

Core Clinical Service Guide (CCSG) Revision Listing

Please note: Material in each section of the Core Clinical Service Guide (CCSG) was condensed, reformatted and/or had information eliminated due to duplication. LHD guidance regarding federal grant requirements and other policy information was relocated to the Administrative Reference (AR). For more detailed information regarding these changes, please use the [PHPR & Core Clinical Service Guide \(CCSG\) Crosswalk](#).

The links below contain information provided by DPH program staff regarding specific clinical guidance changed in the corresponding section. Please review with your staff for compliance.

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CANCER SCREENING SECTION REVISIONS

Updated Cervical Cancer Screening Recommendations

- Pages 3 - New cervical cancer screening recommendations from the United States Preventive Services Task Force (USPSTF), American Cancer Society (ACS), American Society for Colposcopy and Cervical Pathology (ASCCP) and the American Society for Clinical Pathology (ASCP) were released in March 2012.
- These new recommendations have been adopted by the Centers for Disease Control and Prevention (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP).
- As a CDC grantee, the Kentucky Women's Cancer Screening Program will also be adopting these new recommendations for cervical cancer screening. They have been incorporated into the Cancer Screening/Follow-Up Section of the CCSG under Cervical Cancer Screening. The interval between screenings may be lengthened when following specific guidelines listed in this section for women who are not high-risk.

Second Opinion for Breast Cancer Surgical Referral

- Page 8 - patient may receive a second opinion from the contracted surgeon when she self-reports finding a breast lump even if the lump is not identified on Clinical Breast Examination at the Local Health Department.

Colposcopy Follow-Up:

- Page 18 - Wording added: Information in this section is guidance. All patients who have had a colposcopy or treatment must have an order for her next step in follow-up, treatment or future screening from the contracted provider who performed her services.

CPT Code Update

- Page 20 - CPT codes 99241-99244 are no longer reimbursed by the KWCSF.

Follow-up Arrangements

- Page 25 - Wording has been added to Sections B1-B3, Follow-Up Arrangements, stating that minors with a potentially life-threatening test result (includes a "HSIL" or "ASC-H" result on a Pap test or a "Suspicious Abnormality" or "Highly Suggestive of Malignancy" mammogram or ultrasound result) and cannot be contacted, the parent or guardian must be contacted. Minors shall be made aware of this policy at the screening visit. This was already in B3 and has been added to the other sections for consistency and clarification.

Home Visits

- Requirement for a home visit to patients who cannot be reached for notification of a possibly life-threatening test result has been removed. Attempts to contact the patient by the process described in the case management section (phone call, letter and then certified letter if unable to reach her) are still required to notify the patient of her result and need for follow-up.

Medical Home Transfer for Follow-up

- When a patient has a medical home and her care is being transferred for her follow-up, the LHD is still required to offer to make the appointment for the patient and forward her pertinent medical records. However, the LHD Nurse Case Manager is not required to contact the provider to determine if the patient kept her appointment with her medical home provider.

IMMUNIZATION SECTION REVISIONS

- A “Precautions and Contraindications” section was added to the beginning of each protocol that states to “screen all patients for precautions and contraindications to immunization.”
- The “Adverse Events” section was updated or added to all protocols and states:
 - *See the product’s package insert.*
 - *See Adverse Events Following Vaccinations page of this section.*
- The immunization section pages have been numbered 1 to 101 instead of individually by each vaccine.
- M.D. signature and date has been removed from individual vaccine protocols.
- The date the protocol was updated has been added to each protocol.
- MMR protocol for children through 18 years of age was updated to include vaccinating infants as young as 6 months of age who are traveling internationally and during an outbreak.
- MMR protocol for adults, 19 years of age and older, was updated to include information for healthcare workers.
- Varicella protocol was updated to include information about healthcare workers and employees of the local health departments.
- The protocol for Influenza A (H1N1) 2009 Monovalent Vaccine was deleted.
- The protocol for Pneumococcal Conjugate Vaccine (PCV7) was deleted.
- Guidance for vaccinating children during the 2012 Pentacel and Daptacel shortage was added.
- Recommendations were updated for live vaccines regarding tuberculin skin testing (TST) to provide guidance (Live Attenuated Influenza Virus, MMR, MMRV, Rotavirus, Varicella and Zoster). A tuberculin skin test (TST) can be applied at the same visit during which these vaccines are administered. Measles vaccine temporarily can suppress tuberculin reactivity for at least 4 to 6 weeks. The effect of live-virus varicella, yellow fever, and live-attenuated influenza vaccines on tuberculin skin test reactivity is not known.
- The “Adverse Events Following Vaccination” section was shortened with all tables deleted from the section and replaced with a link to the tables.

FAMILY PLANNING SECTION REVISIONS

Matrix Page 1-3

- Consolidated Medical History/Reproductive History/Risk Factors into one section, “Medical History”; deleted duplications in history and risk factors listings.
- Removed - initial visit physical exam “External pelvic exam may benefit adolescents in anatomy and physiology education and assessment of sexual development” due to some LHD interpreting this must be done for all adolescents. APRN’s should use their medical judgment what is needed for each individual patient for education.
- Removed in all Lab visit columns “< 25 within areas of low positivity and all 26 or older should only be tested if symptoms, exposure, new partner or multiple partners within 60 days per”: hyperlinked to the CT/GC algorithm for routine screening for CT/GC at FP visit. (Do not automatically screen for CT or GC in women 25 and older; must be medically necessary).
- Added - at the end of the matrix “Clinicians and nurses must follow the Title X Clinical Requirements outlined in the Training Guidelines and Program Descriptions Section of the AR”.

Deferred Exam Page 4

- Condensed information by referring to the FP matrix, removed signature line, and referred staff “**oral contraceptive/s as per standing orders for RNs outlined on the introduction/signature page**”.

Estrogen/Progesterone Contraindications Page 5

- New page which outlines the contraindications for all estrogen and/or progesterone methods. Includes the sign and symptoms of “ACHES” to prevent duplication of this information for each hormonal method. Each hormonal method refers back to this page for contraindications.

ECP Page 9

- Removed the signature line and the following statement “**See the name of the specific ECP method and dosing approved as a standing order on the introduction signature page**”.

IUDs Page 10

- Removed - outdated language related to “mutually monogamous relationship without history of PID, HIV infection, injecting drug use and leukemia or other medical conditions that are associated with increased susceptibility to infection”.
- Added - “Data support the safety of IUDs for most women, including adolescents: Chlamydia and gonorrhea testing in high risk patients may be performed. Proceed with insertion and treat any positive findings promptly without the removing device”.
- **All other changes were related to clarification or elimination of duplicated information. All birth control methods refer to the “CDC U.S. Medical Eligibility Criteria for Contraceptive Use to screen for contraindications to this method based on patient and family medical history and risk factors”. All other changes are outlined in the NEC recommendations.**

PEDIATRIC SECTION REVISIONS

Please note: Compared to the 2011 PPHR, there are no new protocols for this section other than the updates needed to align with the current AAP/Bright Futures recommendations:

- Updated matrix's to meet current AAP/Bright Future (BF) recommendations , (see Developmental Assessment, Blood Pressure, Testicular Exam, Vision, Hearing, Metabolic Screening , and Sickle Cell & Dental Referral)
- Added "30 month" column to meet current AAP/BF and EPSDT recommendations
- Page 3 (#9)in the CCSG has been updated from p.3 (#2) in the 2012 PPHR: Removed prior sentences, as side sleeping is no longer acceptable. AAP guidelines now recommend counseling on all aspects of safe sleep; therefore the language has been updated to say "*parents and caregivers should be advised to place infants on their backs, in a separate bed, free of soft bedding, in a smoke-free environment when putting infants to sleep*".
- Added "BMI" row with "X's" under appropriate ages to be performed
- Renamed "Pediatric Preventive Health Guidelines" to "Clinical Protocols for Management of Abnormal Screenings" to reflect *critical referral points only*. The general guidance that abnormal findings on the preventative health history and exam should be referred is still valid and the timing and method are up to the provider; however, these selected Critical Referral Points should be followed with specific actions as noted.

PRENATAL SECTION CHANGES

Please note: Compared to the 2011 PPHR, there are no new protocols for this section other than the updates needed to align with the current AGOG recommendations. Large amounts of material from the 2011 PPHR were condensed, revised or eliminated. Updated information and revisions are the following:

- Revised name of chapter from “Maternity” to “Prenatal”
- Page 1 Prenatal Service Matrix
 - Added a column for the “Postpartum Visit” to follow ACOG recommendations
 - A single Prenatal Risk Assessment Form is being developed at the request of the NEC and will be available by Sept 1. This will eliminate the need for several other lists of risks
 - Hct an Hgb added to the 35-37 weeks column per ACOG Guidelines and ACOG forms
 - All prenatal patients should now be screened for GDM
- Page 2 – Added “notes” section to explain the matrix and required services; this information is a condensed form of previous PPHR material
- Page 3 – Added statement below matrix that prenatal vitamin supplement should be approved by the prenatal provider
- Page 4 – Updated and eliminated unnecessary language to meet current (2009) IOM recommendations
- Page 5 - BMI chart for Pregnant Women moved here from PE chapter
- Page 7
 - Removed duplicated material from the Hepatitis B Section (Included in Immunization Section)
 - Updated language in the HIV Section to meet current ACOG guidelines (Opt Out)
- Page 8 - Updated language in the Cystic Fibrosis Screening Section to meet current ACOG guidelines
- Page 9 - Updated language in the Perinatal Group B Strep Section to meet current ACOG guidelines
- Page 10/11 – GDM Section
 - Language was revised and updated to meet the most current ACOG guidelines
 - Table 1 was updated to the most current ACOG guidelines
- Page 12 – Language revised in row 2 under GDM Assessment to reflect most current ACOG guidelines (All pregnant women should be screened for GDM)
- Pages 13 through 18 – Updated and eliminated unnecessary language.