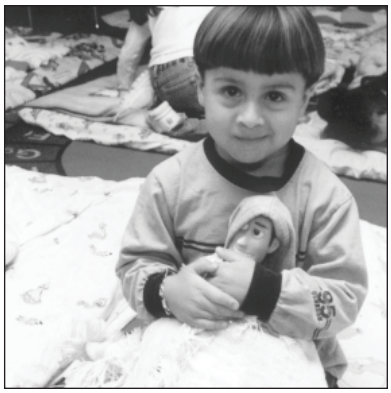
Preventive Health Care for Children in a Medical Home



First Edition, 2006

California Childcare Health Program
Administered by the University of California, San Francisco School of Nursing,
Department of Family Health Care Nursing
(510) 839-1195 • (800) 333-3212 Healthline
www.ucsfchildcarehealth.org

FIRST 5 CALIFORNIA℠ Funded by First 5 California with additional support from the California Department of Education Child Development Division and Federal Maternal and Child Health Bureau.

This module is part of the California Training Institute's curriculum for Child Care Health Consultants.

LEARNING OBJECTIVES

To define a medical home.

To describe the importance of periodic preventive health care for children in a medical home.

WHY IS PREVENTIVE HEALTH CARE IN A MEDICAL HOME IMPORTANT?

The American Academy of Pediatrics (AAP) promotes the use of a "medical home," which is defined as primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective (AAP, 2002). Having a usual source of health care facilitates access to health services for children and is associated with higher total physician visits, higher rates of preventive care use and immunization status. Factors associated with having a usual source include insurance status, race and ethnicity, education, income and health status (Sia, Tonniges, Osterhaus & Taba, 2004). The key to the detection of disabilities is quality health surveillance and screening provided through the medical home (AAP, 2002). In contrast to care provided in a medical home, health care provided through the emergency departments, walk-in clinics, and other urgent care facilities, is more costly and often less efficient. Child Care Health Consultants (CCHCs) play a crucial role in promoting preventive health care for children, the use of a medical home, and enrollment in health insurance plans for children.

WHAT THE CCHC NEEDS TO KNOW

Promoting preventive health care in a medical home is a core function for CCHCs and the Child Care Health Advocates (CCHAs) with whom they work. Assuring each child receives periodic health screening and treatment lays the foundation for school readiness.

A national agenda for children with special health care needs has been developed by the Maternal and Child Health Bureau entitled, "Achieving and Measuring Success: A National Agenda for Children with Special Health Care Needs." The following six critical indicators of progress have been defined:

1. All children with special needs and other disabilities will receive regular ongoing comprehensive care within a medical home.
2. All families of children with special needs and other disabilities will have adequate public and/or private insurance to pay for the services that they need.
3. All children will be screened early and continuously for special health care needs.
4. Families of children with special needs and other disabilities will participate in decision making at all levels and will be satisfied with the services that they receive.
5. Community-based service systems will be organized so that families can use them easily.
6. All children with special needs will receive the services necessary to make transitions to all aspects of adult life.

School Readiness

Preventive health care for children in a medical home lays the foundation for school readiness. Many young children have undetected health conditions that, if left untreated, could lead to injury, illness or developmental delay. Children with special health care needs require coordinated care over time if early intervention is to be effective. Certain health conditions can interfere with learning. For example, a child in pain from tooth decay cannot concentrate on learning, a child with an undetected vision impairment may not see well enough to read, and a child with anemia may lack the energy to fully participate. Parents also benefit from the planned visits inherent in care at a medical home because of the guidance and counseling they receive. Having a child's comprehensive health record at a single site makes access to health information easier, protects confidentiality, and provides for continuity of care.

The Healthy Child Care America campaign framed the Blueprint for Action (see *Handout: Blueprint for Action—10 Steps Communities Can Take*) with 10 steps communities can take to promote safe and healthy child care. The Blueprint for Action (www.healthychildcare.org) helps CCHCs formulate their goals to meet a national agenda. Of the 10 steps, three address preventive health care for children:

Step 2 Increase immunization rates and preventive services for children in early care and education (ECE) programs.

Step 3 Assist families in accessing key public and private health and social service programs.

Step 4 Promote and increase comprehensive access to health screenings.

Immunizations

CCHCs must know the schedule of routine preventive care and immunizations in a medical home and promote it at every opportunity. (Specific information on immunizations and doing an immunization assessment can be found in the *Preventing and Managing Illness in a Child Care Setting* module of this curriculum).

Handout: American Academy of Pediatrics (AAP) Policy Statement on The Medical Home contains an expanded and more comprehensive interpretation of the concept and operational definition of the medical home. The AAP schedule of routine visits, screenings, and anticipatory guidance (*Handout: Recommendations for Preventive Pediatric Health Care*) explains what activities are to occur at each visit. The frequency and timing of preventive health visits, called periodicity, were developed to target prevalent issues. The immunization schedule parallels the schedule for pre-

ventive health care, so when promoting immunization compliance, CCHCs can also promote the use of a child's medical home rather than simply referring to a stand-alone immunization clinic. This is also provides an opportunity for families to connect to an on-going health insurance plan.

Health assessments and screening recommended during preventive visits may include:

- health and developmental history
- complete physical examination, including height and weight
- oral health assessment
- behavioral assessment
- age-appropriate immunizations
- vision screening
- hearing screening
- screening tests for anemia, blood lead, blood pressure, tuberculosis, urine abnormalities, sexually transmitted diseases, and other problems as needed
- health education and guidance

Health Insurance

Health insurance has shown to be one of the factors that supports having a medical home and subsequent periodic screening and immunizations. In doing outreach to families on immunization compliance, it's always useful to include information on comprehensive pediatric health care providers and on health insurance (Inkelas, Schuster, Olson, Park & Halfon, 2004).

Health Records

Community Care Licensing regulations (State of California, Health and Human Services, Department of Social Services, 2002) require health records that document routine immunizations at the ages recommended but fail to require routine and periodic health screenings.

California regulations require that a child receive all required immunizations throughout enrollment in ECE programs and require a physical assessment at the time of entry. The regulations do not specify how often the health assessments/screenings must be repeated, but you will find standards in *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, Second Edition* (CFOC) (American Academy of Pediatrics [AAP], American Public Health Association, & National Resource Center for Health and Safety in Child Care, 2002). If a child receives the recommended immunizations according to schedule in a medical home, it is more likely that the routine assessments are also being done simultaneously by the health care provider.

Findings from Routine Health Assessments/Screenings

A CCHC can facilitate follow-up on findings from health assessments when there is a concern. However a child's health care provider may not always provide the written findings from health assessments/screenings every time one is done, unless a parent requests it. Hopefully, written documentation of the findings could be given to the ECE program in an on-going way or at least once a year. If there are specific health concerns from an ECE program, a request can be made ahead of time for written feedback from the health care provider.

To facilitate this transfer of information, Community Care Licensing has provided form 701 (*Handout: Physician's Report—Child Care Centers*) that must be completed by a health care professional. Although the form provides minimal feedback, it provides a place for immunizations and for TB risk factor assessment. There are a variety of health assessment forms in the health files at an ECE program. Many health care providers use their own forms. Additional child health assessment forms can be found in CFOC appendix Z, *Child Health Assessment*, and appendix X, *Emergency Information form for Children With Special Needs* (AAP et al, 2002). Most of these forms are acceptable to Community Care Licensing regulators.

Screening for Tuberculosis

Tuberculosis risk assessment has replaced mass TB skin testing because risk factor assessment has shown to be more e□cient and e□ective than mass skin testing. Some ECE programs may still require skin testing. □e CCHC can be very helpful in updating these outdated policies by reviewing the health form, the regulations and standards and by seeking guidance from the local health department's communicable disease unit.

Parental Consent

Parental consent is required for a CCHC to review a child's health records.

Immunization records are the exception. All public health professions may view immunization records without parental consent.

Parents' Perspectives

Handout: The Child's Preadmission Health History–Parent's Report (form 702) is also required by Community Care Licensing regulations and the CCHC may find that a review of this form provides useful information on a child's health status from a parent's perspective (State of California, 2002). Follow up on topics a parent is concerned about, such as child's history of illness, injury, development, daily routines and social-emotional concerns, can be facilitated by the CCHC. A review of this information can also be done by the CCHA and follow-up can be provided by the CCHC if that is part of the scope of work.

Developmental and Sensory Screening

Developmental and sensory (hearing, vision) screening takes places during routine visits to a health care provider. It also takes place in some ECE programs where sta□ has had training in various screening methods. It is important for the CCHC, ECE sta□ and parents to understand the results and limits of screening. Screening tests are designed for use on well populations as a means to a more important end: getting families needed assistance including referrals, delivery of information to families, developmental promotion, and enrollment in early intervention programs (Glascoe & Shapiro, 2005). Screening results will not tell you what's wrong, but are designed to answer the question "Is additional assessment needed?" □e answer will be a simple "yes" or "no." Some providers re-screen after several weeks if there are negative findings and others will refer to additional developmental or assessment resources. Many screening instruments (PEDS, ASQ) used in ECE programs or in primary health care settings involve parent observations, which are generally accurate except with parents with limited education. □ey are considered acceptable for special education programs that require parent assessment. Some developmental screening tools are available in multiple languages. A description of the pitfalls of screening and an excellent review of screening tools (PEDS, ASQ, Infant Development Inventory, Pediatric Symptom Checklist, etc.) used with young children is available at the Pediatric Development and Behavior Web site www.dbpeds.org. See *Session III: Behavioral Health Module* for a table of developmental screening tools.

Many state-funded programs are using a revised child development evaluation tool *Desired Results for Children* (www.sonoma.edu/cihs/desiredresults/training/forms.htm). In addition to the individualized screening tool, the evaluation package includes an environmental rating scale for centers and family child care and comes in multiple languages. For CCHCs working with state-funded ECE programs, it is useful to know the ECE providers have a problem-solving tool they can share with you.

Medical Home Resources

A variety of resources are available to support preventive health care in a medical home. See the resource section of this module.

California Child Health and Disability Prevention (CHDP)

□e CHDP program is a preventive health program serving California's children and youth ages birth to 19 (see *Handout: Program Overview*). CHDP is the

state version of the federal program called Early Periodic Screening, Diagnosis and Treatment (EPSDT). All states have an EPSDT program, usually located in public health departments. CHDP makes early health care available to children and youth with health problems as well as to those who seem well. Through the CHDP program, eligible children and youth receive periodic preventive health assessments. Children and youth with suspected problems are then referred for diagnosis and treatment. Many health problems can be prevented or corrected, or the severity reduced, by early detection and prompt diagnosis and treatment.

CHDP works with a wide range of health care providers and organizations to ensure that eligible children and youth receive appropriate services. These CHDP providers include private physicians, local health departments, schools, nurse practitioners, dentists, health educators, nutritionists, laboratories, community clinics, nonprofit health agencies, social and community service agencies. CCHCs and ECE programs can request lists of CHDP-approved health care providers, such as pediatricians and dentists, for their service area. These lists provide very useful information for use in making referrals.

To be eligible for services, families must be Medi-Cal recipients enrolled in Medi-Cal Managed Care Plans or whose family income is equal to or less than 200 percent of the federal income guidelines. Children enrolled in Head Start or State Preschool programs are eligible while enrolled.

CHDP Gateway

CHDP also has a streamlined insurance eligibility process called the CHDP Gateway. A single application determines enrollment into Medi-Cal or Healthy Families. Pre-enrollment provides immediate temporary full-scope comprehensive health care coverage to qualifying children for the month of the application and the subsequent month. Information is available on the CHDP web site at www.dhs.ca.gov/pcfh/cms/chdp or from the regional CHDP program located in health departments in every county in California.

Local CHDP programs will occasionally sponsor training on vision or hearing screening or nutrition assessments for their local health care providers and may include CCHCs or CCHAs.

Healthy Families

The Healthy Families Program offers low-cost insurance for children and teens up to age 19. It provides health, dental and vision coverage to children who meet the program rules and do not qualify for free Medi-Cal. People who qualify for Healthy Families receive 12 months of health coverage, as long as they pay the monthly premiums. They receive health services through the health, dental and visions plans that work with Healthy Families. Each member can choose his or her own plan. Healthy Families members pay a low monthly premium. The plans cover most visits to doctors, dentists, specialists, prescriptions, hospital care, labs and preventive care. Each county in California offers different plans to choose from.

The Healthy Families Web site is at www.healthyfamilies.ca.gov/hf/hfhome.jsp. It includes application forms, lists of participating doctors and dentists, and eligibility guidelines. Information is available in Spanish. Healthy Families is also available by calling (800) 880-5305. To download or order marketing materials in multiple languages visit www.healthyfamilies.ca.gov/English/caa/marketing.htm. For materials specific to ECE issues see the 100% Campaign at www.100percentcampaign.org.

Bright Futures

Bright Futures is a national initiative to promote and improve the health and well-being of children from birth through adolescence. It is dedicated to the principles that every child deserves to be healthy and that optimal health involves a trusting relationship among the health professional, the child, the family, and the community as partners in health practice. This philosophy is promoted in its publications, distance education materials, and training tools, including *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* and a variety of award-winning implementation tools such as a series focusing on nutrition, physical activity, mental health, oral health, and family materials. Bright Futures' Web site at www.brightfutures.org lists provides links to other groups developing Bright Futures materials and program initiatives. Since its inception in 1990, Bright Futures has been funded by the U.S. Department of Health and Human Services, under the direction of the Maternal and Child Health Bureau.

WHAT THE CCHC NEEDS TO DO

CCHCs can promote preventive health care for children in a medical home by:

- educating ECE programs, sta and families of the value of medical homes
- disseminating information on periodicity schedules for immunizations and health screenings
- developing and disseminating resource lists for health services and insurance
- reviewing children's records (with signed parental consent) for critical health screenings and developing systems for parent reminders
- reviewing children's health records (with parental consent) to assist caregivers in understanding and special care planning related to findings on health forms
- learning the confidentiality issues related to health records
- collaborating with CHDP, Healthy Families, and health care providers to promote medical homes
- becoming familiar with screening tools used in primary health care settings and ECE programs
- attending training programs to develop screening skills
- assisting ECE programs with policies and procedures to assure children receive preventive health care
- developing systems for information sharing from ECE program to health care provider using the schedule of preventive health care

WAYS TO WORK WITH CCHAs

CCHAs play a critical role in setting up and monitoring tracking systems that assure children receive their preventive health care. Among the activities that may require additional collaboration with the CCHA are disseminating community resource lists and reminding parents of due dates for health care and immunization.

ACTIVITY 1: HEALTH FORMS

An ECE program director has asked a CCHC to review health forms for all of the children enrolled in her program. She wants advice on what she should do with the information on these forms (see *Handouts: CCL Forms 701 and 702*). Review the forms in small groups and discuss the following:

What information on the forms raises warnings that something is wrong?

What guidance should the CCHC give the ECE director?

What types of tracking systems can be used to remind families of upcoming health needs?

How can a CCHC aid a program in setting up a reminder system to assure periodicity is accomplished?

ACTIVITY 2: MEDICAL HOME PRESENTATION

Prepare a three-minute presentation to ECE providers to stress the importance of preventive health care in a medical home and their role in promoting it in their programs. What handouts would you bring? If time allows, take turns conducting the mock presentation.

NATIONAL STANDARDS

From *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, Second Edition*

2.055	Family Source of Health Care
8.013	Written Procedure for Obtaining Preventive Health Service Information
8.015	Identification of Child's Medical Home and Parental Consent for Information Exchange
8.048	Content of Child's Health Report
8.050	Content of a Child Care Program's Health History

Appendices H Recommendations for Preventive Pediatric Health Care, AAP 2001, and Z Child Health Assessment.

CALIFORNIA REGULATIONS

From *Manual of Policies and Procedures for Community Care Licensing Division*

101220	Child's Medical Assessment
101220.1	Immunizations
101221	Child's Records
Form 701	Physician's Report
Form 702	Child's Preadmission Health History

RESOURCES

Organizations and Resources

Organization Name and Contact Information	Description of Resources
American Academy of Pediatrics www.aap.org	Medical Homes Initiatives for children with Special Needs. (n.d.) *Integrating surveillance and screening with the medical home.* Retrieved November 10, 2004, from www.medicalhomeinfo.org/screening. American Academy of Pediatrics, The National Center of Medical Home Initiatives for Children with Special Needs (n.d.) *Every child deserves a medical home training program.* Retrieved November 10, 2004, from www.medicalhomeinfo.org/training/survindex.html. American Academy of Pediatrics, Healthy Child Care America Campaign www.healthy childcare.org.
California Childcare Health Program 1333 Broadway, Suite 1010 Oakland, CA 94612-1926 (510) 839-1195 www.ucsfchildcarehealth.org	The Child Care Healthline, at (800) 333-3212, provides health and safety information to ECE providers, the families they serve, and related professionals in California. The Healthline team of specialists consults on issues such as infectious disease, health promotion, behavioral health, serving children with disabilities and special needs, nutrition, infant-toddler development, car seat safety, lead poisoning prevention and more. The Child Care Health Linkages Project, funded by the California Children and Families Commission, created child care health consultation services in 20 counties, staffed by trained CCHCs and CCHAs. *The Child Care Health Connections Newsletter,* a bimonthly publication disseminated statewide, provides current and emerging health and safety information for the ECE community. Articles are designed to be copied by programs and broadly distributed to direct service providers and parents. Other publications include Health and Safety Notes and Fact Sheets for Families, available in both English and Spanish.
Champions for Progress Center http://championsfor progress.org	Provides leadership support for state and territorial Title V programs in the process of systems building at the state and community levels for children and youth with special health care needs (CYSHCN). Web site links states and communities in their efforts to create community-based systems of care for CYSHCN.

Organization Name and Contact Information	Description of Resources
DisabilityInfo.gov www.disabilityinfo.gov	This comprehensive federal web site has disability-related government resources.
Maternal and Child Health Bureau www.mchb.hrsa.gov/programs/specialneeds/measuresuccess.htm	MCHB works towards the development of systems of care for children with special needs that are family-centered, community-based, coordinated and culturally competent.
National Center for Health and Safety in Child Care www.nrc.uchsc.edu	Child Care Health Consultant Standards from Caring for Our Children, 2nd Ed.
National Center for Hearing Assessment and Management (NCHAM) www.infanthearing.org	The goal of the National Center for Hearing Assessment and Management (NCHAM - pronounced “en-cham”) at Utah State University is to ensure that all infants (newborns) and toddlers with hearing loss are identified as early as possible and provided with timely and appropriate audiological, educational, and medical intervention.
National Center of Medical Home Initiatives for Children with Special Needs www.medicalhomeinfo.org	Provides support to physicians, families, and other medical and nonmedical providers who care for children with special needs so that they have access to a medical home.
National Newborn Screening and Genetics Resource Center (NNSGRC) http://genes-r-us.uthscsa.edu	NNSGRC is a cooperative agreement between the Maternal and Child Health Bureau (MCHB), Genetic Services Branch and the University of Texas Health Science Center at San Antonio (UTHSCSA), Department of Pediatrics. The organization provides information and resources in the area of newborn screening and genetics to benefit health professionals, the public health community, consumers and government officials.
National Resource Center for Health and Safety in Child Care (NRC) www.nrc.uchsc.edu	The National Resource Center is located at the University of Colorado Health Sciences Center in Denver, Colorado, and is funded by the Maternal and Child Health Bureau, U.S. Department of Health & Human Services, HRSA. The NRC’s primary mission is to promote health and safety in ECE programs throughout the nation. The standard resource for information concerning this subject is the *Caring for Our Children: National Health and Safety Performance Standards Guidelines for Out-of-Home Child Care Programs,* Second Edition published in January 2002. The guidelines were developed through the collaborative efforts of the American Public Health Association, the American Academy of Pediatrics, and the Maternal and Child Health Bureau. The entire text of this publication is available on this Web site.

Organization Name and Contact Information	Description of Resources
National Training Institute for Child Care Health Consultants (NTI) www.sph.unc.edu	Supports the health and safety of young children in ECE programs through the development of a national child care health consultant training program. Developed and implemented a state-of-the-art national train-the-trainers approach that includes both face-to-face and self-study components.

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HANDOUTS FOR FIELD OF PREVENTIVE HEALTH CARE FOR CHILDREN IN A MEDICAL HOME MODULE

Page **Handout Title**

AMERICAN ACADEMY OF PEDIATRICS

POLICY STATEMENT

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

Medical Home Initiatives for Children With Special Needs Project Advisory Committee

The Medical Home

ABSTRACT. The American Academy of Pediatrics proposed a definition of the medical home in a 1992 policy statement. Efforts to establish medical homes for all children have encountered many challenges, including the existence of multiple interpretations of the "medical home" concept and the lack of adequate reimbursement for services provided by physicians caring for children in a medical home. This new policy statement contains an expanded and more comprehensive interpretation of the concept and an operational definition of the medical home.

ABBREVIATION. AAP, American Academy of Pediatrics.

The American Academy of Pediatrics (AAP) believes that the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family centered, coordinated,[1] compassionate, and culturally effective.[2] It should be delivered or directed by well-trained physicians who provide primary care[3] and help to manage and facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a partnership of mutual responsibility and trust with them. These characteristics define the "medical home." In contrast to care provided in a medical home, care provided through emergency departments, walk-in clinics, and other urgent-care facilities, though sometimes necessary, is more costly and often less effective. Although inadequate reimbursement for services offered in the medical home remains a very significant barrier to full implementation of this concept,[4,5] reimbursement is not the subject of this statement. It deserves coverage in other AAP forums.

Physicians should seek to improve the effectiveness and efficiency of health care for all children and strive to attain a medical home for every child in their community.[6] Although barriers such as geography, personnel constraints, practice patterns, and economic and social forces create challenges, the AAP believes that comprehensive health care for infants, children, and adolescents should encompass the following services:

1. Provision of family-centered care through developing a trusting partnership with families, respecting their diversity, and recognizing that they are the constant in a child's life.
2. Sharing clear and unbiased information with the family about the child's medical care and management and about the specialty and community services and organizations they can access.
3. Provision of primary care, including but not restricted to acute and chronic care and preventive services, including breastfeeding promotion and management,[7] immunizations, growth and developmental assessments, appropriate screenings, health care supervision, and patient and parent counseling about health, nutrition, safety, parenting, and psychosocial issues.
4. Assurance that ambulatory and inpatient care for acute illnesses will be continuously available (24 hours a day, 7 days a week, 52 weeks a year).
5. Provision of care over an extended period of time to ensure continuity. Transitions, including those to other pediatric providers or into the adult health care system, should be planned and organized with the child and family.
6. Identification of the need for consultation and appropriate referral to pediatric medical subspecialists and surgical specialists. (In instances in which the child enters the medical system through a specialty clinic, identification of the need for primary pediatric consultation and referral is appropriate.) Primary, pediatric medical subspecialty, and surgical specialty care providers should collaborate to establish shared management plans in partnership with the child and family and to formulate a clear articulation of each other's role.
7. Interaction with early intervention programs, schools, early childhood education and child care programs, and other public and private community agencies to be certain that the special needs of the child and family are addressed.
8. Provision of care coordination services in which the family, the physician, and other service providers work to implement a specific care plan as an organized team.
9. Maintenance of an accessible, comprehensive, central record that contains all pertinent information about the child, preserving confidentiality.

TABLE 1. Desirable Characteristics of a Medical Home

Accessible
Care is provided in the child's or youth's community.
All insurance, including Medicaid, is accepted.
Changes in insurance are accommodated.
Practice is accessible by public transportation, where available.
Families or youth are able to speak directly to the physician when needed.
The practice is physically accessible and meets Americans With Disabilities Act[10] requirements.
Family centered
The medical home physician is known to the child or youth and family.
Mutual responsibility and trust exists between the patient and family and the medical home physician.
The family is recognized as the principal caregiver and center of strength and support for child.
Clear, unbiased, and complete information and options are shared on an ongoing basis with the family.
Families and youth are supported to play a central role in care coordination.
Families, youth, and physicians share responsibility in decision making.
The family is recognized as the expert in their child's care, and youth are recognized as the experts in their own care.
Continuous
The same primary pediatric health care professionals are available from infancy through adolescence and young adulthood.
Assistance with transitions, in the form of developmentally appropriate health assessments and counseling, is available to the child or youth and family.
The medical home physician participates to the fullest extent allowed in care and discharge planning when the child is hospitalized or care is provided at another facility or by another provider.
Comprehensive
Care is delivered or directed by a well-trained physician who is able to manage and facilitate essentially all aspects of care.
Ambulatory and inpatient care for ongoing and acute illnesses is ensured, 24 hours a day, 7 days a week, 52 weeks a year.
Preventive care is provided that includes immunizations, growth and development assessments, appropriate screenings, health care supervision, and patient and parent counseling about health, safety, nutrition, parenting, and psychosocial issues.
Preventive, primary, and tertiary care needs are addressed.
The physician advocates for the child, youth, and family in obtaining comprehensive care and shares responsibility for the care that is provided.
The child's or youth's and family's medical, educational, developmental, psychosocial, and other service needs are identified and addressed.
Information is made available about private insurance and public resources, including Supplemental Security Income, Medicaid, the State Children's Health Insurance Program, waivers, early intervention programs, and Title V State Programs for Children With Special Health Care Needs.
Extra time for an office visit is scheduled for children with special health care needs, when indicated.
Coordinated
A plan of care is developed by the physician, child or youth, and family and is shared with other providers, agencies, and organizations involved with the care of the patient.
Care among multiple providers is coordinated through the medical home.
A central record or database containing all pertinent medical information, including hospitalizations and specialty care, is maintained at the practice. The record is accessible, but confidentiality is preserved.
The medical home physician shares information among the child or youth, family, and consultant and provides specific reason for referral to appropriate pediatric medical subspecialists, surgical specialists, and mental health/developmental professionals.
Families are linked to family support groups, parent-to-parent groups, and other family resources.
When a child or youth is referred for a consultation or additional care, the medical home physician assists the child, youth, and family in communicating clinical issues.
The medical home physician evaluates and interprets the consultant's recommendations for the child or youth and family and, in consultation with them and subspecialists, implements recommendations that are indicated and appropriate.
The plan of care is coordinated with educational and other community organizations to ensure that special health needs of the individual child are addressed.
Compassionate
Concern for the well-being of the child or youth and family is expressed and demonstrated in verbal and nonverbal interactions.
Efforts are made to understand and empathize with the feelings and perspectives of the family as well as the child or youth.
Culturally effective
The child's or youth's and family's cultural background, including beliefs, rituals, and customs, are recognized, valued, respected, and incorporated into the care plan.
All efforts are made to ensure that the child or youth and family understand the results of the medical encounter and the care plan, including the provision of (para)professional translators or interpreters, as needed.
Written materials are provided in the family's primary language.

Physicians should strive to provide these services and incorporate these values into the way they deliver care to all children. (Note: pediatricians, pediatric medical subspecialists, pediatric surgical specialists, and family practitioners are included in the definition of "physician.")

10. Provision of developmentally appropriate and culturally competent health assessments and counseling to ensure successful transition to adult-oriented health care, work, and independence in a deliberate, coordinated way.

Medical care may be provided in various locations, such as physicians' offices, hospital outpatient clinics, school-based and school-linked clinics, community health centers, and health department clinics. Regardless of the venue in which the medical care is provided, to meet the definition of medical home, a designated physician must ensure that the aforementioned services are provided (see Table 1 for more details).

The need for an ongoing source of health care—ideally a medical home—for all children has been identified as a priority for child health policy reform at the national and local level. The US Department of

Health and Human Services' *Healthy People 2010* goals and objectives state that "all children with special health care needs will receive regular ongoing comprehensive care within a medical home"[8] and multiple federal programs require that all children have access to an ongoing source of health care. In addition, the Future of Pediatric Education II goals and objectives state: "Pediatric medical education at all levels must be based on the health needs of children in the context of the family and community" and "all children should receive primary care services through a consistent 'medical home.'"[9] Over the next decade, with the collaboration of families, insurers, employers, government, medical educators, and other components of the health care system, the quality of life can be improved for all children through the care provided in a medical home.

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All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

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.**

	INFANCY[4]									EARLY CHILDHOOD[4]					MIDDLE CHILDHOOD[4]				ADOLESCENCE[4]										
AGE[5]	PRENATAL[1]	NEWBORN[2]	2-4d[3]	By 1mo	2mo	4mo	6mo	9mo	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]	O	O	O	O	O	S	O	S	S	O	S	S	O	S	S	S
Hearing		O[7]	S	S	S	S	S	S	S	S	S	S	S	O	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]									★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Cholesterol Screening[18]												★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
STD Screening[19]																			★	★	★	★	★	★	★	★	★	★	★
Pelvic Exam[20]																			★	★	★	★	★	★	★	★ ◄	★ [20]	► ★	★
ANTICIPATORY GUIDANCE[21]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Injury Prevention[22]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Violence Prevention[23]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Sleep Positioning Counseling[24]	•	•	•	•	•	•	•																						
Nutrition Counseling[25]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
DENTAL REFERRAL[26]									◄	►				•															

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, rescreen 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 "Positioning and Sudden Infant Death Syndrome (SIDS): Update" (1996).
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.

Key: ● = to be performed ★ = to be performed for patients at risk
S = subjective, by history O = objective, by a standard testing method
◄—● —► = the range during which a service may be provided, with the dot indicating the preferred age.

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.

American Academy of Pediatrics

CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM OVERVIEW

From: www.dhs.ca.gov/pcfh/cms/chdp/

The CHDP program is a preventive health program serving California's children and youth. CHDP makes early health care available to children and youth with health problems as well as to those who seem well. Many children and youth in California have unmet health needs. Through the CHDP program, eligible children and youth receive periodic preventive health assessments. Children and youth with suspected problems are then referred for diagnosis and treatment. Many health problems can be prevented or corrected, or the severity reduced, by early detection and prompt diagnosis and treatment.

CHDP works with a wide range of health care providers and organizations to ensure that eligible children and youth receive appropriate services. These CHDP providers include private physicians, local health departments, schools, nurse practitioners, dentists, health educators, nutritionists, laboratories, community clinics, nonprofit health agencies, social and community service agencies.

CHDP provides periodic preventive health services to Medi-Cal recipients based on the federally-mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. All California Medi-Cal recipients from birth to age 21 are eligible for health assessments based on the following schedule:

- less than 1 month of age
- 2 months of age
- 4 months of age
- 6 months of age
- 9 months of age
- 12 months of age
- 15 months of age
- 18 months of age
- 2 years of age
- 3 years of age
- 4-5 years of age
- 6-8 years of age
- 9-12 years of age
- 13-16 years of age
- 17-20 years of age

Medi-Cal recipients who are enrolled in Medi-Cal Managed Care Plans are eligible for health assessments according to the American Academy of Pediatrics' (AAP's) *Recommendations for Preventive Pediatric Health Care*.

Non-Medi-Cal Eligible Children and Youth

CHDP provides periodic preventive health services to non-Medi-Cal eligible children and youth from birth to age 19 whose family income is equal to or less than 200 percent of the federal income guidelines. They are eligible for health assessments based on the same schedule as Medi-Cal eligible children and youth.

Head Start/State Preschool

Children in Head Start and State Preschool programs are eligible for CHDP health assessments while enrolled in these programs.

STATE OF CALIFORNIA–HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME: Jeremy Jones | SEX: M | BIRTH DATE: 1/20/03

FATHER'S NAME: John Jones | DOES FATHER LIVE IN HOME WITH CHILD? yes

MOTHER'S NAME: Doris Jones | DOES MOTHER LIVE IN HOME WITH CHILD? yes

IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN? No | DATE OF LAST PHYSICAL/MEDICAL EXAMINATION: 11/20/04

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
12 MONTHS	24 MONTHS	24 MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☑ Asthma	vaccination 1/2004	☐ Epilepsy	X	☐ Ten-Day Measles (Rubeola)	X
☐ Rheumatic Fever		☐ Whooping cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☑ YES ☐ NO | HOW MANY IN LAST YEAR? 5 | LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF: egg allergies, asthma

DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
6 a.m.	10 p.m.	wakes up twice
DOES CHILD SLEEP DURING THE DAY?*	**WHEN?***	**HOW LONG?***
long nap	10 a.m. and 1 p.m.	1-1/2 hours

DIET PATTERN: (What does child usually eat for these meals?)

BREAKFAST: cereal & bottle

LUNCH: crackers & bottle

DINNER: noodles & bottle

WHAT ARE USUAL EATING HOURS?
BREAKFAST 7
LUNCH noon
DINNER 5

ANY FOOD DISLIKES? pork; dislikes fruits, vegetables, solids | ANY EATING PROBLEMS? fussy, loves his bottle

IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
☑ YES ☐ NO	during day	☐ YES ☑ NO constipated	?

WORD USED FOR "BOWEL MOVEMENT"* ka-ka | WORD USED FOR URINATION* pee-pee

PARENT'S EVALUATION OF CHILD'S HEALTH: good—ear infections, asthma

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)?	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
☐ YES ☑ NO		☑ YES ☐ NO asthma	??
DOES CHILD USE ANY SPECIAL DEVICE(S):	**IF YES, WHAT KIND:**	**DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?**	**IF YES, WHAT KIND:**
☐ YES ☑ NO		☐ YES ☑ NO	

PARENT'S EVALUATION OF CHILD'S PERSONALITY: temper tantrums

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN? no siblings

HAS THE CHILD HAD GROUP PLAY EXPERIENCES? no

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.) wakes up at night

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL? send him home

REASON FOR REQUESTING DAY CARE PLACEMENT: have to go to work

PARENT'S SIGNATURE: Doris Jones | DATE: 2/15/05

LIC 702 (7/99) (CONFIDENTIAL)

Today's Date: 1/20/05

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

Jeremy Jones (NAME OF CHILD), born 1/20/03 (BIRTH DATE) is being studied for readiness to enter Little Lambs C.D.C. (NAME OF CHILD CARE CENTER/SCHOOL). This Child Care Center/School provides a program which extends from 6:00 (a.m.)/p.m. to 6:30 a.m./(p.m.), 5 days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

Doris Jones (SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) 1/20/05 (TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware: frequent ear infections, food allergy—eggs, overweight, anemia

Hearing: OK? hearing loss

Vision: OK

Developmental:

Language/Speech: hard to understand

Allergies: medicine: Ø

Insect stings: Ø

food: wean from bottle, more solids

(asthma) yes

other: dental caries

Other (Include behavioral concerns): mo. reports freq. temper tantrums

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD: theophylline inhaler daily & severe episodes

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	3/20/03	5/20/03	7/20/03	/ /	/ /
DTP/DTaP/DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	3/20/03	5/20/03	7/20/03	4/20/04	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	1/20/04	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	3/20/03	5/20/03	7/20/03	1/20/04	
HEPATITIS B	3/20/03	5/20/03	/ /		
VARICELLA (CHICKENPOX)	1/20/04	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

☑ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

I have ☑ have not ☐ reviewed the above information with the parent/guardian.

Physician: Dr. D. Wright
Address: 123 Main Street, SF
Telephone:

Date of Physical Exam:
Date This Form Completed: 1/20/05
Signature D. Wright

☑ Physician ☐ Physician's Assistant ☐ Nurse Practioner

LIC 701 (8/01) (Confidential)

RISK FACTORS FOR TB IN CHILDREN:

* Have a family member or contacts with a history of confirmed or suspected TB.
* Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
* Live in out-of-home placements.
* Have, or are suspected to have, HIV infection.
* Live with an adult with HIV seropositivity.
* Live with an adult who has been incarcerated in the last five years.
* Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
* Have abnormalities on chest X-ray suggestive of TB.
* Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

HEALTHY CHILD CARE AMERICA
BLUEPRINT FOR ACTION

Goals

- Safe, healthy child care environments for all children including those with special needs
- Up-to-date immunizations for children in child care
- Access to quality health, dental, and developmental screening and comprehensive follow-up for children in child care
- Health and mental health consultation, support, and education for all families, children and child care providers
- Health, nutrition, and safety education for children in child care, their families, and child care providers

10 Steps Communities Can Take to Promote Safe and Healthy Child Care

One Promote safe, healthy, and developmentally appropriate environments for all children in child care.

Two Increase immunization rates and preventive services for children in child care setting.

Three Assist families in accessing key public and private health and social service programs.

Four Promote and increase comprehensive access to health screenings.

Five Conduct health and safety education and promotion programs for children, families, and child care providers.

Six Strengthen and improve nutrition services in child care.

Seven Provide training and ongoing consultation to child care providers and families in the area of social and emotional health.

Eight Expand and provide ongoing support to child care providers and families caring for children with special health needs.

Nine Use child care health consultants to help develop and maintain healthy child care.

Ten Assess and promote the health, training, and work environment of child care providers.

Sponsored by the U.S. Department of Health and Human Services,
Child Care Bureau, Administration for Children and Families
Maternal and Child Health Bureau, Health Resources Services Administration
Retrieved from the Healthy Child Care America Web site www.aap.org 11/9/04