POLICY TITLE: Preventative and Ongoing Healthcare		PAGE 1 OF 13
	**CHILD AND FAMILY SERVICES AGENCY** **Approved by: Rogue Gerald** Agency Director **Date: September 1, 2011**	**REVISION HISTORY:**
LATEST REVISION: May 17, 2011	**EFFECTIVE DATE:** September 1, 2011	

I. AUTHORITY	The Director of the Child and Family Services Agency adopts this policy to be consistent with the Agency's mission and applicable Federal and District of Columbia laws and regulations, including 45 CFR § 1340.14; provisions of Title 4, Title 7 and Title 16 of the DC Code; 22 DCMR Chapter 6 and B200-299; 29 DCMR Chapters 60, 62 and 63; and the LaShawn A. v. Gray Implementation and Exit Plan.
II. APPLICABILITY	All Agency staff, contracted agency staff and contracted personnel.
III. RATIONALE	According to the American Academy of Pediatrics, children entering foster care are often in poor health and have much higher rates of serious emotional and behavioral problems, chronic physical disabilities, birth defects, developmental delays and poor school achievement. Often, barriers exist that hinder the delivery of quality healthcare to these children. Such barriers can include: information about health care services children have received and their health status before placement is often hard to obtain; social workers are not always able to review a child's health history in detail with birth parents at the time of placement; foster care parents often have been given limited training in health care issues or in accessing the health care system; social workers often lack information about the type of health care services that children in foster care receive; and complicated physical and mental health conditions in children in foster care make taking care of these children difficult. The above-stated factors underscore the need for children in foster care to receive ongoing primary medical, dental, and mental/behavioral health care and periodic assessments of their health, development and emotional status to determine any changes in their status and/or the need for additional services and interventions.

IV. POLICY	It is the policy of the Child and Family Services Agency (CFSA) to ensure that children and youth in foster care receive preventative and ongoing health care in order to regularly evaluate physical, psychological and emotional development and provide appropriate treatment and support as needed and to gather information that can assist in ensuring the most appropriate placement setting. CFSA will adhere to the requirements of the federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services program (known in the District of Columbia as "HealthCheck"). It is important for the "family team" to work in concert to achieve child well-being. The family team, i.e. the social worker, nurse care manager (if applicable), foster parent(s), guardian, or residential facility staff, medical and mental health practitioners, birth parents (when available and involved) shall work collaboratively so that medical and mental health decisions and services promote permanency and stability for children and youth. The social worker, with the support of the Office of Clinical Practice (OCP) nursing staff, shall encourage the participation and involvement of birth parents, when available and if appropriate. Confidential medical information will only be divulged, if necessary, to extended family members who are directly involved in the treatment or care of a child. This information may also be divulged when necessary to identify service needs or resources. It is the expectation that there will be ongoing communication and evidence of documentation between the assigned social worker and OCP in order to achieve child well-being. This policy prescribes protocols and procedures for children and youth in CFSA out-of-home care. For the child or youth and their families who remain at home and receive services through CFSA, the assigned social worker shall consult with the OCP-Clinical and Health Services Administration for assistance and guidance in ensuring these families receive all necessary preventative and on-going healthcare services and supports.
V. CONTENTS	**A.** Routine Preventative Healthcare **B.** Well-Child Visits **C.** Dental Care Services **D.** Mental/Behavioral Health Services **E.** Developmental Services **F.** Management of Medical Conditions **G.** Communicable Disease Containment and Prevention Protocols
VI. ATTACHMENTS	**A.** Recommended Immunization Schedules, U.S. Centers for Disease Control **B.** District of Columbia Health Check Periodicity Schedule **C.** District of Columbia Dental Periodicity Schedule

VII. PROCEDURES	**Procedure A: Routine Preventative Healthcare**

Routine preventative healthcare promotes the health and well-being of all children. To help achieve optimum preventative healthcare, every child and youth must have periodic comprehensive medical assessments, also known as well child visits, on an ongoing basis, as recommended by EPSDT guidelines.

Note: For a child or youth for whom a nurse care manager (NCM) has been identified, the social worker shall collaborate with the NCM to coordinate and perform tasks for the child or youth. If no NCM has been assigned, all related tasks shall be performed by the social worker. The social worker shall consult with the OCP-Clinical and Health Services administrator, as needed

1. Routine preventative healthcare begins at the time of removal when the social worker and nurse obtain the child's critical medical and medication information obtained during the pre-placement process. Information should be obtained from the birth parents, guardians, or other caregivers; the child (if old enough to convey information); health care practitioners; other service providers (e.g. school nurse, day care center); and existing medical records.

2. The social worker shall place a copy of the initial medical screening documentation (*Cleared for Placement Authorization Form*) in the placement folder. At the time the child is placed, the assigned social worker shall discuss with the foster parent/caregiver the plans for immediate and ongoing healthcare. *(See policy on Initial Evaluation of Children's Health.)*

3. Results of screening for HIV/AIDS must be forwarded to the CFSA medical director and kept confidential within the case record, maintained in an envelope in the medical section of the case record marked "Confidential". Information regarding the child's HIV status shall be given to the caregiver by the social worker prior to placement, but the child's name should not be disclosed until the placement is confirmed. *(See HIV and AIDS policy.)*

4. The caregiver may select a private pediatrician (or healthcare practitioner qualified to provide HealthCheck services) or utilize a pediatrician or healthcare practitioner through the District of Columbia Medicaid provider network. The caregiver shall notify the assigned social worker of this decision. The pediatrician or healthcare practitioner must accept DC Medicaid as a form of reimbursement. The social worker shall inform the pediatrician or healthcare practitioner that all documentation related to the child's healthcare must be forwarded to OCP. The social worker, NCM and caregiver shall work with the pediatrician or healthcare practitioner to ensure compliance with these procedures.

5. The assigned social worker shall provide the caregiver with the recommended well-visit appointment dates provided by OCP as well as any other requirements by placing this information in the placement packets and discussing it with the caregiver.

	6. The assigned social worker and caregiver shall work collaboratively to schedule the child's well-visit appointments. 7. The social worker and/or caregiver shall accompany the child to the appointment. Birth parents/legal guardians who are available shall be encouraged to participate in the child's medical treatment and follow-up as appropriate. If the caregiver is unable to accompany the child to the appointment, and it can not be rescheduled, the caregiver shall notify the social worker in a timely manner and the social worker shall accompany the child to the visit. It is the expectation that the caregiver or the social worker will accompany the child or youth to all well-visit appointments. If the caregiver cannot be present at the appointment, the social worker is responsible for providing the caregiver with all information regarding the outcome of the visit and any necessary follow-up activities. 8. The social worker, in consultation with the OCP nursing staff, shall encourage the caregiver (and birth parents, where appropriate) to engage the healthcare practitioner to discuss and explain any healthcare issues with the child or youth, where appropriate. 9. Through visits with the caregiver and conversations with the health care providers, any medical information gathered by the social worker shall be entered into FACES. The social worker shall be responsible for placing any related documents into the child or youth's official case record.
	Procedure B: Well-Child Visits Following the comprehensive medical evaluation, periodic well-child visits shall occur according to the current guidelines of the American Academy of Pediatrics (AAP). Well-child visits shall be monitored by the NCM. The assigned social worker shall coordinate with the NCM, caregiver and birth parents (where appropriate) to ensure adherence to the following guidelines: 1. Initial visits shall occur once a month after birth for the first 6 months and every 3 months thereafter up to 2 years of age (per concurrence from the Department of Health Care Finance). 2. Semi annual visits shall occur for ages 2 through adolescence (per concurrence from the Department of Health Care Finance). 3. Additional visits shall occur consistent with current standards for primary care of specific conditions that may be present (e.g., HIV infection, conditions resulting from premature birth, cystic fibrosis, etc.). 4. Well child visits shall include: a. Clinical examinations by a pediatrician, pediatric nurse practitioner or other healthcare practitioner qualified to provide HealthCheck services. b. Immunizations consistent with current AAP recommendations for age, with special immunization recommendations for specific conditions that may be present such as HIV infection, sickle cell, asthma or diabetes. (*See Attachment A, Recommended Immunization*

	Schedules, U.S. Centers for Disease Control.) c. Periodic screening tests that are consistent with the current AAP well-child visit schedule and the District of Columbia Department of Health regulations for age and current professional standards for specific conditions, e.g. blood tests for lead poisoning. (*See Attachment B, District of Columbia Health Check Periodicity Schedule*). d. Health education and anticipatory guidance (long term guidance for chronic healthcare issues) consistent with current AAP recommendations for age. e. Review and updating of the medical problem list and treatment plan at each well-child visit. 5. The assigned social worker is responsible for contacting the healthcare practitioner regarding follow-up, referrals, missed appointments, or other important information and providing all updates to the caregiver. 6. After each well-child visit, the NCM, social worker and caregiver shall: a. Review the child or youth's medical examination record report to determine whether further treatment is recommended, including referrals and medications. b. Contact the healthcare practitioner, if necessary, to obtain information on follow up care and treatment. c. Offer assistance to the caregiver with follow up care. d. Document all communication between and among the NCM, social worker and caregiver regarding the care and treatment of the child or youth.
	Procedure C: Dental Care Services Comprehensive dental care for children and youth in foster care shall include ongoing dental examinations, restorative care, preventative services and treatment as recommended by the dentist. Follow up care for all conditions identified in the initial dental assessment (occurring within 30 days of a child or youth entering placement) shall be required. 1. The NCM, social worker and the caregiver shall ensure that the child or youth receives ongoing dental care, as prescribed in the District of Columbia Dental Periodicity schedule (Attachment C), and that the social worker and caregiver shall accompany the child or youth to all dental appointments including follow up care. 2. All dental appointments must be made with dental providers who accept DC Medicaid. The caregiver should verify acceptance of DC Medicaid with the dental provider. 3. Dental care services shall include: a. Initial examination for any child as early as 6 months of age performed by the Healthy Horizons Assessment Center (HHAC) Nurse Practitioner. Referral to a dentist should occur as early as 6 months after the first tooth erupts or 12 months of age (whichever

comes first).

b. Ongoing routine dental care for children and youth:
   i. Preventative care every 6 months
   ii. Examination by a hygienist and dentist at each 6-month visit.

c. Preventative service sealants on permanent molar teeth at the time of entry into care, if deemed necessary by the dentist, and sealants on newly erupted molars at preventative visits.

d. Restorative care to promptly address every problem identified including, but not limited to:
   i. Timely access to restorative care
   ii. Fillings
   iii. Root canals
   iv. Replacement of missing and damaged teeth
   v. Periodontal care for gum disease.

e. Immediate access to dentist or oral surgeon for acute dental pain or trauma.

f. Immediate access to medication to relieve dental pain.

g. Orthodontics based on medical necessity as deemed by DC Medicaid for severe handicapping dental conditions.

Procedure D: Mental/Behavioral Health Services

Children and youth in foster care should receive timely and individualized professional diagnosis, treatment and services for any mental or behavioral health needs identified in the initial mental health screening and subsequent assessments. Psychiatric, psychological and other essential services shall be made available appropriate to the needs of children and youth in out-of-home care.

1. Mental/behavioral health services for children, families, and caregivers served through CFSA are coordinated by the assigned social worker and the OCP-Mental Health Specialist.

2. The initial mental/behavioral health screening shall occur within 30 days of placement (*see policy on Initial Evaluation of Children's Health*). Based upon the findings in the initial mental/behavioral health screening, the assigned social worker and NCM shall:

   a. Consult with the OCP-Mental Health Specialist for referral advice to a mental healthcare practitioner.

   b. In consultation with the caregiver, schedule the first appointment with the mental healthcare practitioner.

   c. Attend the appointment with the child or youth and the caregiver. The birth parent should be encouraged to attend the appointment and participate in treatment planning and services, when clinically appropriate.

   d. Ensure that the mental healthcare practitioner receives all background information that is necessary for the mental/behavioral

health appointment.

e. Ensure that each child or youth receiving mental health services has a treatment plan that includes treatment objectives, methods, interventions and services, and participates in the development of the plan.

f. Ensure that the caregiver schedules all on going appointments and coordinates with the caregiver the transportation of the child or youth to the scheduled appointments.

g. Incorporate the mental/behavioral health services treatment plan in the child or youth's case plan.

h. Document all appointments, findings, treatment plans and follow-up information in FACES and place all relevant documents in the child or youth's case record.

i. Monitor the child or youth's mental health treatment through regular contact with the treatment provider and regular written reports from the provider.

3. The OCP-Mental Health Specialist is responsible for processing referrals linking children and youth with identified mental health needs to providers for mental health assessments, evaluations, and treatment services, and troubleshooting between the Department of Mental Health and other mental health providers when challenges are identified. The mental health specialist shall also follow up with the assigned social worker to ensure children and youth receive the services that have been identified.

4. When CFSA has physical custody of a child or youth during the 72-hour period prior to the initial court hearing, CFSA may consent to an outpatient psychiatric evaluation or emergency outpatient psychiatric treatment without first obtaining parental/legal guardian consent *(see the policy on Medical Consents).*

a. When there is a mental health emergency involving a child or youth, the Children and Adolescent Mobile Psychiatric Service (ChAMPS) shall be contacted immediately by the caregiver, the school personnel, the assigned social worker, or other CFSA or private agency staff. ChAMPS will be dispatched to the location of the child or youth to de-escalate the situation and determine the most appropriate course of action. The assigned social worker shall be notified immediately at the first available opportunity (if not making the initial call to ChAMPS).

b. The assigned social worker shall then notify their supervisor, the parent or legal guardian, CFSA's medical director or designee, and the assigned assistant attorney general (AAG).

c. If prior consent has been provided by the parent or legal guardian, a copy of the written consent shall be provided to the AAG and CFSA's medical director

d. The assigned social worker shall make reasonable attempts to consult with the birth parent(s) or legal guardian (s) should ongoing treatment be required.

	5. When CFSA has physical custody of a child or youth during the 72-hour period prior to the initial court hearing, CFSA may consent to non-emergency outpatient treatment for a child or youth when reasonable efforts to obtain the parent/legal guardian's written consent have been made but the parent/legal guardian cannot be consulted. *(See the policy on Medical Consents.)* 6. Consent of a parent or legal guardian is required for any minor to be admitted for inpatient mental health services. Further, consent of a parent or guardian, or authorization of the court, is required before a hospital providing inpatient mental health services may administer a psychotropic drug to a minor. *(See policy on Medical Consents.)* 7. Before a child or youth may be admitted to a substance abuse treatment and detox program, CFSA must obtain a Court order for treatment. If there is a need for medication, it shall be addressed with the AAG on a case by case basis.
	Procedure E: Developmental Services Children and youth entering out-of-home care most often come from families that have experienced chronic poverty, homelessness, poor education, unemployment, substance abuse, mental illness and/or domestic violence. Some children experience problems in physical growth and/or cognitive, social, or emotional development resulting from abuse and neglect, premature birth, and/or poor prenatal and infant healthcare. The effects of these experiences are then compounded by the separation, losses, and uncertainty accompanying out-of-home placements. The Child Abuse Prevention and Treatment Act (CAPTA), requires that all children under 3 years of age who are involved in a substantiated case of child abuse and/or neglect be screened for developmental delays. Children older than 3 years of age shall receive age-appropriate developmental assessments at routine medical visits. Developmental services for children and youth in foster care include timely access to services identified in the initial medical or subsequent developmental assessments. The assigned social worker, in consultation with the caregiver and birth parent (where appropriate) and the OCP shall facilitate the process for referrals and access to appropriate developmental services. 1. The Office of the State Superintendent of Education (OSSE) is the lead agency for the statewide system of early intervention services for families with children under the age of 36 months that have developmental delays. 2. The District of Columbia Public Schools Early Stages program is for children between the ages of 2 years 9 months and 5 years 10 months. Early Stages is designed to identify evaluate and provide therapy for special needs in children in this age category.

	3. Each well child visit shall include an assessment of the child or youth's developmental, educational and emotional status based on an interview with the caregivers, standardized tests of development and/or review of school progress. For all children and youth, the assigned social worker and the NCM shall ensure that children and youth are assessed as prescribed by the HealthCheck Periodicity schedule.
	Procedure F: Management of Medical Conditions Children and youth in foster care may experience serious, chronic medical conditions that need ongoing treatment and monitoring (e.g., asthma, skin problems, seizures, vision and hearing problems and chronic infectious diseases). Ongoing primary and specialized healthcare includes the management of such conditions. The OCP shall be notified of every child and youth in care that is defined as "special needs". CFSA defines special needs as "children and youth with special health care needs that have a chronic physical, developmental, behavioral, or emotional condition that requires health and related services of a type or amount beyond that required by children generally". For these children and youth, it is the expectation that the foster parent/caregiver is intimately involved in the implementation of the treatment plan. 1. When a child or youth has a chronic illness or condition requiring long term medical, mental/behavioral health, dental or other services, a treatment plan shall be established by the primary healthcare practitioner detailing the proposed treatment, alternative treatments and any risks or benefits. The assigned social worker should make reasonable efforts to engage the birth parent(s) in participating in the health care of the child and in obtaining informed consent for the treatment plan. The final decisions for care shall be the responsibility of the birth parent(s), primary healthcare practitioner, and CFSA. *(For any information concerning proposed treatments or treatment plans and obtaining consent regarding the HIV status of a child, refer to the HIV Policy.)* 2. The assigned social worker and the NCM shall ensure the caregiver and birth parent are provided with the training in order to manage the day to day care of the child. The assigned social worker shall notify the OCP nurse of any diagnoses given by the healthcare practitioner. The OCP-Clinical and Health Services Administration shall facilitate and coordinate the treatment planning, follow-up care and multidisciplinary approach, as indicated. 3. Comprehensive healthcare includes treatment for acute illness and injury. The OCP-Clinical and Health Services Administration is available 24-hours-a-day, 7-days-a-week to provide consultative services when there are questions or concerns regarding acute illness, injury and/or the need for emergency care. 4. In any emergency situation, the assigned social worker shall at first opportunity make every effort to notify the birth parent(s). Treatment may proceed as prescribed by the healthcare practitioner with the consent of

CFSA in an emergency (*see b.(5). below*).

a. CFSA recognizes that emergency care is imperative for attending to life-threatening conditions. Emergency room care shall be utilized only in the following situations:
   i. When medically necessary
   ii. When no other 24-hour care is available
   iii. When injuries indicate the need
   iv. When hospitalization is recommended

b. In the event of life threatening circumstances, the following is prescribed for accessing emergency care:
   i. When in a caregiver's judgment there is a potentially life threatening circumstance, the caregiver shall immediately call 911, and follow their instructions. The caregiver shall at first opportunity (no later than 30 minutes), notify the CFSA Hotline.
   ii. After the caregiver has given the information to the Hotline on the life-threatening incident, the caregiver may contact the assigned social worker.
   iii. The Hotline worker shall follow the notification procedures outlined in the Critical Events policy, including notifying the Deputy Director, Administrators and Program Managers in OCP.
   iv. The assigned social worker shall meet the caregiver and child or youth at the emergency room.
   v. CFSA may consent to the following without first obtaining the consent of the parent or guardian:
      a) Emergency medical, surgical or dental treatment;
      b) Emergency outpatient psychiatric treatment.

c. The OCP-Clinical and Health Services Administration, in conjunction with the assigned social worker, the caregiver and the birth parent, shall follow up regarding the prescribed plan of care and discharge planning.

Procedure G: Communicable Disease Containment and Prevention Protocols

By definition, communicable diseases are acute or chronic infectious conditions that are capable of being transmitted from one person to another. Chickenpox, impetigo and scabies are a few examples of communicable diseases. All children and youth with potential communicable diseases shall receive immediate medical attention. The assigned social worker shall be in consultation with the OCP, either directly with the HHAC or the OCP on-call staff at 202-498-8456.

1. Children and youth brought to the HHAC for a placement or re-placement screening who present with symptoms of a possible communicable disease shall be evaluated. Guidance shall be provided to the social worker and caregiver regarding necessary precautions and treatment and follow-up.

2. Social workers shall make every effort to engage the birth parent(s)/legal guardian(s) in the diagnostic/treatment process, as appropriate.

3. Social workers shall exercise sensitivity to the greatest extent possible when in contact with children or youth exhibiting symptoms of a potential communicable disease. This includes:
   a. Consideration of language (how the child or youth is referenced);
   b. Ways in which the child or youth is physically handled; and
   c. Demonstration of empathy and concern.

4. If a child or adult presents to the CFSA (other than for a placement screening) with symptoms of a communicable disease, the social worker shall immediately notify the OCP-Clinical and Health Services Administration and obtain immediate guidance as to universal/isolation precautions and the appropriate course for securing immediate health care for the infected child(ren) or adult(s).
   - This shall include direction on how to conduct physical contact, isolation requirements (jointly identified with the Facilities Management Administration), and transport to a medical facility, as necessary.

5. CFSA requires agency staff, contracted agency staff, caregivers and residential facilities engaged in providing direct services to children, youth and families to be trained in and to use universal infection control precautions on a daily basis. CFSA staff shall consult applicable procedures outlined in this policy. Contract agency staff shall also abide by the policies and procedures in effect in the agency in which they are employed.

6. If a social worker observes symptoms believed to be caused by a communicable disease in a child or youth or in others in constant contact with the child or youth (caregiver, other children) during a field visit to an in-home family or the home of a caregiver or to a residential facility, the social worker shall advise the caregiver to contact their primary care health practitioner immediately for an urgent office appointment or take the child or youth to an emergency room.
   a. Upon completion of that visit, the social worker shall confirm medical treatment and diagnosis and document in FACES.
   b. The assigned social worker, in consultation with the OCP nurse, shall follow-up with the caregiver to ensure appropriate medical attention is provided and inform and engage the child or youth's birth parents/legal guardians, as appropriate.

7. In the event that the social worker must transport the potentially infected child or youth for medical attention, social workers are strongly advised to utilize the safety kits placed in each government vehicle by the Facilities Management Administration in order to reduce the risk of transmission to the social worker and others. The safety kits shall include the following items:
   a. Non-sterile gloves

b. Hand sanitizer
c. Covering for the seats of the car
d. Surgical masks
e. Plastic caps (to be used in the event that the child has head lice and/or ringworm)
f. Disinfectant wipes
g. Tissues

8. In the event that a child(ren) exhibits coughing as part of a potential communicable disease, the social worker shall use the surgical mask on the child/youth to contain transmission of the disease. Likewise, if the child(ren) exhibits dermatological symptoms suggestive of scabies or ringworm, the social worker shall cover the child/youth's affected areas (the head with a plastic cap, arms with long sleeve clothing, if available, etc.) to prevent transmission. If the child is to be transported, the social worker shall use the seat covering in the car.

9. When transporting a potentially infected child or youth, the social worker shall inform Facilities Management so that the vehicle can be immediately detailed and restocked with a safety kit.

10. In collaboration with the medical director or designee, the social worker shall obtain the following information on any child or youth diagnosed with an infectious disease which must be reported for epidemiological and tracking purposes to the District of Columbia Health Department.
    a. Child's name
    b. Address
    c. Date of birth Age
    d. Sex
    e. Ethnicity
    f. Country of birth
    g. Pre-existing medical condition(s)
    h. Vaccination history
    i. Past medical history (to include information on previous communicable diseases)

11. Official notifications regarding possible exposure of staff to a communicable disease shall be made only by the Deputy or Medical Director for the Office of Clinical Practice. Any communications identifying persons who may or may not be affected by a communicable disease or any other medical condition is strictly prohibited and may be prosecuted as a violation of law.

12. The deputy or medical director for OCP shall immediately notify the Office of Risk Management and Facilities Management of the discovery of a communicable disease to ensure timely and safe containment of the identified disease.

	13. In the event of exposure to a communicable disease, and the social worker is unable to complete an Unusual Incident Report, the social work supervisor shall complete the Unusual Incident Report and submit it to the CFSA Office of Risk Management within 6 hours. 14. Social workers of childbearing age are advised to inform their physician of their place of employment so as to obtain timely and appropriate vaccinations to be safeguarded against the transmission of a communicable disease. 15. Similarly, social workers who have been diagnosed with a chronic disease or who have been medically immune compromised shall inform their physician of their place of employment so as to also be safeguarded against the transmission of a communicable disease. 16. If CFSA staff and/or clients are exposed to a communicable disease, the OCP-Clinical and Health Services Administration shall advise of the need for affected individuals to seek medical attention.

Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States • 2010

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼ / Age ►	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B[1]	HepB	HepB			HepB						
Rotavirus[2]			RV	RV	RV[2]						
Diphtheria, Tetanus, Pertussis[3]			DTaP	DTaP	DTaP	*see footnote 3*	DTaP				DTaP
Haemophilus influenzae type b[4]			Hib	Hib	Hib[4]	Hib					
Pneumococcal[5]			PCV	PCV	PCV	PCV				PPSV	
Inactivated Poliovirus[6]			IPV	IPV	IPV						IPV
Influenza[7]					Influenza (Yearly)						
Measles, Mumps, Rubella[8]						MMR	*see footnote 8*				MMR
Varicella[9]						Varicella	*see footnote 9*				
Hepatitis A[10]						HepA (2 doses)				HepA Series	
Meningococcal[11]										MCV	

Range of recommended ages for all children except certain high-risk groups

Range of recommended ages for certain high-risk groups

Recommended Immunization Schedule for Persons Aged 7 Through 18 Years— United States • 2010

For those who fall behind or start late, see the schedule below and the catch-up schedule

Vaccine ▼ / Age ►	7–10 years	11–12 years	13–18 years
Tetanus, Diphtheria, Pertussis[1]		Tdap	Tdap
Human Papillomavirus[2]	*see footnote 2*	HPV (3 doses)	HPV series
Meningococcal[3]	MCV	MCV	MCV
Influenza[4]	Influenza (Yearly)		
Pneumococcal[5]	PPSV		
Hepatitis A[6]	HepA Series		
Hepatitis B[7]	Hep B Series		
Inactivated Poliovirus[8]	IPV Series		
Measles, Mumps, Rubella[9]	MMR Series		

Range of recommended ages for all children except certain high-risk groups

Range of recommended ages for catch-up immunization

Range of recommended ages for certain high-risk groups

District of Columbia HealthCheck Periodicity Schedule

The DC HealthCheck Periodicity Schedule follows the American Academy of Pediatrics (AAP) health recommendations in consultation with the local medical community. The recommendations are for the care of children who have no manifestation of any important health problems. Additional visits or interperiodic screens may become necessary if circumstances suggest the need for more screens, i.e., medical conditions, referral by parent, Head Start, DC Public Schools, Early Intervention Programs. If a child comes under care for the first time at any point on the schedule, or if any items are not done at the suggested age, the schedule should then be brought up to date as soon as possible.

	INFANCY[4]									EARLY CHILDHOOD[4]			MIDDLE CHILDHOOD[4]						ADOLESCENCE[4]										
Age[5]	Prenatal[1]	Newborn[2]	2-4d[3]	by 1m	2m	4m	6m	9m	12mo	15mo	18mo	24mo	3y	4y	5y	6y	8y	10y	11y	12y	13y	14y	15y	16y	17y	18y	19y	20y	21y†
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	O[6]	S	O	O	O	O	S	O	S	S	O	S	S	O	S	S	S
Hearing		O[7]	S	S	S	S	O	S	S	S	S	S	S	S	O	O	O	O	S	O	S	S	O	S	S	O	S	S	S
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT[8]		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Physical Examination[9]		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Procedures-General[10]																													
Hereditary/Metabolic Screening[11]		◄	•	►																									
Immunization[12]		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Hematocrit or Hemoglobin[13, 14]								►		*	*	*	*	*	*	*	*	*	◄		•								►
Urinalysis[15]													◄	•	►				◄					•					►
PROCEDURES-PATIENTS AT RISK																													
Lead Screening[16]							◄	•	•	*	*	•	*	*	*	*													
Tuberculin Test[17] (PPD)									•	*	*	*	◄	•	►	*	•	•	•	•	•	•	•	•	•	•	•	•	•
Cholesterol Screening[18]													*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
STD Screening[19]																			*	*	*	*	*	*	*	*	*	*	*
Pelvic Exam[20]																			*	*	*	*	*	*	*	*	◄	*	►
ANTICIPATORY GUIDANCE[21]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Injury Prevention[22]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Violence Prevention[23]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Sleep Positioning Counseling[24]		•	•	•	•	•	•																						
Nutrition Counseling[25]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
DENTAL EVALUATION/REFERRAL[26]									◄	O	O	►	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•

KEY: • = to be performed * = to be performed for patients at risk S = subjective, by history O = objective, by a standard testing methods

◄•► = the range during which a service may be provided, with the dot indicating the preferred age. ◄O► 12m thru 24 m

†HealthCheck provides preventive care services from birth until the child's 21st birthday.

General Guidelines

1. 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 offered 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 refer to AAP statement "Hospital Stay for Healthy Term Newborn" (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, re-screen within 6 months.
7. All newborns should be screened per the AAP Task Force on Newborn and Infant Hearing Loss: Detection and Intervention (1999).
8. By history and appropriate physical examinations: 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 (e.g., thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to state law.
12. Every visit should be an opportunity to update and complete a child's immunizations as per AAP (American Academy of Pediatrics) guidelines.
13. See AAP Pediatric Nutrition Handbook (1998) for a discussion of universal and selective screening options. Consider earlier screening for high-risk infants (premature infants and low birth weight infants). See also "Recommendations to Prevent and Control Iron Deficiency in the United States". MMWR. 1998; 47.
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 refer to the District of Columbia "Childhood Lead Poisoning Screening and Reporting Emergency Act of 2002". After 26 months, blood lead level testing is required twice up to age 6, if not done previously. If family history cannot be ascertained and other risk factors are present, a lead blood level should be drawn.
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). Refer to STD practice guidelines.
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 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. Between 12 months and 24 months, one documented dental evaluation must be performed. Referrals to the dentist must begin at 3 years of age.

Updated 10/03

District of Columbia Department of Health
Medical Assistance Administration
Dental Periodicity Schedule

The District of Columbia Department of Health Medical Assistance Administration (DC DOH MAA) Dental Health Periodicity Schedule follows the American Academy of Pediatric Dentistry Periodicity Schedule oral health recommendations in consultation with local medical communities. This schedule is designed for the care of children who have no contributing medical conditions and are developing normally. The DC DOH MAA Dental periodicity schedule will be modified for children with special health care needs or if disease or trauma manifests variations from normal.

Age	Birth -12 months	12 -24 months	24 months – 3 years	3 -6 years	6 -12 years	12 years & Older
Clinical Oral screening[1]	•	•	•	•		
Assess oral growth and development[2]	•	•	•	•	•	•
Referral for Regular & Periodic Dental care[3]		If at risk	•	•	•	•
Counseling for nonnutritive Habits[4]	•	•	•	•	•	•
Oral hygiene counseling[5]	•	•	•	•	•	•
Dietary Counseling[6] Injury prevention counseling[7]	•	•	•	•	•	•
Fluoride Supplementation[8]		•	•	•	•	•
Radiographic Assessment[9]			•	•	•	•
Pit & Fissure Sealants[10]			•	•	•	•
Assessment & Treatment of Developing Malocclusion				•	•	•
Assessment and Removal of 3rd molars						•
Substance Abuse Counseling					•	•
Anticipatory Guidance[11]	•	•	•	•	•	•

1. The Primary Care Physician/Pediatrician should perform the first/initial oral health screening following AAP guidelines.
2. An oral assessment can be done by the Primary Care Physician/Pediatrician up to age 3. Every infant should receive an oral health risk assessment from his/her primary health care provider or qualified health care professional by 6 months of age that includes: (1) assessing the patient's risk of developing oral disease using the AAPD Caries-risk assessment tool; (2) providing education on infant oral health; and (3) evaluating and optimizing fluoride exposure.
3. All children should be referred to a dentist for the establishment of a dental home no later than age 3. Children determined by the PCP/Pediatrician to be at risk for dental caries should be referred to a dentist as early as 6 months after the first tooth erupts, or 12 months of age (whichever comes first) for establishment of a dental home. Children at risk are defined as:
    - Children with special health care needs
    - Children of mothers with a high caries rate
    - Children with demonstrable caries, plaque, demineralization, and or staining
    - Children who sleep with a bottle or breastfeed throughout the night
    - Later-order offspring
    - Children in families of low socioeconomic status.

    Once dental care is established with a dental professional, it is recommended and is the right of every child enrolled in Medicaid to see the Dentist every six months.
4. At first discussion of the need for additional sucking: digits vs. pacifiers; then the need to wean from the habit before malocclusion or skeletal dysphasia occurs.
5. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism. Counseling is given to parents/guardians/caregivers up to age 2. At age 2, the provider should include the patient/child in the counseling. For children 12 years and older, counseling need only be done with the child/patient if the dentist feels this is appropriate – Otherwise include the parents.
6. At every screening discuss the role of refined carbohydrates, frequency of snacking, etc.
7. Initial discussions should include play objects, pacifiers, and car seats; when learning to walk, include injury prevention. For school-age children and adolescent patients, counsel regarding sports and routine playing.
8. Fluoride supplementation as indicated including a topical fluoride varnish, as indicated by the child's risk for caries and periodontal disease and the water source. (Performed by dental professional only)
9. As per AAPD "Clinical guideline on prescribing dental radiographs." (Performed by dental professional only)
10. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and/ or fissures; placed as soon as possible after eruption. (Performed by dental professional only)
11. Appropriate oral health discussion and counseling should be an integral part of each visit for care. (Performed by dental professional only)