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EARLY CHILDHOOD MENTAL HEALTH SERVICES

POLICY

It is the policy of Detroit Wayne Integrated Health Network (DWIHN) to provide Early Childhood Mental Health Services (ECMHS) to promote and support early developing attachment relationships between infants, toddlers, preschoolers, and young children and their families, as well as to reduce the risk of developmental delays and disorders of infancy and early childhood.

PURPOSE

To ensure the Authority, contractors and subcontractors provide evidence-based practices and best practices within its continuum of services in order to promote the best interests of the infants, toddlers, preschoolers and young children and their families receiving services.

APPLICATION

1. The following groups are required to implement and adhere to this policy: DWIHN Staff, Contractual Staff, Access Center, Network Providers, Crisis services vendor, Credentialing Verification Organization (CVO)
2. This policy serves the following populations: Adults, Children, I/DD, SMI/SEI, SED, SUD, Autism
3. This policy impacts the following **contracts/service lines**: Medicaid, SUD, Autism, Grants, General Fund

KEYWORDS

1. Baby Court
2. Case Record
3. Contractor
4. Ecosystem
5. Family
6. Family-Driven
7. Family Member

8. Individual Plan of Service/Person Centered Planning
9. Minor
10. Serious Emotional Disturbances (SED)
11. Service Provider
12. System of Care (SOC)

STANDARDS

Responsibility of Providers: The Authority's network of providers shall develop and implement policies, procedures, practices and monitoring activities to ensure that at a minimum the Medicaid standards are implemented for Infant Mental Health (IMH) services and Early Childhood Mental Services (ECMHS).

Early Childhood Mental Health (birth through six) programs must meet the home-based requirements and be approved by MDHHS in order to provide Infant Mental Health services and Early Childhood Mental Health Services.

1. Each Provider shall ensure that the population enrolled serves:
 - a. Women exhibiting psychosocial or medical risk during pregnancy (and their infants, toddlers, preschoolers, or young children).
 - b. Adolescent parents and their infants, toddlers, preschoolers, or young children.
 - c. Parents/legal guardian engaged in suspected or substantiated child abuse and neglect and their infants, toddlers, preschoolers or young children.
 - d. Mentally ill or emotionally disordered parents/legal guardian and their infants, toddlers, preschoolers or young children.
 - e. Parents/legal guardian with developmental disabilities and their infants, toddlers, preschoolers or young children.
 - f. Infants discharged from neonatal intensive care units and their parents/legal guardian; toddlers, preschoolers, or young children who are medically fragile and their parents/legal guardian.
 - g. Infants, toddlers, preschoolers or young children with developmental delays.
 - h. Infants, toddlers, preschoolers, or young children who are in situations that place them and their parents/legal guardian at risk (Refer to Medicaid Chapter III, Section 7.2.B).
 - i. Infants, toddlers, preschoolers, or young children who have a diagnosable behavioral or emotional disorder.
 - j. Infant, toddlers, preschoolers, or young children who may be at risk of being excluded from school/child care due to functional impairment(s).
2. Each Provider shall develop and implement policies and procedures to ensure delivery of the following service components:
 - a. Proactive interventions with at risk infants and their families initiated during pregnancy, neonatal period, or infancy.
 - b. Reactive interventions with distressed infants, toddlers, preschoolers, and young children and their families initiated because of overt indications of deficient nurturance and psychosocial risk (e.g., failure to thrive, child abuse, developmental delay, or depression).

- c. Proactive interventions with at risk preschoolers and young children and their families initiated during the third through sixth years of life.
3. Characteristics of intervention occur through the modality of home visits, home and office visits, school/ child care observations and group sessions with structured intervention activities. Home visits are a necessary component of all Early Childhood Services.
All Early Childhood mental health interventions have the following components:
 - a. The focus of assessment and intervention is the parent-infant (or toddler, preschooler or young child) dyad in the context of the family system.
 - b. Intervention is designed to support and nurture the parent as the primary caregiver, including attention to parental needs; increasing parental self-esteem; and reinforcement of appropriate parent-infant, toddler, preschooler or young child interactions; and parental capacity to empathize with the child's needs.
 - c. Provision of developmental guidance and information about infant, toddler, preschooler or young child behavior and corresponding child caring practices.
 - d. Facilitate and promote management of real life problems including crisis resolution, linkage to community resources, advocacy, facilitation of problem-solving skills, and linkage to informal support systems.
 - e. Resolution of intrapsychic and family system issues impeding attachment, self-regulation and exploration.
4. Service plans address all relevant issues affecting the well-being of the infant, toddler, preschooler or young child and include:
 - a. Parent-child attachment and relationships,
 - b. Child caring practices, including cognitive stimulation; health of the parent's interpersonal relationships and past history,
 - c. Development of ongoing support systems,
 - d. Case management needs,
 - e. Income maintenance,
 - f. Housing, food, equipment, etc.,
 - g. Family planning; and custody issues,
 - h. School readiness (cognitive, physical, social and emotional).
5. Development/Behavioral Assessments will be administered in accordance with the recommendation of the American Academy of Pediatrics Bright Futures:
 - a. Ages and Stages Questionnaire (ASQ) at 9 months, 18 months and 30 months or as clinically indicated.
 - b. Modified Checklist for Autism in Toddlers (MCHAT) to screening for Autism Spectrum Disorders at ages 18 and 24 months when clinically indicated.
6. Standardized assessments tools will be utilized to determine level of function and level of care. All Child Mental Health Professionals (CMHP) who provide direct Early Childhood Services or supervise clinical CMHP who provide Early Childhood Services must be certified to administer the assessment tools. All tools must be administered baseline (14 days of intake), quarterly and discharge.

- a. The DECA-I (Devereux Early Childhood Assessments for Infants) is used for assessing the social and emotional needs of infants 0 to 18 months old.
- b. The DECA-T (Devereux Early Childhood Assessment for Toddlers) is used for assessing the social and emotional needs of toddlers 18 to 36 months old.
- c. DECA-C (Devereux Early Childhood Assessment-Clinical for Preschoolers) is used for assessing the social and emotional needs of children 2 up to 4 years of age.
- d. The DECA is to be completed at intake, quarterly, and at exit for children in this age range receiving behavioral health.
- e. The Preschool and Early Childhood Functioning Assessment Scale (PECFAS) is a required assessment tool for all children in the CMHSP systems that are 4 through 6 years of age. The PECFAS is to be completed at intake, quarterly, and at exit for children in this age range receiving behavioral health
- f. Trauma Symptom Checklist for Young Children or Child Behavior Checklist (CBCL 1 ½ - 5), and Ages and Stages Questionnaire (ASQ) to track trauma symptoms or concerning behaviors along with child development.
- g. Recommended: Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO), Edinburgh Depression Inventory, Parent Stress Inventory Short Form (PSI) to track parent-child interactions, parent's endorsement of symptoms of depression and stress related to parenting.

7. The Responsibility of the Authority:

- a. Coordination of local activities to ensure ongoing development and maintenance of an infrastructure that supports the fidelity, quality and workforce development of Early Childhood Mental Health Service (ECMHS), including Infant Mental Health (IMH) services, in Wayne County.
- b. To ensure the model is developed and maintained within the Authority's System of Care (SOC) of children with Serious Emotional Disturbances (SED) in order to promote the values, practices, and principles of SOC and system transformation within the Authority's continuum of services for children.
- c. To ensure availability and access to ECMHS, including IMH, when clinically and developmentally appropriate.
- d. Support development of the ECMHS workforce as defined in the MDHHS requirements to ensure a sustainable workforce that is qualified and maintains model fidelity.
- e. Submit waiver applications on an annual basis for eligible staff serving children birth to 47 months of age.

8. Staff Qualifications of Infant Mental Health and Early Childhood Mental Health Clinicians must meet the following:

- a. Infant Mental Health services clinicians must:
 - a. Meet the qualifications of a child mental health professional, AND
 - b. Must have, at a minimum, a Level II Endorsement, OR
 - c. Must request a Provisional Endorsement, and be in the process of applying for "Endorsement" through the Michigan Association for Infant Mental Health (MI-AIMH)
 - d. Must obtain Level II Endorsement within two years of requesting a Provisional Endorsement,

AND

- e. Comply with the Endorsement requirements as outlined by MI-AIMH.
- b. Early Childhood Mental Health Services Clinicians must:
 - a. Meet the qualifications of a child mental health professional, AND
 - b. Attend any relevant trainings specific to this age group that the sponsors.
- 9. Contractors providing Early Childhood Mental Health Services are recommended to include one or more evidence based practices in their programs to best serve this population:
 - a. Parent-Child Interaction Therapy (PCIT) including use of Dyadic Parent-Child Interaction Coding System (DPICS) and the Eyberg Child Behavior Inventory (ECBI) to track progress in parent skills and child behavior concerns.
 - b. Child Parent Psychotherapy (CPP)
 - c. Mom Power
 - d. Prescriptive Play Therapy including child centered play therapy, directive interventions guided by the Structured Play Therapy Model, and sand play.

Contractors Providing Services Within Baby Court Will:

- a. Conduct assessments and provide reports (both verbal and written), and make recommendations to the court.
 - b. Attend all court hearings.
 - c. Intervene therapeutically with an array of mental health services for parent(s) and their children as needed according to the proposed treatment plans.
 - d. Deliver Infant Mental Health services to provide intensive didactic therapy and model effective interactions between parent(s) and their children.
 - e. Infant Mental Health will participate in baby court permanency planning case conferences.
 - f. Coordinate other services as ordered or needed to support the recovery of the family unit.
10. Responsibility of the Contractor:
- a. Contractors shall ensure that adherence to this policy, including development, implementation and monitoring of any policies and procedures relevant to this policy, be carried out with regard to the cultural, ethnic, gender identity and community values of the minors and families
 - b. Contractors shall collaborate with systems that are likely to influence the lives of minors and their families with an effort toward affecting an outcome that supports the minor living with the family, including ensuring that the coordination of services and programs occurs within the community to better support improved functioning in the minors' home, school and community.
 - c. Contractors shall demonstrate and document activities that engage families in collaborative partnerships and community support systems so services are sufficiently comprehensive to support minors living with their families and support improved functioning in their home, school and community.
 - d. Contractors shall develop, administer, provide and coordinate services that are family focused within the context of the person and family driven planning model.

QUALITY ASSURANCE/IMPROVEMENT

DWIHN shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives.

The quality improvement programs of Providers must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

COMPLIANCE WITH ALL APPLICABLE LAWS

DWIHN staff, Providers, contractors, and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY

1. Michigan Mental Health Code, P.A. 258 of 1974, as amended
2. Michigan Association for Infant Mental Health Competency Guidelines (2011)

RELATED POLICIES

1. Individual Plan of Service/Person Centered Planning
2. Children's Diagnostic Treatment Services Program

RELATED DEPARTMENTS

1. Administration
2. Claims Management
3. Clinical Practice Improvement
4. Compliance
5. Customer Service
6. Integrated Health Care
7. Legal
8. Managed Care Operations
9. Quality Improvement
10. Recipient Rights
11. Utilization Management

CLINICAL POLICY

YES

INTERNAL/EXTERNAL POLICY

EXTERNAL

Attachments:

Approval Signatures

Approver

Date

Dana Lasenby: Chief Clinical Officer

02/2019

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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.

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AGE ¹	INFANCY									EARLY CHILDHOOD						MIDDLE CHILDHOOD						ADOLESCENCE															
	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	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
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/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 EXAMINATION¹⁷		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
PROCEDURES¹⁸																																					
Newborn Blood		● ¹⁹	● ²⁰	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	
Newborn Bilirubin ²¹		●																																			
Critical Congenital Heart Defect ²²		●																																			
Immunization ²³		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia ²⁴																																					
Lead ²⁵																																					
Tuberculosis ²⁷																																					
Dyslipidemia ²⁸																																					
Sexually Transmitted Infections ²⁹																																					
HIV ³⁰																																					
Cervical Dysplasia ³¹																																					
ORAL HEALTH³²																																					
Fluoride Varnish ³⁴																																					
Fluoride Supplementation ³⁵																																					
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

- 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.
- 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>).
- Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
- 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>).
- 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).

- Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
- 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>).
- 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>).
- Verify results as soon as possible, and follow up, as appropriate.
- 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](http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext)).
- 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>).

- Screening should occur per "Identification and Evaluation of Children With Autism Spectrum Disorders" (<http://pediatrics.aappublications.org/content/120/5/1183.full>).
- 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>).
- A recommended assessment tool is available at <http://www.ceasar-boston.org/CRAFT/index.php>.
- 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.
- Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice" (<http://pediatrics.aappublications.org/content/126/5/1032>).
- 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>).
- These may be modified, depending on entry point into schedule and individual need.

(continued)

19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (<http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf>), 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/sites/genes-r-us/files/nbsdisorders.pdf>) 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. See "Diagnosis and Prevention of Iron Deficiency and Iron-Deficiency Anemia in Infants and Young Children (0-3 Years of Age)" (<http://pediatrics.aappublications.org/content/126/5/1040.full>).
25. For children at risk of lead exposure, see "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 (<http://www.uspreventiveservicestaskforce.org/uspstf/uspsscerv.htm>). 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 (<http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf>) 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/uspdsnch.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 February 2017 and published in April 2017.

For updates, visit www.aap.org/periodicityschedule.

For further information, see the *Bright Futures Guidelines*, 4th Edition, *Evidence and Rationale* chapter (https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_Evidence_Rationale.pdf).

CHANGES MADE IN FEBRUARY 2017

HEARING

- Timing and follow-up of the screening recommendations for hearing during the infancy visits have been delineated. Adolescent risk assessment has changed to screening once during each time period.
- Footnote 8 has been updated to read as follows: "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>)."
- Footnote 9 has been added to read as follows: "Verify results as soon as possible, and follow up, as appropriate."
- Footnote 10 has been added to read as follows: "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](http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext))."

PSYCHOSOCIAL/BEHAVIORAL ASSESSMENT

- Footnote 13 has been added to read as follows: "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>)."

TOBACCO, ALCOHOL, OR DRUG USE ASSESSMENT

- The header was updated to be consistent with recommendations.

DEPRESSION SCREENING

- Adolescent depression screening begins routinely at 12 years of age (to be consistent with recommendations of the US Preventive Services Task Force [USPSTF]).

MATERNAL DEPRESSION SCREENING

- Screening for maternal depression at 1-, 2-, 4-, and 6-month visits has been added.
- Footnote 16 was added to read as follows: "Screening should occur per 'Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice' (<http://pediatrics.aappublications.org/content/126/5/1032>)."

NEWBORN BLOOD

- Timing and follow-up of the newborn blood screening recommendations have been delineated.
- Footnote 19 has been updated to read as follows: "Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (<http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf>), 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/sites/genes-r-us/files/nbsdisorders.pdf>) establish the criteria for and coverage of newborn screening procedures and programs."
- Footnote 20 has been added to read as follows: "Verify results as soon as possible, and follow up, as appropriate."

NEWBORN BILIRUBIN

- Screening for bilirubin concentration at the newborn visit has been added.
- Footnote 21 has been added to read as follows: "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>)."

DYSLIPIDEMIA

- Screening for dyslipidemia has been updated to occur once between 9 and 11 years of age, and once between 17 and 21 years of age (to be consistent with guidelines of the National Heart, Lung, and Blood Institute).

SEXUALLY TRANSMITTED INFECTIONS

- Footnote 29 has been updated to read as follows: "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*."

HIV

- A subheading has been added for the HIV universal recommendation to avoid confusion with STIs selective screening recommendation.
- Screening for HIV has been updated to occur once between 15 and 18 years of age (to be consistent with recommendations of the USPSTF).
- Footnote 30 has been added to read as follows: "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."

ORAL HEALTH

- Assessing for a dental home has been updated to occur at the 12-month and 18-month through 6-year visits. A subheading has been added for fluoride supplementation, with a recommendation from the 6-month through 12-month and 18-month through 16-year visits.
- Footnote 32 has been updated to read as follows: "Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (<http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf>) 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>)."
- Footnote 33 has been updated to read as follows: "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>)."
- Footnote 35 has been added 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' (<http://pediatrics.aappublications.org/content/134/3/626>)."