committee on Practice and Ambulatory Medicine and Bright Futures Periodicity Schedule Workgroup. PEDIATRICS Vol. 143 No. 3, March 2019.
Louisiana Department of Health MCO Manual

ATTACHMENTS:
Required Medical, Vision, and Hearing Screenings (~~2022~~ 2023Periodicity Schedule)
~~**https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf**~~
https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

ROLES & RESPONSIBILITIES:

REGULATORY REPORTING REQUIREMENTS:
~~HB 434, Act 319~~La R.S. 46:460.54 applies to material changes to this policy.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
New Policy Document	Procedure section updated with EPSDT Required Services. Control Monitoring Report updated with Care Gap Report Section. VPMA replaced with Chief Medical Director. Additions made to E. 1. General member education. Removed "Corp" from CMS 416 report. Changed "*Practitioner EPSDT Participation Report"* to "Care Gap Report". Deleted section on "Healthcheck Days"	11/2011
Annual Review	Revised KidMed links and sites to LaMedicaid	10/2012
Annual Review	Provider Interventions for Improvement updated. Removed provider specific member detail reports and listing of members due and members past due made available online and sent to PCP upon request. Added "PCP Reports" and monthly provider report that shows status of members under 21 who are due this month, past due, up-to-date, or initial screening needed made available via mail. Updated Targeted Member Information. Removed past due reminder postcards.	10/2013
Annual Review	Revised EPSDT Periodicity Schedule link and sample. Removed EPSDT/Connections Staff under "Member Interventions for Improvement" 2b.	07/24/14
Annual Review	Replaced "Provider Relations" with "Provider Consultants" Provider Interventions for Improvement updated. 3A – Replaced "mail" with "Plan's secure web portal"	06/24/15
Annual Review	No revisions	05/24/16
Annual Review	No revisions	05/24/17
Annual Review	Revised EPSDT Periodicity Schedule link and attached a sample of the new Periodicity Schedule LDH began using effective 5/1/18. Revised Member Services to Customer Services Revised Customer Relationship Manager (CRM) to OMNI Revised Centene University Course #142 to SharePoint and the Centene learning Center Community Health Connections changed to Community Health Representatives Removed the sample attachments: EPSDT Plan Participation Rate Report, EPSDT Provider Profile Report, EPSDT PCP report	05/24/18

	Minor grammatical edits; Referenced the department as QI/QM to encompass all Plans' Quality department name; clarified section B.1.a to include "in compliance with the terms of the state contract, as applicable". Updated section C. to include reference to the current training available on the Centene learning center. Updated References. A. Bi-monthly the predictive modeling… Updated 2. d. Care Gaps… Updated Under references, revised the link for: Department of Health and Human Services. Overview: Medicaid Early & Periodic Screening & Diagnostic Treatment Benefit. Centers for Medicare & Medicaid Services. https://www.medicaid.gov/medicaid/benefits/epsdt/index.html	
Annual Review	Removed CMS 416 report. Revised AAP reference *Recommendations for Preventive Pediatric Health Care* to reflect most recent update.	05/16/19
Ad Hoc Review	Care Gap Report Section, revised bi-monthly to monthly Revised Community Health Representatives to Community Health Service Representatives. Revised Case Manager to Care Manager EPSDT Required Services – Revised section to include oral health assessment and Lead risk assessment. Link to Periodicity Schedule reflects most recent schedule	02/25/20
Annual Review	Revised Section E. Member Interventions for Improvement, 1f and 2c to include (Currently on hold due to COVID restrictions. Revised Section D. Provider Interventions for Improvement, 2b to include and/or virtual EPSDT Required Services – Revised section to include Developmental screenings	03/2021
Annual Review	Updated verbiage to reflect CMS goal for EPSDT compliance	05/27/22
Annual Review	Reformatted to latest Policy Template Included Perinatal Depression Screening Updated verbiage to reflect lead screening requirements	05/09/23
Annual Review	Updated verbiage to reflect new standards language. Updated with 2023 Periodicity Schedule	023/~~/05~~12/~~20~~24

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

2023~~2022~~ Periodicity Schedule
~~2022 Periodicity Schedule~~

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 nurturing 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 more frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest concerns.

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. 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.

	INFANCY								EARLY CHILDHOOD						
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
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] →		→	★	★	★	★	★	★	★	★	★	●
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH															
Maternal Depression Screening[11]				●	●	●	●								
Developmental Screening[12]								●			●		●		
Autism Spectrum Disorder Screening[13]											●	●			
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●
Behavioral/Social/Emotional Screening[14]		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[15]															
Depression and Suicide Risk 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]															
Hepatitis B Virus Infection[31]		★ →													
Hepatitis C Virus Infection[32]															
Sudden Cardiac Arrest/Death[33]															
Cervical Dysplasia[34]															
ORAL HEALTH[35]							●[36]	●[36]	★		★	★	★	★	★
Fluoride Varnish[37]							←				●				
Fluoride Supplementation[38]							★	★	★		★	★	★	★	★
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

	MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	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	●	●	★	●	★	●	←		●[10]	→	←	●	→	←		●	→
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																	
Maternal Depression Screening[11]																	
Developmental Screening[12]																	
Autism Spectrum Disorder Screening[13]																	
Developmental Surveillance	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Behavioral/Social/Emotional Screening[14]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[15]							★	★	★	★	★	★	★	★	★	★	★
Depression and Suicide Risk Screening[16]								●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[17]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																	
Newborn Blood																	
Newborn Bilirubin[21]																	
Critical Congenital Heart Defect[22]																	
Immunization[23]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]	★	★															
Tuberculosis[27]	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]		★		★	←	●	→	★	★	★	★	★	←			●	→
Sexually Transmitted Infections[29]							★	★	★	★	★	★	★	★	★	★	★
HIV[30]							★	★	★	★	● →						→
Hepatitis B Virus Infection[31]																	→
Hepatitis C Virus Infection[32]														● →			→
Sudden Cardiac Arrest/Death[33]							★ →										→
Cervical Dysplasia[34]																	●
ORAL HEALTH[35]	★	★															
Fluoride Varnish[37]	→																
Fluoride Supplementation[38]	★	★	★	★	★	★	★	★	★	★	★	★					
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" (https://doi.org/10.1542/peds.2018-1218).
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" (https://doi.org/10.1542/peds.2011-3552). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborn Infants" (https://doi.org/10.1542/peds.2015-0699).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (https://doi.org/10.1542/peds.2007-2329C).
6. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (https://doi.org/10.1542/peds.2017-1904). 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" (https://doi.org/10.1542/peds.2015-3596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (https://doi.org/10.1542/peds.2015-3597).
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" (https://doi.org/10.1542/peds.2007-2333).
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" (https://www.sciencedirect.com/science/article/abs/pii/S1054139X16000483).
11. Screening should occur per "Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice" (https://doi.org/10.1542/peds.2018-3259).
12. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening" (https://doi.org/10.1542/peds.2019-3449).
13. Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder" (https://doi.org/10.1542/peds.2019-3447).

(continued)

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

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3-365/0223

(continued)

14. Screen for behavioral and social-emotional problems per "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (https://doi.org/10.1542/peds.2014-3716), "Mental Health Competencies for Pediatric Practice" (https://doi.org/10.1542/peds.2019-2757), "Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders" (https://pubmed.ncbi.nlm.nih.gov/32439401), and "Screening for Anxiety in Adolescent and Adult Women: A Recommendation From the Women's Preventive Services Initiative" (https://pubmed.ncbi.nlm.nih.gov/32510990). The screening should be family centered and may include asking about caregiver emotional and mental health concerns and social determinants of health, racism, poverty, and relational health. See "Poverty and Child Health in the United States" (https://doi.org/10.1542/peds.2016-0339), "The Impact of Racism on Child and Adolescent Health" (https://doi.org/10.1542/peds.2019-1765), and "Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health" (https://doi.org/10.1542/peds.2021-052582).
15. A recommended assessment tool is available at http://crafft.org.
16. Screen adolescents for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See "Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management" (https://doi.org/10.1542/peds.2017-4081), "Mental Health Competencies for Pediatric Practice" (https://doi.org/10.1542/peds.2019-2757), "Suicide and Suicide Attempts in Adolescents" (https://doi.org/10.1542/peds.2016-1420), and "The 21st Century Cures Act & Adolescent Confidentiality" (https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2019-(1)/NASPAG-SAHM-Statement.aspx).
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" (https://doi.org/10.1542/peds.2011-0322).
18. These may be modified, depending on entry point into schedule and individual need.
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 (https://www.babysfirsttest.org/) 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" (https://doi.org/10.1542/peds.2009-0329).
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" (https://doi.org/10.1542/peds.2011-3211).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at https://publications.aap.org/redbook/pages/immunization-schedules. 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" (https://doi.org/10.1542/peds.2016-1493) and "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (https://www.cdc.gov/nceh/lead/docs/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. Screen adolescents for HIV at least once between the ages of 15 and 21, making every effort to preserve confidentiality of the adolescent, as per "Human Immunodeficiency Virus (HIV) Infection: Screening" (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening); after initial screening, youth at increased risk of HIV infection should be retested annually or more frequently, as per "Adolescents and Young Adults: The Pediatrician's Role in HIV Testing and Pre- and Postexposure HIV Prophylaxis" (https://doi.org/10.1542/peds.2021-055207).
31. Perform a risk assessment for hepatitis B virus (HBV) infection according to recommendations per the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-screening) and in the 2021–2024 edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*, making every effort to preserve confidentiality of the patient.
32. All individuals should be screened for hepatitis C virus (HCV) infection according to the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening) and Centers for Disease Control and Prevention (CDC) recommendations (https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm) at least once between the ages of 18 and 79. Those at increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually.
33. Perform a risk assessment, as appropriate, per "Sudden Death in the Young: Information for the Primary Care Provider" (https://doi.org/10.1542/peds.2021-052044).
34. See USPSTF recommendations (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (https://doi.org/10.1542/peds.2010-1564).
35. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/) 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" (https://doi.org/10.1542/peds.2014-2984).
36. Perform a risk assessment (https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/). See "Maintaining and Improving the Oral Health of Young Children" (https://doi.org/10.1542/peds.2014-2984).
37. The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1). Once teeth are present, apply fluoride varnish to all children every 3 to 6 months in the primary care or dental office based on caries risk. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (https://doi.org/10.1542/peds.2020-034637).
38. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (https://doi.org/10.1542/peds.2020-034637).

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

This schedule reflects changes approved in December 2022 and published in April 2023. For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

CHANGES MADE IN DECEMBER 2022

HIV

The HIV screening recommendation has been updated to extend the upper age limit from 18 to 21 years (to account for the range in which the screening can take place) to align with recommendations of the US Preventive Services Task Force and AAP policy ("Adolescents and Young Adults: The Pediatrician's Role in HIV Testing and Pre- and Postexposure HIV Prophylaxis").

- Footnote 30 has been updated to read as follows: "Screen adolescents for HIV at least once between the ages of 15 and 21, making every effort to preserve confidentiality of the adolescent, as per 'Human Immunodeficiency Virus (HIV) Infection: Screening' (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening); after initial screening, youth at increased risk of HIV infection should be retested annually or more frequently, as per 'Adolescents and Young Adults: The Pediatrician's Role in HIV Testing and Pre- and Postexposure HIV Prophylaxis' (https://doi.org/10.1542/peds.2021-055207)."

CHANGES MADE IN NOVEMBER 2021

HEPATITIS B VIRUS INFECTION

Assessing risk for HBV infection has been added to occur from newborn to 21 years (to account for the range in which the risk assessment can take place) to be consistent with recommendations of the USPSTF and the 2021–2024 edition of the AAP *Red Book-Report of the Committee on Infectious Diseases*.

- Footnote 31 has been added to read as follows: "Perform a risk assessment for hepatitis B virus (HBV) infection according to recommendations per the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-screening) and in the 2021–2024 edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*, making every effort to preserve confidentiality of the patient."

SUDDEN CARDIAC ARREST AND SUDDEN CARDIAC DEATH

Assessing risk for sudden cardiac arrest and sudden cardiac death has been added to occur from 11 to 21 years (to account for the range in which the risk assessment can take place) to be consistent with AAP policy ("Sudden Death in the Young: Information for the Primary Care Provider").

- Footnote 33 has been added to read as follows: "Perform a risk assessment, as appropriate, per 'Sudden Death in the Young: Information for the Primary Care Provider' (https://doi.org/10.1542/peds.2021-052044)."

DEPRESSION AND SUICIDE RISK

Screening for suicide risk has been added to the existing depression screening recommendation to be consistent with the GLAD-PC and AAP policy.

- Footnote 16 has been updated to read as follows: "Screen adolescents for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See 'Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management' (https://doi.org/10.1542/peds.2017-4081), 'Mental Health Competencies for Pediatric Practice' (https://doi.org/10.1542/peds.2019-2757), 'Suicide and Suicide Attempts in Adolescents' (https://doi.org/10.1542/peds.2016-1420), and 'The 21st Century Cures Act & Adolescent Confidentiality' (https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2019-(1)/NASPAG-SAHM-Statement.aspx)."

BEHAVIORAL/SOCIAL/EMOTIONAL

The Psychosocial/Behavioral Assessment recommendation has been updated to Behavioral/Social/Emotional Screening (annually from newborn to 21 years) to align with AAP policy, the American College of Obstetricians and Gynecologists (Women's Preventive Services Initiative) recommendations, and the American Academy of Child & Adolescent Psychiatry guidelines.

- Footnote 14 has been updated to read as follows: "Screen for behavioral and social-emotional problems per 'Promoting Optimal Development: Screening for Behavioral and Emotional Problems' (https://doi.org/10.1542/peds.2014-3716), 'Mental Health Competencies for Pediatric Practice' (https://doi.org/10.1542/peds.2019-2757), 'Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders' (https://pubmed.ncbi.nlm.nih.gov/32439401), and 'Screening for Anxiety in Adolescent and Adult Women: A Recommendation From the Women's Preventive Services Initiative' (https://pubmed.ncbi.nlm.nih.gov/32510990/). The screening should be family centered and may include asking about caregiver emotional and mental health concerns and social determinants of health, racism, poverty, and relational health. See 'Poverty and Child Health in the United States' (https://doi.org/10.1542/peds.2016-0339), 'The Impact of Racism on Child and Adolescent Health' (https://doi.org/10.1542/peds.2019-1765), and 'Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health' (https://doi.org/10.1542/peds.2021-052582)."

FLUORIDE VARNISH

- Footnote 37 has been updated to read as follows: "The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1). Once teeth are present, apply fluoride varnish to all children every 3 to 6 months in the primary care or dental office based on caries risk. Indications for fluoride use are noted in 'Fluoride Use in Caries Prevention in the Primary Care Setting' (https://doi.org/10.1542/peds.2020-034637)."

FLUORIDE SUPPLEMENTATION

- Footnote 38 has been updated to read as follows: "If primary water source is deficient in fluoride, consider oral fluoride supplementation. See 'Fluoride Use in Caries Prevention in the Primary Care Setting' (https://doi.org/10.1542/peds.2020-034637)."

HRSA
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