

PROVIDER

Newsletter

PATIENT SAFETY ASSESSMENT

At WellCare, we strive to ensure our members have access to care that reflects safe clinical practices. To support this commitment, we have established standards for the identification and investigation of potential quality of care issues, as summarized below.

A quality of care issue is one in which a patient allegedly experiences or perceives:

- Treatment which led to injury, disability or death
- Post-operative complications
- A delay or omission of care
- Inappropriate or incorrect performance of a procedure
- A medication error

When quality of care issues are identified, the Georgia-based Quality Improvement (QI) Department gathers member interaction history, utilization records (such as authorization information) and claims data for the date(s) of service in question. In addition, medical records are sometimes requested to assist in the full investigation of the member complaint and/or clinical event. Once all pertinent background information is collected, the QI Department nurses create a case summary that is reviewed by the Medical Director. The Medical Director may determine that peer review is warranted, either by committee or by an individual specialist, trained in the same or similar field of expertise.



Regardless of the number of steps required to review an individual case, our goal is to provide complete resolution within 90 days for all cases. In 2006, we exceeded this goal, as all complaints investigated (52) were closed within 90 days or less. It is important to note the disposition of these complaints, with:

- 65% closed, no Track and Trend (T/T)
- 35% closed, T/T
- 0% to peer review specialist
- 0% to peer review committee

In addition, WellCare reviews other aspects of delivery of care such as appropriate medical record keeping related to NKA or allergies, and the level of communication between primary and specialty care physicians in referral situations. In the fourth quarter of 2006, medical record review (MRR) activities showed that “NKA or allergies noted” scored a high 92 percent and communication between PCPs and specialists scored on the opposite end at 31 percent. This demonstrates the broad range of score results obtained. Because a passing score is 80% or greater, WellCare will take additional steps in 2007 to partner with our providers to improve MRR rates.



SNAPSHOT:

WELLCARE OF GEORGIA CLINICAL PRACTICE GUIDELINES FOR DIABETIC CARE

In the fourth quarter of 2006, WellCare began taking steps to assess Primary Care Physician (PCP) compliance to our Diabetic Care Guidelines. For Medicare members, the assessment was done through review of the claims data for key procedures. For Medicaid, a random sample of PCP medical records was evaluated. The results are as follows:

MEDICARE: CLAIMS DATA		MEDICAID: MEDICAL RECORD REVIEW	
HgbA1c Test Completed	76%	HgbA1c Test Completed	88%
Eye Exam	82%	Eye Exam	25%
LDL-C Screening	78%	LDL-C Screening	75%
LDL-C Level < 100mg/dl	0%	LDL-C Level < 100mg/dl	75%
Nephropathy Screening	82%	Nephropathy Screening	75%

Data shows that there is room for improvement. Please note that at every visit, a diabetic patient should be assessed for:

- Blood pressure
- Weight
- Foot examination to screen for neuropathy and peripheral artery disease
- Depressed mood and/or anxiety
- Medication review
- Smoking and alcohol use
- Basic understanding of “self-management” skills
- Observation for signs and symptoms of organ disease, acute complications and hypoglycemia

Annually, a diabetic patient should have the following exams:

- Lipid panel goals:
 - LDL <100 mg/dl
 - HDL >40 mg/dl (men)
 - HDL >50 mg/dl (women)
 - Triglycerides <150 mg/dl
- Urinalysis for microalbuminuria
- HgbA1c test with the results <7%
- Dilated eye examination by an optometrist or ophthalmologist
- Influenza vaccination

In addition, a pneumococcal vaccination should be provided (see Diabetes Case Management Guidelines for recommendations).

To help support our providers and their patients, WellCare offers a diabetic disease management program. Referrals may be arranged by calling the Disease Management Program at 1-866-593-2538.

PHARMACY UPDATE

FDA Issues Public Health Advisory

On December 11, 2006, the Food and Drug Administration (FDA) ordered firms to stop marketing unapproved drug products containing quinine, citing serious safety concerns, including death. The FDA also cautioned consumers about off-label use of quinine to treat leg cramps and similar conditions. Quinine, a drug used to treat malaria, has a narrow margin between an effective dose and a toxic dose.

It is important to note that there are multiple unapproved products containing quinine in the market. However, one quinine product, Qulaquin, is FDA-approved to treat certain types of malaria without complications. The dosing for Qulaquin is supported by data to maximize the safety and efficacy of the product.

Qulaquin is covered on the WellCare Medicare formulary. It requires prior authorization and is covered for FDA-approved indication. Qulaquin is **not** covered on the WellCare Medicaid formulary.

Source: FDA Updates. Available at: http://www.fda.gov/fdac/departs/695_updates.html.

OVER-THE-COUNTER (OTC) PROGRAM

Members can get a monthly supply of over-the-counter medications and health supplies mailed directly to their home by calling Member Services at 1-866-231-1821.

Benefit limits are: WellCare Medicaid: \$10/month
WellCare Medicare: \$10-\$20/month (on certain plans only; check benefits)

GEORGIA MEDICAID FORMULARY ADDITIONS			
Antibiotics	Avelox Cefzil (Generic Cefprozil)	HIV/AIDS	Atripla Prezista
Asthma	Advair HFA Asmanex Proair HFA Peak Flow Meters Spacers	OB/GYN	Balziva Koro-flex Mirena Nuvaring Seasonale
Antidepressants	Surmontil (Generic Trimipramine) Effexor (Generic Venlafaxine)	Osteoporosis	Actonel w/Calcium Fosamax D
Antifungals	Lamisil AT (OTC) Tinactin (OTC)	Prostate	Avodart Proscar (Generic Finasteride)
Dermatological	Derma-Smoothe FS Gladase	Other	Campral Mobic (Generic Meloxicam) Tyzeka
Diabetes	Avandaryl Glucovance Prandin		

ACCESS AND AVAILABILITY REQUIREMENTS FOR WELLCARE OF GEORGIA PRIMARY CARE PROVIDERS



It is WellCare's policy to follow access and availability standards set by federal and state requirements. Participating WellCare of Georgia Primary Care Providers (PCPs) are to adhere to the following scheduling practices:

- Emergencies presenting imminent risk to the member's life shall be seen immediately or directed to the nearest emergency room
- Schedule and see urgent appointments within 24 hours
- Schedule and see adult "sick" care appointments within 72 hours
- Schedule and see pediatric "sick" care appointments within 24 hours
- Schedule routine "well" care visits within 21 calendar days of a member request

After normal business hours, PCPs should provide patients with one of the following:

- An answering service to page the provider
- An advice nurse with access to the PCP
- An on-call provider

Remember that it is a requirement for providers to be available to patients 24 hours a day, 7 days per week. WellCare will monitor appointment and after-hour availability on a routine basis to ensure that access and availability standards are met.



2006 QUALITY IMPROVEMENT PROGRAM HIGHLIGHTS

As WellCare of Georgia began to provide services to its first Georgia members, we launched our Quality Improvement Program. While much of last year's activity was focused on ensuring that appropriate processes were in place, we were able to record some quality improvement highlights at year end.

- Mailed approximately 500,000 letters to members to remind them of their PCP's role and the importance of seeking preventive health care
- Identified and outreached to parents of more than 20,000 children afflicted with asthma, assisting with care management needs, as appropriate
- Assessed PCP medical records for compliance to practice guidelines
 - Overall: 86% of providers reviewed scored at $\geq 80\%$
 - EPSDT: 98% health education and counseling
 - EPSDT: 96% complete immunizations
 - Asthma: 98% pulmonary assessment
 - Asthma: 98% medication monitoring
- Launched focus on patient safety
 - Potential quality of care complaints at .13/K (Benchmark: $<.31/K$)
 - 92% of medical records demonstrating allergies or NKA documented
- Monitored continuity and coordination of care
 - 81.5% of SCP visits completed within 30 CDs of PCP visit
- Assessed network capacity, finding
 - 8 of 11 PCP GeoAccess segments (urban and rural) indicating $\geq 92\%$ compliance
 - OB/GYN GeoAccess at 100% in all segments
 - PCP appointment timeliness for routine, sick and pediatric care at $\geq 93.6\%$
- Contacted 51 high-volume provider groups since December 2006 to collaborate in outreach to members in need of preventive services
- Conducted provider orientation at 1289 provider offices, in-service training visits in 1337 offices, and "Provider Summit" workshops for 927 offices
- Maintained Customer Service metrics which exceeded standards and benchmarks: for 2006, ASA 92.8% in 30 seconds (members) and 92.9% within 30 seconds (providers); Abandonment rates 0.84% (members) and 0.76% (providers); Zero blocked calls for members and providers. Web site search time was 0.381 seconds for the year's average and record retrieval time on the Web site of 1.928 seconds
- 4,501 providers were credentialed during the year
- 90.2% of claims were processed within 10 days, 99.4% within 15 days, and 99.9% within 30 days

2007 QUALITY IMPROVEMENT FOCUS

- Preparation for NCQA accreditation (2008)
- Expansion of the scope for Patient Safety Standards
- Increased child immunization rates
- Improved quality monitoring of calls by the provider and member call centers
- Member education on the importance of EPSDT/Health Checks
- Compliance monitoring of Preventive Health and Clinical Practice Guidelines through medical record reviews
- Ongoing assessment of provider appointment timeliness

To receive a copy of our Quality Improvement Program guidelines, please fax your request to the Quality Improvement Department at 1-877-277-1810.



WELLCARE MEMBER VOICEMAIL SYSTEM



As an added benefit, each WellCare member is given a dedicated voicemail box upon enrollment, free of cost. This voicemail box is a confidential line where providers may leave sensitive information for an individual member. Members are able to retrieve these messages from the WellCare voicemail system from any telephone, including a pay phone—24 hours a day, 7 days a week.

Members are notified of this benefit upon enrollment and given instructions on how to operate their voicemail. Distribution of a WellCare member's voicemail box number is strictly up to the member. However, you may ask a member for their voicemail box number if you find it a helpful tool in improving communication with your patient.

To leave a message for a WellCare member, just follow these easy steps:

1. Call the WellCare Provider Hotline at **1-866-231-1821**
2. Choose prompt #8
3. Enter the members' voicemail box number
4. Leave your message

Keep in mind that the voicemail system is available to WellCare members only. If a member disenrolls or loses eligibility, the voicemail box is disconnected. Members may contact Member Services at **1-866-231-1821** from 7am to 7pm, Monday through Friday, to set up their voicemail box or to receive assistance in using the system. You may call the same number and access the Provider Hotline should you have questions related to the voicemail system. Our voicemail support team will be happy to help.

INVOLUNTARY DISENROLLMENT

WellCare members have specific rights and responsibilities related to their participation with our plan. Member rights and responsibilities are detailed in the member and provider handbooks, which are the key documents to understanding how WellCare works. An essential responsibility for members is to establish a good medical care relationship with their primary care physician (PCP). One way for providers to establish the basis of this patient-physician relationship is to encourage members to become familiar with their rights and responsibilities. They should also follow the basic guidelines listed below, to ensure a productive relationship with their provider.

Members should be reminded to:

- Be on time for appointments
- Provide a complete medical history
- Follow plans and instructions for care
- Cooperate with all health care providers
- Respect the rights of all providers, their property, and their other patients

If a WellCare member chooses not to work toward a positive patient-physician relationship, and exemplifies behaviors that impair the PCP's ability to give needed services, the PCP may request that the member be disenrolled from his or her practice. If the behavior is not caused by an illness, or if fraud is confirmed, WellCare has the ability to disenroll the member from the plan. A form is available to providers on our Web site at <http://georgia.wellcare.com>. Select the Forms and Documents page under the Resources menu. When an involuntary disenrollment is requested, the Department of Community Health is notified.

We value your participation with WellCare and are glad to count on your expertise.



FASHIONABLE HEALTH RISKS



As an ongoing feature, we will highlight health care topics that cross from the medical field into other health care areas such as mental health, dental, and vision services. This month, the focus is on a procedural fad that has both dental and medical health risk implications.

TONGUE PIERCING

Since oral piercing has become fashionable over the past decade, a brief overview of the procedure and its common health risks are appropriate. While oral piercing can involve the lips, cheek, and/or uvula, the tongue is the most commonly pierced and will be the focus of this review.

Oral piercing is generally done by unlicensed, self-trained individuals; piercing is usually accomplished without the use of anesthesia and infection control protocol. The tongue is most commonly pierced along the midline and anterior to the lingual frenum. The tongue is held using open-ended forceps, with the open end centered over the area to be pierced. A hollow 14-16 gauge needle is used to pierce the tongue in a dorsal-ventral direction. As the needle is being removed, the free end of a barbell is inserted and a ball-shaped tip is screwed onto the bar that is protruding out of the ventral surface of the tongue. The forceps are removed and the procedure is complete.

Tongue piercing can lead to a number of sequelae, the most common of which are listed below, along with suggestions for treatment:

Infection (typically due to non-sterile technique)—Treatment can range from antibiotic therapy and localized cleansing (including removal of the tongue ornament) and oral hygiene instructions, to emergency hospitalization for a rapidly spreading cellulitis involving sublingual, submandibular, and submental fascial spaces.

Prolonged Bleeding (usually occurring shortly after the piercing procedure, with the individual receiving minimal post-operative instructions)—Treatment can include compressing the pierced site with a clean piece of cotton gauze for up to 30 minutes. Electrocautery may also be used to stop the bleeding.

Embedded Ornament—This situation can occur if an oversized barbell is not used during the piercing procedure; subsequent normal swelling of the tongue can cause embedding of the ornament. Surgical intervention is necessary.

Mandibular Anterior Gingival Recession—Over time, repeated contact of the ornament with the gums can lead to significant lingual gingival recession on the mandibular anterior teeth, especially when long stem barbells are used. This implies that, after the initial swelling has subsided, the oversized barbell should be replaced with a smaller ornament. Removal of the ornament is necessary in order to prevent further recession.

Chipped/Fractured Posterior Teeth (from repeated trauma of the barbell impacting the tooth)—Treatment can range from smoothing of sharp edges to fabrication of a full-cast crown.

Crowns involving porcelain must be avoided due to porcelain's brittle nature and low resistance to impact.

When examining a patient who has a pierced tongue, the following additional patient instructions should be considered:

- Remove tongue jewelry daily, clean with detergent, wipe with alcohol;
- Clean the pierced site of tongue with a brush and use antiseptic mouth rinse;
- Exercise conscious control of the tongue jewelry movement during mastication or speech;
- Consider replacing the metallic jewelry ball with a non-metallic alternative (soft rubber ends have become available).

Sources:

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- Dibart S, De Feo P, Surabian G, Hart A, Capri D, Su MF. Oral piercing and gingival recession: Review of the literature and a case report. *Quintessence Int.* 2002 Feb;33(2):110-2. Review.
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NPI ALERT

WellCare providers should be aware that the federal deadline for National Provider Identifier compliance is fast approaching. By May 23, 2007, all providers must have and use their 10-digit NPI numbers. With that in mind, please take note of the following:

Getting Your NPI

- Any health care provider or organization defined as a covered entity under HIPAA is required to obtain an NPI. Providers who transmit health care information via HIPAA standard electronic transactions are covered entities under HIPAA, whether they transmit the transactions themselves or use a vendor to transmit them.
- Type 2 (organizational) providers must obtain and submit NPI numbers for the organization as well as for all providers sub-parted within the organization.
- The Centers for Medicare and Medicaid Services (CMS) estimates that once a provider obtains an NPI number, it will take about 120 days to update office systems, coordinate with all of the entities that require the number and begin using it. Taking those 120 days into account makes May 23 seem a lot closer.



Submitting Your NPI to WellCare

- There are NPI submission forms available on the provider area of our Web site, <http://georgia.wellcare.com/>. The forms will allow providers to enter their NPI numbers directly into our database. In addition, you will find a wealth of NPI information on that Web page.
- WellCare has sent communications soliciting NPI numbers by fax and mail. If you have received this correspondence but not yet submitted your NPI to WellCare, please fill out the submission form and return it as soon as possible. Alternatively, you can download a copy of the Web form from our Web site as mentioned above.
- **Continue to use your WellCare ID.** The NPI will only replace your WellCare ID in HIPAA transactions such as claims processing. It will not replace your WellCare ID for daily business transactions with our plan. You should continue to identify yourself using your WellCare ID when calling WellCare Member Services or your Provider Relations Representative.

More NPI Information

- Further NPI information can be found on the CMS Web site at <http://www.cms.hhs.gov/NationalProvdentStand/>. Be sure to periodically check the CMS and WellCare Web sites for updates.

Time is of the essence. Don't let the NPI deadline catch you by surprise. Get compliant now.

LANGUAGE TRANSLATION SERVICES AND SERVICES FOR THE HEARING IMPAIRED

WellCare provides language translation and services for the hearing-impaired to all members. Our Member Services Department is staffed with representatives who speak English and Spanish and are able to coordinate services for the translation of additional languages as well as specific services for the hearing impaired. To make arrangements for these services, members or providers should contact Member Services at 1-866-231-1821 (TTY/TDD: 1-877-247-6272).



MEMBER HEALTH CHECK GUIDELINES

WellCare of Georgia follows the AAP Periodicity schedule, and has included the pediatric guidelines in this newsletter for your reference.

FRAUD AND ABUSE: WHAT YOU CAN DO

Health care fraud costs the country millions of dollars every year. It can show up in many different forms. Examples include:

- Members sharing ID cards
- Members selling prescription drugs
- Providers billing for services not provided
- Providers up-coding services to enhance revenue
- Providers prescribing drugs or services that are not medically necessary

WellCare of Georgia has established a program to identify, investigate and address fraud and abuse by members, non-members and providers. We are asking for your help to identify fraud and abuse by reporting questionable situations.

Once reported, situations are investigated. If the allegation is confirmed, action is taken and the consequences may include loss of member eligibility, loss of provider participation, legal pursuit for overpayment, reporting to the National Practitioner Data Bank or prosecution.

You can report fraud by contacting the Trust Hotline at **1-866-678-8355**. When submitting a report, please provide as many details as you can, including names and telephone numbers.



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RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC HEALTH CARE (RE9535)

Committee on Practice and Ambulatory Medicine

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 satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal.

These guidelines represent a consensus by the Committee on Practice and Ambulatory Medicine in consultation with national committees and sections of the American Academy of Pediatrics. The Committee emphasizes the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

PERIODICITY SCHEDULE (effective Date of Service 10/1/05)

	INFANCY								EARLY CHILDHOOD				MIDDLE CHILDHOOD				ADOLESCENCE												
Screen Sequence Number	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	
AGE ⁵	new-born ²	2 to 4 days ³	By 1 mo.	2 to 4 mo.	4 to 6 mo.	6 to 9 mo.	9 to 12 mo.	12 to 15 mo.	15 to 18 mo.	18 mo. to 2 yrs.	2 to 3 yrs.	3 to 4 yrs.	4 to 5 yrs.	5 to 6 yrs.	6 to 8 yrs.	8 to 10 yrs.	10 to 11 yrs.	11 to 12 yrs.	12 to 13 yrs.	13 to 14 yrs.	14 to 15 yrs.	15 to 16 yrs.	16 to 17 yrs.	17 to 18 yrs.	18 to 19 yrs.	19 to 20 yrs.	20 to 21 yrs.	21 to 27 yrs, 30d	
HISTORY																													
Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																													
Height and Weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference	●	●	●	●	●	●	●	●	●	●	●	●	●																
Blood Pressure												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																													
Vision	S	S	S	S	S	S	S	S	S	S	S	○ ⁶	○	○	○	○	○	S	○	S	S	○	S	S	○	S	S	S	
Hearing	○ ⁷	S	S	S	S	S	S	S	S	S	S	S	○	○	○	○	○	S	○	S	S	○	S	S	○	○	S	S	
DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT⁸																													
DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT ⁸	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION⁹																													
PHYSICAL EXAMINATION ⁹	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES- GENERAL¹⁰																													
Hereditary/Metabolic Screening ¹	←●→																												
Immunization ²	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin ¹³							●	→	*				→					←		● ¹⁴								→	
Urinalysis														●				←				● ¹⁵						→	
PROCEDURES-PATIENTS AT RISK																													
Lead Screening ¹⁶							●	→			●																		
Tuberculin Test ¹⁷							*		*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Cholesterol Screening ¹⁸											*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	
STD Screening ¹⁹																		*	*	*	*	*	*	*	*	*	*	*	
Pelvic Exam ²⁰																		*	*	*	*	*	*	*	*	←●→ ²⁰	*	*	
ANTICIPATORY GUIDANCE²¹																													
Injury Prevention ²²	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Violence Prevention ²³	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Sleep Positioning Counseling ²⁴	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Nutrition Counseling ²⁵	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
DENTAL REFERRAL²⁶																													
DENTAL REFERRAL ²⁶								←	←		●																		

Key: ● = to be performed
 ○ = objective, by a standard testing method
 ←●→ = the range during which a service may be provided, with the dot indicating the preferred age
 S = subjective, by history
 * = to be performed for patients at risk

NB: Special chemical, immunologic, and endocrine testing is usually carried out upon specific indications. Testing other than newborn (eg, inborn errors of metabolism, sickle disease, etc) is discretionary with the physician. 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. Copyright ©2000 by the American Academy of Pediatrics. No part of this statement may be reproduced in any form or by any means without prior written permission from the American Academy of Pediatrics except for one copy for personal use.

FOOTNOTES:

1. 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 AAP statement "The Prenatal Visit" (1996).
2. Every infant should have a newborn evaluation after birth. Breastfeeding should be encouraged and instruction and support offered. Every breastfeeding infant should have an evaluation 48-72 hours after discharge from the hospital to include weight, formal breastfeeding evaluation, encouragement, and instruction as recommended in the AAP statement "Breastfeeding and the Use of Human Milk" (1997).
3. For newborns discharged in less than 48 hours after delivery per AAP statement "Hospital Stay for Healthy Term Newborns" (1995).
4. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.
5. 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.
6. If the patient is uncooperative, prescreen within 6 months.
7. All newborns should be screened per the AAP Task Force on Newborn and Infant Hearing statement, "Newborn and Infant Hearing Loss: Detection and Intervention" (1999).
8. By history and appropriate physical examination: if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.
9. At each visit, a complete physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.
10. These may be modified, depending upon entry point into schedule and individual need.
11. Metabolic screening (eg, thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to state law.
12. Schedule(s) per the Committee on Infectious Diseases, published annually in the January edition of Pediatrics. Every visit should be an opportunity to update and complete a child's immunizations.
13. See AAP Pediatric Nutrition Handbook (1998) for a discussion of universal and selective screening options. Consider earlier screening for high-risk infants (eg, premature infants and low birth weight infants). See also "Recommendations to Prevent and Control Iron Deficiency in the United States. MMWR.1998;47(RR-3):1-29.
14. All menstruating adolescents should be screened annually.
15. Conduct dipstick urinalysis for leukocytes annually for sexually active male and female adolescents.
16. For children at risk of lead exposure consult the AAP statement "Screening for Elevated Blood Levels" (1998). Additionally, screening should be done in accordance with state law where applicable.
17. TB testing per recommendations of the Committee on Infectious Diseases, published in the current edition of Red Book: Report of the Committee on Infectious Diseases. Testing should be done upon recognition of high-risk factors.
18. Cholesterol screening for high-risk patients per AAP statement "Cholesterol in Childhood" (1998). If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.
19. All sexually active patients should be screened for sexually transmitted diseases (STDs).
20. All sexually active females should have a pelvic examination. A pelvic examination and routine pap smear should be offered as part of preventive health maintenance between the ages of 18 and 21 years.
21. Age-appropriate discussion and counseling should be an integral part of each visit for care per the AAP Guidelines for Health Supervision III (1998).
22. From birth to age 12, refer to the AAP injury prevention program (TIPP®) as described in A Guide to Safety Counseling in Office Practice (1994).
23. Violence prevention and management for all patients per AAP Statement "The Role of the Pediatrician in Youth Violence Prevention in Clinical Practice and at the Community Level" (1999).
24. Parents and caregivers should be advised to place healthy infants on their backs when putting them to sleep. Side positioning is a reasonable alternative but carries a slightly higher risk of SIDS. Consult the AAP statement "Changing Concepts of Sudden Infant Death Syndrome: Implications for Infant Sleeping Environment and Sleep Position" (2000).
25. Age-appropriate nutrition counseling should be an integral part of each visit per the AAP Handbook of Nutrition (1998).
26. Earlier initial dental examinations may be appropriate for some children. Subsequent examinations as prescribed by dentist.

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