BEST-PRACTICES FOR SERVING EXPECTANT & PARENTING TEENS & FAMILIES

A Resource Guide for School-Based Health Centers

envision new mexico
The Initiative for Child Healthcare Quality

UNM | SCHOOL of MEDICINE Department of Pediatrics

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This guide is designed for use by School-Based Health Centers to help them understand the basics of reproductive health care for pregnant and parenting teens. It is intended to be used as a reference for SBHCs in their role mentoring students and contains a list of recommended web resources. It is not intended to provide clinical protocols or treatment guidance for healthcare providers. The information is current as of the date issued and is subject to change. The information is not a complete reference however it does contain a list of recommended web resources. This guide may need to be modified to be culturally appropriate for some patients.

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To download this guide, visit: www.envisionnm.org
Supplemental training webinars are also available.

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RESOURCE MANUAL

Chapter 1 – Sexual & Reproductive Health

SECTION 1: PREGNANCY PREVENTION

BACKGROUND

- Teen birth rates have declined in the last decade in the United States but remain substantially higher than in most other developed countries and ethnic and geographic disparities persist. [1]
- Teen pregnancy and parenthood are associated with poorer health, economic and education outcomes for teen parents and their children. [2]
- New Mexico has the highest teen pregnancy rate and the fourth highest teen birth rate among 15-19 year olds in the country (37.8 per 1,000 in 2014). [1, 3]
    - Teen birth rates are highest among Latino/Hispanic teens both in NM and nationally. [1,3]
- In New Mexico, 27.5% of sexually active youth report using reliable birth control when they last had sex. Additionally, 10% used a reliable method with a condom. [4]
- LARC methods are reportedly being used by 5% of teens in New Mexico, while 14% are not using any method to prevent pregnancy. [4]

RECOMMENDATIONS

Contraception Counseling for Adolescents

American Academy of Pediatrics Recommendations, September 2014[5]:

- Counsel about and ensure access to a broad range of contraceptive services for your adolescent patients. This includes educating patients about all contraceptive methods that are safe and appropriate for them and describing the most effective methods first.
- Educate your adolescent patients about LARC methods, including the progestin implant and IUDs. Given the efficacy, safety, and ease of use, LARC methods should be considered first-line contraceptive choices for adolescents. Some providers may choose to acquire the skills to provide these methods to adolescents. Those who do not should identify health care providers in their communities to whom patients can be referred. *(See Ch.1, Sec.2)*
- Despite increased attention to adverse effects, DMPA (depot medroxyprogesterone acetate) and the contraceptive patch are highly effective methods of contraception that are much safer than pregnancy. You should continue to make them available to your patients.
- Allow the adolescent to consent to contraceptive care and to control the disclosure of this information within the limits of state and federal laws. There are a number of supports for protecting minor consent and confidentiality, including state law, federal statutes, and federal case law. Providers need to be familiar with national best practice recommendations for confidential care and with the relevant minor consent laws in New Mexico. *(See Ch. 5)*
- Be aware that it is appropriate to prescribe contraceptives or refer for IUD placement without first conducting a pelvic examination. Screenings for STIs, especially chlamydia, can be performed without a pelvic examination and should not be delayed.

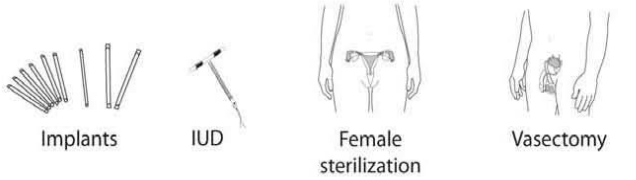
SEXUAL & REPRODUCTIVE HEALTH

- Ensure the consistent and correct use of condoms with every act of sexual intercourse by educating adolescents during each visit.
- Have a working knowledge of the different combined hormonal methods and regimens, because these provide excellent cycle control both for contraception and medical management of common conditions, such as acne, dysmenorrhea, and heavy menstrual bleeding.
- Remember that adolescents with chronic illness and disabilities have similar sexual health and contraceptive needs to healthy adolescents while recognizing that medical illness may complicate contraceptive choices.
- Regularly update adolescent patients' sexual histories and provide a confidential and nonjudgmental setting in which to address needs for contraception, STI screening, and sexual risk reduction counseling for patients who choose not to be abstinent. (*See Ch.1, Sec.4*).
- Allow sufficient time with your adolescent patients to address contraceptive needs using a developmentally appropriate, patient-centered approach, such as motivational interviewing. If necessary, arrangements should be made for a separate visit for contraceptive follow-up to increase adherence and monitor for adverse effects and complications.
- Complement the skills and resources of the School-Based Health Center by being aware of state or federally subsidized insurance programs and clinics, such as Public Health Offices, that provide confidential and free or low-cost reproductive health care services and supplies, including contraception.

Comparing Effectiveness of Family Planning Methods

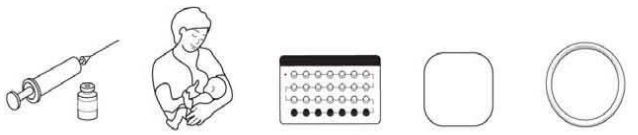
More effective

Less than 1 pregnancy per 100 women in 1 year



Implants, IUD, female sterilization: After procedure, little or nothing to do or remember

Vasectomy: Use another method for first 3 months

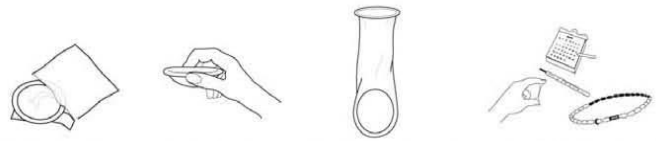


Injectables: Get repeat injections on time

Lactational amenorrhea method, LAM (for 6 months): Breastfeed often, day and night

Pills: Take a pill each day

Patch, ring: Keep in place, change on time



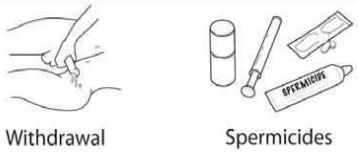
Condoms, diaphragm: Use correctly every time you have sex

Fertility awareness methods: Abstain or use condoms on fertile days. Newest methods (Standard Days Method and TwoDay Method) may be easier to use.

How to make your method more effective

Less effective

About 30 pregnancies per 100 women in 1 year



Withdrawal, spermicides: Use correctly every time you have sex

USAID FROM THE AMERICAN PEOPLE

World Health Organization

Sources:

Steiner MJ, Trussell J, Mehta N, Condon S, Subramaniam S, Bourne D. Communicating contraceptive effectiveness: a randomized controlled trial to inform a World Health Organization family planning handbook. *Am J Obstet Gynecol* 2006;195(1):85–91.

World Health Organization/Department of Reproductive Health and Research (WHO/RHR), Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). *Family Planning: A Global Handbook for Providers*. Baltimore, MD and Geneva: CCP and WHO, 2007.

Trussell J. Choosing a contraceptive: efficacy, safety, and personal considerations. In: Hatcher RA, Trussell J, Stewart F, Nelson AL, Cates W Jr., Guest F, Kowal D, eds. *Contraceptive Technology, Nineteenth Revised Edition*. New York: Ardent Media, Inc., in press.

2007

SECTION 2: PREGNANCY PREVENTION- LONG ACTING REVERSIBLE CONTRACEPTION (LARC)

BACKGROUND

In 2012 (reaffirmed 2014), American College of Obstetricians and Gynecologists Committee on Adolescent Health Care released recommendations that LARC (ie. intrauterine devices/IUD and contraceptive implants) are the best reversible methods for preventing pregnancy in adolescents and are the best reversible methods for preventing rapid repeat pregnancy.[6]

LARC Highlights[6,7]

Long-Acting Reversible Contraceptives:

- Are safe and highly effective with less than 1% pregnancy rate.
- Have the highest rate of satisfaction and continuation.
  - Discontinuation rates for long-acting contraceptive methods are between 15-20% as compared to 45% for short-active methods.
- Complications are rare and differ little for adolescents and older women.
- Counseling can improve patient perceptions and encourage uptake.

Forms of LARC[6,7,8]

- **Copper IUD – ParaGard®**
  - ParaGard® polyethylene wrapped with copper wire
  - Approved for use up to 10 years
  - Mechanisms of action:
    - Inhibition of sperm migration and viability
    - Change in ovum transport speed
    - Damage to or destruction of ovum
    - Damage to or destruction of fertilized ovum
    - All effects occur before implantation
  - Highly effective
  - Timing of Insertion:
    - Any time during the menstrual cycle
    - Reasonably exclude pregnancy *(see Ch.1 Resources)*
    - No major advantage to insertion during menses
    - Difficult insertions are rare

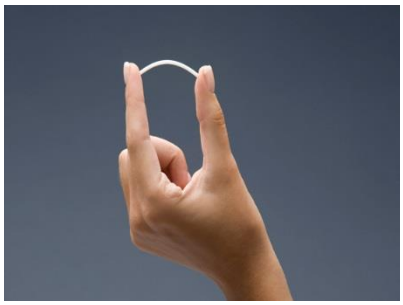
Levonorgestrel Intrauterine System (LNG IUS) – Mirena®

- Mirena® LNG IUS releases 20 mcg levonorgestrel/day
- Approved for use up to 5 years
- Mechanisms of action:
  - Similar effects as copper IUD
  - Also causes endometrial suppression and changes in cervical mucus
  - All effects occur before implantation
- Highly effective
- FDA approved for treating heavy bleeding
- Timing of Insertion:
  - Any time during the menstrual cycle
  - Reasonably exclude pregnancy *(see Ch.1 Resources)*
  - No major advantage to insertion during menses
  - Backup method for 7 days unless inserted:
    - → within 7 days of menses;
    - → immediately postpartum or post-abortion; or
    - → immediately upon switching from another hormonal method

Levonorgestrel Intrauterine System (LNS IUS) – Skyla®

- Skyla® LNG IUS releases 5 mcg levonorgestrel/day (progestin only)
- Approved for use up to 3 years
- Highly Effective
- Timing of Insertion:
  - Any time during the menstrual cycle
  - Reasonably exclude pregnancy (see Ch.1 Resources)
  - No major advantage to insertion during menses
  - Backup method for 7 days unless inserted:
    - → within 7 days of menses;
    - → immediately postpartum or post-abortion; or
    - → immediately upon switching from another hormonal method

- **Single-Rod Contraceptive Implant (hormonal implant) – Nexplanon® or Implanon®**
  - Nexplanon ® releases 68 mg/day (progesterone only)
  - Discreet
  - Rapidly reversible
  - Approved for use up to 3 years
  - Most effective method of reversible contraception
  - Can improve dysmenorrhea
  - Timing of Insertion:
    - Any time during the menstrual cycle
    - Reasonably exclude pregnancy *(see Ch.1 Resources)*
    - Backup method for 7 days unless inserted:
      - → within 5 days of menses;
      - → immediately postpartum or post-abortion; or
      - → immediately upon switching from another hormonal method



LARC Common Concerns among Patients & Providers[6,7]

Misconceptions among patients and providers can present a barrier to access or uptake of LARC methods. Some common concerns are described below:

- *Menstrual Irregularities*: This is the most common side effect of LARC methods and needs to be included in patient counseling. Adolescents using copper or hormonal IUDs or implants can expect changes in menstrual bleeding, especially during the first months of use. Anticipatory guidance regarding bleeding patterns may support continuation and satisfaction with the devices.
  - Copper IUD may cause initial heavier menses that can be treated with NSAIDs.
  - More regular menstrual cycles can be expected with the use of a copper IUD over time.
  - Irregular bleeding can be expected until lighter periods are established with the use of a hormonal IUD.
  - Hormonal IUD users will have a decrease in bleeding duration and amount initially and over time.
  - Contraceptive implant users can expect changes through the duration of use, with infrequent bleeding being the most common followed by amenorrhea, prolonged bleeding, and frequent bleeding respectively. These changes are the most common reason for discontinuation.
- *Weight Gain*: Weight gain is a side effect of hormonal birth control methods, including hormonal IUD and implant. IUD and implant related weight gain is similar/less than other methods. Counseling with adolescents should include that hormonal methods are associated with weight gain for some women though it cannot be predicted which women would experience this effect.

- *Acne*: Circulating levels of hormone are associated with acne. Some women report new/worsening acne, while others report improvements. It is important to inform patients that the impact of LARC on acne is not predictable and will vary for each person.
- *Cancer*: There is no causal relationship shown with the use of IUDs or implants and gynecologic or other cancers. IUDs have shown a potential protective effect against endometrial cancer and some research shows a protective effect against cervical cancer with the use of a copper IUD.

IUD Specific Concerns[6,7]

- *Pelvic Inflammatory Disease* (PID): Relative risk of PID only increases in the first month after IUD insertion. Bacterial contamination associated with insertion or a preexisting STD at the time of insertion increases risk is likely the cause of infection versus the IUD itself. Risk of PID is 0-2% with no cervical infection present and 0-5% when inserted with an undetected chlamydia or gonorrhea infection.
- *Infertility*: Upon removal of an IUD, baseline fertility returns. Infertility after IUD discontinuation is not more likely than after discontinuation of other reversible contraceptive methods. Chlamydia, not previous IUD use, is associated with infertility.
- *Pain*: More than half of young nulliparous women report discomfort with IUD insertion. The most effective method of pain control for insertion has yet to be established, though pain control methods may include supportive care, nonsteroidal anti-inflammatory drugs (NSAIDs), narcotics, anxiolytics or paracervical blocks. Evidence supports that pain with continued use of IUDs decreases over time.
- *Size of IUD*: No current evidence supports that changing the size of the IUD has an effect on side effects such as pain or bleeding.
- *Insertion*: Little evidence suggests that IUD insertion is more technically difficult in adolescents.
- *Perforation*: Risk of perforation is 0%-1.3%.
- *Expulsion*: Checking IUD strings should be offered as an option to women/teens, but is not a requirement for placement. It is important to counseling women on the signs and symptoms of expulsion so that they can recognize when they should seek provider care. Copper IUD and hormonal IUD demonstrate similar rates of expulsion for nulliparous and parous women with about 5%.

RECOMMENDATIONS

Given the efficacy, safety, and ease of use, LARC methods should be considered first-line contraceptive choices for adolescents. Recommendations include:

- Counseling specific to LARC methods should be included in a patient visit where contraception is being discussed, regardless of your ability to provide LARC on-site.[6,7]
    - Counseling should occur at all health care visits with sexually active adolescents including visits for preventive health.
- Providers should understand the concerns patients may have, be familiar with the current and accurate literature, and be able to discuss with patients and parents.

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- When providing care for sexually active adolescent patients, educate them about LARC methods, including the progestin implant and IUDs.
- When discussing with a patient their options for contraception, the discussion should also include a review of expectations about the patient's menstrual periods.
- Counseling with adolescents should include that hormonal methods are associated with side effects for some women, though it cannot be predicted which women will experience these effects.
    - The most common side effect of LARC methods are irregular bleeding and needs to be included in patient counseling.
    - Providers should counsel patients to understand normal changes in bleeding patterns.
    - Strategies to control bleeding include short term use of oral contraceptive pills or NSAIDs.
- Anticipatory guidance should include information about pain and provision of analgesia during insertion of a LARC device. Guidance should be tailored to the individual.
- For patients who select IUD devices, providers should counsel their patients on the signs and symptoms of expulsion so that they can recognize when they should seek provider care.
- If your SBHC cannot provide LARC on-site, the provide should refer the patient to a youth-friendly, accessible clinic that can provide a LARC method.
    - Help your patient explore low-cost or no-cost options available to them for acquiring a LARC method.
- Adolescents have the right to discontinue LARC without barrier. Ensure responsiveness to requests for LARC removal and offer an alternative contraceptive choice. If your clinic is not able to remove a LARC method in a timely manner, refer.

SECTION 3: PREGNANCY PREVENTION- REPEAT PREGNANCIES

BACKGROUND

A repeat teen birth is the second (or more) pregnancy ending in a live birth before age 20.[9]

Repeat Pregnancies in Teens

- In New Mexico, 17% of births to women under the age of 20 are repeat births.[10]
- Factors associated with repeat teen pregnancy include:[11]
  - not returning to school within 6 months
  - being married or living with a male partner
  - receiving major child care assistance from a family member
  - not using LARC within 3 months of delivery
  - experiencing intimate partner violence
  - having peers who were adolescent parents
  - mood disorders, including PPD
- Knowledge and access to contraceptives is not always enough, teens often report that second pregnancies are intentional. [11]
- Teen mothers have an increased chance of repeat pregnancy within two years when physically abused within 3 months of delivery.

RECOMMENDATIONS

Recommendations for delaying second pregnancies[9, 11]:

- Initiate contraceptive counseling during pregnancy, with emphasis on LARC methods.
  - For postpartum and postabortal Long-Acting Reversible Contraception initiation guidelines, refer to Centers for Disease Control and Prevention U.S. Medical Eligibility Criteria for Contraceptive Use, 2010.
- Counseling should focus on:
  - Defining and supporting educational/career goals
  - Providing motivations for delaying second pregnancies
- Advise teen mothers that births should be spaced at least 2 years apart to support the health of the baby.

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- Remind sexually active teens to use a condom every time to prevent sexually transmitted diseases, including HIV/AIDS.
- Connect teen mothers with support services that can help prevent repeat pregnancies, such as home visiting programs.

SECTION 4: SEXUAL HEALTH HISTORY

BACKGROUND

A sexual history will help you identify individuals at risk for STIs and what anatomic sites to screen. It will also provide you an opportunity to counsel your patients on how to make healthy decisions about their sexual behaviors. Teens expect their providers to bring up the issue of STI testing and may assume that they are automatically tested during routine visits. Teens who have had a previous STI are more likely to get another infection in the next few months; rescreening can greatly reduce their risk[12].

RECOMMENDATIONS

Recommendations for taking a sexual health history[12]:

- A sexual history should be taken during a patient's initial visit (as appropriate), during routine preventive exams, and when you see signs of sexually transmitted infections (STIs).
- Utilize the Student Health Questionnaire (SHQ) or other comprehensive risk screen as a means to identify sexually active patients and initiate the discussion.
- To begin the conversation, normalize the discussion by stating that *all* patients are asked the same questions and let the teen know that by asking personal questions you can provide them with the best care possible.
- Set expectations for the clinical encounter.
    - When applicable, speak to the parent(s), and teen together to let them know what to expect in the visit, including that the teen will have some private time with you. Respectfully disengage the parent so that you can speak with the teen alone.
    - Before talking to your patient, reinforce confidentiality. Teens are more likely to disclose sensitive information if consent and confidentiality are explained to them. Clarify the laws and limits of confidentiality, explaining situations where confidentiality may have to be breached, such as in cases of reported abuse or suicidal thoughts.
    - For patients receiving STI screening, describe how screening test results will be delivered.
    - Avoid assumptions about the patient's sexual orientation, sexual behaviors, gender identity, or number of partners; using gender-neutral language can help teens feel more comfortable.
    - Avoid clinical terms.
    - Ask for clarification when you do not understand.
    - Be nonjudgmental and acknowledge strengths/protective factors.
    - Be concrete and specific with your questions.
- Use the "5 Ps" as a general guide for taking a patient's sexual history. Remember to use open-ended questions. The "5 Ps" stand for:

- Partners: Ask questions to determine the number, sex, and concurrency of your patient's sex partners. You may need to define the term "partner" to the patient or use other, relevant terminology. Below are some sample questions:
  - "Are you dating/seeing/talking to anyone?"
  - "Are you currently having sex?"
  - "Are you having sex with men, women, both, or anyone else?"
  - "Partner having sex with anyone else?"
  - "In the past 12 months, how many partners?"
- Practices: Ask about the types of sexual activity that your patient engages in, such as vaginal, anal, and oral sex. Consider this example: "so that I understand your risks of STIs, what kind of sexual contact do you have or have you had?"
- Past STI history: Ask your patient about their history of STIs, including whether their partners have ever had an STI. Some questions may include:
  - Have you ever been tested for HIV other STIs?
  - Have you ever had an STI? If so, when? How were you treated?
  - Are you having any symptoms?
- Protection from STIs: Ask about condom use, with whom they do or do not use condoms, and situations that make it harder or easier to use condoms. Questions may include:
  - "What do you do to protect yourself from STIs like HIV? If nothing, can you tell me the reason? If so, what kind of protection?"
  - "How often do you use protection?"
- Pregnancy history and plans: Explore whether your patient wants to become pregnant and discuss current and future contraceptive options. This is an opportunity to assess for reproductive coercion. Initial questions may include:
  - "What are your current plans or desires regarding pregnancy?"
  - "At what age would you like to be pregnant?"
  - "Are you concerned about getting pregnant/getting your partner pregnant? If concerned, what are you doing to prevent a pregnancy?"

- Recognize and reinforce any protective practices mentioned such as using protection, communication about risks with partner, regular STI screening for patient or partner.
- Encourage STI testing as appropriate and explain the different tests you recommend and why.
- End the discussion by thanking your patient for being open and honest and asking if they have any questions or other concerns and offer support by letting them know these concerns are normal.

SECTION 5: SEXUALLY TRANSMITTED INFECTIONS

BACKGROUND

- Nearly half of all new sexually transmitted infections (STIs) are in adolescents 15-24 years.
- Chlamydial genital infection is the most frequently reported infectious disease and the highest rates are among adolescents ≤25 years of age.
- Adolescents are at higher risk for STIs because they frequently have unprotected intercourse, are biologically more susceptible to infection, are engaged in sexual partnerships frequently of limited duration, and face multiple obstacles to accessing health care.
- Chlamydia infection may be asymptomatic in both men and women. The infection in women can cause urethritis, cervicitis, and pelvic inflammatory disease (PID) which can result in long-term complications of ectopic pregnancy, chronic pelvic pain, and infertility.
    - Studies have demonstrated that screening women at risk reduces the incidence of PID and of ectopic pregnancy. In men, Chlamydia can cause urethritis and epididymitis. Reactive arthritis is a less likely complication.

RECOMMENDATIONS

STI Screening Guidelines[13, 14, 15]

- Screen all sexually active adolescent females and males annually for Chlamydia/gonorrhea.
- Screen all pregnant adolescent females for Chlamydia/gonorrhea, HIV, HBsAg, syphilis, and Hepatitis C antibodies (if at risk) or refer to a known testing and treatment center that offers timely screening.
- Annual screening for STIs is indicated for all sexually active men who have sex with men (MSM).
- Test all symptomatic adolescent females and males at risk for STI (discharge, dysuria, urethral irritation or itching, lower abdominal pain, back pain, dyspareunia, heavy menstrual bleeding or bleeding between menses, rectal pain) for Chlamydia/gonorrhea as well as conduct a genitourinary (GU) exam and other testing as indicated (wet prep, syphilis, HIV, etc.).
- Routine **HIV screening** is recommended by the CDC for:
    - All persons 13-64 years of age
    - All persons who seek evaluation and treatment for STIs
    - All pregnant females
    - Specific signed consent for HIV testing is not required. General informed consent for medical care is sufficient. Each SBHC should determine if HIV testing will be available onsite or, if not, refer students wanting HIV testing to a known testing center that offers timely screening and that will also treat or refer for any necessary treatment.
    -

SEXUAL & REPRODUCTIVE HEALTH

Diagnostic Tests

- **Nucleic Acid Amplified Tests (NAATs)** "are currently recommended by the Centers for Disease Control and Prevention (CDC) as the Chlamydia and gonorrhea diagnostic assays of choice. NAATs can be used to test endocervical, urine, and vaginal specimens. At present, specimens are dually tested for both Chlamydia and gonorrhea.
  - For females the vaginal swab is the sample of choice for Chlamydia infection. For asymptomatic females, a first catch urine specimen may be preferable when a pelvic examination and/or Pap test is not indicated.
  - For males a first catch urine specimen is the sample of choice for Chlamydia infection.

Treatment/Follow-Up

- Refer to CDC's most current *Treatment Guidelines for Sexually Transmitted Diseases* (www.cdc.gov/std/treatment) for treatment and follow-up guidelines.
- A pregnancy test should be completed on all females.
- A test-of-cure is not necessary unless the patient is pregnant. The CDC does recommend that infected females and males with gonorrhea or Chlamydia be re-tested 3 months after treatment because of high rates of re-infection.
  - If retesting at 3 months is not possible, providers should test whenever patient next presents in the 12 months following treatment.
- All patients testing positive for Chlamydia and/or gonorrhea should also:
  - Undergo a complete GU exam, if they have not already, looking for physical findings of other STIs, especially if there are any complaints or symptoms.
  - Be offered testing for HIV and syphilis.
  - Females should be assessed for need for Pap smear if ≥ 21 years of age.

Education & Counseling

- Education and counseling should be provided to all students on preventing STI/HIV and pregnancy.
- Infected students should be advised to abstain from sexual intercourse until they and their sex partner(s) have completed treatment or until 7 days after single-dose regimen.

Hepatitis B Vaccination

- All adolescents aged 11 through 18 years of age who have not previously received three doses of Hepatitis B vaccine should be immunized.

HPV Vaccination

- Human Papillomavirus (HPV) vaccination (3 doses) is recommended for females 11-12 years. HPV vaccine can be administered to females as young as age 9 years and catch-up vaccination is recommended for females aged 13-26 years who have not yet been vaccinated.

- Eligible males can also be immunized using *Vaccines for Children*-provided vaccine to prevent genital warts.

Partner Management

In order to prevent re-infection, it is imperative that the sexual partners of infected patients be treated. Ideally, partners of patients with STIs would be seen by their primary healthcare provider, tested and treated for STIs, provided needed vaccinations, and offered risk-reduction counseling and community referrals. However, this is not always possible. One of the following strategies should be utilized to manage partners of patients with STIs:

- **Provider referral** – The local health department* or provider notifies a partner of an STI exposure and encourages them to be seen by a healthcare provider.
  *In New Mexico, the New Mexico Department of Health (NMDOH) provides confidential partner notification services for gonorrhea, syphilis and HIV. Chlamydia investigations for partner notification are prioritized as resources permit; teens are considered a priority.

- **Patient referral** – The patient is provided information by the provider to give to his/her partner(s) on STIs, the name of the specific infection the patient was treated for, and antibiotic recommendations for partner to give to his/her physician.

- **Expedited Partner Therapy –** When patients indicate their partners are unlikely to seek evaluation and treatment for Chlamydia, gonorrhea or trichomoniasis, the provider dispenses medication or a prescription for medication to patients infected with Chlamydia, gonorrhea, or trichomoniasis for delivery to his/her sex partner(s) without the partner receiving medical evaluation from a healthcare provider.
  - Expedited partner therapy is legal in both New Mexico. It is a mechanism for prescribing practitioners to treat the sexual partners of infected patients without conducting an examination and without providing counseling messages.
    - For further information on EPT, including CDC's published guidelines on EPT in managing STIs, go to: http://www.cdc.gov/std/ept/
  - The New Mexico Medical Board amended the Medical Practice Act to allow health professionals to offer expedited partner therapy to partners of patients with STIs under guidelines developed by NMDOH. The New Mexico Board of Pharmacy adopted language to permit expedited partner therapy under NMDOH guidelines.
    - The NMDOH guidelines can be found at: http://www.health.state.nm.us/idb/ept.shtml

Reporting

- By law, providers are required to report all cases (laboratory confirmed) of STIs to the state health department. Providers are encouraged to report suspected cases as well. This includes Chlamydia, gonorrhea, syphilis, HIV, and infective hepatitis but not Human Papillomavirus (HPV) infection or trichomoniasis (NMAC 7.4.3.13).[16]
    - New Mexico Morbidity Report for Sexually Transmitted Diseases can be downloaded at www.health.state.nm/std.html.

SECTION 6: SEXUAL HEALTH RESOURCES

Youth-Friendly Sexual Health Information

Partnership for Male Youth Health Provider Toolkit for Adolescent & Young Adult Males
www.ayamalehealth.org

Scarleteen
www.scarleteen.com

Bedsider
www.bedsider.org

Sex, Etc.
www.sexetc.org

Stay Teen- created by the National Campaign to End Teen Pregnancy
http://stayteen.org/

Association of Reproductive Health Professionals (ARHP), Patient Resources
http://arhp.org/publications-and-resources/patient-resources

CDC STI Fact Sheets
http://www.cdc.gov/std/

Provider Information

CDC U.S. Selected Practice Recommendations for Contraceptive Use, 2013:
http://www.cdc.gov/mmwr/pdf/rr/rr6205.pdf

CDC U.S. Medical Eligibility Criteria (US MEC) for Contraceptive Use, 2010
http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/USMEC.htm
Also available on an iPhone/iPad app

Adolescent Health Research Program (AHRP), Adolescent Health
http://arhp.org/Topics/Adolescent-Health

American College of Obstetrics & Gynecology, LARC Program
http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception

Bedsider for Providers
http://providers.bedsider.org/

The Partnership for Male Youth – Health Provider Toolkit for Adolescent & Young Adult Males
www.ayamalehealth.org

UCSF Intrauterine Devices & Implants: A Guide to Reimbursement
http://larcprogram.ucsf.edu/

CDC – 2015 STD Treatment Guidelines
http://www.cdc.gov/std/tg2015/

SEXUAL & REPRODUCTIVE HEALTH

Provider Training

Envision New Mexico:
www.envisionnm.org

Adolescent Reproductive and Sexual Health Education Program (ARSHEP)
https://prh.org/teen-reproductive-health/arshep-explained/

INCLUDED RESOURCES

US Selected Practice Recommendations for Contraceptive Use, CDC (2013)

When to Start Using Specific Contraceptive Methods

How to Be Reasonably Certain That a Woman is Not Pregnant

Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use, CDC (2012)

IUDs & Implants: A Guide to Reimbursement – Before the Appointment

IUDs & Implants: A Guide to Reimbursement – Coding

STD Screening Guidelines, CDC (2015)

STD Screening, Testing, and Follow-Up Best Practice Flow Chart

How to Be Reasonably Certain That a Woman is Not Pregnant

A health-care provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:

- is ≤7 days after the start of normal menses
- has not had sexual intercourse since the start of last normal menses
- has been correctly and consistently using a reliable method of contraception
- is ≤7 days after spontaneous or induced abortion
- is within 4 weeks postpartum
- is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), amenorrheic, and <6 months postpartum

In situations in which the health-care provider is uncertain whether the woman might be pregnant, the benefits of starting the implant, depot medroxyprogesterone acetate (DMPA), combined hormonal contraceptives and progestin-only pills likely exceed any risk; therefore, starting the method should be considered at any time, with a follow-up pregnancy test in 2-4 weeks. For IUD insertion, in situations in which the health-care provider is not reasonably certain that the woman is not pregnant, the woman should be provided with another contraceptive method to use until the health-care provider can be reasonably certain that she is not pregnant and can insert the IUD.

When to Start Using Specific Contraceptive Methods

Contraceptive method	**When to start** (if the provider is reasonably certain that the woman is not pregnant)	**Additional contraception** (i.e., back up) needed	**Examinations or tests needed before initiation**[1]
Copper-containing IUD	Anytime	Not needed	Bimanual examination and cervical inspection[2]
Levonorgestrel-releasing IUD	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	Bimanual examination and cervical inspection[2]
Implant	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	None
Injectable	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	None
Combined hormonal contraceptive	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	Blood pressure measurement
Progestin-only pill	Anytime	If >5 days after menses started, use back-up method or abstain for 2 days.	None

Abbreviations: BMI = body mass index; IUD = intrauterine device; STD = sexually transmitted disease

[1]Weight (BMI) measurement is not needed to determine medical eligibility for any methods of contraception because all methods can be used or generally can be used among obese women. However, measuring weight and calculating BMI at baseline might be helpful for monitoring any changes and counseling women who might be concerned about weight change perceived to be associated with their contraceptive method.

[2]Most women do not require additional STD screening at the time of IUD insertion if they have already been screened according to CDC's STD Treatment Guidelines (available at http://www.cdc.gov/std/treatment). If a woman has not been screened according to guidelines, screening can be performed at the time of IUD insertion and insertion should not be delayed. Women with purulent cervicitis, current chlamydial infection, or gonorrhea should not undergo IUD insertion. Women who have a very high individual likelihood of STD exposure (e.g., those with a currently infected partner) generally should not undergo IUD insertion. For these women, IUD insertion should be delayed until appropriate testing and treatment occurs.

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

Source: For the full recommendations, see the US Selected Practice Recommendations for Contraceptive Use, 2013 (http://www.cdc.gov/mmwr/pdf/rr/rr6205.pdf).

Routine Follow-Up After Contraceptive Initiation*

Action	Contraceptive Method				
	LNG-IUD or Cu-IUD	Implant	Injectable	CHC	POP
General Follow-Up					
Advise a woman to return at any time to discuss side effects or other problems or if they want to change the method. Advise women using IUDs, implants, or injectables when the IUD or implant needs to be removed or when reinjection is needed. No routine follow-up visit is required.	X	X	X	X	X
Other Routine Visits					
Assess the woman's satisfaction with her current method and whether she has any concerns about method use.	X	X	X	X	X
Assess any changes in health status, including medications, that would change the method's appropriateness for safe and effective continued use based on the U.S. MEC (i.e., category 3 and 4 conditions and characteristics).	X	X	X	X	X
Consider performing an examination to check for the presence of IUD strings.	X	–	–	–	–
Consider assessing weight changes and counseling women who are concerned about weight change perceived to be associated with their contraceptive method.	X	X	X	X	X
Measure blood pressure.	–	–	–	X	–

Abbreviations: CHC = combined hormonal contraceptive; Cu-IUD = copper-containing intrauterine device; IUD = intrauterine device; LNG-IUD = levonorgestrel-releasing intrauterine device; POP = progestin-only pills; U.S. MEC = *U.S. Medical Eligibility Criteria for Contraceptive Use,* 2010.

*These recommendations address when routine follow-up is recommended for safe and effective continued use of contraception for healthy women. The recommendations refer to general situations and might vary for different users and different situations. Specific populations that might benefit from more frequent follow-up visits include adolescents, those with certain medical conditions or characteristics, and those with multiple medical conditions.
Source: For the full recommendations, see the US Selected Practice Recommendations for Contraceptive Use, 2013 (http://www.cdc.gov/mmwr/pdf/rr/rr6205.pdf).

Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

Key:	
1	No restriction (method can be used)
2	Advantages generally outweigh theoretical or proven risks
3	Theoretical or proven risks usually outweigh the advantages
4	Unacceptable health risk (method not to be used)

Updated June 2012. This summary sheet only contains a subset of the recommendations from the US MEC. For complete guidance, see: http://www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm

Most contraceptive methods do not protect against sexually transmitted infections (STIs). Consistent and correct use of the male latex condom reduces the risk of STIs and HIV.

Condition	Sub-condition	Combined pill, patch, ring		Progestin-only pill		Injection		Implant		LNG--IUD		Copper-IUD	
		I	C	I	C	I	C	I	C	I	C	I	C
Age		Menarche to <40=1		Menarche to <18=1		Menarche to <18=2		Menarche to <18=1		Menarche to <20=2		Menarche to <20=2	
		≥40=2		18-45=1		18-45=1		18-45=1		≥20=1		≥20=1	
				>45=1		>45=2		>45=1					
Anatomic abnormalities	a) Distorted uterine cavity									4		4	
	b) Other abnormalities									2		2	
Anemias	a) Thalassemia	1		1		1		1		1		2	
	b) Sickle cell disease‡	2		1		1		1		1		2	
	c) Iron-deficiency anemia	1		1		1		1		1		2	
Benign ovarian tumors	(including cysts)	1		1		1		1		1		1	
Breast disease	a) Undiagnosed mass	2*		2*		2*		2*		2		1	
	b) Benign breast disease	1		1		1		1		1		1	
	c) Family history of cancer	1		1		1		1		1		1	
	d) Breast cancer‡												
	i) current	4		4		4		4		4		1	
	ii) past and no evidence of current disease for 5 years	3		3		3		3		3		1	
Breastfeeding (see also Postpartum)	a) < 1 month postpartum	3*		2*		2*		2*					
	b) 1 month or more postpartum	2*		1*		1*		1*					
Cervical cancer	Awaiting treatment	2		1		2		2		4	2	4	2
Cervical ectropion		1		1		1		1		1		1	
Cervical intraepithelial neoplasia		2		1		2		2		2		1	
Cirrhosis	a) Mild (compensated)	1		1		1		1		1		1	
	b) Severe‡ (decompensated)	4		3		3		3		3		1	
Deep venous thrombosis (DVT) /Pulmonary embolism (PE)	a) History of DVT/PE, not on anticoagulant therapy												
	i) higher risk for recurrent DVT/PE	4		2		2		2		2		1	
	ii) lower risk for recurrent DVT/PE	3		2		2		2		2		1	
	b) Acute DVT/PE	4		2		2		2		2		2	
	c) DVT/PE and established on anticoagulant therapy for at least 3 months												
	i) higher risk for recurrent DVT/PE	4*		2		2		2		2		2	
	ii) lower risk for recurrent DVT/PE	3*		2		2		2		2		2	
	d) Family history (first-degree relatives)	2		1		1		1		1		1	
	e) Major surgery												
	(i) with prolonged immobilization	4		2		2		2		2		1	
	(ii) without prolonged immobilization	2		1		1		1		1		1	
	f) Minor surgery without immobilization	1		1		1		1		1		1	
Depressive disorders		1*		1*		1*		1*		1*		1*	
Diabetes mellitus (DM)	a) History of gestational DM only	1		1		1		1		1		1	
	b) Non-vascular disease												

Condition	Sub-condition	Combined pill, patch, ring		Progestin-only pill		Injection		Implant		LNG--IUD		Copper-IUD	
		I	C	I	C	I	C	I	C	I	C	I	C
Diabetes mellitus (cont.)	(i) non-insulin dependent	2		2		2		2		2		1	
	(ii) insulin dependent‡	2		2		2		2		2		1	
	c) Nephropathy/ retinopathy/ neuropathy‡	3/4*		2		3		2		2		1	
	d) Other vascular disease or diabetes of >20 years' duration‡	3/4*		2		3		2		2		1	
Endometrial cancer‡		1		1		1		1		4	2	4	2
Endometrial hyperplasia		1		1		1		1		1		1	
Endometriosis		1		1		1		1		1		2	
Epilepsy‡	(see also Drug Interactions)	1*		1*		1*		1*		1		1	
Gallbladder disease	a) Symptomatic												
	(i) treated by cholecystectomy	2		2		2		2		2		1	
	(ii) medically treated	3		2		2		2		2		1	
	(iii) current	3		2		2		2		2		1	
	b) Asymptomatic	2		2		2		2		2		1	
Gestational trophoblastic disease	a) Decreasing or undetectable ß-hCG levels	1		1		1		1		3		3	
	b) Persistently elevated ß-hCG levels or malignant disease‡	1		1		1		1		4		4	
Headaches	a) Non-migrainous	1*	2*	1*	1*	1*	1*	1*	1*	1*	1*	1*	
	b) Migraine												
	i) without aura, age <35	2*	3*	1*	2*	2*	2*	2*	2*	2*	2*	1*	
	ii) without aura, age ≥35	3*	4*	1*	2*	2*	2*	2*	2*	2*	2*	1*	
	iii) with aura, any age	4*	4*	2*	3*	2*	3*	2*	3*	2*	3*	1*	
History of bariatric surgery‡	a) Restrictive procedures	1		1		1		1		1		1	
	b) Malabsorptive procedures	COCs: 3 P/R: 1		3		1		1		1		1	
History of cholestasis	a) Pregnancy-related	2		1		1		1		1		1	
	b) Past COC-related	3		2		2		2		2		1	
History of high blood pressure during pregnancy		2		1		1		1		1		1	
History of pelvic surgery		1		1		1		1		1		1	
HIV	High risk	1		1		1*		1		2	2	2	2
	HIV infected (see also Drug Interactions)‡	1*		1*		1*		1*		2	2	2	2
	AIDS (see also Drug Interactions) ‡	1*		1*		1*		1*		3	2*	3	2*
	Clinically well on therapy	If on treatment, see Drug Interactions								2	2	2	2
Hyperlipidemias		2/3*		2*		2*		2*		2*		1*	
Hypertension	a) Adequately controlled hypertension	3*		1*		2*		1*		1		1	
	b) Elevated blood pressure levels (properly taken measurements)												
	(i) systolic 140-159 or diastolic 90-99	3		1		2		1		1		1	
	(ii) systolic ≥160 or diastolic ≥100‡	4		2		3		2		2		1	
	c) Vascular disease	4		2		3		2		2		1	

Condition	Sub-condition	Combined pill, patch, ring		Progestin-only pill		Injection		Implant		LNG--IUD		Copper-IUD	
		I	C	I	C	I	C	I	C	I	C	I	C
Inflammatory bowel disease	(Ulcerative colitis, Crohn's disease)	2/3*		2		2		1		1		1	
Ischemic heart disease‡	Current and history of	4		2	3	3		2	3	2	3	1	
Liver tumors	a) Benign												
	i) Focal nodular hyperplasia	2		2		2		2		2		1	
	ii) Hepatocellular adenoma‡	4		3		3		3		3		1	
	b) Malignant‡	4		3		3		3		3		1	
Malaria		1		1		1		1		1		1	
Multiple risk factors for arterial cardiovascular disease	(such as older age, smoking, diabetes and hypertension)	3/4*		2*		3*		2*		2		1	
Obesity	a) ≥30 kg/m² body mass index (BMI)	2		1		1		1		1		1	
	b) Menarche to < 18 years and ≥ 30 kg/m² BMI	2		1		2		1		1		1	
Ovarian cancer‡		1		1		1		1		1		1	
Parity	a) Nulliparous	1		1		1		1		2		2	
	b) Parous	1		1		1		1		1		1	
Past ectopic pregnancy		1		2		1		1		1		1	
Pelvic inflammatory disease	a) Past, (assuming no current risk factors of STIs)												
	(i) with subsequent pregnancy	1		1		1		1		1	1	1	1
	(ii) without subsequent pregnancy	1		1		1		1		2	2	2	2
	b) Current	1		1		1		1		4	2*	4	2*
Peripartum cardiomyopathy‡	a) Normal or mildly impaired cardiac function												
	(i) < 6 months	4		1		1		1		2		2	
	(ii) ≥ 6 months	3		1		1		1		2		2	
	b) Moderately or severely impaired cardiac function	4		2		2		2		2		2	
Postabortion	a) First trimester	1*		1*		1*		1*		1*		1*	
	b) Second trimester	1*		1*		1*		1*		2		2	
	c) Immediately post-septic abortion	1*		1*		1*		1*		4		4	
Postpartum (see also Breastfeeding)	a) < 21 days	4		1		1		1					
	b) 21 days to 42 days												
	(i) with other risk factors for VTE	3*		1		1		1					
	(ii) without other risk factors for VTE	2		1		1		1					
	c) > 42 days	1		1		1		1					
Postpartum (in breastfeeding or non-breastfeeding women, including post-cesarean section)	a) < 10 minutes after delivery of the placenta									2		1	
	b) 10 minutes after delivery of the placenta to < 4 weeks									2		2	
	c) ≥ 4 weeks									1		1	
	d) Puerperal sepsis									4		4	
Pregnancy		NA*		NA*		NA*		NA*		4*		4*	
Rheumatoid arthritis	a) On immunosuppressive therapy	2		1		2/3*		1		2	1	2	1
	b) Not on immunosuppressive therapy	2		1		2		1		1		1	
Schistosomiasis	a) Uncomplicated	1		1		1		1		1		1	
	b) Fibrosis of the liver‡	1		1		1		1		1		1	
Severe dysmenorrhea		1		1		1		1		1		2	
Sexually transmitted infections (STIs)	a) Current purulent cervicitis or chlamydial infection or gonorrhea	1		1		1		1		4	2*	4	2*
	b) Other STIs (excluding HIV and hepatitis)	1		1		1		1		2	2	2	2

Condition	Sub-condition	Combined pill, patch, ring		Progestin-only pill		Injection		Implant		LNG--IUD		Copper-IUD	
		I	C	I	C	I	C	I	C	I	C	I	C
Sexually transmitted infections (cont.)	c) Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	1		1		1		1		2	2	2	2
	d) Increased risk of STIs	1		1		1		1		2/3*	2	2/3*	2
Smoking	a) Age < 35	2		1		1		1		1		1	
	b) Age ≥ 35, < 15 cigarettes/day	3		1		1		1		1		1	
	c) Age ≥ 35, ≥15 cigarettes/day	4		1		1		1		1		1	
Solid organ transplantation‡	a) Complicated	4		2		2		2		3	2	3	2
	b) Uncomplicated	2*		2		2		2		2		2	
Stroke‡	History of cerebrovascular accident	4		2	3	3		2	3	2		1	
Superficial venous thrombosis	a) Varicose veins	1		1		1		1		1		1	
	b) Superficial thrombophlebitis	2		1		1		1		1		1	
Systemic lupus erythematosus‡	a) Positive (or unknown) antiphospholipid antibodies	4		3		3	3	3		3		1	1
	b) Severe thrombocytopenia	2		2		3	2	2		2*		3*	2*
	c) Immunosuppressive treatment	2		2		2	2	2		2		2	1
	d) None of the above	2		2		2	2	2		2		1	1
Thrombogenic mutations‡		4*		2*		2*		2*		2*		1*	
Thyroid disorders	Simple goiter/ hyperthyroid/hypothyroid	1		1		1		1		1		1	
Tuberculosis‡ (see also Drug Interactions)	a) Non-pelvic	1*		1*		1*		1*		1		1	
	b) Pelvic	1*		1*		1*		1*		4	3	4	3
Unexplained vaginal bleeding	(suspicious for serious condition) before evaluation	2*		2*		3*		3*		4*	2*	4*	2*
Uterine fibroids		1		1		1		1		2		2	
Valvular heart disease	a) Uncomplicated	2		1		1		1		1		1	
	b) Complicated‡	4		1		1		1		1		1	
Vaginal bleeding patterns	a) Irregular pattern without heavy bleeding	1		2		2		2		1	1	1	
	b) Heavy or prolonged bleeding	1*		2*		2*		2*		1*	2*	2*	
Viral hepatitis	a) Acute or flare	3/4*	2	1		1		1		1		1	
	b) Carrier/Chronic	1	1	1		1		1		1		1	
Drug Interactions													
Antiretroviral therapy	a) Nucleoside reverse transcriptase inhibitors	1*		1		1		1		2/3*	2*	2/3*	2*
	b) Non-nucleoside reverse transcriptase inhibitors	2*		2*		1		2*		2/3*	2*	2/3*	2*
	c) Ritonavir-boosted protease inhibitors	3*		3*		1		2*		2/3*	2*	2/3*	2*
Anticonvulsant therapy	a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	3*		3*		1		2*		1		1	
	b) Lamotrigine	3*		1		1		1		1		1	
Antimicrobial therapy	a) Broad spectrum antibiotics	1		1		1		1		1		1	
	b) Antifungals	1		1		1		1		1		1	
	c) Antiparasitics	1		1		1		1		1		1	
	d) Rifampicin or rifabutin therapy	3*		3*		1		2*		1		1	

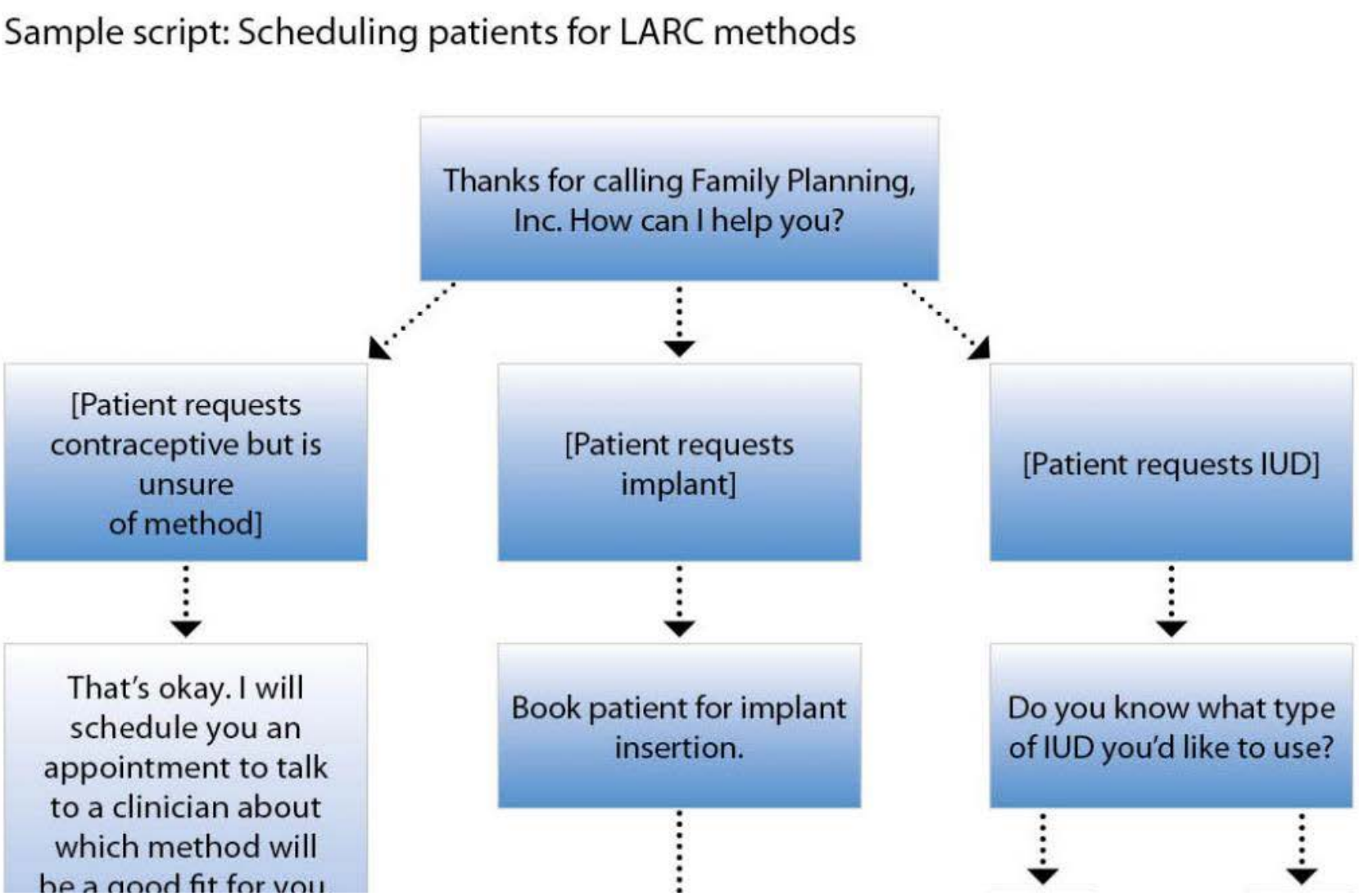
I = initiation of contraceptive method; C = continuation of contraceptive method; NA = Not applicable

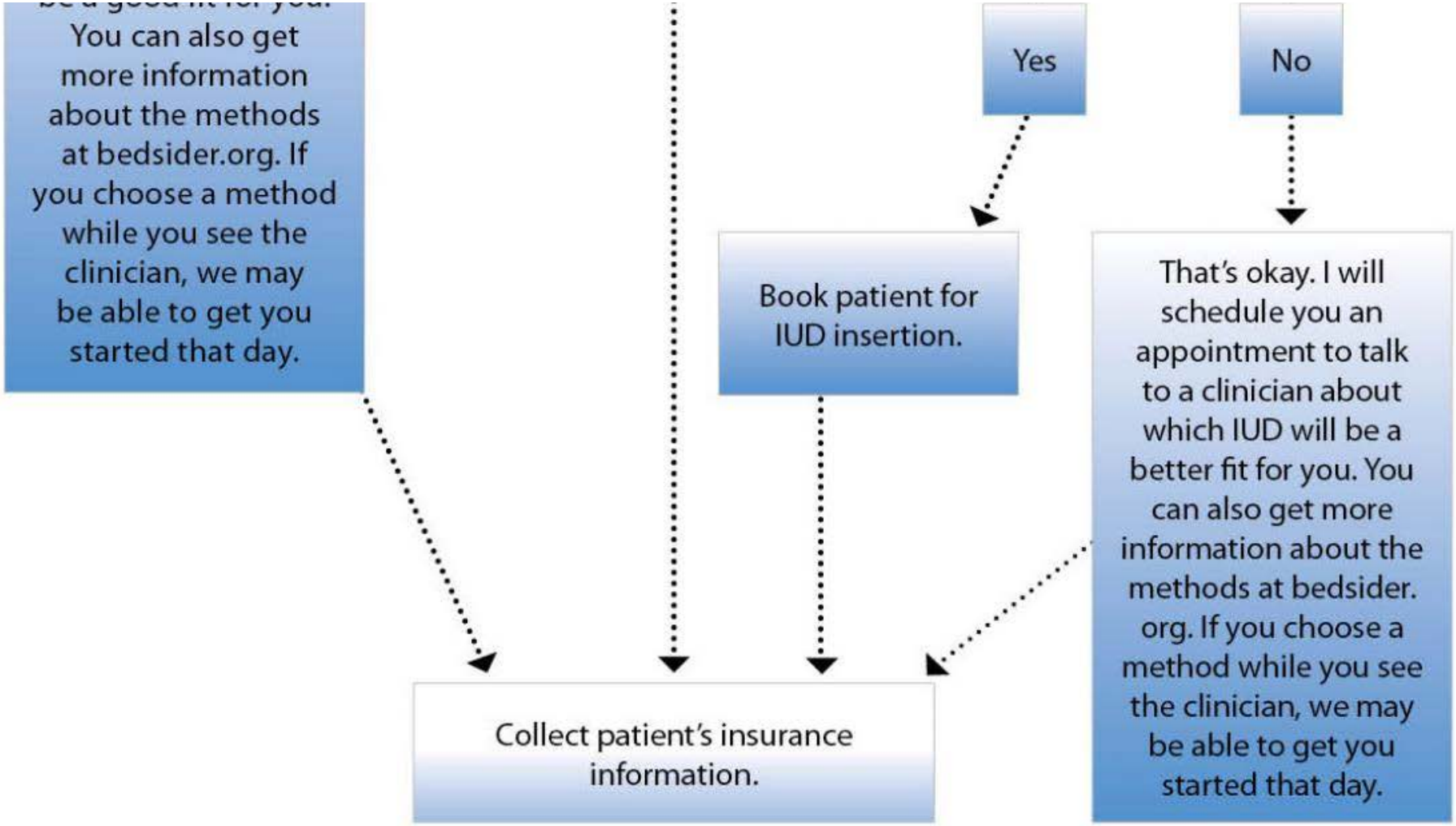
* Please see the complete guidance for a clarification to this classification: www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm

‡ Condition that exposes a woman to increased risk as a result of unintended pregnancy.

Before the appointment

As described in the section on coverage eligibility [1], there are coverage requirements that apply to both commercial and public insurance plans. Collecting information about a patient's insurance status prior to an appointment can facilitate same-day placement of LARC methods by clarifying what requirements pertain to the patient's coverage. Furthermore, patients may not always know which contraceptive method they want while making their appointment, so it is important to provide them with information regarding methods before the appointment to assist with the provision of any contraceptive method, including LARC methods. One way to facilitate this is to provide staff with a brief script exploring which contraceptive methods, if any, interest a patient.





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Coding

Correct coding can result in more appropriate compensation for services. To help practices receive appropriate payment for providing LARC methods, the following information can be helpful. Please see the online version of this Quick Coding Guide [1] for updates, as well as the Billing Quiz [2] that delves into further detail.

Basic contraceptive implant coding

The insertion and/or removal of the implant are reported using one of the following CPT®* codes:

11981 Insertion, non-biodegradable drug delivery implant

11982 Removal, non-biodegradable drug delivery implant

11983 Removal with reinsertion, non-biodegradable drug delivery implant

The diagnostic coding will vary, but usually will be selected from the Encounter for Contraceptive Management code series - V25 in ICD-9-CM or Z30 in ICD-10-CM. These codes are:

V25.5 Encounter for contraceptive management, insertion of implantable subdermal contraceptive or

Z30.018 Encounter for initial prescription of other contraceptives in ICD-10-CM.

V25.43 Surveillance of previously prescribed contraceptive method; implantable subdermal contraceptive or

Z30.49 For checking, reinsertion, or removal of the implant in ICD-10-CM.

> **Note: ICD-10 codes are scheduled to go into effect October 1, 2015. They may not be reported prior to effective date.**

The CPT procedure codes do not include the cost of the supply. Report the supply separately using a HCPCS (Healthcare Procedural Coding System) code:

J7307 Etonogestrel [contraceptive] implant system, including implant and supplies

Basic IUD coding

The insertion and/or removal of IUDs are reported using one of the following CPT codes:

58300 Insertion of IUD

58301 Removal of IUD

Most IUD services will be linked to a diagnosis code from the V25 series (Encounter for Contraceptive Management) or the Z30 series in ICD-10-CM:

V25.11 Insertion of intrauterine contraceptive device or

Z30.430 Encounter for insertion of intrauterine contraceptive device in ICD-10-CM.

V25.12 Removal of intrauterine contraceptive device or

Z30.432 Encounter for removal of intrauterine contraceptive device in ICD-10-CM.

V25.13 Removal and reinsertion of intrauterine contraceptive device or

Z30.433 Encounter for removal and reinsertion of intrauterine contraceptive device in ICD-10-CM.

V25.42 Surveillance of previously prescribed contraceptive method, intrauterine device or

Z30.431 Encounter for routine checking of intrauterine contraceptive device in ICD-10-CM.

The CPT procedure codes do not include the cost of the supply. Report the supply separately using a HCPCS code:

J7297 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3 year duration (Begin use of J7297 on January 1, 2015)

J7298 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration (Begin use of J7298 on January 1, 2015)

J7300 Intrauterine copper contraceptive

J7301 Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg

J7302 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg (Discontinue use of J7302 on December 31, 2015)

Reporting contraceptive services with other services

Under some circumstances, an Evaluation and Management (E/M) services code, a procedure code, and a HCPCS code, may all be reported. Documentation must support each billing code.

E/M Services Code

If a patient comes in to discuss contraception options but no procedure is provided at that visit:

- If the discussion takes place during a preventive visit (99381– 99387 or 99391–99397), it is included in the Preventive Medicine code. The discussion is not reported separately.

- If the discussion takes place during an E/M office or outpatient visit (99201–99215), an E/M services code may be reported if an E/M service (including history, physical examination, or medical decision making or time spent counseling) is documented. Link the E/M code to ICD-9-CM diagnosis code V25.09 (General family planning counseling and advice) or ICD-10-CM diagnosis code Z30.09 (Encounter for other general counseling and advice on contraception).

E/M Services Code and Procedure Code

If discussion of contraceptive options takes place during the same encounter as a procedure, such as insertion of a contraceptive implant or IUD, it may or may not be appropriate to report both an E/M services code and the procedure code:

- If the clinician and patient discuss a number of contraceptive options, decide on a method, and then an implant or IUD is inserted during the visit, an E/M service may be reported, depending on the documentation.
- If the patient comes into the office and states, "I want an IUD," followed by a brief discussion of the benefits and risks and the insertion, an E/M service is not reported since the E/M services are not significant and separate.
- If the patient comes in for another reason, such as an annual exam, and during the same visit a procedure is performed, then both the E/M services code and procedure may be reported.

If reporting both an E/M service and a procedure, the documentation must indicate a significant, separately identifiable E/M service. The documentation must indicate either the key components (history, physical examination, and medical decision making) or time spent counseling. In order to report an evaluation and management visit based on time, more than 50% of the visit must be spent counseling the patient. When time is the determining factor for the selection of the level of service, documentation should include the following:

- The total length of time spent by the physician with the patient,
- The time spent in counseling and/or coordination of care activities, and
- A description of the content of the counseling and/or coordination of care activities.

Note the "typical times" listed in outpatient E/M services codes 99201–99215. For example, if an established patient is seen for 25 minutes, including 15 minutes spent counseling, report code 99214—this code lists a "typical time" of 25 minutes. The level of history, physical examination, and medical decision making do not matter in selecting this code. Not all payers recognize time spent counseling. Providers should consult third-party payers before instituting this coding practice to ensure compliance with specific plan guidelines.

A modifier 25 (significant, separately identifiable E/M service on the same day as a procedure or other service) is added to the E/M code to indicate that this service was significant and separately identifiable from the insertion. This indicates that two distinct services were provided: an E/M service and a procedure.

Additional coding guidance

Coding guidance for specific LARC clinical scenarios can also be found on the ACOG LARC Program website [3] and the ACOG Department of Coding and Nomenclature website [4].

ACOG Fellows and their staff can submit specific coding questions to the ACOG Department of Health Economics and Coding at the coding ticket database [5]. Questions are answered in the order received, usually within 3–5 weeks. There is no charge for this service.

Source URL: http://larcprogram.ucsf.edu/coding

Links:
[1] http://acog.org/-/media/Departments/LARC/LARCQuickCodingGuide.pdf?la=en
[2] http://acog.org/-/media/Departments/LARC/LARCBillingQuiz.pdf?la=en
[3] http://www.acog.org/goto/larc
[4] http://www.acog.org/About-ACOG/ACOG-Departments/Coding
[5] http://acogcoding.freshdesk.com

Screening Recommendations Referenced in the 2015 STD Treatment Guidelines and Original Recommendation Sources

	Women	Pregnant Women	Men	Men Who Have Sex With Men (MSM)	Persons with HIV
CHLAMYDIA	Sexually active women under 25 years of age *USPSTF*[1] Sexually active women aged25 years and older if at increased risk[2] *USPSTF*[1] Retest approximately 3 months after treatment *CDC*[3]	All pregnant women under 25 years of age *USPSTF*[1] Pregnant women, aged 25 years and older if at increased risk[2] *USPSTF*[1] Retest during the 3rd trimester for women under 25 years of age or at risk[4] *CDC*[3] Pregnant women with chlamydial infection should have a test-of-cure 3-4 weeks after treatment and be retested within 3 months *USPSTF*[1]	Consider screening young men in high prevalence clinical settings[5] or in populations with high burden of infection (e.g. MSM) *CDC*[6]	At least annually for sexually active MSM at sites of contact (urethra, rectum) regardless of condom use *CDC*[6] Every 3 to 6 months if at increased risk[7] *CDC*[7]	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter *CDC*[8] More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology *CDC*[8]
GONORRHEA	Sexually active women under 25 years of age *USPSTF*[1] Sexually active women age 25 years and older if at increased risk[9] *USPSTF*[1] Retest 3 months after treatment *CDC*[10]	All pregnant women under 25 years of age and older women if at increased risk[11] *USPSTF*[1] Retest 3 months after treatment *CDC*[10]		At least annually for sexually active MSM at sites of contact (urethra, rectum, pharynx) regardless of condom use *CDC*[10] Every 3 to 6 months if at increased risk[7] *CDC*[7]	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter *CDC*[10] More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology *CDC*[10]
SYPHILIS		All pregnant women at the first prenatal visit *USPSTF*[11] Retest early in the third trimester and at delivery if		At least annually for sexually active MSM *CDC*[13] Every 3 to 6 months if at increased risk[7]	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter *CDC, HRSA, IDSA, NIH*[14,15,16]

	Women	Pregnant Women	Men	Men Who Have Sex With Men (MSM)	Persons with HIV
		at high risk *AAP/ACOG*[12]		*CDC*[7]	More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology *CDC*[13]
TRICHOMONAS	Consider for women receiving care in high-prevalence settings (e.g., STD clinics and correctional facilities) and for women at high risk for infection (e.g., women with multiple sex partners, exchanging sex for payment, illicit drug use, and a history of STD) *CDC*[17]				Recommended for sexually active women at entry to care and at least annually thereafter *CDC*[14]
HERPES	Type-specific HSV serologic testing should be considered for women presenting for an STD evaluation (especially for women with multiple sex partners) CDC[17]	Evidence does not support routine HSV-2 serologic screening among asymptomatic pregnant women. However, type-specific serologic tests might be useful for identifying pregnant women at risk for HSV infection and guiding counseling regarding the risk for acquiring genital herpes during pregnancy *CDC*[17]	Type-specific HSV serologic testing should be considered for men presenting for an STD evaluation (especially for men with multiple sex partners) *CDC*[17]	Type-specific serologic tests can be considered if infection status is unknown in MSM with previously undiagnosed genital tract infection *CDC*[17]	Type-specific HSV serologic testing should be considered for persons presenting for an STD evaluation (especially for those persons with multiple sex partners), persons with HIV infection, and MSM at increased risk for HIV acquisition CDC[17]
HIV	All women aged 13-64 years (opt-out)** *CDC*[18] All women who seek evaluation and treatment for STDs *CDC*[19]	All pregnant women should be screened at first prenatal visit (opt-out) *USPSTF*[20] Retest in the third trimester if at high risk *CDC*[21]	All men aged 13-64 years (opt-out)** *CDC*[18] All men who seek evaluation and treatment for STDs *CDC*[19]	At least annually for sexually active MSM if HIV status is unknown or negative and the patient himself or his sex partner(s) have had more than one sex partner since most recent HIV test *CDC*[22]	

	Women	Pregnant Women	Men	Men Who Have Sex With Men (MSM)	Persons with HIV
CERVICAL CANCER	Women 21-29 years of age every 3 years with cytology Women 30-65 years of age every 3 years with cytology, or every 5 years with a combination of cytology and HPV testing *USPSTF[23],ACOG[24],ACS[25]*	Pregnant women should be screened at same intervals as nonpregnant women *USPSTF[23],ACOG[24],ACS[25]*			Women should be screened within 1 year of sexual activity or initial HIV diagnosis using conventional or liquid-based cytology; testing should be repeated 6 months later *CDC, NIH, IDSA[26]*
HEPATITIS B SCREENING	Women at increased risk *CDC[27]*	Test for HBsAg at first prenatal visit of each pregnancy regardless of prior testing; retest at delivery if at high risk *CDC,[27] USPSTF [28]*	Men at increased risk *CDC[27]*	All MSM should be tested for HBsAg *CDC[27]*	Test for HBsAg and anti-HBc and/or anti-HBs. *CDC[27]*
HEPATITIS C SCREENING	Women born between 1945-1965 *CDC,[29] USPSTF[30]* Other women if risk factors are present[30] *USPSTF[30]*	Pregnant women born between 1945-1965 *CDC,[29] USPSTF[30]* Other pregnant women if risk factors are present[30] *USPSTF[30]*	Men born between 1945-1965 *CDC,[29] USPSTF[30]* Other men if risk factors are present[30] *USPSTF[30]*	MSM born between 1945-1965 *CDC[29]* Other MSM if risk factors are present[30] *USPSTF[30]* Annual HCV testing in MSM with HIV infection *CDC[31]*	Serologic testing at initial evaluation *CDC, NIH, IDSA[32,33]* Annual HCV testing in MSM with HIV infection *CDC[31]*

**Italics represent source of recommendations*
*** USPSTF recommends screening in adults and adolescents ages 15-65*

[1] LeFevre ML. Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement. Annals of internal medicine. Sep 23 2014.
[2] Those who have a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection. Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement. Annals of internal medicine. Sep 23 2014.
[3] Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.
[4] e.g., those with a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.
[5] Adolescent clinics, correctional facilities, and STD clinics. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.
[6] Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.
[7] More frequent STD screening (i.e., for syphilis, gonorrhea, and chlamydia) at 3–6-month intervals is indicated for MSM, including those with HIV infection if risk behaviors persist or if they or their sexual partners have multiple partners. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.
[8] Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

[9] Those who have a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has an STI. Additional risk factors for gonorrhea include inconsistent condom use among persons who are not in mutually monogamous relationships; previous or coexisting sexually transmitted infections; and exchanging sex for money or drugs. Clinicians should consider the communities they serve and may opt to consult local public health authorities for guidance on identifying groups that are at increased risk. Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement. Annals of internal medicine. Sep 23 2014.

[10] Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

[11] US Preventive Services Task Force. Screening for syphilis infection in pregnancy: reaffirmation recommendation statement. Annals of internal medicine. 5/19/2009 2009;150(10):705-709.

[12] American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and March of Dimes Birth Defects Foundation. Guidelines for Perinatal Care. 6th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2007

[13] Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

[14] CDC, Health Resources and Services Administration, National Institutes of Health, HIV Medicine Association of the Infectious Diseases Society of America, HIV Prevention in Clincal Care Working Group. Recommendations for incorporating human immunodeficiency virus (HIV) prevention into the medical care of persons living with HIV. Clin Infect Dis. Jan 1 2004;38(1):104-121.

[15] Aberg JA, Gallant JE, Ghanem KG et al. Primary Care Guidelines for the Management of Persons Infected With HIV: 2013 Update by the HIV Medicine Association of the Infectious Diseases Society of America. CID. Jan 1 2014;58: e1-e34.

[16] Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institutes of Health, American Academy of HIV Medicine, Association of Nurses in AIDS Care, International Association of Providers of AIDS Care, the National Minority AIDS Council, and Urban Coalition for HIV/AIDS Prevention Services. *Recommendations for HIV Prevention with Adults and Adolescents with HIV in the United States, 2014*. 2014. http://stacks.cdc.gov/view/cdc/26062. December 11, 2014.

[17] Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

[18] CDC. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *MMWR.* 9/22/2006 2006;55(No. RR-14):1-17.

[19] Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

[20] Moyer VA, US Preventive Services Task Force. Screening for HIV: US Preventive Services Task Force Recommendation Statement. *Annals of internal medicine.* 2013;159:51–60.

[21] Women who use illicit drugs, have STDs during pregnancy, have multiple sex partners during pregnancy, live in areas with high HIV prevalence, or have partners with HIV infection. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

[22] Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

[23] Moyer VA. Screening for cervical cancer: US Preventive Services Task Force recommendation statement. *Annals of internal medicine.* Jun 19 2012;156(12):880-891, W312.

[24] American College of Obstetricians and Gynecologists (ACOG). Screening for cervical cancer. ACOG Practice Bulletin Number 131. Obstet Gynecol. Nov 2012;120(5):1222-1238.

[25] Saslow D, Solomon D, Lawson HW, et al. American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer. CA Cancer J Clin. May-Jun 2012;62(3):147-172.

[26] Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents. Guidelines for prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America.Available at: http://aidsinfo.nih.gov/contentfiles/lvguidelines/adult_oi.pdf

[27] Those at increased risk include persons born in regions of high endemicity (>=2% prevalence), IDU, MSM, persons on Immunosuppresive therapy, Hemodialysis patients, HIV positive individuals, and others. For detailed recommendations refer to: Centers for Disease Control and Prevention. Recommendations for Identification and Public Health Management of Person swith Chronic Hepatitis B Virus Infection,2008. MMWR September 19th, 2008; 57(RR-8);1-21. Available at: http://www.cdc.gov/mmwr/pdf/rr/rr5708.pdf

[28] U.S. Preventive Services Task Force. Screening for Hepatitis B Virus Infection in Pregnancy: U.S. Preventive Services Task Force Reaffirmation Recommendation Statement. *Ann Intern Med* 2009;150:869-73

[29] Smith BD, Morgan RL, Beckett GA, et al. Recommendations for the identification of chronic hepatitis C virus infection among persons born during 1945-1965. MMWR. Aug 17 2012;61(No. RR-4):1-32.

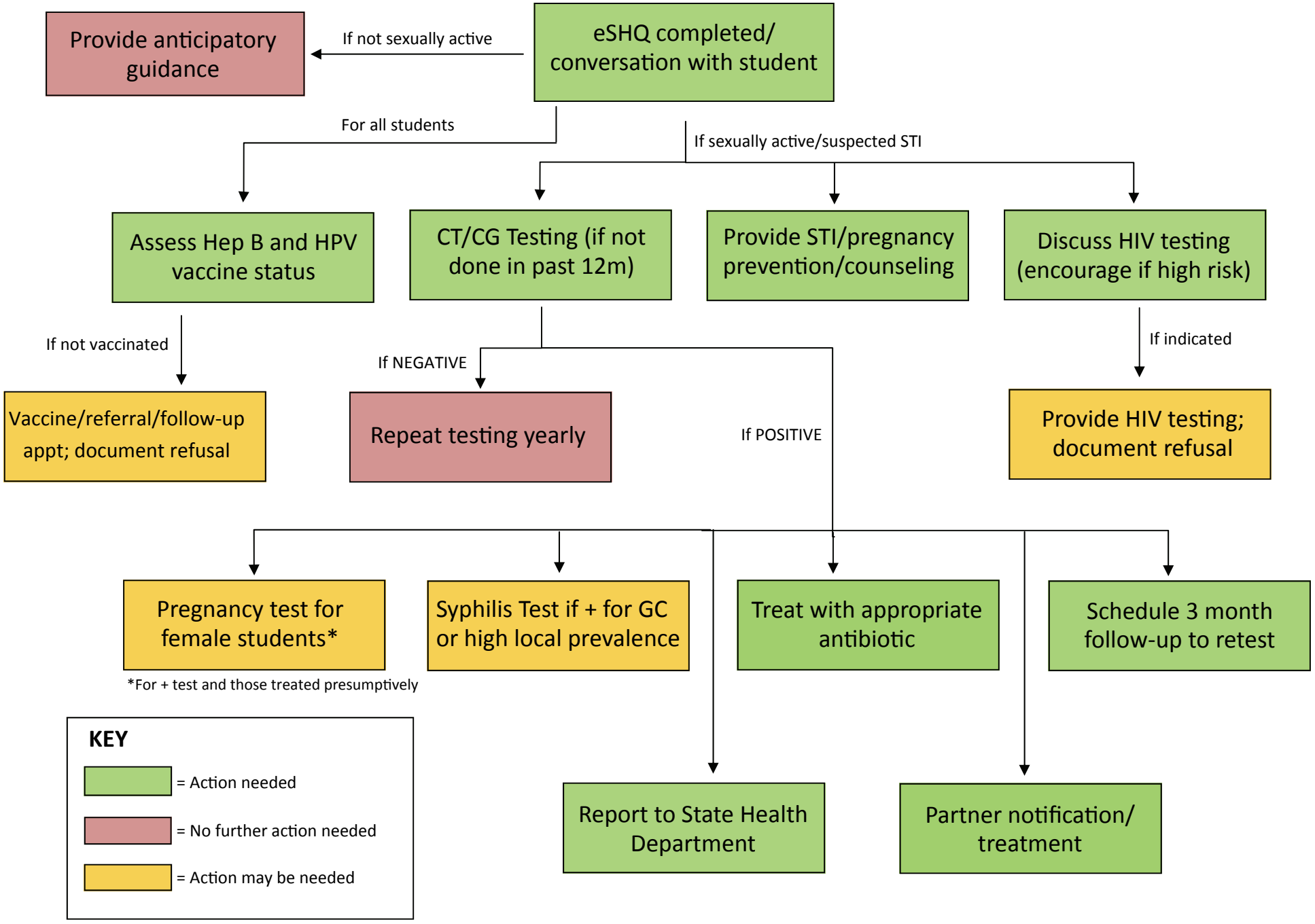
[30] Past or current injection drug use, receipt of blood transfusion before 1992, long term hemodialysis, born to mother with Hep. C, intranasal drug use, receipt of an unregulated tattoo, and other percutaneous exposures. Moyer VA. Screening for hepatitis C virus infection in adults: US Preventive Services Task Force recommendation statement. Annals of internal medicine. Sep 3 2013;159(5):349-357.

[31] Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

[32] Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents. Guidelines for prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America.Available at: http://aidsinfo.nih.gov/contentfiles/lvguidelines/adult_oi.pdf

[33] Aberg JA, Gallant JE, Ghanem KG et al. Primary Care Guidelines for the Management of Persons Infected With HIV: 2013 Update by the HIV Medicine Association of the Infectious Diseases Society of America. CID. Jan 1 2014;58: e1-e34.

STI Screening, Testing and Follow-up Best Practice Flow Chart



Chapter 2 – Prenatal Care

SECTION 1: PREGNANCY OPTIONS COUNSELING

BACKGROUND

- Evidence does not substantiate the use of shame and stigma to discourage teen parenthood as effective. Such approach can diminish a young parents' perception of their ability to thrive.
- Adolescents may face particular barriers to pregnancy care, such as: inappropriate information/referrals, not recognizing symptoms of pregnancy, denying possibility of pregnancy, concerns about confidentiality, transportation, cost, or logistics.
- A fundamental principal of pregnancy options counseling is that the patient has the answer. Be cognizant of personal bias about what age is "too young" to be pregnant. Providers should be able to discuss all pregnancy options without interjecting personal bias, or should refer to another provider for non-directive, unbiased options counseling in a timely manner.
- SBHCs that are providing pregnancy testing are well-positioned to provide pregnancy options counseling.

RECOMMENDATIONS

Pregnancy Options Counseling with Adolescents [19,33]

- When approaching adolescents with making a decision about their pregnancy, providers should listen, not assume, and self-reflect
  - Inquire be open to, and interested in the patient's process without having an agenda for the outcome
- Prepare to disclose results. Before administering a pregnancy test, provide pretesting counseling
  - Ask questions including:
    - "Do you have an idea of what the results of your pregnancy test might be?"
    - "What are you hoping the results will be?"
    - "Do you know what your options are if your pregnancy test is positive?"
    - "Have you thought about what you might do if your test is positive today?"
- Disclose results using clear communication. For a positive pregnancy result:
  - **Normalize experiences**. Some examples of normalizing statements include:
    - "You know lots of people have asked me that question."
    - "That's not a strange question at all. I'm glad you asked."
    - "This is a clinic where it is ok to talk about those feelings."
  - **Validate** the feelings that you see and hear.

        - "It's ok to not know the answer"
        - "I can see why it may have been hard for you to come here."
        - "You're doing a good job."
        - "It's okay to cry here."
        - "I see your point; that makes sense."
    - **Seek understanding** of feelings and beliefs.
        - "How are you doing with the information?"
        - "What's coming up for you?"
        - "Say more about that."
        - "What's that like for you?"
    - **Reassure** the patient
        - "I will support you no matter what you decide."
        - "You don't have to decide today."
        - "You have time to change your mind."
        - "You're a good person no matter what you decide."

- Describe all pregnancy options using clear communication and accurate information.

- Address ambivalence in pregnancy decision making.
    - Ambivalence in pregnancy decision making is normal. Offer the patient to return for a follow-up visit or to be seen by the SBHC behavioral health provider.
    - Obtain additional contact information for the patient so that you can follow-up regarding their decision.
    - Seek understanding from your patient about individual factors (ie. future goals, desire to parent, beliefs) and familial/relational/community factors (ie. perspectives of family/friends/partner).
    - Use motivational interviewing techniques to support decision-making.
        - Shift focus: temporarily shift focus away from contentious area to common ground
        - Emphasize personal choice and control
        - Double-sided reflection: used when both sides of ambivalence have been expressed

- **Refer** accordingly.
    - Ensure referral sources are teen-friendly and offer additional support to mothers.
    - Encourage the patient to include a parent, grandparent or other close adult in the process.

SECTION 2: CARE FOR EXPECTANT MOTHERS

BACKGROUND

- Pregnancy complications are most prevalent in youngest adolescents.
- Teen mothers are less likely to receive adequate prenatal care and graduate from high school.
- Absenteeism and dropout rates may be reduced for pregnant adolescents receiving prenatal care or prenatal support at a school-based health center.
- Compared to non-pregnant teens and adults, expectant teens may have an increased risk for depression. Early screening, identification and treatment of depression for young pregnant women is critical to ensuring positive maternal child health outcomes.
- Expectant adolescents often lack resources to foster their children's development.

RECOMMENDATIONS

While SBHCs may not be considered the prenatal home, they can provide care geared toward expectant adolescent patients to address particular prenatal health needs within the scope of the SBHC. Recommendations for serving expectant adolescents within a school-based health center include[11, 20, 21, 22]:

- At minimum, SBHC providers should assess and refer
  - As per NM-DOH OSAH Primary Care Standards (2015)*: a system for triage is in place based on student acuity. No student is turned away based on a pre-existing condition, including pregnancy. At a minimum, the provider will assess and refer.*
- Acute care visits are opportunities for supporting expectant mothers.
  - Provide support for management of morning sickness and other challenging pregnancy symptoms like sciatica, or sleep disturbance.
  - Communicate/coordinate care with prenatal provider.
  - Support youth health literacy by educating the student as to when may be appropriate to seek urgent care or emergency care or when to utilize the school nurse when the SBHC is closed.
    - When possible, work with the school nurse to develop a plan for supporting expectant mothers during instances of minor illness or symptom management.
- Ensure the student is connected to a prenatal home.
  - Ask the student if they are receiving regular prenatal care.
    - Provide counseling as to the importance of receiving prenatal care and what they can expect from prenatal visits.

        - If patient is not receiving current prenatal care, help the student identify a place of care that is accessible and cost-effective (accepts their insurance or sliding scale) and refer appropriately.

    - Work with the GRADS case manager to help link the student to regular care.

    - If the patient is insured through Medicaid, contact their Care Coordinator through their MCO if additional support is needed to identify a prenatal home for the patient and/or to ensure continuity of services.

    - Provide notification to prenatal provider of relevant services provided at the SBHC to ensure coordination of care.

- Assess immunization status to support maternal/child health.
    - Provide counseling on the importance of immunizations during pregnancy.
        - If your SBHC provides the recommended vaccines for expectant mothers, offer this as an option, while also ensuring that care coordination/communication is occurring with the prenatal provider to avoid duplication of vaccines.

        - Administer needed vaccines or refer to a provider who can immunize.

    - Provide counseling on the importance of ensuring that others who will be in contact with the baby (ie. partners, caregivers and household members) are up-to-date on their vaccines, especially pertussis and influenza.
        - If your SBHC can provide vaccines to others outside of the student population, offer this as an option

- Assess oral health.
    - Advise expectant mothers that oral health care improves a woman's general health through her lifespan and may reduce the transmission of potentially caries-producing oral bacteria from mothers to their infants.

    - Reinforce routine oral health maintenance, such as limiting sugary foods and drinks, brushing twice a day with fluoridated toothpaste, flossing once daily, and dental visits twice a year.

    - Reassure patients that prevention, diagnosis, and treatment of oral conditions, including dental X-rays (with shielding of the abdomen and thyroid) and local anesthesia (lidocaine with or without epinephrine), are safe during pregnancy.

    - Be aware of patients' health coverage for dental services during pregnancy so that referrals to the appropriate dental provider can be made as needed.

- Review nutrition and physical activity
    - Provide counseling to expectant adolescents to partake in regular physical activity as appropriate.
        - Tailor guidance for participation in sports or physical education class.
        - Information on any limitations may need to be communicated to the physical education teacher/coach via the patient, which may be done in the form of a letter/note from the provider.

    - Guidance may include how to make food choices in the school cafeteria.

- Provide anticipatory guidance around social/academic competence and stress management.

- Review medications, including supplements and vitamins.
  - A folic acid supplement or prenatal vitamin may be recommended if the patient is awaiting referral to a prenatal provider.

- Screen for substance use.
  - Administer the CRAFFT (substance abuse screen; as part of well-care visits).
    - This is an embedded screening tool in the SHQ/eSHQ and should be administered once per school year during the student's first SBHC visit of the school year.
    - If applicable to your SBHC, a positive CRAFFT screen should trigger administration of the CHIPSA substance abuse screening tool, which is embedded in the iPad Apex Apps.
    - For expectant adolescents who are using substances, provide a brief intervention using motivational interviewing techniques and refer for additional treatment within or outside of the SBHC dependent on accessibility and severity.
  - Provide information on the effect of maternal substance use and cigarette smoking on child health and development.

- Screen for depression.
  - Administer the PHQ-2 (depression screen; as part of well-care visits).
    - This is an embedded screening tool in the SHQ/eSHQ and should be administered once per school year during the student's first SBHC visit of the school year.
    - If student answers "yes" to both PHQ-2 questions, administer a full PHQ-9 (or other depression assessment tool); refer to behavioral health if clinically indicated.
      - → The PHQ-9 is included in the Apex Apps program for SBHCs that use iPads. Use this feature if available to you, otherwise, use a paper form. (*Ch. 2 Resources*)
      - → Use the PHQ-9 (or other screening tool) to reassess in 6 weeks.

- Screen for Intimate Partner Violence (IPV).
  - Screening to assess IPV can include asking the adolescent if she has been hit, kicked, or punched by a partner or ex-partner.

- Screen for Reproductive Coercion.
  - Reproductive coercion can occur in the form of pregnancy outcome control by a partner for a patient who is already pregnant. Asking questions to screen for reproductive coercion may be appropriate if a patient is deciding how to deal with an unintended pregnancy. Questions may include:
    - "Do you and your partner agree on what you should do about your pregnancy?"
    - "Is your partner pressuring you do to what they want with your pregnancy, even though it is not what you want?"

        - "Are you worried about what your partner will do if you don't do what they want with your pregnancy?"

    - If a patient screens positive for reproductive coercion, intervene by: 1) addressing the quality of her relationship, 2) helping her take control of her own fertility, and 3) ensuring her safety.
        - Develop a safety plan with the patient.

- Encourage and praise healthy behaviors and self-care.
    - Provide anticipatory guidance around social/academic competence and stress management.

- Refer to behavioral health provider at SBHC or elsewhere as appropriate.
    - Expectant teen mothers may have specific concerns related to becoming a parent, managing a relationship with the child's other parent, managing relationships with their family, finances, school, etc., that can best be addressed by a behavioral health provider.

- Assess for support and refer to school or community resources, such as:
    - **Home visiting programs, peer and support groups, mentoring programs**
    - Prenatal/birthing classes
    - Child care
        - Many childcare centers and Head Start programs have waiting lists. Early enrollment is encouraged to avoid any delay in childcare once the child is born.
    - WIC and other public benefits
    - Job and life skills training
    - Parenting classes
    - Care coordination through their Managed Care Organization
        - Remind student to inquire with their MCO about obtaining infant supplies (such as a breast pump, car seat, etc.) and rewards (often in the form of gift cards) for attending prenatal appointments.
    - School-based programs to encourage graduation, such as NM GRADS
    - School nurse for minor instances of care or support when SBHC is not accessible

SECTION 3: CARE FOR EXPECTANT FATHERS

BACKGROUND

- Research on adolescent fathers is understudied and there are fewer teen fathers than mothers.
- Past attempts to involve teen fathers focused on child support.
- Teen fathers have higher school dropout rates, poor academic performance, and decreased income capacity.
- Treating adolescent fathers as peripheral in their parenting role marginalizes an already alienated group and negatively affects the ability of the father to seek future advice and education.
- Early involvement strengthens the father-child bond and contributes to improved child outcomes.

RECOMMENDATIONS

Recommendations for effectively involving males in prenatal care the SBHC include[11, 20, 22]:

- Encourage early involvement of fathers and include both parents in patient education.
  - Actively involve fathers in prenatal related health care conversations, when possible and agreed upon.
  - The National Fatherhood Initiative: www.fatherhood.org
- Assist men in communicating effectively about their reproductive health, sexual limits, and desires.
- Help young men examine and break down negative stereotypes surrounding their reproductive health, behaviors, fatherhood, and values.
- Develop recruitment and retention strategies for working with young fathers.
  - A Fatherhood Mentor through the GRADS program can support with this effort.
- Assess immunization status to support child health.
  - Provide counseling on the importance of ensuring that others who will be in contact with the baby (ie. partners, caregivers and household members) are up-to-date on their vaccines, especially pertussis and influenza.
    - If your SBHC can provide vaccines to others outside of the student population, offer this as an option.
  - Administer needed vaccines or refer to a provider who can immunize.
- Screen for substance use.
  - Administer the CRAFFT (substance abuse screen; as part of well-care visits).
    - This is an embedded screening tool in the SHQ/eSHQ and should be administered once per school year during the student's first SBHC visit of the school year.

- If applicable to your SBHC, a positive CRAFFT screen should trigger administration of the CHIPSA substance abuse screening tool, which is embedded in the iPad Apex Apps.
- For expectant adolescents who are using substances, provide a brief intervention using motivational interviewing techniques and refer for additional treatment within or outside of the SBHC dependent on accessibility and severity.

- Screen for depression.
  - Administer the PHQ-2 (depression screen; as part of well-care visits).
    - This is an embedded screening tool in the SHQ/eSHQ and should be administered once per school year during the student's first SBHC visit of the school year.
    - If student answers "yes" to both PHQ-2 questions, administer a full PHQ-9 (or other depression assessment tool); refer to behavioral health if clinically indicated.
      - → The PHQ-9 is included in the Apex Apps program for SBHCs that use iPads. Use this feature if available to you, otherwise, use a paper form. (*Ch. 2 Resources*)
      - → Use the PHQ-9 (or other screening tool) to reassess in 6 weeks.
- Refer to behavioral health provider at SBHC or elsewhere as needed.
  - Expectant teen fathers may have specific concerns related to becoming a parent, managing a relationship with the child's other parent, managing relationships with their family, finances, school, etc., that can best be addressed by a behavioral health provider.
- Encourage and praise healthy behaviors and self-care.
  - Provide anticipatory guidance around social/academic competence and stress management.
- Refer to school or community resources, such as:
  - Home visiting programs, peer and support groups, mentoring programs
  - Prenatal/birthing classes
  - Child care
    - Many childcare centers and Head Start programs have waiting lists; early enrollment is encouraged to avoid any delay in childcare once the child is born.
  - WIC and other public benefits
  - Job and life skills training
  - Parenting classes
  - School-based programs to encourage graduation, such as NM GRADS
  - School nurse for minor instances of care or support when SBHC is not accessible

SECTION 4: PRENATAL CARE RESOURCES

Youth-Friendly Information

Association of Reproductive Health Professionals (ARHP), Patient Resources
http://arhp.org/publications-and-resources/patient-resources

Teens Health – Having a Healthy Pregnancy
http://kidshealth.org/en/teens/pregnancy.html

Teens Health- Telling Your Parents You're Pregnant
http://kidshealth.org/en/teens/tell-parents.html

ACOG: Having A Baby - Frequently Asked Questions, Especially for Teens
http://www.acog.org/Patients/FAQs/Having-a-Baby-Especially-for-Teens

Healthy Teen Network, Resources for Pregnant & Parenting Teens
http://www.healthyteennetwork.org/resources-pregnant-and-parenting-teens

Girl-Mom: Community Advocacy & Support By and For Young Mothers
http://girl-mom.com/

Young Women United
www.youngwomenunited.org

Strong Families
www.strongfamiliesmovement.org/young-parents

For Fathers:

Young Men's Health (Division of Adolescent & Young Adult Medicine, Boston Children's Hospital)- Becoming a Father
http://youngmenshealthsite.org/guides/becoming-a-father/

National Center for Fathering
http://www.fathers.com/resource-center/

National Fatherhood Initiative
http://www.fatherhood.org/

Provider Information

Adolescent Reproductive and Sexual Health Education Program (ARSHEP) – Caring For Pregnant & Parenting Adolescents
https://prh.org/teen-reproductive-health/arshep-explained/

Association of Reproductive Health Professionals- Healthy Pregnancy
http://arhp.org/topics/pregnancy

PRENATAL CARE

National Coalition Against Domestic Violence – Reproductive Coercion Toolkit
https://www.ncadv.org/about-us/our-programs/reproductive-coercion

Pregnancy Options Resources

Pegasus Legal Services for Children (NM)
www.pegasuslaw.org

Planned Parenthood
www.plannedparenthood.org

INCLUDED RESOURCES

AAP Statement: Caring for Teenage Parents and their Children

PHQ-9 Modified for Teens (English)

PHQ-9 Modified for Teens (Spanish)

GRADS/SBHC Dual Referral Flow Chart

American Academy of Pediatrics Statement: Caring for Teenage Parents and Their Children

Provide	Medical home for teen parents and their children
Address	Development of both infant and adolescent parent
Encourage	Continuation of healthful behaviors from pregnancy
Assess	Risk for domestic violence; adolescent parents are at greater risk
Include	Both parents/caregivers in patient education
Utilize	Community resources such as WIC
Emphasize	Importance of completing high school
Praise	Achievements and healthful behaviors

Caring for Pregnant & Parenting Adolescents. Physicians for Reproductive Health, Adolescent Reproductive and Sexual Health Education Program (ARSHEP). https://prh.org/teen-reproductive-health/arshep-downloads/

PHQ-9: Modified for Teens

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) **Not At All**	*(1)* **Several Days**	*(2)* **More Than Half the Days**	*(3)* **Nearly Every Day**
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
[ ] Yes [ ] No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

[ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?
[ ] Yes [ ] No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?
[ ] Yes [ ] No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: Severity score: _____

Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)

CUESTIONARIO SOBRE LA SALUD DEL PACIENTE-9:

Modificado

Nombre: _____ Clinico: _____ Fecha: _____

Instrucciones: ¿Qué tan a menudo ha sentido cada uno de los siguientes síntomas durante las **dos ultimas semanas**? Por cada síntoma escriba una "X" en el cuadro que mehor describe como se siente.

	(0) **Ninguno**	*(1)* **Varios Días**	*(2)* **Mas de la Mitad de los Días**	*(3)* **Casi Todos los Días**
1. ¿Se seinte deprimido, irritado, o sin esperanza?				
2. ¿Poco interés or placer para hacer cosas?				
3. ¿Tiene dificultad para dormirse, quedarse dormido, o duerme demasiado?				
4. ¿Poco apetito, perdida de peso, o come demasiado?				
5. ¿Se siente cansado o tiene poca energía?				
6. ¿Se seinte mal por usted mismo-o siente que es un fracasado, o que le ha fallado a su familia y a usted mismo?				
7. ¿Tiene problema para concetrarse en cosas tales como tareas escolares, leer, o ver televisión?				
8. ¿Se mueve o habla tan lentamente que las otras personas pueden notarlo? ¿O al contrario-esta tan inquieto que se mueve mas de lo usual?				
9. ¿Pensamientos que estaría mejor muerto o de hacerse daño usted mismo de alguna manera ?				

¿En el año pasado se ha sentido deprimido o triste la mayoría de los días, aun cuando se siente bien algunas veces?

[ ] Si [ ] No

Si usted esta pasando por cualquiera de los problemas mencionados en este formulario, ¿qué tan difícil estos problemas le causan para hacer su trabajo, hacer las cosas de la casa, o relacionarse con las demás personas?

[ ] No difícil [ ] Un poco difícil [ ] Muy difícil [ ] Sumamente difícil

¿En el mes pasado hubo algún momento donde usted pensó seriamente en terminar con su vida?

[ ] Si [ ] No

¿Alguna vez en su vida, trato de matarse o trato de suicidarse?

[ ] Si [ ] No

***Si usted piensa que estaría mejor muerto o piensa hacerse daño de alguna manera, por favor hable sobre esto con el Clinico de Atencion de Salud, o vaya a la sala de emergencia de un hospital o llame al 911.*

Para uso de la oficina solamente: Severity score: _____

Translated by the Asian/American Center of Queens College with funds provided by the Queens Borough President Helen Marshall.
Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)

Scoring the PHQ-9 modified for Teens

Scoring the PHQ-9 modified for teens is easy but involves thinking about several different aspects of depression.

To use the PHQ-9 as a diagnostic aid for Major Depressive Disorder:

- Questions 1 and/or 2 need to be endorsed as a "2" or "3"
- Need five or more positive symptoms (positive is defined by a "2" or "3" in questions 1-8 and by a "1", "2", or "3" in question 9).
- The functional impairment question (How difficult….) needs to be rated at least as "somewhat difficult."

To use the PHQ-9 to screen for all types of depression or other mental illness:

- All positive answers (positive is defined by a "2" or "3" in questions 1-8 and by a "1", "2", or "3" in question 9) should be followed up by interview.
- A total PHQ-9 score $\geq$ 10 (see below for instructions on how to obtain a total score) has a good sensitivity and specificity for MDD.

To use the PHQ-9 to aid in the diagnosis of dysthymia:

- The dysthymia question (In the past year…) should be endorsed as "yes."

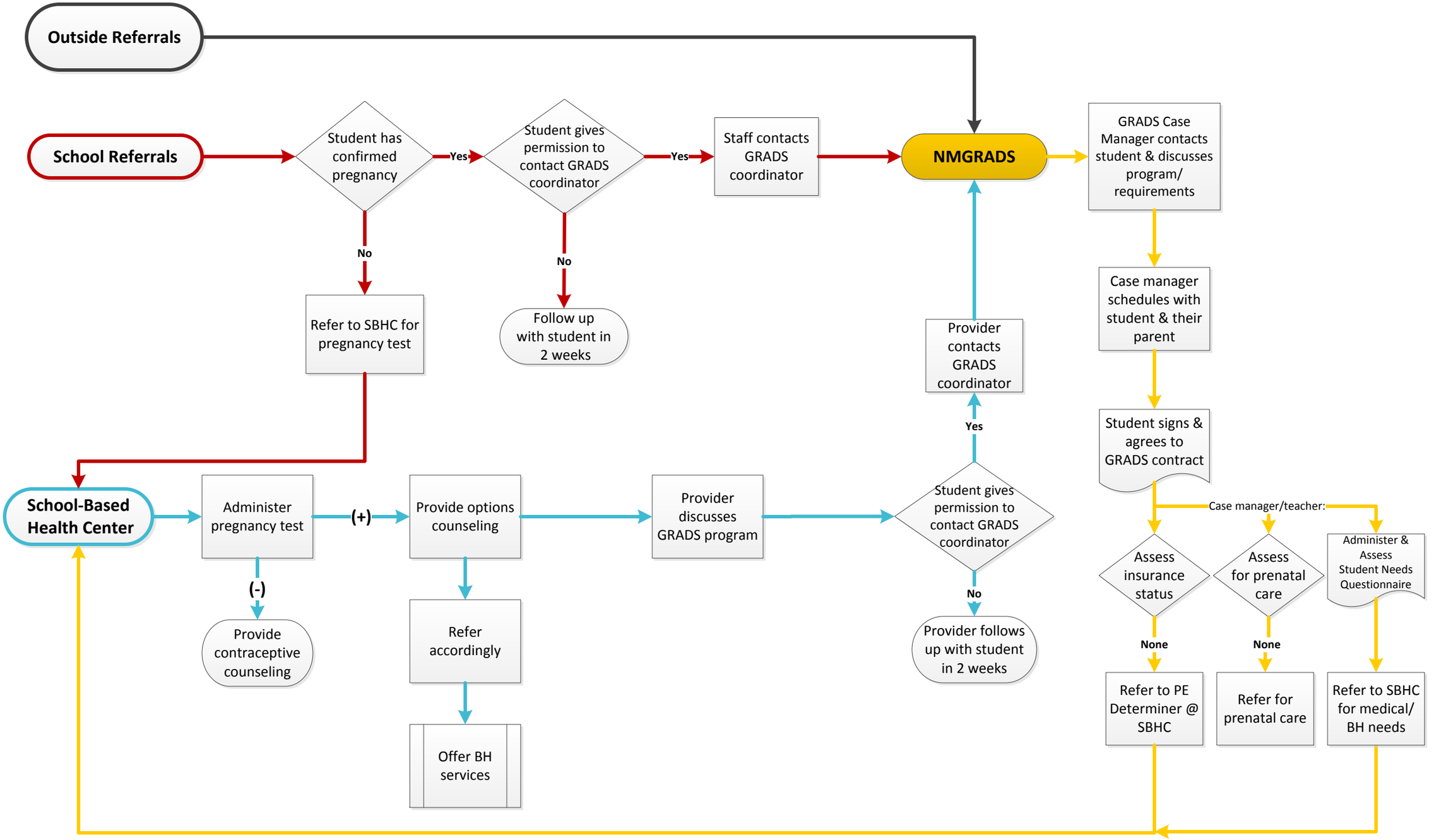
To use the PHQ-9 to screen for suicide risk:

- All positive answers to question 9 as well as the two additional suicide items MUST be followed up by a clinical interview.

To use the PHQ-9 to obtain a total score and assess depressive severity:

- Add up the numbers endorsed for questions 1-9 and obtain a total score.
- See Table below:

Total Score	**Depression Severity**
0-4	No or Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression


Outside Referrals
School Referrals
Student has confirmed pregnancy
Yes
Student gives permission to contact GRADS coordinator
Yes
Staff contacts GRADS coordinator
NMGRADS
GRADS Case Manager contacts student & discusses program/ requirements
No
Refer to SBHC for pregnancy test
No
Follow up with student in 2 weeks
Case manager schedules with student & their parent
Student signs & agrees to GRADS contract
Case manager/teacher:
Assess insurance status
Assess for prenatal care
Administer & Assess Student Needs Questionnaire
None
None
Refer to PE Determiner @ SBHC
Refer for prenatal care
Refer to SBHC for medical/ BH needs
Provider contacts GRADS coordinator
Yes
Student gives permission to contact GRADS coordinator
No
Provider follows up with student in 2 weeks
School-Based Health Center
Administer pregnancy test
(+)
(-)
Provide contraceptive counseling
Provide options counseling
Refer accordingly
Offer BH services
Provider discusses GRADS program

Best Practices for Serving Expectant & Parenting Teens & Families

RESOURCE MANUAL

Chapter 3 –

Postpartum Care

SECTION 1: GENERAL CARE FOR ADOLESCENT PATIENTS WHO ARE PARENTING

BACKGROUND

- Use of cigarettes and alcohol increases steadily during the first 6 months postpartum.
- IPV rates are significant among pregnant and parenting teens.
- Fathers who maintain active participation in the prenatal, neonatal, and immediate postpartum processes have a greater likelihood of ongoing involvement with their children.

RECOMMENDATIONS

While school-based health centers may not be considered the medical home, they can provide care geared toward the adolescent parenting patient to address particular postpartum health needs. General care for both parenting mothers and fathers should include:

- Ensure regular well-care for both infants and parents (see Chapter V)
  - Healthcare providers can build on their established relationship with adolescent parents and their children to provide developmentally appropriate care to both
- Screen for substance use.
  - Administer the CRAFFT (substance abuse screen; as part of well-care visits).
    - This is an embedded screening tool in the SHQ/eSHQ and should be administered once per school year during the student's first SBHC visit of the school year.
    - If applicable to your SBHC, a positive CRAFFT screen should trigger administration of the CHIPSA substance abuse screening tool, which is embedded in the iPad Apex Apps.
    - For parenting adolescents who are using substances, provide a brief intervention using motivational interviewing techniques and refer for additional treatment within or outside of the SBHC dependent on accessibility and severity.
  - Provide information on the effect of maternal substance use and cigarette smoking on child health and development.
- Screen for depression.
  - Administer the PHQ-2 (depression screen; as part of well-care visits).
    - This is an embedded screening tool in the SHQ/eSHQ and should be administered once per school year during the student's first SBHC visit of the school year.
    - If student answers "yes" to both PHQ-2 questions, administer a full PHQ-9 (or other depression assessment tool); refer to behavioral health if clinically indicated.

→ The PHQ-9 is included in the Apex Apps program for SBHCs that use iPads. Use this feature if available to you, otherwise, use a paper form. (*Ch. 2 Resources*)

→ Use the PHQ-9 (or other screening tool) to reassess in 6 weeks.

- Screen for Intimate Partner Violence (IPV).
  - See Chapter 2.
- Screen for Reproductive Coercion.
  - See Chapter 2.
- Refer to behavioral health provider at SBHC or elsewhere as needed.
  - Young parents may have specific concerns related to managing a relationship with the child's other parent, managing relationships with their family, finances, school, etc., that can best be addressed by a behavioral health provider.
- Encourage early involvement of fathers.
  - Early involvement strengthens the father-child bond and contributes to improves child outcomes.
  - Treating adolescent fathers as peripheral in their parenting role marginalizes an already alienated group and negatively affects the ability of the father to seek future advice and education.
  - Actively involve fathers in all infant and postpartum-related health care conversations when possible.
- Encourage positive parent-child interactions and home literacy.
  - Young parents need support around basic caregiving skills, positive parenting techniques and incorporating literacy activities in the home
  - Consider having baby books or literacy resources available to young parents and providing them during visits or connecting with the school library to make them available.
- Educate young parents on topics related to being new parents including, but not limited to:
  - Signs/symptoms of infection
    - How to triage and when to take baby in for emergency care, urgent care, or primary care.
    - When to keep baby home from child care.
  - Shaken baby
  - Bathing and sleep safety
  - Strategies for calming crying baby (swaddling, etc.)
  - Self-care and stress management
- Assess for support and refer to school or community resources, such as:
  - Home visiting programs, peer and support groups, mentoring programs

POSTPARTUM CARE

- Child care
- WIC and other public benefits
- Job and life skills training
- Parenting classes
- Care coordination through their Managed Care Organization
- School-based programs to encourage graduation, such as NM GRADS

SECTION 2: BREASTFEEDING IN ADOLESCENTS

BACKGROUND

- 60% of mothers under 20 initiate breastfeeding, only 22% are still breastfeeding at 6 months; many discontinue in less than 6 weeks.[24]
- The father of the baby often has an influence on the mother's decision to breastfeed or not.[25]
- Cultural beliefs and norms also affect the mother's breastfeeding decisions.
- Breastfeeding leads to reduced infections in infants and helps mothers return to their pre-pregnancy weight faster, while decreasing postpartum bleeding and risk of breast and ovarian cancer.[23]

RECOMMENDATIONS

- The AAP recommends exclusive breastfeeding for about 6 months, followed by continued breastfeeding as complementary foods are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant.[23]
- Breastfeeding information should be provided during pregnancy and supported in the early postpartum period.[25]
- Information should be youth-friendly and include[25]:
    - The benefits and myths of breastfeeding
    - How to manage breastfeeding, including practical guidance
    - Tips for discretely breastfeeding in public
- Provide praise and encouragement to breastfeeding mothers and address any concerns, including:
    - Potential impact on current/future relationship(s)
    - Potential impact on daily activities and how to plan for leaving their baby
- Encourage support from and provide information to the teen's partner and her mother.
- Discuss options and strategies for breastfeeding in school and/or at work and provide a private space for breastfeeding at the SBHC if feasible and needed.
- Provide resources and refer to a lactation specialist for additional support.

SECTION 3: POSTPARTUM DEPRESSION IN ADOLESCENTS[26-29]

BACKGROUND

Postpartum depression (PPD) refers to depressive episodes that occur in the postpartum period. Depression, while always a disabling disorder, is especially problematic for new mothers who are caring for a young infant in addition to managing their normal responsibilities.[26]

- Teen mothers are at higher risk for PPD and report high depression symptom severity.[27]
  - One-third to two-thirds of young moms experience PPD, compared to 13-19%[4] for women of all ages
  - Research suggests that PPD symptoms peak for teen moms between 1 and 6 months postpartum
- Predictors of PPD in teens include family conflict, lack of social support and low self-esteem.[28]
- Involvement from the father of the child is a protective factor for PPD.[27]
- PPD symptoms are associated with increased parenting stress, repeat pregnancies, infant difficulties, and non-optimal parenting techniques.[27]
- PPD is associated with adverse outcomes for children, including developmental delay, lower levels of social engagement and greater stress reactivity.[29]
- PPD is often undiagnosed, with only about half of women receiving treatment.

RECOMMENDATIONS

- Assess for and address PPD early in teens, either at their own or their child's health care visits.[29]
- Screen for PPD using the Edinburgh Postnatal Depression Scale (EPDS). *See Ch. 3 resources.*
- Following a positive screen, make referrals for treatment and help the teen address any access barriers.[25]
- Assist the teen in identifying and cultivating her social support networks.[25]

SECTION 4: INTIMATE PARTNER VIOLENCE (IPV)[30, 31]

BACKGROUND

Intimate Partner Violence (IPV) among adolescents, also known as adolescent relationship abuse (ARA) or teen dating violence, refers to a pattern of repeated acts in which a person physically, sexually or emotionally abuses someone else in the context of a dating or similarly defined relationship. Examples include monitoring cell phone usage, telling a partner what she/he can wear and controlling whether the partner goes to school that day.

Reproductive coercion can occur in the form of pregnancy pressure when a woman is not currently pregnant. This is when an individual pressures or coerces a woman into becoming pregnant against her will, and in the form of birth control sabotage, when an individual interferes with a woman's use of contraception to cause her to become pregnant against her will.

IPV in Teens

- One in five female teens in the U.S. report ever experiencing physical and/or sexual violence from someone they were dating; rates are higher among pregnant and parenting teens.
- Reproductive coercion is one type of IPV that involves behaviors that interfere with contraceptive use and/or involve pregnancy pressure.
- ARA is related to adverse health outcomes include poor mental health, substance use, poor reproductive and sexual health, risky social behavior and even homicide.

RECOMMENDATIONS

- Provide education and counseling about healthy, safe and consensual relationships. Universal education messages for all patients:
  - Distinguish between healthy and unhealthy relationships.
  - Focus on healthy relationships.
  - Encourage youth to choose safe and respectful relationships, and reject unhealthy relationship behavior.
  - Support youth to take action to report or confront unhealthy behavior they witness among peers.
  - Educate sexually active teens about reproductive coercion and the importance of consent.
  - Create an environment where youth will see the clinic as a safe space to discuss relationships, seek advice and assistance.
- Discuss confidentiality and its limitations, ensure the opportunity for a private discussion.
-

POSTPARTUM CARE

- Assess for IPV, including reproductive coercion.

  Start with a Framing Statement
  - "We've started talking to all of our patients about safe and healthy relationships because it can have such a large impact on your health."

  Confidentiality
  - "Before we get started, I want you to know that everything here is confidential, meaning that I won't talk to anyone else about what is said unless you tell me that you're planning to hurt yourself or someone else."

  Sample Questions
  - "Has your current partner ever threatened you or made you feel afraid?"
    - Threatened to hurt you or your children if you did or did not do something, controlled who you talked to or where you went, or gone into rages
  - "Has your partner ever hit, choked, or physically hurt you?"
    - "Hurt" includes being hit, slapped, kicked, bitten, pushed, or shoved.)
  - "Has your partner ever forced you to do something sexually that you did not want to do, or refused your request to use condoms?"
  - "Does your partner support your decision about when or if you want to become pregnant/have a child?"
  - "Has your partner ever tampered with your birth control or tried to get you pregnant when you didn't want to be?"
  - "Do you and your partner use birth control every time you have sex?"
  - "Are you comfortable talking to your partner about using birth control?"

- If you feel that a patient is being victimized by IPV/reproductive coercion, the manner in which you intervene will vary based on the type and severity of the situation. In general, intervening in clinical staff should intervene by:
  - Addressing the quality of her relationship.
  - Helping her take control of her own fertility (in cases of reproductive coercion).
  - Ensuring her safety.
    - Develop a safety plan with the patient.

- Become familiar with local resources and educate patients about their options for help.

- Refer to behavioral health services as appropriate.

SECTION 5: POSTPARTUM RESOURCES

New Mexico Resources

Resources for Parents, CYFD
https://pulltogether.org/

Home Visiting Programs
https://cyfd.org/home-visiting

Infant Mental Health
https://cyfd.org/behavioral-health/infant-and-early-childhood-mental-health-services

New Mexico Young Fathers Project
http://www.youngfathers.org/

Young Women United
http://www.youngwomenunited.org/

Breastfeeding

Kelly Mom, *Encouraging Teen Moms to Breastfeed*
kellymom.com/pregnancy/bf-prep/teenbf

La Leche League International, *Helping Adolescent Mothers Breastfeed:*
www.llli.org/llleaderweb/lv/lvmarapr90p19.html

Intimate Partner Violence

Break the Cycle
www.breakthecycle.org

Love is Respect
www.loveisrespect.org

That's Not Cool
www.thatsnotcool.com

New Mexico Domestic Violence Resource Center
http://www.dvrcnm.org/

Rape Crisis Center of Central NM
http://rapecrisiscnm.org/

Safety Planning

http://www.thehotline.org/HELP/PATH-TO-SAFETY/#TAB-ID-6

POSTPARTUM CARE

http://www.loveisrespect.org/FOR-YOURSELF/SAFETY-PLANNING/

http://www.endabusewi.org/sites/default/files/resources/safety_plan_for_teens.pdf

Toolkits

Futures Without Violence – Hanging Out or Hooking Up: Clinical Guidelines on Responding to Adolescent Relationship Abuse
https://www.futureswithoutviolence.org/userfiles/file/HealthCare/Adolescent%20Health%20Guide.pdf

National Coalition Against Domestic Violence- Reproductive Coercion Toolkit
https://www.ncadv.org/files/RCtoolkit.pdf

INCLUDED RESOURCES

CRAFFT Screening Tool

Edinburgh Postnatal Depression Screening Tool

ACOG Committee Opinion, Intimate Partner Violence (ACOG)

Safety Plan for Teens

Futures Without Violence – Hanging Out or Hooking Up: Clinical Guidelines on Responding to Adolescent Relationship Abuse

The CRAFFT Screening Interview

Begin: "I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."

Part A

During the PAST 12 MONTHS, did you:	**No**	**Yes**
1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")	☐	☐

For clinic use only: Did the patient answer "yes" to any questions in Part A?

No ☐ → **Ask CAR question only, then stop**

Yes ☐ → **Ask all 6 CRAFFT questions**

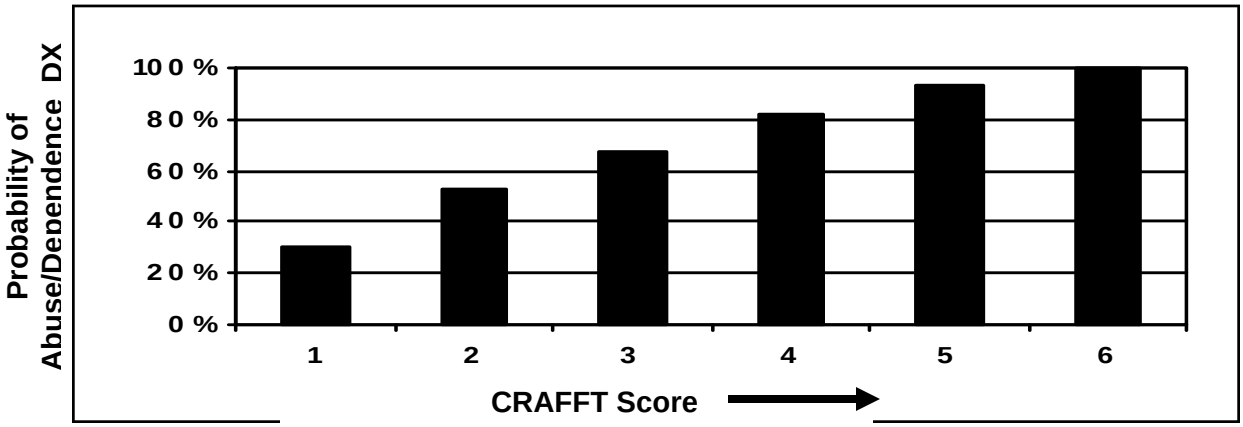
Part B

	No	**Yes**
1. Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
4. Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
5. Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

SCORING INSTRUCTIONS: FOR CLINIC STAFF USE ONLY

CRAFFT Scoring: Each "yes" response in **Part B** scores 1 point.
A total score of 2 or higher is a positive screen, indicating a need for additional assessment.

Probability of Substance Abuse/Dependence Diagnosis Based on CRAFFT Score[1,2]



DSM-IV Diagnostic Criteria[3] (Abbreviated)

Substance Abuse (1 or more of the following):

- Use causes failure to fulfill obligations at work, school, or home
- Recurrent use in hazardous situations (e.g. driving)
- Recurrent legal problems
- Continued use despite recurrent problems

Substance Dependence (3 or more of the following):

- Tolerance
- Withdrawal
- Substance taken in larger amount or over longer period of time than planned
- Unsuccessful efforts to cut down or quit
- Great deal of time spent to obtain substance or recover from effect
- Important activities given up because of substance
- Continued use despite harmful consequences

References:

1. Knight JR, Shrier LA, Bravender TD, Farrell M, Vander Bilt J, Shaffer HJ. A new brief screen for adolescent substance abuse. Arch Pediatr Adolesc Med 1999;153(6):591-6.
2. Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. Arch Pediatr Adolesc Med 2002;156(6):607-14.
3. American Psychiatric Association. Diagostic and Statistical Manual of Mental Disorders, fourth edition, text revision. Washington DC, American Psychiatric Association, 2000.

La entrevista de diagnóstico CARLOS (CRAFFT)

Inicio: "Le voy a hacer algunas preguntas que le hago a todos mis pacientes. Le agradezco que responda con la mayor sinceridad posible. Trataré sus respuestas de manera confidencial."

Parte A

Durante los ÚLTIMOS 12 MESES:	**No**	**Sí**
1. ¿Ha consumido bebidas alcohólicas (más de unos pocos sorbos)? (Sin tomar en cuenta sorbos de bebidas alcohólicas consumidas durante reuniones familiares o religiosas)	☐	☐
2. ¿Ha fumado marihuana o probado hachís?	☐	☐
3. ¿Ha usado algún otro tipo de sustancias que alteren su estado de ánimo o de conciencia?	☐	☐

(El término "algún otro tipo" se refiere a drogas ilícitas, medicamentos de venta libre o de venta con receta médica, así como a sustancias inhalables que alteren su estado mental.)

Para uso exclusivo del personal médico: ¿Respondió el paciente "sí" a cualquiera de las preguntas de la Parte A?

No ☐ → **Pasar a la pregunta B1 solamente**

Sí ☐ → **Pasar a las 6 preguntas CARLOS**

Parte B

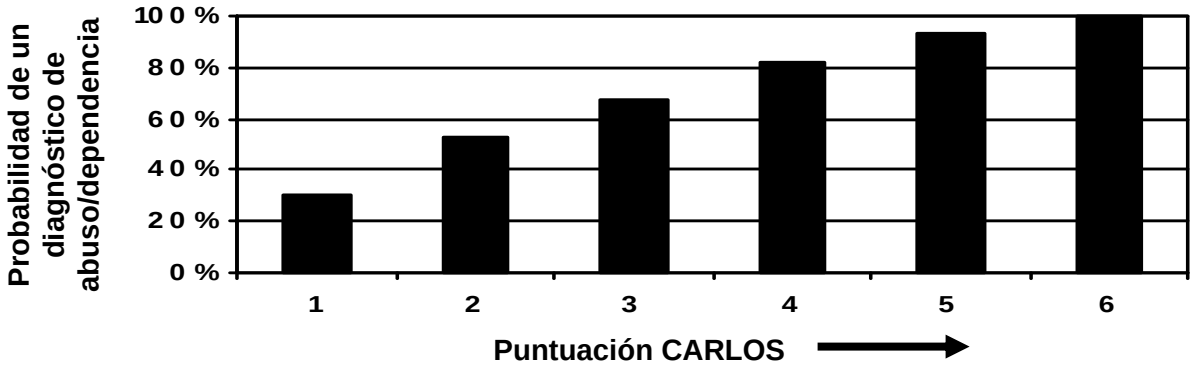
	No	**Sí**
1. ¿Ha viajado, alguna vez, en un **CARRO** o vehículo conducido por una persona (o usted mismo/a) que haya consumido alcohol, drogas o sustancias psicoactivas?	☐	☐
2. ¿Le han sugerido, alguna vez, sus **AMIGOS o su familia** que disminuya el consumo de alcohol, drogas o sustancias psicoactivas?	☐	☐
3. ¿Ha usado, alguna vez, bebidas alcohólicas, drogas o sustancias psicoactivas para **RELAJARSE**, para sentirse mejor consigo mismo o para integrarse a un grupo?	☐	☐
4. ¿Se ha metido, alguna vez, en **LÍOS** o problemas al tomar alcohol, drogas o sustancias psicoactivas?	☐	☐
5. ¿Se le ha **OLVIDADO,** alguna vez, lo que hizo mientras consumía alcohol, drogas o sustancias psicoactivas?	☐	☐
6. ¿Alguna vez ha consumido, alcohol, drogas o alguna sustancia psicoactiva mientras estaba **SOLO** o SOLA, sin compañía?	☐	☐

NOTA SOBRE EL CARÁCTER CONFIDENCIAL DE LA INFORMACIÓN:
La información incluida en esta página puede estar protegida por normas federales sobre confidencialidad (42 CFR Parte 2) que prohíben su divulgación, a no ser que medie una autorización escrita para el caso específico. NO basta con que se cuente con una autorización generalizada en materia de divulgación de la información médica.

INSTRUCTIVO DE PUNTUACIÓN: PARA USO EXCLUSIVO DEL PERSONAL MÉDICO

Puntuación de las preguntas CARLOS: Cada respuesta afirmativa ("sí") en la **Parte B** vale 1 punto. Una puntuación total mayor a 2 puntos equivale a un diagnóstico positivo, lo cual indica la necesidad de realizar una evaluación adicional.

Probabilidad de un diagnóstico de abuso/dependencia del alcohol o de substancias psicoactivas basado en la puntuación CARLOS[1,2]



Criterios de diagnóstico DSM-IV[3] (abreviados)

Abuso del alcohol o de sustancias psicoactivas (1 ó más de los siguientes factores):

- Su uso conlleva a un incumplimiento de sus obligaciones laborales, escolares o domésticas
- Uso recurrente en situaciones riesgosas (por ejemplo, conducir)
- Recurrencia de problemas legales
- Continuación de su uso a pesar de la recurrencia de problemas asociados

Dependencia de sustancias psicoactivas (3 ó más de los siguientes factores):

- Tolerancia
- Síndrome de abstinencia
- Consumo de la sustancia en cantidades cada vez mayores o durante un período de tiempo mayor al estimado
- Esfuerzos fallidos de reducir o abandonar el consumo de la sustancia
- Una gran cantidad de tiempo invertido en obtener la sustancia o en recuperarse de sus efectos
- Abandono de actividades importantes debido al uso de la sustancia
- Uso continuado a pesar de sus consecuencias nocivas

Citas:

1. Knight JR, Shrier LA, Bravender TD, Farrell M, Vander Bilt J, Shaffer HJ. A new brief screen for adolescent substance abuse [Un nuevo procedimiento breve para diagnosticar el abuso de sustancias en los adolescentes]. Arch Pediatr Adolesc Med 1999;153(6):591-6.
2. Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients [Validez de la prueba diagnóstica del abuso de sustancias CRAFFT en pacientes adolescentes en clínica]. Arch Pediatr Adolesc Med 2002;156(6):607-14.
3. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision [Manual de diagnósticos y estadísticas de los trastornos mentales, cuarta edición, texto corregido]. Washington DC, American Psychiatric Association, 2000.

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.

2. All the items must be completed.

3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)

4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 518 • February 2012

Committee on Health Care for Underserved Women

This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Intimate Partner Violence

ABSTRACT: Intimate partner violence (IPV) is a significant yet preventable public health problem that affects millions of women regardless of age, economic status, race, religion, ethnicity, sexual orientation, or educational background. Individuals who are subjected to IPV may have lifelong consequences, including emotional trauma, lasting physical impairment, chronic health problems, and even death. Although women of all ages may experience IPV, it is most prevalent among women of reproductive age and contributes to gynecologic disorders, pregnancy complications, unintended pregnancy, and sexually transmitted infections, including human immunodeficiency virus (HIV). Obstetrician–gynecologists are in a unique position to assess and provide support for women who experience IPV because of the nature of the patient–physician relationship and the many opportunities for intervention that occur during the course of pregnancy, family planning, annual examinations, and other women's health visits. The U.S. Department of Health and Human Services has recommended that IPV screening and counseling should be a core part of women's preventive health visits. Physicians should screen all women for IPV at periodic intervals, including during obstetric care (at the first prenatal visit, at least once per trimester, and at the postpartum checkup), offer ongoing support, and review available prevention and referral options. Resources are available in many communities to assist women who experience IPV.

Intimate partner violence (IPV) is a pattern of assaultive behavior and coercive behavior that may include physical injury, psychologic abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and reproductive coercion (1). These types of behavior are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and is aimed at establishing control of one partner over the other (1). It can occur among heterosexual or same-sex couples and can be experienced by both men and women in every community regardless of age, economic status, race, religion, ethnicity, sexual orientation, or educational background. Individuals who are subjected to IPV may have lifelong consequences, including emotional trauma, lasting physical impairment, chronic health problems, and even death.

More than one in three women in the United States have experienced rape, physical violence, or stalking by an intimate partner in their lifetime (2). In the United States, women experience 4.8 million incidents of physical or sexual assault annually (3). However, the true prevalence of IPV is unknown because many victims are afraid to disclose their personal experiences of violence. Intimate partner violence caused 2,340 deaths in 2007; of this number, 1,640 were female and 700 were male (4).

Patterns of Intimate Partner Violence

Intimate partner violence encompasses subjection of a partner to physical abuse, psychologic abuse, sexual violence, and reproductive coercion. Physical abuse can include throwing objects, pushing, kicking, biting, slapping, strangling, hitting, beating, threatening with any form of weapon, or using a weapon. Psychologic abuse erodes a woman's sense of self-worth and can include harassment; verbal abuse such as name calling, degradation, and blaming; threats; stalking; and isolation. Often, the abuser progressively isolates the woman from family and friends and may deprive her of food, money, transportation, and access to health care (5). Sexual violence includes a continuum of sexual activity that covers unwanted kissing, touching, or fondling; sexual coercion; and rape (6). Reproductive coercion involves behavior used to maintain power and control in a relationship related to reproductive health and can occur in the absence of physical or sexual violence. A partner may sabotage efforts at contraception, refuse to practice safe sex, intentionally

expose a partner to a sexually transmitted infection (STI) or human immunodeficiency virus (HIV), control the outcome of a pregnancy (by forcing the woman to continue the pregnancy or to have an abortion or to injure her in a way to cause a miscarriage), forbid sterilization, or control access to other reproductive health services (1).

Approximately 20% of women seeking care in family planning clinics who had a history of abuse also experienced pregnancy coercion and 15% reported birth control sabotage (7). In addition to unintended pregnancy risk, there are also risks specific to partner notification of an STI, which should be taken into account especially when considering expedited partner treatment. Women experiencing physical or sexual IPV are more likely to be afraid to notify their partners of an STI. In a study with a culturally diverse sample of women seeking care at family planning clinics, clients exposed to IPV were more likely to have partners who responded to partner notification by saying that the STI was not from them or accusing her of cheating (8). Some women reported threats of harm or actual harm in response to notifying their partners of an STI (9). Expedited partner therapy is only recommended after a health care provider has assessed for and confirmed that there is no risk of IPV associated with partner notification. It is also not intended for child abuse, sexual assault, or any situation where there is a question of safety.

Consequences of Intimate Partner Violence

Some women subjected to IPV present with acute injuries to the head, face, breasts, abdomen, genitalia, or reproductive system, whereas others have nonacute presentations of abuse such as reports of chronic headaches, sleep and appetite disturbances, palpitations, chronic pelvic pain, urinary frequency or urgency, irritable bowel syndrome, sexual dysfunction, abdominal symptoms, and recurrent vaginal infections. These nonacute symptoms often represent clinical manifestations of internalized stress (ie, somatization). This stress can lead to posttraumatic stress disorder, which is often associated with depression, anxiety disorders, substance abuse, and suicide. Research confirms the long-term physical and psychologic consequences of ongoing or past violence (10).

Approximately 324,000 pregnant women are abused each year in the United States (11). Although more research is needed, IPV has been associated with poor pregnancy weight gain, infection, anemia, tobacco use, stillbirth, pelvic fracture, placental abruption, fetal injury, preterm delivery, and low birth weight (11–14). In addition, the severity of violence may sometimes escalate during pregnancy or the postpartum period (15, 16). Homicide has been reported as a leading cause of maternal mortality, with the majority perpetrated by a current or former intimate partner (14). High rates of birth control sabotage and pregnancy pressure and coercion in abusive relationships are correlated with unintended pregnancies (1, 7).

The societal and economic effects of IPV are profound. Approximately one quarter of a million hospital visits occur as a result of IPV annually (17). The cost of intimate partner rape, physical assault, and stalking totals more than $8.3 billion each year for direct medical and mental health care services and lost productivity from paid work and household chores (17, 18). Additional medical costs are associated with ongoing treatment of alcoholism, attempted suicide, mental health symptoms, pregnancy, and pediatric-related problems associated with concomitant child abuse and witnessing abuse. Intangible costs include women's decreased quality of life, undiagnosed depression, and lowered self-esteem. Destruction of the family unit often results in loss of financial stability or lack of economic resources for independent living, leading to increased populations of homeless women and children (19). Efforts to control health care costs should focus on early detection and prevention of IPV (18).

Special Populations

Adolescents

Approximately one out of ten female high-school students in the United States reported experiencing physical violence from their dating partners in the previous year (20). Of those who reported ever having had sexual intercourse, one out of five girls experienced dating violence. These girls were also more likely to have experienced pregnancy and STIs, including HIV, and to report tobacco use and mental health problems, including suicide attempts (20). It is important for adolescents to be aware of behavior that aims to maintain power and control in a relationship such as monitoring cell phone usage, digital dating abuse (including posting nude pictures against her will, stalking her through social networks, and humiliating her through social networks), telling a partner what to wear, controlling whether the partner goes to school that day, as well as manipulating contraceptive use (1). Early recognition is critical in this population because adolescent violence can be associated with partner violence in adult life.

Immigrant Women

Women from different backgrounds may have different perceptions about IPV and need culturally relevant care that is sensitive to language barriers, acculturation, accessibility issues, and racism. Immigrant women may be hesitant to report IPV because of fears of deportation. It is important to increase awareness that a U Nonimmigrant Visa allows immigrants who have been subjected to substantial physical or mental abuse caused by IPV or other crimes to legally remain in the United States if it is justified on humanitarian grounds, ensures family unity, or is otherwise in the public interest (21).

Women With Disabilities

Women with physical and developmental disabilities usually are less able to care for themselves and are more reliant on their partners or caregivers for help. This sets up a dangerous dynamic where abusers may be in a position to physically abuse their victims by withholding medication, preventing use of assistive equipment such as canes or wheelchairs, and sabotaging other personal service needs such as help with bathing, bathroom functions, or eating. Also, many violence shelters do not accept women with disabilities or are not trained to respond adequately to the needs of women with disabilities.

Older Women

An estimated 1–2 million U.S. citizens aged 65 years or older have been injured, exploited, or mistreated by someone caring for them (22). For the obstetrician–gynecologist, the importance of elder abuse relates to the increasing number of older women in the population (23). Older women seek care for pelvic floor relaxation, sexual dysfunction, breast and reproductive tract cancer, and other problems. Elder abuse can occur in the patient's home, the home of the caregiver, or in a residential facility in which the patient is residing. There is no typical victim of elder abuse. Elder abuse occurs in all racial, social, educational, economic, and cultural settings. Victims of elder abuse know their perpetrator 90% of the time (24). Approximately two thirds of abusers are adult children or partners (24). Abuse can be physical, sexual, and psychologic and includes neglect (refusal or failure to fulfill caregiving obligations), abandonment, and financial exploitation (illegal or improper exploitation of funds or other assets through undue influence or misuse of power of attorney). For more information go to: http://www.acog.org/About_ACOG/ACOG_Departments/Violence_Against_Women/Elder_Abuse__An_Introduction_for_the_Clinician.aspx.

Role of Health Care Providers

The medical community can play a vital role in identifying women who are experiencing IPV and halting the cycle of abuse through screening, offering ongoing support, and reviewing available prevention and referral options. Health care providers are often the first professionals to offer care to women who are abused. The U.S. Department of Health and Human Services has endorsed the Institute of Medicine's recommendation that IPV screening and counseling be a core part of women's health visits (25). Adequate training and education among health care providers will provide the skills and confidence they need to work with patients, colleagues, and health care systems to combat violence and abuse (26). Obstetrician–gynecologists are in the unique position to provide assistance for women who experience IPV because of the nature of the patient–physician relationship and the many opportunities for intervention that occur during the course of annual examinations, family planning, pregnancy, and follow-up visits for ongoing care. Screening all patients at various times is also important because some women do not disclose abuse the first time they are asked. Health care providers should screen all women for IPV at periodic intervals, such as annual examinations and new patient visits. Signs of depression, substance abuse, mental health problems, requests for repeat pregnancy tests when the patient does not wish to be pregnant, new or recurrent STIs, asking to be tested for an STI, or expressing fear when negotiating condom use with a partner should prompt an assessment for IPV. Screening for IPV during obstetric care should occur at the first prenatal visit, at least once per trimester, and at the postpartum checkup. Studies have shown that patient self-administered or computerized screenings are as effective as clinician interviewing in terms of disclosure, comfort, and time spent screening (27, 28). Screening for IPV should be done privately. Health care providers should avoid questions that use stigmatizing terms such as "abuse," "rape," "battered," or "violence" (see sample questions in Box 1) and use culturally relevant language instead. They should use a strategy that does not convey judgment and one with which they are comfortable. Written protocols will facilitate the routine assessment process:

- Screen for IPV in a private and safe setting with the woman alone and not with her partner, friends, family, or caregiver.
- Use professional language interpreters and not someone associated with the patient.
- At the beginning of the assessment, offer a framing statement to show that screening is done universally and not because IPV is suspected. Also, inform patients of the confidentiality of the discussion and exactly what state law mandates that a physician must disclose.
- Incorporate screening for IPV into the routine medical history by integrating questions into intake forms so that all patients are screened whether or not abuse is suspected.
- Establish and maintain relationships with community resources for women affected by IPV.
- Keep printed take-home resource materials such as safety procedures, hotline numbers, and referral information in privately accessible areas such as restrooms and examination rooms. Posters and other educational materials displayed in the office also can be helpful.
- Ensure that staff receives training about IPV and that training is regularly offered.

Even if abuse is not acknowledged, simply discussing IPV in a caring manner and having educational materials readily accessible may be of tremendous help. Providing all patients with educational materials is a useful strategy that normalizes the conversation, making it acceptable for them to take the information without disclosure.

Box 1. Sample Intimate Partner Violence Screening Questions

While providing privacy, screen for intimate partner violence during new patient visits, annual examinations, initial prenatal visits, each trimester of pregnancy, and the postpartum checkup.

Framing Statement

"We've started talking to all of our patients about safe and healthy relationships because it can have such a large impact on your health."*

Confidentiality

"Before we get started, I want you to know that everything here is confidential, meaning that I won't talk to anyone else about what is said unless you tell me that…(insert the laws in your state about what is necessary to disclose)."*

Sample Questions

"Has your current partner ever threatened you or made you feel afraid?"
(Threatened to hurt you or your children if you did or did not do something, controlled who you talked to or where you went, or gone into rages)†

"Has your partner ever hit, choked, or physically hurt you?"

("Hurt" includes being hit, slapped, kicked, bitten, pushed, or shoved.)†

For women of reproductive age:

"Has your partner ever forced you to do something sexually that you did not want to do, or refused your request to use condoms?"*

"Does your partner support your decision about when or if you want to become pregnant?"*

"Has your partner ever tampered with your birth control or tried to get you pregnant when you didn't want to be?"*

For women with disabilities:

"Has your partner prevented you from using a wheelchair, cane, respirator, or other assistive device?"‡

"Has your partner refused to help you with an important personal need such as taking your medicine, getting to the bathroom, getting out of bed, bathing, getting dressed, or getting food or drink or threatened not to help you with these personal needs?"‡

*Family Violence Prevention Fund. Reproductive health and partner violence guidelines: an integrated response to intimate partner violence and reproductive coercion. San Francisco (CA): FVPF; 2010. Available at: http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Repro_Guide.pdf. Retrieved October 12, 2011. Modified and reprinted with permission.

†Family Violence Prevention Fund. National consensus guidelines on identifying and responding to domestic violence victimization in health care settings. San Francisco (CA): FVPF; 2004. Available at: http://www.futureswithoutviolence.org/userfiles/file/Consensus.pdf. Retrieved October 12, 2011. Modified and reprinted with permission.

‡Center for Research on Women with Disabilities. Development of the abuse assessment screen-disability (AAS-D). In: Violence against women with physical disabilities: final report submitted to the Centers for Disease Control and Prevention. Houston (TX): Baylor College of Medicine; 2002. p. II-1–II-16. Available at http://www.bcm.edu/crowd/index.cfm?pmid=2137. Retrieved October 18, 2011. Modified and reprinted with permission.

Futures Without Violence and the American College of Obstetricians and Gynecologists have developed patient education cards about IPV and reproductive coercion for adults and teens that are available in English and Spanish. For more information visit http://fvpfstore.stores.yahoo.net/safetycards1.html.

If the clinician ascertains that a patient is involved in a violent relationship, he or she should acknowledge the trauma and assess the immediate safety of the patient and her children while assisting the patient in the development of a safety plan. Risk factors for intimate partner homicide include having experienced previous acts of violence, estrangement from partner, threats to life, threats with a weapon, previous nonfatal strangulation, and partner access to a gun (29). Patients should be offered information that includes community resources (mental health services, crisis hotlines, rape relief centers, shelters, legal aid, and police contact information) and appropriate referrals. Clinicians should not try to force patients to accept assistance or secretly place informa-

tion in her purse or carrying case because the perpetrator may find the material and increase aggression. To assist clinicians in responding to IPV, a local domestic violence agency is often the best resource. It is important to note that when abuse is identified, it is very useful to offer a private phone for the patient to use to call a domestic violence agency. Controlling partners often monitor cell phone call logs and Internet usage. Offering a private phone to call the National Domestic Violence hotline is a simple but important part of supporting a victim of violence. The National Domestic Violence hotline is a multilingual resource that can connect a patient to local domestic violence programs, help with safety planning, and provide support. A protocol with all the information needed to perform an IPV assessment should be kept on site. Futures Without Violence also provides educational materials, IPV assessment and safety assessment tools (including scripts for clinical assessment of IPV and reproductive coercion), and free technical assistance specifically for health care providers and settings. For more information, visit www.futureswithoutviolence.org/section/our_work/health.

Reporting of the abuse of children is mandatory; however, reporting IPV, particularly mandatory reporting, is controversial. Although the intent of mandatory reporting is to identify and protect individuals before the next act of violence, the individual's safety, in fact, may be jeopardized (30). Most states do not mandate reporting of IPV or only mandate reporting in certain circumstances (31). To ensure compliance with state laws and federal regulations, it is important to contact the local law enforcement or domestic violence agency to become familiar with the laws in a specific jurisdiction. A summary of state laws can be found at: www.futureswithoutviolence.org/userfiles/file/HealthCare/MandReport2007FINALMMS.pdf. All fifty states and the District of Columbia have laws in effect authorizing the provision of adult protective services in cases of elder abuse or the abuse of individuals with disabilities, although the laws vary significantly between states. Physicians generally are mandated to report abuse in these instances. A current listing of state laws on elder abuse can be found at: www.ncea.aoa.gov/NCEAroot/Main_Site/Find_Help/State_Resources.aspx.

Documentation of the clinical interaction provides important evidence for any future legal proceedings. Accurate reflection of the patient's condition, including any pertinent photographs or body maps, should be included with direct and specific quotations. The health care provider should review with the patient in advance what form of future communication is best because medical bills and follow-up phone calls may prompt retaliation from the abuser. Despite encountering violence, a patient may deny her circumstances based on fear of retaliation from her partner, fear of involvement with law enforcement and the justice system, embarrassment, or shame. Even if women do not reveal violence to their physicians, hearing validating messages and knowing that options and resources may be available could help prompt them to seek help on their own in the future.

Conclusion

Based on the prevalence and health burden of IPV among women, education about IPV; screening at periodic intervals, including during obstetric visits; and ongoing clinical care can improve the lives of women who experience IPV. Preventing the lifelong consequences associated with IPV can have a positive effect on the reproductive, perinatal, and overall health of all women.

Intimate Partner Violence National Resources

Hotlines

- National Domestic Violence Hotline
  1-800-799-SAFE (7233)
- Rape Abuse & Incest National Network (RAINN) Hotline
  1-800-656-HOPE (4673)

Web Sites

- Futures Without Violence (previously known as Family Violence Prevention Fund)
  www.futureswithoutviolence.org
- National Coalition Against Domestic Violence
  www.ncadv.org
- National Network to End Domestic Violence
  www.nnedv.org
- National Resource Center on Domestic Violence
  www.nrcdv.org
- Office on Violence Against Women (U.S. Department of Justice)
  www.usdoj.gov/ovw

References

1. Family Violence Prevention Fund. Reproductive health and partner violence guidelines: an integrated response to intimate partner violence and reproductive coercion. San Francisco (CA): FVPF; 2010. Available at: http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Repro_Guide.pdf. Retrieved October 12, 2011.
2. Black MC, Basile KC, Breidig MJ, Smith SG, Walters ML, Merrick MT, et al. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 summary report. Atlanta (GA): National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2011. Available at: http://www.cdc.gov/ViolencePrevention/pdf/NISVS_Report2010-a.pdf. Retrieved December 16, 2011.
3. Tjaden P, Thoennes N. Extent, nature, and consequences of intimate partner violence: findings from the National Violence Against Women Survey. Washington, DC: Department of Justice; 2000. Available at: https://www.ncjrs.gov/pdffiles1/nij/181867.pdf. Retrieved August 17, 2011.
4. Bureau of Justice Statistics. Homicide trends in the United States. Washington, DC: Department of Justice; 2010.

Available at: http://bjs.ojp.usdoj.gov/content/pub/pdf/htius.pdf. Retrieved August 12, 2011.

5. American Medical Association. Diagnostic and treatment guidelines on domestic violence. Chicago (IL): AMA; 1992.
6. Baram DA, Basson R. Sexuality, sexual dysfunction, and sexual assault. In: Berek JS, editor. Berek & Novak's gynecology. 14th ed. Philadelphia (PA): Lippincott Williams & Wilkins; 2007. p. 313–49.
7. Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, et al. Pregnancy coercion, intimate partner violence and unintended pregnancy. Contraception 2010; 81:316–22.
8. Decker MR, Miller E, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, et al. Intimate partner violence and partner notification of sexually transmitted infections among adolescent and young adult family planning clinic patients. Int J STD AIDS 2011;22:345–7.
9. Bauer HM, Gibson P, Hernandez M, Kent C, Klausner J, Bolan G. Intimate partner violence and high-risk sexual behaviors among female patients with sexually transmitted diseases. Sex Transm Dis 2002;29:411–6.
10. Commonwealth Fund. Addressing domestic violence and its consequences: policy report of the Commonwealth Fund Commission on Women's Health. New York (NY): CF; 1998.
11. Brown HL. Trauma in pregnancy. Obstet Gynecol 2009; 114:147–60.
12. McFarlane J, Wust WH. Documentation of abuse to pregnant women: a medical chart audit in public health clinics. J Womens Health 1996;5:137–42.
13. Parker B, McFarlane J, Soeken K. Abuse during pregnancy: effects on maternal complications and birth weight in adult and teenage women. Obstet Gynecol 1994;84:323–8.
14. Kady DE, Gilbert WM, Xing G, Smith LH. Maternal and neonatal outcomes of assaults during pregnancy. Obstet Gynecol 2005;105:357–63.
15. Brownridge DA, Taillieu TL, Tyler KA, Tiwari A, Chan KL, Santos SC. Pregnancy and intimate partner violence: risk factors, severity, and health effects. Violence Against Women 2011;17(7):858–81.
16. Cheng D, Horon IL. Intimate-partner homicide among pregnant and postpartum women. Obstet Gynecol 2010; 115:1181–6.
17. National Center for Injury Prevention and Control. Costs of intimate partner violence against women in the United States. Atlanta (GA): Centers for Disease Control and Prevention; 2003. Available at: http://www.cdc.gov/violenceprevention/pdf/IPVBook-a.pdf. Retrieved August 12, 2011.
18. Family Violence Prevention Fund. The health care costs of domestic and sexual violence. San Francisco (CA): FVPF; 2010. Available at: http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Health_Care_Costs_of_Domestic_and_Sexual_Violence.pdf. Retrieved August 12, 2011.
19. Health care for homeless women. Committee Opinion No. 454. American College of Obstetricians and Gynecologists. Obstet Gynecol 2010;115:396–9.
20. Silverman JG, Raj A, Clements K. Dating violence and associated sexual risk and pregnancy among adolescent girls in the United States. Pediatrics 2004;114:e220–5.
21. Immigrant Legal Resource Center. Department of Labor U visa process and protocols: question – answer. San Francisco (CA): ILRC; 2011. Available at: http://www.ilrc.org/files/documents/dol_u-visa_certification_protocols.pdf. Retrieved August 12, 2011.
22. National Center on Elder Abuse. Elder abuse prevalence and incidence. Washington, DC: NCEA; 2005. Available at: http://www.ncea.aoa.gov/ncearoot/Main_Site/pdf/publication/FinalStatistics050331.pdf. Retrieved October 11, 2011.
23. Cooper C, Selwood A, Livingston G. The prevalence of elder abuse and neglect: a systematic review. Age Ageing 2008;37:151–60.
24. National Center on Elder Abuse. The national elder abuse incidence study: final report. Washington, DC: NCEA; 1998. Available at: http://aoa.gov/AoA_Programs/Elder_Rights/Elder_Abuse/docs/ABuseReport_Full.pdf. Retrieved October 11, 2011.
25. Institute of Medicine. Recommendations. In: Clinical preventive services for women: closing the gaps. Washington, DC: National Academies Press; 2011. p. 71–141.
26. Ambuel B, Trent K, Lenahan P, Cronholm P, Downing D, Jelley M, et al. Competencies needed by health professionals for addressing exposure to violence and abuse in patient care. Eden Prairie (MN): Academy on Violence and Abuse; 2011. Available at: http://www.avahealth.org/vertical/Sites/%7B75FA0828-D713-4580-A29D-257F3-15BB94F%7D/uploads/%7B7E905305-99AC-4CE1-AA7B-8C4E940A34BA%7D.PDF. Retrieved August 12, 2011.
27. Chen PH, Rovi S, Washington J, Jacobs A, Vega M, Pan KY, et al. Randomized comparison of 3 methods to screen for domestic violence in family practice. Ann Fam Med 2007; 5:430–5.
28. Ahmad F, Hogg-Johnson S, Stewart DE, Skinner HA, Glazier RH, Levinson W. Computer-assisted screening for intimate partner violence and control: a randomized trial. Ann Intern Med 2009;151:93–102.
29. Campbell JC, Glass N, Sharps P, Laughon K, Bloom T. Intimate partner homicide: review and implications of research and policy. Trauma Violence Abuse 2007;8:246–69.
30. Hyman A, Schillinger D, Lo B. Laws mandating reporting of domestic violence. Do they promote patient well-being? JAMA 1995;273:1781–7.
31. Futures Without Violence. State codes on intimate partner violence victimization reporting requirements for health care providers. Available at: http://www.futureswithoutviolence.org/userfiles/file/HealthCare/MandReport2007FINALMMS.pdf. Retrieved October 7, 2011.

Intimate partner violence. Committee Opinion No. 518. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012; 119:412–7.

TEEN DATING ABUSE SAFETY PLAN

IF YOU ARE IN A RELATIONSHIP

If you are in a relationship that has been frightening or violent, chances are it will happen again, even if your boyfriend or girlfriend has promised that it won't. For your own safety, it's important to be prepared just in case. Remember, you do not have any control over your boyfriend/girlfriend's behavior. You do have control over how you prepare for it and respond to it. Take a few minutes to answer these questions and prepare your safety plan.

1. These are the cues I've seen that my boyfriend/girlfriend is getting angry or violent:

2. These are some situations I've been in where I haven't felt safe:

Tip: If you are feeling unsafe or in an argument, go to a place where other people might hear and/or a place where there is less risk of injury. (Avoid kitchens, bathrooms, garages, stairwells, rooms without an exit, or being near anything that could be used as a weapon.

3. These are people I trust and can ask for help:

Tip on talking with adults: Some adults, such as teachers, counselors and health care providers, are required by law to report abuse happening to anyone under age 18. If you are nervous about talking to an adult, ask whether they are required to report abuse to anyone under 18. Let them know that you are worried about your privacy, and talk with them about some of the ways they can help you. Also, you can always ask an adult about how you can help a friend who's in a dangerous relationship without revealing that you have the same problem.

4. This is my code word. I can share it with people I trust and use it to let them know I'm scared or need help:

5. When I share my code word, I can tell the people I trust what kind of help I want. I can also tell them what not to do. Here is the what I will tell them:

6. If I'm with my boyfriend/girlfriend and am not feeling safe, here are some things I can say or do to get away:

7. Here are some things I can do to help myself cope and feel better:

Tip: Doing things that make you feel happy, confiding in someone you trust or exercising are some ways to help manage the pressure of a difficult relationship. Some people use drugs or alcohol to cope with their problems. But they can drain your energy, cloud your judgment and make you more vulnerable.

8. If I can't think of anyone I can trust to talk to about my relationship or if I want more information, I can visit or call:

National Dating Abuse Helpline (24/7 anonymous and confidential)
Phone: 1-866-331-9474, TTY: 1-866-331-8453, Text: loveis to 77054
www.loveisrespect.org Live personal chat online

I can also call a domestic violence program, sexual assault program or crisis line at anytime without giving my real name. I can ask them to help me find someone I can trust.

For the nearest domestic violence program, call the National Domestic Violence Hotline at 800-799-SAFE, or go to the web site of the Wisconsin Coalition Against Domestic Violence at www.wcadv.org and click on "Get Help." For the nearest sexual assault program, call the National Sexual Assault Hotline at 1-800-656-HOPE, or go to the web site of the Wisconsin Coalition Against Sexual Assault at www.wcasa.org and click on "Find Help."

No one deserves to be abused. This is not my fault.

Compiled by the Wisconsin Coalition Against Domestic Violence www.wcadv.org
Adapted from a safety plan developed by the Vermont Network Against Domestic and Sexual Violence

TEEN DATING ABUSE SAFETY PLAN

IF YOU DECIDE TO BREAK UP

If you decide to break up with an abusive boyfriend or girlfriend, it is important to have a safety plan in place before attempting to end the relationship. Sometimes during and after breaking up are the most dangerous periods in the relationship.

1. I will plan the breakup carefully with the help of people I trust. If I don't have friends I can trust, I can talk to a parent, teacher or other adult. I can also call my local domestic violence or sexual assault crisis line anonymously. The more people who know what's going on and can look out for me and support me, the safer I am. These are the people I can trust to help me:

2. It is not safe to break up with my partner in an isolated place. I will try to do it in public with people nearby who are part of my safety plan. If necessary, I will do it by phone, letter or email. This is where and when I will break up with my boyfriend/girlfriend:

3. This is who I will ask to be watching out for me during the break-up:

4. I will be very clear with my boyfriend/girlfriend that I am ending the relationship and that my decision is final. These are the words I will use:

5. I will try to be prepared for my boyfriend/girlfriend's reaction. S/he may be violent or very sad, or be very sweet and try to win me back. These are ways my boyfriend/girlfriend might react:

6. After breaking up, I will avoid being alone with my ex or being in a situation where s/he might try to corner me or talk me out of the break–up. This is what I will do if my ex tries to talk to me at my home, work, school or elsewhere:

   Tip: If you are interested in a court order to protect you from your boyfriend or girlfriend, you may be able to get a harassment injunction or a child abuse restraining order. This process can be complicated, and procedures vary from county to county. For more information about this, contact a domestic violence or sexual assault program in your county. If you are being assaulted or are afraid that an assault is about to occur, you can always call 911 or the police.

7. This is what I will say if my ex calls me:

8. After breaking up, my ex may try to use other people to get through to me. If this happens, here is what I will say to them:

9. Here are some other things I can do to keep myself safe:
   - Always have a cell phone with me, along with important phone numbers.
   - Block my ex's access to my email, Facebook and other places where I share information.
   - Ask friends, family and co-workers to not to relay notes or messages from my ex.
   - Change my routine so I'm harder to locate.
   - Ask an adult that I trust at school to help me stay safe when I am there.
   - Have friends go to and from school with me and walk with me between classes.
   - Tell friends, family and co-workers to call school staff or the police if they see my ex bothering me.
   - Find someone I trust travel with me, sit with me, stay by me or watch out for me at my job, school events and other activities.
   - Arrange to call someone I trust to let them know that I have arrived safely or that I'm OK. If I do not call as planned, I will tell then to call the police.
   - If I am being assaulted or afraid an assault is about to occur, I can the police or 911.

Compiled by the Wisconsin Coalition Against Domestic Violence www.wcadv.org
Adapted from a safety plan developed by the Vermont Network Against Domestic and Sexual Violence

Hanging Out or Hooking Up:

Clinical Guidelines on Responding to Adolescent Relationship Abuse

An Integrated Approach to Prevention and Intervention

Second Edition

By Elizabeth Miller, MD, PhD
and Rebecca Levenson, MA

FUTURES WITHOUT VIOLENCE™

Our vision is now our name.

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CONTENTS

PART 1: INTRODUCTION

This resource, ***Hanging Out or Hooking Up: Clinical Guidelines on Responding to Adolescent Relationship Abuse: An Integrated Approach to Prevention and Intervention,*** focuses on the transformative role of the adolescent health care provider in preventing, identifying and addressing adolescent relationship abuse (ARA). With one in five (20%) U.S. teen girls reporting ever experiencing physical and/or sexual violence from someone they were dating[1] and one in four (25%) teens in a relationship reporting being called names, harassed, or put down by their partner via cell phone/texting,[2] ARA is highly prevalent and has major health consequences. Health care providers can help by providing prevention messages about healthy relationships and helping those exposed to abuse.

These guidelines are all the more critical because, in the summer of 2011, the Institute of Medicine (IOM) issued guidelines that screening for domestic and interpersonal violence be a core component of preventive health services for women and adolescent girls. The recommendations require that new health insurance plans cover domestic violence screening without co-pay and were adopted by the Department of Health and Human Services. Beginning in August 2012, domestic violence screening and counseling will be reimbursed as part of preventive health care services at no additional cost to patients under new health plans. As a result, health care providers need to understand how to routinely assess for and respond to victims of violence.

Background

Futures Without Violence, a leading advocate for addressing intimate partner violence (IPV) in the health care setting, has produced numerous data-informed publications, programs, and resources

to promote routine assessment and effective responses by health care providers. This new resource is adapted from a California publication co-produced by the California Health Adolescent Collaborative and Futures Without Violence, entitled The Healthcare Education, Assessment, and Response Tool for Teen Relationships (HEART) Primer.

In October 2009, California Adolescent Health Collaborative, in partnership with Futures Without Violence and University of California Davis School of Medicine, received funding from the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice to develop a toolkit and accompanying in-person training for California health care providers for addressing adolescent relationship abuse in the clinical setting. Over the course of a year, the HEART Primer and Training Program provided training to over 500 providers throughout the state of California.

At the same time, Futures Without Violence implemented Project Connect: A Coordinated Public Health Initiative to Prevent Violence against Women (Project Connect), a national public health initiative funded by the Office of Women's Health to prevent domestic and sexual violence in reproductive, perinatal/MCH, and adolescent health settings. As part of the initiative, state level partners across the country began to train their adolescent health providers on how to respond to ARA. It became clear that a national version of the HEART primer was needed—with a robust focus on prevention of violence through anticipatory guidance about respectful and safe relationships. These guidelines are also informed by a set of reproductive health guidelines created through the Project Connect initiative for adults and adolescents that provide direction on an integrated response to violence and reproductive coercion. (See discussion below)

The Adolescent Relationship Abuse Clinical Guidelines Include:

- Definitions, prevalence, and dimensions of ARA
- An overview of confidentiality and reporting issues and patient-centered reporting
- Clinical strategies to promote universal education about healthy relationships
- Clinical strategies to provide direct assessment and harm reduction strategies for reproductive coercion and ARA
- An overview of preparing your practice to address ARA
- Keys for success, including developing relationships with local domestic violence advocates and community programs
- Policy recommendations

These guidelines are applicable, but not limited to, the following settings serving adolescents:

- Adolescent health clinics and programs
- Pediatric settings
- Family planning clinics
- School-based health centers
- School nurse programs
- OB/GYN and women's health
- Prenatal care and programs
- STI/HIV clinics
- Title X clinics
- HIV prevention programs
- Abortion clinics and services

Adolescent health care providers play an essential role in violence prevention by discussing healthy, consensual, and safe relationships with all patients. The clinical setting may be the sole place an adolescent experiencing abuse may be identified and connected to resources to stay safe.

- Health care providers serving adolescents can offer confidential, safe spaces in which to discuss behaviors that may be abusive and that may be affecting a young person's health.
- Discussions in the clinical context of how abusive behaviors are linked to health risk may facilitate adolescents' recognition of ARA, as well as provide an opportunity to introduce harm reduction behaviors to increase safety and protect their health.
- New research finds that by conducting an assessment and a brief intervention, reproductive health providers can dramatically decrease risk for violence AND unplanned pregnancy.[3]

Unfortunately, the standard-of-care within adolescent health settings does not currently include specified protocols to assess for or intervene to reduce ARA. These guidelines are written with a goal that all adolescents are given universal education on safe, consensual and healthy relationships, and strategies to respond to health issues in a trauma-informed manner. (See box below)

Definitions

One of the challenges in the field of domestic violence research has been a lack of standardized definitions. This is even more so for ARA, also known as dating violence. Although ARA is included in the definition of IPV, experts in the field have noted that while many aspects of ARA are similar to IPV, there are also distinct characteristics relative to the age of the victims and/or perpetrator and different patterns of abusive behaviors.

Adolescent Relationship Abuse

A pattern of repeated acts in which a person physically, sexually, or emotionally abuses another person of the same or opposite sex in the context of a dating or similarly defined relationship, in which one or both partners is a minor. Similar to adult IPV, the emphasis on repeated controlling and abusive behaviors distinguishes relationship abuse from isolated events (e.g. a single occurrence of sexual assault at a party with two people who did not know each other). Sexual and physical assaults often occur in the context of relationship abuse, but the defining characteristic is a repetitive pattern of behaviors aiming to maintain power and control in a relationship. Such behaviors can include monitoring cell phone usage, telling a partner what she/he can wear, controlling whether the partner goes to school that day, and interfering with contraceptive use.

What is Trauma-Informed Care?

According to Substance Abuse and Mental Health Services Administration (SAMSHA): Most individuals seeking public behavioral health services and many other public services, such as homeless and domestic violence services, have histories of physical and sexual abuse and other types of trauma-inducing experiences. These experiences often lead to mental health and co-occurring disorders such as chronic health conditions, substance abuse, eating disorders, and HIV/AIDS, as well as contact with the criminal justice system. When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization. **http://www.samhsa.gov/nctic/trauma.asp**

Dimensions of Abuse	Examples
Emotional/psychological	Name calling via instant messaging or verbally; telling partner what s/he can wear; threatening to spread rumors; threatening to commit suicide if partner tries to leave relationship; smashing things; breaking partner's things; criticizing partners family and friends.
Social	Monitoring partner's cell phone use; preventing partner from going to school or doing things with friends; calling or text messaging multiple times a day to monitor partner's whereabouts; getting angry if partner is talking to someone else.
Financial	Controlling what partner can or can't buy; refusing to help pay for condoms, birth control, or reproductive healthcare; refusing to pay for things that the abuser insisted the partner purchase.
Sexual	Insisting on sexual acts; manipulating contraceptive use; videotaping (including by cell phone) sexual acts then threatening to put them on the internet; preventing partner from using condoms/birth control; forcing partner to get pregnant; forcing partner to use drugs before sexual activity; forced sex/rape.
Physical	Threatening to hit; threatening with a weapon; hurting the partner's pet; hitting slapping, kicking, choking, or shoving.

Adolescent Relationship Abuse (ARA) vs. Teen Dating Violence (TDV)

Teens use a lot of different words for dating and romantic relationships including 'going out,' 'hooking up,' 'talking to,' 'seeing someone,' and many others. These relationships can be a fleeting occurrence or more long term. The term TDV implies a 'dating' relationship, and therefore does not accurately represent the full spectrum of risky or unhealthy relationships. *ARA is a term that encompasses the broadest definition of 'romantic' relationships among teens,* and encourages providers to keep conversations open when framing discussions with patients about relationships. Furthermore, the term 'abuse' calls to mind a wider spectrum of controlling behaviors than the term 'violence.'

"Like the first couple of times, the condom seems to break every time. You know what I mean, and it was just kind of funny, like, the first 6 times the condom broke. Six condoms, that's kind of rare, I could understand 1 but 6 times, and then after that when I got on the birth control, he was just like always saying, like you should have my baby, you should have my daughter, you should have my kid."[4]

-17 year old female who started Depo-Provera without partner's knowledge

The intersections between ARA, reproductive and sexual coercion, and reproductive health have enhanced our understanding of the dynamics and health effects of abusive teen relationships. This has led to expanded terminology to describe forms of abuse and controlling behaviors related to reproductive health.

Reproductive and Sexual Coercion

Reproductive and sexual coercion involves behaviors aimed to maintain power and control in a relationship related to reproductive health by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent. Most forms of behavior used to maintain power and control in a relationship impacting reproductive health disproportionately affect females. There are, however, some forms of reproductive and sexual coercion that males experience which are included in the definitions below.

Reproductive Coercion

Reproductive coercion is related to behaviors that interfere with contraception use and/or pregnancy. Two types of reproductive coercion, birth control sabotage and pregnancy pressure and coercion, are described below.

Birth Control Sabotage

Birth control sabotage is active interference with a partner's contraceptive methods. Examples of birth control sabotage include:

- Hiding, withholding, or destroying a partner's birth control pills
- Breaking or poking holes in a condom on purpose or removing it during sex in an explicit attempt to promote pregnancy
- Not withdrawing when that was the agreed upon method of contraception
- Pulling out vaginal rings
- Tearing off contraceptive patches

"He really wanted the baby… he always said, 'If I find out you have an abortion… I'm gonna kill you,' and so I really was forced into having my son. I didn't want to... I just got into [college] on a full scholarship, I just found out, I wanted to go to college and didn't want to have a baby but I was really scared. I was scared of him."[5]

-26 year old female

Pregnancy Pressure and Coercion

Pregnancy pressure involves behaviors that are intended to pressure a female partner to become pregnant when she does not wish to become pregnant. Pregnancy coercion involves coercive behaviors such as threats or acts of violence if she does not comply with her partner's wishes regarding the decision of whether to terminate or continue a pregnancy. Examples of pregnancy pressure and coercion include:

- Threatening to leave a partner if she does not become pregnant
- Threatening to hurt a partner who does not agree to become pregnant
- Forcing a female partner to carry to term against her wishes through threats or acts of violence
- Forcing a female partner to terminate a pregnancy when she does not want to
- Injuring a female partner in a way that she may have a miscarriage

Sexual Coercion

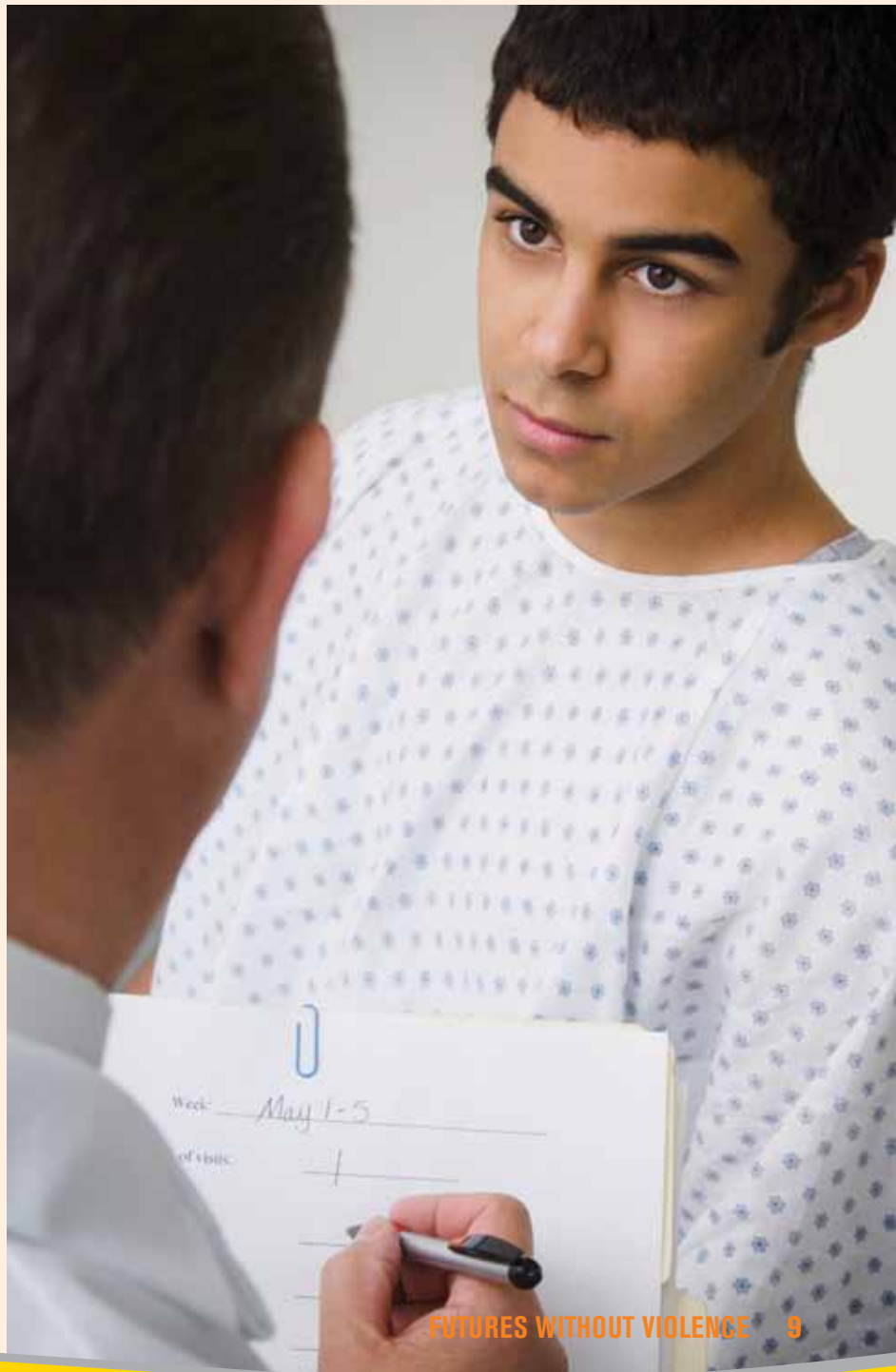
All experiences of sexual violence, including rape, impact sexual and reproductive health. Over the past twenty years, the healthcare field has made tremendous strides in responding to sexual assault,

"I'm not gonna say he raped me, he didn't use force, but I would be like, 'No' and then next thing, he pushes me to the bedroom, and I'm like 'I don't want to do anything' and then we ended up doing it, and I was crying like a baby and he still did it. And then after that he got up, took his shower, and I just stayed there like shock."[6]

through such innovative programs as Sexual Assault Response Teams (SARTS), and Sexual Assault Nurse Examiners (SANE). This guide further supports those programs, with interventions to address a specific aspect of sexual violence within the context of a relationship : sexual coercion.

Sexual coercion includes a range of behaviors that a partner may use related to sexual decision-making to pressure or coerce a person to have sex without using physical force. Examples of sexual coercion, which may occur in heterosexual or same sex relationships include:

- Repeatedly pressuring a partner to have sex when they do not want to
- Threatening to end a relationship if a person does not have sex
- Forced non-condom use or not allowing other prophylaxis use
- Intentionally exposing a partner to a STI or HIV
- Retaliation by a partner if notified of a positive STI result



Males and Reproductive and Sexual Coercion

Adolescent and adult males may also experience reproductive and sexual coercion. A recent national survey on intimate partner and sexual violence in the United States provided the first population based data on males' experiences with reproductive and sexual coercion.[7] Research on the impact of reproductive and sexual coercion on men's reproductive health is urgently needed. This research is essential to inform the development and evaluation of evidence-based interventions for males who experience reproductive and sexual coercion.

What Messages Do We Want to Share with Adolescent and Adult Males?

Male patients need to hear the same messages about the importance of healthy relationships, consensual sex, and consensual contraception to prevent unwanted pregnancies as female patients. Strategies for assessment, harm reduction, and intervention described in these guidelines can be adapted for male patients. As research evidence is being accumulated, clinical experience will help to inform best practices for male patients.

Recent research provides some insight into gay and bisexual males' experiences with sexual coercion. In a survey with gay and bisexual men, 18.5% reported unwanted sexual activity.[8] Qualitative data from interviews with gay and bisexual men suggest many of the factors underlying sexual coercion are related more to masculine sexuality versus gay sexuality and that society's response to same sex relationships leads to circumstances such as marginalization that increases vulnerability to sexual violence.[9]

Health care providers have an essential role in prevention by discussing healthy, consensual, and safe relationships with all patients. Some of the screening and intervention strategies described in the guidelines can be adapted for male patients. It is anticipated that future research will provide more information on how to better serve men, same sex couples, and other at-risk populations.

Pediatrics: ARA and Opportunities for Anticipatory Guidance

Many teens seek services at confidential teen clinics because they are or are about to become sexually active—and seek those services because they don't require parent or caregiver consent. All teens are at risk for ARA, including those that receive care from pediatric providers. In some cases, pediatric settings are a primary opportunity to have general conversations before teens begin sexual relationships and seeking out the specialized teen clinics that offer conditional confidential teen health services. The next section of the Guidelines reviews data on the high rates of violence among adolescents seeking services in non-pediatric settings. But this data implies that pediatric providers should also consider conducting

conversations with preteens and their parents about the elements of healthy and safe relationships before they seek other services—and what to do and where to go for help if they ever find themselves in an unsafe or unhealthy relationship. The American Academy of Pediatrics has developed guidelines and materials for pediatricians and parents to talk to young people in developmentally appropriate stages about healthy and safe relationships. Please see Connected Kids at **http://www2.aap.org/connectedkids/** for tools and resources.

While Connected Kids spans from early childhood through adolescence, these Clinical Guidelines on Responding to Adolescent Relationship Abuse are focused more narrowly on early to mid adolescence (ages 11-18), offering in-depth strategies for addressing healthy teen relationships specifically during a range of clinical encounters with adolescent patients.

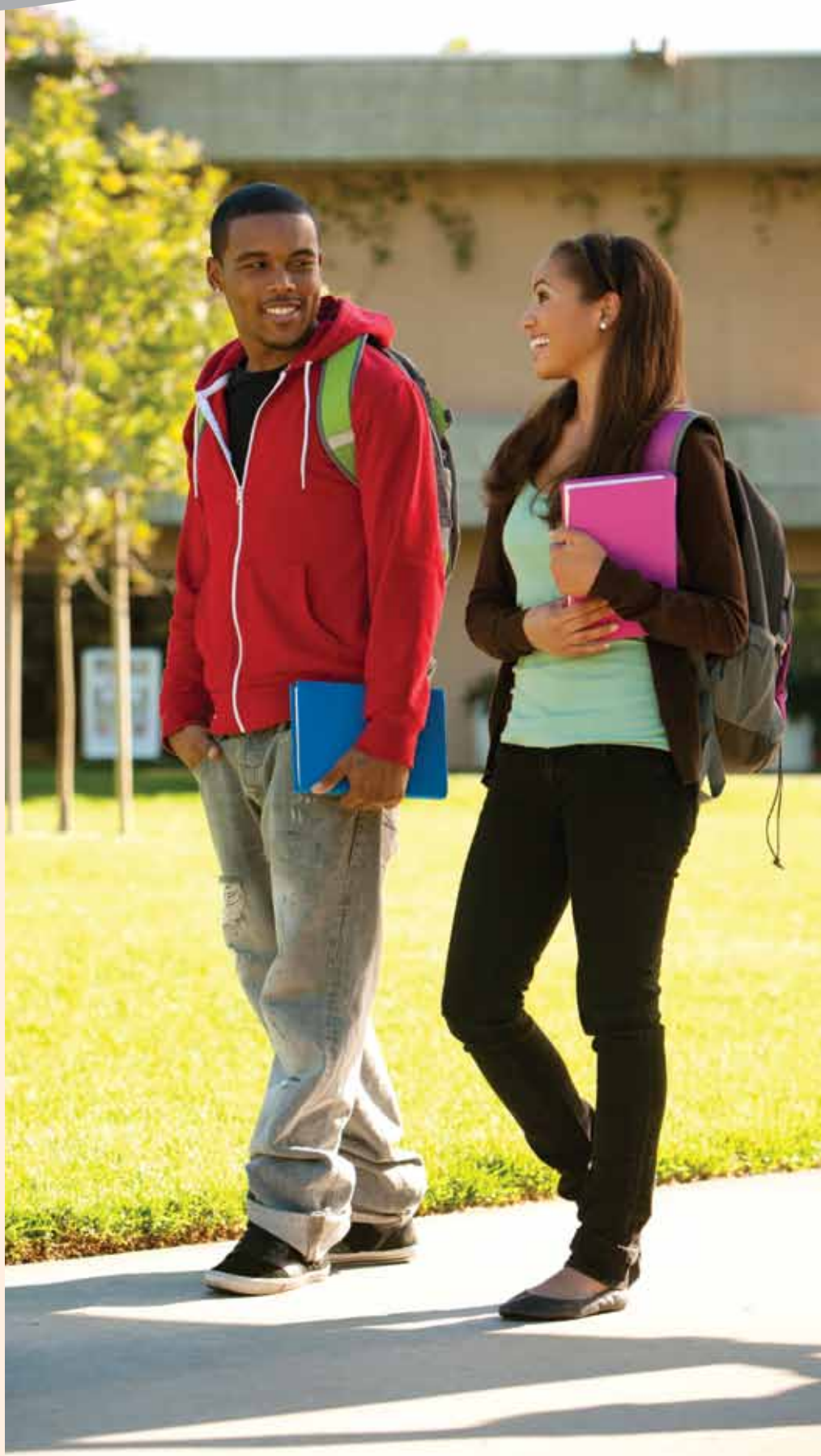
Teen Clinics Essential Sites for ARA Intervention

Adolescent relationship abuse is rarely identified in clinics serving adolescents,[10] but ARA is common among adolescents seeking clinical services.[11,12]

The following adolescent care-seeking patterns underscore the need for teen clinic interventions to identify and intervene in ARA and to provide education regarding ARA for **all** adolescents seeking care:

- Adolescent females utilizing teen clinics, school health centers, and reproductive health clinics report higher rates of physical and sexual violence victimization in their dating relationships than adolescents in the general population.[13,14,15,16,17]
- In adolescent clinic-based samples, the lifetime prevalence of physical and/or sexual violence in dating relationships is about 1.5 to 2 times greater than population-based estimates, ranging from 34% to 53%.[18,19,20]
- Patients with ARA histories do not have a particular risk profile: they seek care for a variety of reasons.[21]
- Only one third of respondents to a clinic-based survey (adolescent females ages 14-20 seeking care in teen clinics) reported having ever been screened for ARA.[22]
- Adolescents report disclosing abusive relationship experiences to friends far more often than to adult caregivers or to health professionals, suggesting that education within clinic settings about 'how to help a friend' may resonate with youth.[23]

As adolescent healthcare utilization patterns differ significantly from those of adults,[24] clinics that serve adolescents in particular, such as confidential teen clinics and school health centers, are strategic sites for adolescent health promotion, prevention, and intervention. Often located in low-income community settings and schools, teen clinics eliminate key barriers to health care by providing comprehensive adolescent health services. Such barriers include concerns about confidentiality, lack of health insurance, and limited knowledge of the healthcare system.[25,26,27] Teen clinics serve large numbers of adolescents who otherwise may not come into contact with health care providers in more traditional settings. Ensuring that practitioners in these clinical settings are equipped with tools to address ARA is a critical component for ARA prevention and intervention.



PART 2: HEALTH EFFECTS OF ADOLESCENT RELATIONSHIP ABUSE

Magnitude of the Problem and Focus

ARA is a pervasive and persistent problem that has major implications for girls and young women and society at large: The 2010 National Intimate Partner and Sexual Violence Survey (NISVSS) by the Centers for Disease Control and Prevention found that more than one in three women (35.6%) and more than one in four men (28.5%) in the US experienced rape, physical violence and/or stalking by an intimate partner in their lifetime. Most female and male victims (69% of female and 53% of male victims) experienced some form of intimate partner violence for the first time before 25 years of age.[28] Each year in the U.S., at least **400,000 adolescents** experience serious physical and/or sexual dating violence.[29] **Two in five (40%)** of female adolescent patients seen at urban adolescent clinics had experienced IPV; 21% reported sexual victimization.[30] In addition to physical injury, ARA is closely linked to many adverse health outcomes including poor mental health, substance use, poor reproductive and sexual health, risky social behavior, and even homicide.

Mental Health and Substance Abuse Risks

The presence of mental health issues such as depression, thoughts of suicide, substance abuse and disordered eating may be clinical indicators to assess for ARA. **Population-based data indicates that adolescents who experienced forced sexual intercourse were more likely to engage in binge drinking and attempt suicide.**[31] Victims of physical and sexual violence in dating relationships are more likely to:

- Report sadness, hopelessness[32] or suicidal ideation.[33] Over 50% of youth reporting both dating violence and rape also reported attempting suicide.[34]
- Engage in substance use.[35]
- Use vomiting for weight loss.[36]

"It got so bad, I tried to kill myself. I tried jumping off the bridge, and stuff like that; 'cause I just couldn't deal with it anymore. I couldn't deal with it. I stopped talking to all my friends. I had a ton of friends from [my hometown], and I wasn't allowed to talk to any of them."[37]

Teen Pregnancy Risks

Although a myriad of teen pregnancy prevention programs have been developed at state and local levels, few directly address the connection between ARA and pregnancy risk, or recognize the identification of one of these risks as a clinical indicator to screen for the other. A large body of research points to the connection between ARA and teen pregnancy:

- Adolescent girls in physically abusive relationships were 3.5 times more likely to become pregnant than non-abused girls.[38]
- Adolescent mothers who experienced physical abuse within three months after delivery were nearly twice as likely to have a repeat pregnancy within 24 months than non-abused mothers.[39]
- Among teen mothers on public assistance who experienced recent ARA, 66% experienced birth control sabotage by a dating partner.[40]

Condom Use

Numerous studies have linked IPV victimization with inconsistent condom use or a partner refusing to use a condom.[42,43,44,45,46] In a literature review on relationship violence, condom use and HIV risk among adolescent girls, physical partner violence was routinely associated with inconsistent or non-condom use.[47]

"He was like, 'I should just get you pregnant and have a baby with you so that I know you will be in my life forever.' It's just like, for what, you want me to not go back to school, not go to college, not want me to do anything just sit in the house with a baby while you are out with friends."[41]

-19 year old female

Adolescent boys who perpetrate dating violence are less likely to use condoms, particularly in steady relationships,[48] while girls **experiencing dating violence are half as likely to use condoms** consistently compared to non-abused girls.[49] The connection between IPV and not using condoms is not limited to physical violence. In a national study of adolescents, girls' current involvement in verbally abusive relationships was associated with not using a condom during the most recent sexual intercourse.[50]

Sexually Transmitted Infections (STIs)/HIV Risks

Many STI/HIV prevention and intervention programs focus on condom education. However, condom negotiation may not be possible for young women in abusive and controlling relationships. Requests for STI testing may be a clinical indicator to screen for ARA.

- Lack of control over contraception and fear of condom negotiation, coupled with coercive or forced unprotected sex increases risk for HIV and other STIs in abused adolescent females.[51]

- Girls who experienced physical dating violence were 2.8 times more likely to fear the perceived consequences of negotiating condom use than non-abused girls.[52]
- Under high levels of fear of abuse, women with high STI knowledge were more likely to use condoms inconsistently than non-fearful women with low STI knowledge.[53]
- **More than one-third (38.8%)** of adolescents girls tested for STI/HIV have experienced dating violence.[54]
- Teen girls who are abused by male partners are three times as likely to become infected with an STI/HIV than non-abused girls.[55,56]

"I told him to put a condom on, he didn't...I went to a clinic, and they were like, 'Oh, he gave you Chlamydia.' [H]e said it was me messin' around with some other guy, and that's not true, 'cause I was like, 'You were the only guy I was with.' And he's like, 'Oh, that's you, you're messin' around... I thought you loved me.'"[57]

Other Risks and Outcomes

In addition to health issues, ARA is linked to other risk behaviors and adverse outcomes.

- Victims and perpetrators are more likely to carry weapons, as well as engage in physical fighting,[58] and other high risk behaviors, such as gambling.[59]
- Physical and sexual violence victimization is associated with an increased risk for school dropout, lower grades, and less connectedness to school.[60]
- A third (32%) of female homicides among adolescents between the ages of 11 and 18 are committed by an intimate partner.[61]

Conclusion

ARA is a serious problem with far-reaching consequences for the health and well-being of young people. The medical community has a unique vantage point and opportunity to address this issue as advocates for adolescent safety and well-being, and to connect with their patients around this sensitive topic in a safe environment. An understanding of the complexities of adolescent health and relationships allows health care providers to play an essential role in assessment and intervention. The tools and resources provided in these guidelines are intended to assist practitioners with ARA prevention and intervention in their own clinical settings.

PART 3: GUIDELINES FOR PROVIDING ANTICIPATORY GUIDANCE & UNIVERSAL EDUCATION ON ADOLESCENT RELATIONSHIP ABUSE

- PREPARE
- TRAIN
- INFORM
- ASK & EDUCATE
- INTERVENE & REFER

The following sections offer suggestions for ways providers can integrate both prevention messages and assessment for adolescent relationship abuse into their clinic visits with adolescent patients. Rather than treating "violence screening" as a separate add-on to the clinical encounter, providers are encouraged to integrate discussions of healthy and unhealthy relationships into their everyday clinical encounters. The suggested scripts included here are not exhaustive, but are intended to illustrate ways to bring discussions about relationships into a range of clinical encounters.

Assessment of a young person's thoughts, feelings, and experiences related to romantic relationships is central to approaching adolescent relationship abuse prevention and intervention. A strength-based, positive approach to relationships and human sexuality can begin with anticipatory guidance long before youth begin exploring romantic relationships more seriously.

Anticipatory guidance on healthy relationships can be used to identify early warning signs of unhealthy relationships, to promote safe healthy relationships, to prevent unintended pregnancies and prevent other poor health outcomes. Because of the high prevalence of adolescent relationship abuse, this

discussion should be introduced starting at the 11-12 year old well child visit, before patients start dating. **We recommend anticipatory guidance as universal education messages for all patients.** If patients are sexually active, we recommend following up with more direct ARA assessment questions, found in Section Four of these guidelines

PREPARE

Create a Safe Environment

There are several important steps you can take to create a safe and supportive environment for discussing ARA. These steps include:

- Having a written policy and training on ARA, including the appropriate steps to inform patients about conditional confidentiality and reporting requirements. *(See Appendix A for a sample protocol).*
- Developing a collaborative model of care, where providers partner with other staff/colleagues, community resources and the patients themselves to provide developmentally appropriate, effective and safe ARA interventions. *(For more information on setting up your practice to develop effective community partnerships and recommendations on best clinic team approach, please see Part 5: Policy Implications & Systems Response of these guidelines.)*
- Having a private place to interview patients, where conversations cannot be overheard or interrupted.
- Displaying educational posters addressing ARA and healthy relationships, as well as reproductive coercion that are multicultural and multilingual, on display in bathrooms, waiting rooms, exam rooms, hallways, and other highly visible areas.
- Having information including hotline numbers, safety cards, and resource cards on display in common areas as well as private areas, such as bathrooms and exam rooms, for victims and perpetrators.

Futures Without Violence (www.futureswithoutviolence.org/health) has a culturally diverse selection of posters, educational brochures, and safety cards.

Develop Referral Lists and Partnerships with Local and Regional Services

There is a wide array of resources available for victims of abuse on how to get help. Contact the following entities to learn more about these resources:

- The National Teen Dating Abuse Helpline 1 866 331 9474 or online chat at www.loveisrespect.org.
- The domestic violence coalition in your state (for a listing go to: www.nnedv.org/resources/coalitions.html).
- The violence prevention program in your state health department.

Meet with local domestic and sexual violence service providers to understand the services they provide for adolescents. Arrangements can often be made so staff can call a domestic violence advocate for advice and discuss a scenario hypothetically, if needed, to understand how to best meet the needs of a patient who is experiencing abuse.

TRAIN

Training on adolescent relationship abuse should discuss prevalence, use case examples and build clinical skills on how to start the conversation, offer anticipatory guidance on healthy relationships, assess for reproductive coercion and ARA and offer harm reduction strategies and referrals when needed. Those who should receive training include:

- Physicians
- Nurse practitioners
- Physician assistants
- Public health professionals
- Medical interpreters
- Nurses and nursing assistants
- Midwives
- Mental health professionals
- Social workers
- Health educators
- All health clinic staff including front desk and security guards

Core Training on ARA should be mandatory for all clinic staff that have contact with patients.

Ongoing Training opportunities should be available for new hires and staff who want to repeat the training or want to make use of training being offered by other organizations or online resources.

Refresher Training or case consultations are important to introduce advances in the field and offer opportunities for staff to discuss progress, challenges, and opportunities.

When possible, training should include staff from domestic violence and sexual assault programs.

Training Resources

Making the Connection: Intimate Partner Violence and Public Health is a free resource developed by Futures that can be used for self-directed training and to provide training to your staff and students (download at **www.futureswithoutviolene.org/health**). The toolkit consists of a PowerPoint presentation, speaker's notes, and an extensive bibliography. The following topics are addressed in the toolkit:

- IPV and Family Planning, Birth Control Sabotage, Pregnancy Pressure, and Unintended Pregnancy
- IPV and Sexually Transmitted Infections/HIV
- Adverse Childhood Experiences (ACE) Study: Leading Determinants of Health

Video Case Studies: Futures Without Violence has developed clinical vignettes that demonstrate:

- Providing anticipatory guidance for healthy, consensual relationships
- Discussing confidentiality and mandatory reporting with teens
- Creating opportunities for private time during visits when teens are accompanied by their parents
- Introducing harm reduction strategies for victims of reproductive and sexual coercion

Go to **www.futureswithoutviolence.org/health** for information on new training opportunities as they become available.

INFORM

Limits of Confidentiality

Navigating the balance between confidentiality and abuse reporting requirements is the fundamental challenge in ARA intervention. Laws requiring mandatory reporting of child abuse perpetrated by a parent or caregiver are often clear. However, laws vary widely from state to state for adolescents when it comes to sexual or physical abuse by a partner. As a provider, it is critical to understand the state's minor consent and confidentiality, physical and sexual abuse laws (and in some state, statutory rape laws), and that you are able to clearly articulate them to your patients.

Because simply providing anticipatory guidance about healthy relationships can trigger a positive disclosure of abuse or other situation that requires a report to law enforcement or child welfare, it is essential that the limits of confidentiality are reviewed with all patients prior to *any* anticipatory guidance about healthy relationships or direct assessment for ARA.

Contact the following entities for information and resources specific to your state/region:

- Children protection/child welfare services in your state for information about reporting requirements for minors experiencing and/or exposed to violence
- The domestic violence and sexual assault coalitions in your state may have legal advocates or other experts that provide information and training on reporting requirements for IPV. For a complete list go to **www.nnedv.org/resources/coalitions.html.**

Make sure that you have accurate, up-to-date information about reporting laws for your state, and disclose limits of confidentiality prior to screening.

Provider Tips for Discussing Conditional Confidentiality

- Be direct: Discuss confidentiality and the conditions under which it might be breached at the beginning of the visit.
- Keep it simple: Tailor your discussion to the youth's age and context.
- Communicate caring and concern: Frame your need to breach confidentiality in the context of "getting them the help that they might need," rather than using the law, policy, or phrase "I am a mandated child abuse reporter," as a reason to breach confidentiality.
- Assure two-way communication: Let your patient know if you are going to share information that they told you in confidence.
- Know the law.
- Check for understanding: Ask the patient to explain what they understand about conditional confidentiality.
- Document your communications, understanding and actions in the medical record.

Adapted from *Second edition: Duplessis V, Goldstein S and Newlan S, (2010) Understanding Confidentiality and Minor Consent in California: A Module of Adolescent Provider Toolkit. Adolescent Health Working Group, California Adolescent Health Collaborative.*

Sample Script to Inform Patient About Limits of Confidentiality:

"Before we get started I want you to know that everything here is confidential, meaning I won't talk to anyone else about what is happening unless you tell me that you are (add state specifics here: being hurt physically or sexually by someone, planning on hurting yourself [suicidal], or are planning on hurting someone else). Those things I would have to report, ok?"

Even after clearly outlining the limits of confidentiality with your patients, situations will arise when a report of abuse must be made. Principles of patient-centered reporting will be covered in the **Intervene & Refer** section of these guidelines below.

ASK & EDUCATE

Goals for Universal Education about Healthy Relationships:

- Distinguish between healthy and unhealthy relationship behavior
- Focus on healthy relationships
- Encourage youth to choose safe and respectful relationships, and reject unhealthy relationship behavior
- Support youth to take action to report or confront unhealthy behavior they witness among peers
- Educate sexually active adolescents about sexual coercion and the importance of consent
- Create an environment where youth will see the clinic as a safe place to discuss relationships and seek related advice and assistance

How Often Should You Educate?

At least annually and with each new partner

When Should You Provide Universal Education?

During any health appointment—including sports physicals

Where Should You Provide Education?

When the patient is by him/herself without parents, partners, or friends present

Who Should Receive Education About Healthy Relationships?

Every teen regardless of gender or sexual orientation should learn about healthy relationships.

SAFETY TIP

One key recommendation for clinics or providers in private practice is to develop a sign for your waiting room that says: In this clinic, we respect a patient's right to privacy and always see patients alone for some portion of their visit. Having a clearly stated policy like this helps the staff normalize the experience of seeing the patient alone without a friend or family member there—especially if there is an established pattern allowing partners or family members in during the entire visits. Displaying the policy on a sign in the waiting room takes the burden off the patient needing to ask to be seen alone, while allowing the staff member to point to the sign if there is any opposition from the patient's partner.

All adolescents need universal education about safe, consensual and healthy relationships. Universal education is an opportunity to educate patients about how abusive and controlling behaviors in a relationship can affect health and safety. Simple educational messages about ARA let teens know that they are not alone and you are a safe person to talk to, should abuse occur.

Introductory Statements

Now that you're getting older, you may find that you are attracted to boys or girls or both. One of the things that I talk to all my patients/teens/kids about is how you deserve to be treated by the people you go out with.

Anticipatory Guidance & Educational Messages

I'm talking to you about relationships because I want you to know how important I think it is for your relationships to be healthy, respectful, and to make you feel good.

PROVIDER TIP

It is essential to find out, prior to educating about ARA and reproductive and sexual coercion, whether a patient has sex with males, females, or both so you can tailor your conversation appropriately. For example, for a young woman engaging only in same sex relationships, questions would focus on ARA and sexual coercion while it would not be necessary to ask questions about birth control sabotage. The patient's responses to these questions will help to inform the provider about the best way to proceed relative to the assessment questions and treatment plan.

Hanging Out or Hooking Up Safety Card

As the basis of this anticipatory guidance, Futures Without Violence recommends using the *Hanging Out or Hooking Up* safety cards, which provides information that helps teens make the connection between unhealthy relationships and poor health outcomes. Research shows that brochure-based interventions can be effective at promoting health and safety, and that providers find the tool helpful for starting the conversation.

The safety card includes information about:

- Healthy and respectful relationships
- Adolescent relationship abuse and reproductive and sexual coercion
- How to help a friend experiencing these things
- Textual harassment and digital dating abuse
- Basic safety planning strategies for ARA
- National teen hotline numbers

It is important to discuss the card during the visit, rather than simply handing patients the card. Remember, it may not be safe for some patients who are currently experiencing abuse to leave the clinic with the safety card, so providers should always ask if the patient feels it is safe to take the card with him/her.

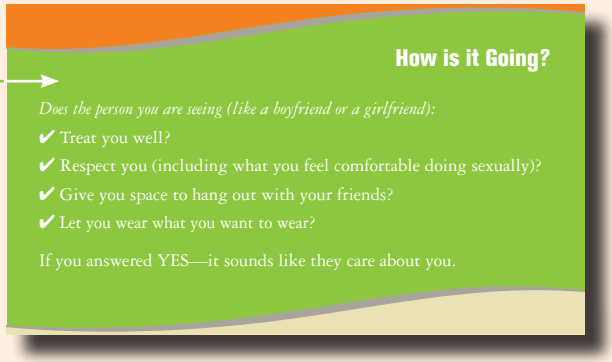
The *Hanging Out or Hooking Up* adolescent safety card, provided as a tear-out resource at the end of this chapter, has been tested in focus groups with a wide range of adolescents—male, female, homeless and LGBTIQ youth. Available in English and Spanish, the safety card is available for free for a limited period of time by going to www.futureswithoutviolence.org/health

Remember to discuss limits of confidentiality BEFORE you introduce the card.

Before you introduce the card—normalize

Sample Script:

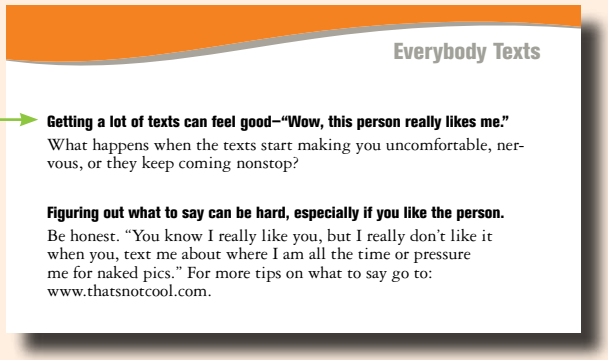
"We've started talking to all the teens in our clinic about what they deserve in relationships. This card is like a magazine quiz (open the card) and it talks about the difference between healthy and unhealthy relationships and tells you how to help a friend if they have anything like this happening to them."



It is not necessary to review all eight panels. Depending on the visit type or questions raised during the visit, the provider can select which panel to focus on. For example,

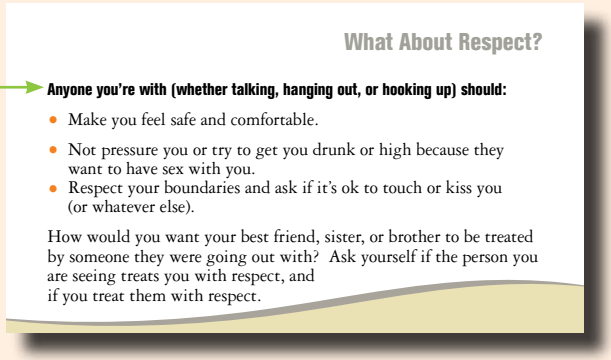
Sample Script:

"I am talking to all the teens in my practice about texting and sending naked pictures online because we know there is a lot a pressure to do this. It can be hard to figure out what to say or do if you are uncomfortable. This section of the card gives you options, things to say and great website to go to for more information to help you figure out what to do if it is an issue for you."



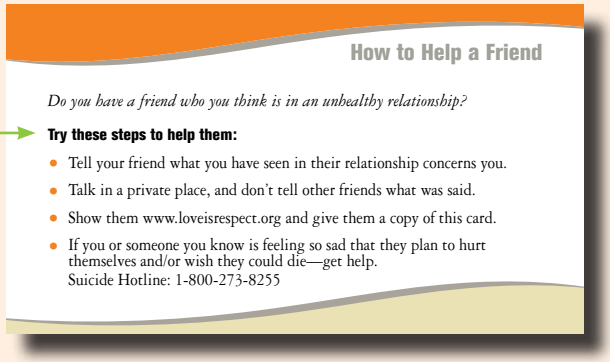
Sample Script:

"It's important that you are treated with respect, and that you treat the person you are seeing with respect, too. Here are some examples of the rights you have in any relationship."



Sample Script:

"I really want to make sure that we spend time talking about relationships, because a healthy relationship is something every young person deserves. If you ever need to help a friend you think is in an unhealthy relationship there are some tips here, and some teen-specific websites and numbers to call. You can take extra cards, if you'd like."



Integrating Assessments: Trauma Informed Responses to Substance Abuse, Depression/Suicide and Disordered Eating

Depending on the purpose and scope of the visit, the *Hanging Out or Hooking Up* safety card can also be used as a tool to talk about other issues, such as substance abuse, disordered eating, depression and suicidal ideation in a trauma-informed manner. As previously noted, ARA is closely linked to many adverse health outcomes and risk behaviors.

Substance Abuse

Remember the facts: Victims of physical and sexual violence in dating relationships are more likely to engage in substance use.[62] Population-based data indicates that adolescents who experienced forced sexual intercourse were more likely to engage in binge drinking and attempt suicide.[63]

What About Respect Panel to provide guidance if your adolescent patient reveals that s/he is smoking, drinking and/or using substances regularly:

Sample Script:

"This card talks about being pressured to get drunk or high with someone because they want to have sex with you—because when you are drunk or high it is a lot easier for someone to pressure you do something you aren't ready to do. Does s/he ever try to make you drink when you don't want to? Do you drink or do other drugs regularly before having sex? Has the drinking or substance use ever gotten in the way of your using birth control?"

Depression and Suicide

Remember the facts: Depressed adolescents are more likely to report having ever been physically or sexually hurt by someone they were dating or going out with.[64]

How to Help a Friend Panel to provide guidance for adolescents that reveal they are sad, irritable, not sleeping well, and/or not motivated:

Sample Script:

"On this panel of the card 'How to Help a Friend' it talks about ways to support someone who might be in an unhealthy relationship. It also talks about if you know someone who is feeling so sad they wish they could die, get help. This is really important because a lot of teens feel depressed or hopeless. Has anyone you were going out with made you feel so bad about yourself that you thought about hurting yourself?"

Disordered Eating

Remember the facts: Adolescents who have experienced ARA are more likely to use vomiting for weight loss.[65]

Sample Script for a patient with an eating disorder:

"This safety card talks a lot about control—ways someone you are seeing can control you. Sometimes, a response to feeling out of control in a relationship, is controlling what you eat and how you eat. Do you ever throw up or use laxatives to make you feel better about yourself, your relationship or to feel more in control?"

INTERVENE & REFER

If your patient says, "No, this is NOT happening in my life:"

Affirm:

- *"I am so glad nothing like that is going on for you"*
- *"It sounds like you are in a healthy relationship, that's great."*

Encourage the patient to take the safety card:

- *"If anything changes or if you have a friend who needs help, this clinic is a safe place to come and talk about it."*
- *"I give this card out to everyone, just in case they have a friend or family member who needs help."*

If a patient discloses abuse: What next?

After ARA has been identified, your goal is to support the patient and gather information without overwhelming the patient. Acknowledge the information shared and validate the strength of the patient for sharing their experience. Once they disclose, the patient may become frightened or overwhelmed, or may not want to discuss the subject any further.

Utilize validating messages

- *"I'm so sorry that happened—it happens way too often."*
- *"You don't deserve to be hurt, and it is not your fault."*
- *"I'm worried about your safety."*

Assure the patient that this is a safe environment

- *"I'm glad you told me, and you can always talk to me about this."*
- *"Is there anything else I can do to help?"*

Remember to address the patient's health issues

It is important to attend to the presenting problem that initiated the patient's visit. Be sure to proceed with your treatment plan in a trauma-informed manner.

Supported Referral Using the Futures Safety Card

The safety card can also be used to discuss safety planning and available resources for patients who are experiencing ARA and/or reproductive and sexual coercion. A sample script for how to use the safety card as an intervention tool is provided below

Sample Script:

"I want you to know that on the back of this safety card there are national hotline numbers with folks who are available 24/7 if you want to talk. They can connect you to local shelter services if you need more urgent help. Also, I know (insert name of local advocate) who I can put you on the phone with right now if you would like to talk to her."

Harm Reduction Strategy

Abusive partners often monitor phones and text messages, so it is important to offer use of a private phone in the clinic to a patient so she can make the call to a shelter or advocacy program without the number being traced by her partner.

If the abusive behavior is not physically dangerous:

> *"I'd like to talk about some strategies for what to say to the person you are seeing when <insert problem here: the constant texting, being disrespected, or being pushed to have sex when you don't want to, etc.> comes up again. Would you feel safe talking to the person you are seeing about this? Are you afraid at all of what they might do if you bring this up?"*

If written information is given to the patient, it should be able to fit in their pocket and done so only if the patient feels safe accepting it.

Work with the patient to identify other adults they may be able to talk to for additional support (parents, older relatives, teachers, clergy, etc.)

> *"Is there any adult you would consider talking to about this, or who could help you if you were hurt?"*

KEY CONSIDERATION

Many clinic staff have never called a local domestic violence service provider or hotline number. We recommend all staff call to find out about the services provided. Clinic staff who engaged in this activity reported greater confidence in giving the referral. Additionally, patients are more likely to use the referral.

For more information on setting up your practice to develop effective community partnerships with local domestic and sexual violence programs, please see Part 5: Policy Implications & Systems Response of these guidelines.

Make a Follow-up Plan

> *"I'd like to check in with you again in a few weeks, let's make an appointment for you."*

Adolescents are often hard to get in touch with. Recording a safe phone number and best ways to follow-up with them will assist in maintaining a connection. This may include getting the young person's permission to contact them through another provider, such as the school nurse, who may have an ongoing relationship with them as well.

If a Positive Disclosure Requires a Report, Practice Patient-centered Reporting

While the language in many mandated reporting laws state that the person who becomes aware of the abuse should report 'immediately' to the relevant authorities, the focus should **always** be on the care and safety of the young person first.

After the reason the young person was seeking care has been addressed, the provider should remind the young person of the limits of confidentiality discussed at the start of the visit, then inform her of the requirement to report.

> *"Remember at the start of this visit how we talked about situations where if your safety is at risk that we might have to get other adults involved? This is one of those times. I know it took a great deal of courage to share this with me, and we need to make sure that you are safe."*

Always acknowledge their feelings:

Many times, a teen will not want a report to be filed, and will feel helpless, betrayed or angry.

> *"I really hear that you don't want me to do the report, and I am sorry but I have to do this even if I don't want to…"*

Offer ways they can shape the reporting process:

"I do have to make the report, but you are welcome to listen as I call in the report so you know what is being said and there are no surprises. I can also put in the report any concerns you have about what will happen when your parent's are told about what happened or the best ways to inform them (place, time, one parent over the other etc)."

- Explain what will happen after the report is made —invite the patient to share their concerns about a report being made, who would find out and how they might react; it often helps a young person to know that they are not at fault and that the provider does not have a choice about making such a report.
- Call an advocate to help her create a safety plan in case of retaliation—for example, offering for a meeting with the child welfare investigator to occur at the clinic site may be an option.
- Maximize the role of the patient—asking the patient how to make the report in a way that is as safe as possible is key; whenever possible, the report should be made with the young person in the room so they can provide accurate information and know what is being disclosed.

Sample Futures Safety Card for Adolescent Relationship Abuse

Tear out this sample card and fold it to wallet size. To order additional free cards for your practice go to: www.FuturesWithoutViolence.org/health

What About Respect?

Anyone you're with (whether talking, hanging out, or hooking up) should:

- Make you feel safe and comfortable.
- Not pressure you or try to get you drunk or high because they want to have sex with you.
- Respect your boundaries and ask if it's ok to touch or kiss you (or whatever else).

How would you want your best friend, sister, or brother to be treated by someone they were going out with? Ask yourself if the person you are seeing treats you with respect, and if you treat them with respect.

FOLD >

How to Help a Friend

Do you have a friend who you think is in an unhealthy relationship?

Try these steps to help them:

- Tell your friend what you have seen in their relationship concerns you.
- Talk in a private place, and don't tell other friends what was said.
- Show them www.loveisrespect.org and give them a copy of this card.
- If you or someone you know is feeling so sad that they plan to hurt themselves and/or wish they could die—get help. Suicide Hotline: 1-800-273-8255

FOLD >

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FUTURES WITHOUT VIOLENCE™

Formerly Family Violence Prevention Fund

FuturesWithoutViolence.org

The American College of Obstetricians and Gynecologists

If you or someone you know ever just wants to talk, you can call these numbers. All of these hotlines are free, confidential, and you can talk to someone without giving your name.

National Teen Dating Abuse Helpline
1-866-331-9474 or online chat
www.loveisrespect.org

Suicide Prevention Hotline
1-800-273-8255

Teen Runaway Hotline
1-800-621-4000

Rape, Abuse, Incest, National Network (RAINN)
1-800-656-HOPE (1-800-656-4673)

FOLD >

Hanging out or Hooking up?

How is it Going?

Does the person you are seeing (like a boyfriend or a girlfriend):

- Treat you well?
- Respect you (including what you feel comfortable doing sexually)?
- Give you space to hang out with your friends?
- Let you wear what you want to wear?

If you answered YES—it sounds like they care about you.

And on a Bad Day?

How often does the person you are seeing:

- Shame you or make you feel stupid?
- Pressure you to go to the next step when you're not ready?
- Control where you go, or make you afraid?
- Grab your arm, yell at you, or push you when they are angry or frustrated?

Nobody deserves to be treated this way. If these things ever happen in your relationship, talk to someone about it. For more info, go to www.loveisrespect.org.

Everybody Texts

Getting a lot of texts can feel good–"Wow, this person really likes me."
What happens when the texts start making you uncomfortable, nervous, or they keep coming nonstop?

Figuring out what to say can be hard, especially if you like the person.
Be honest. "You know I really like you, but I really don't like it when you text me about where I am all the time or pressure me for naked pics." For more tips on what to say go to: www.thatsnotcool.com.

What About Sex?

Can you talk to the person you are seeing about:

- How far you want to go sexually?
- What you don't want to do?
- Preventing STDs by using condoms?
- Birth control?

If you answered NO to any of these questions, maybe this person is pushing you to do things you don't want to do. Or you might not feel comfortable bringing this up. Try using this card as a conversation starter. "I got this card in a clinic and wanted to talk about it with you."

PART 4: DIRECT ASSESSMENT FOR REPRODUCTIVE COERCION OF SEXUALLY ACTIVE ADOLESCENT GIRLS

While the preceding section of these guidelines focused on anticipatory guidance and universal education on healthy relationships, this section focuses on reproductive and sexual coercion as a health issue for adolescent girls, with a particular focus on how both teen and adult males can interfere with and limit their female partners' ability to make choices about their reproductive health.

Which safety card should I use?

These guidelines offer two cards. One (reviewed in Part 3) which focuses on healthy and unhealthy relationships and is intended to be gender neutral and inclusive of diverse sexual orientations. The second card is specific to assessment for reproductive coercion (reviewed below). We recommend utilizing this card specifically when an adolescent female is presenting for:

- Emergency contraception
- Pregnancy testing
- STI testing
- Contraceptive counseling

If the provider's assessment suggests that reproductive coercion may be occurring in the relationship, offering this card to the patient may be more relevant. In other instances, where the provider's assessment suggests that a broader focus on healthy relationships is more relevant, the *Hanging Out Hooking Up* card may be more relevant.

The safety card for reproductive health, developed by Futures Without Violence and co-branded by the American College on Obstetricians and Gynecologists (the College), is a wallet-size card that includes self-administered questions for ARA and reproductive and sexual coercion, harm reduction and safety planning strategies, and information about how to get help and resources. Providers can use the safety card to facilitate screening and educate patients about the impact of ARA and reproductive and sexual coercion on reproductive health.

In a randomized controlled trial, women seen at four family planning clinics were asked questions about IPV and reproductive and sexual coercion and reviewed the safety card with their providers. The time required to review the safety card with a patient varied from less than a minute to longer discussions when IPV and/or reproductive and sexual coercion were disclosed.

Among women who reported IPV in the past three months at the time of initial assessment and received the safety card intervention, there was a 71% reduction in the odds of pregnancy pressure and coercion at the followup, 12 to 24 weeks later.[66]

Women who received the safety card were more likely to report ending a relationship because the relationship was unhealthy or because they felt unsafe regardless of whether they had disclosed a history of IPV. This intervention is based on more than two decades of research, including other randomized controlled trials, which has shown that assessment combined with a small safety card can reduce violence and improve safety behaviors among female patients disclosing IPV.[67,68,69,70]

How can using the safety card help with screening given many women choose not to disclose what is happening to them?

Some patients may not feel safe or comfortable disclosing ARA or reproductive and sexual coercion when asked. Research also shows that cultural stereotypes about rape and sexual assault influence a woman's perceptions of sexually coercive experiences. Coerced sex by an intimate partner may not be perceived as a real sexual assault or rape. Sexual coercion by a dating partner, especially when alcohol is involved, may be minimized due to cultural stereotypes.[71]

Regardless of whether a patient discloses abuse, assessment is an opportunity to educate patients about how abusive and controlling behaviors in a relationship can affect her reproductive health. The safety card provides information that helps adolescents to make the connection between unhealthy relationships and reproductive health concerns such as unintended pregnancies. *Asking about IPV and reproductive and sexual coercion lets patients know that they are not alone and that you are a safe person to talk to.* The safety card includes information about safety strategies and referrals a patient can refer to after her visit. The safety card was designed as a small, easy to conceal card based on strategies used by domestic violence advocates who are experts on safety concerns and safety planning with IPV victims. It is important to remember that it may not be safe for some patients who are currently experiencing abuse to leave the clinic with the safety card.

Remember before you ask — always discuss limits of confidentiality.

How Often Should You Ask?

At least annually and with each new partner (If a patient has multiple repeat visits for pregnancy testing, STI testing etc consider these as clinical indicators to assess more frequently).

When Should You Ask?

During any reproductive health appointments—(Pregnancy tests, STI/HIV tests, initial and annual visits, abortions, birth control options counseling).

Where Should You Ask?

In a private setting such as the exam room and only when the patient is by herself without parents, partners, or friends present.

PROVIDER TIP

Asking questions about reproductive and sexual coercion will help you develop a patient's treatment plan, identify potential complications and compliance considerations, and assess other health risks and safety concerns. This approach will save time and improve outcomes.

Making the link between violence and reproductive health uncovers risk factors that are compromising a patient's reproductive health and allows providers to offer interventions that are the most likely to succeed.

For example, research has shown that women under high levels of fear of abuse with high STI knowledge used condoms less consistently than non-fearful women with low STI knowledge.[72] More HIV education without addressing the role of abuse is unlikely to lead to safer sex practices in this scenario.

Using the safety card integrates assessment with patient education. This integrated approach informs patients about the increased risk of contracting STIs/HIV in abusive relationships and teaches condom negotiation skills within the context of abusive relationships. The safety card also offers less detectable female controlled protective strategies that can improve reproductive health outcomes and enhance quality of care.

Examples of scripts that demonstrate how to counsel a patient about harm reduction strategies when IPV and/or reproductive and sexual coercion is disclosed, including sample scripts for different types of visits and clinical scenarios, are shown below.

Strategic Safety Card Use: Assessment and Intervention for ARA, Reproductive and Sexual Coercion

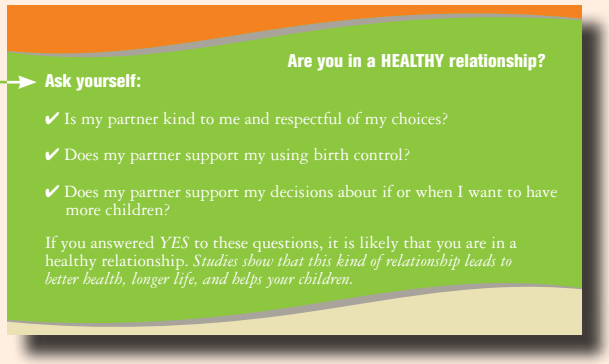
Select relevant panels of the card based on the type of visit for assessment and offer visit-specific harm reduction strategies when problems are identified.

Part of patient education is talking about healthy, safe, and consensual relationships. Health care providers can also play an important role in preventing abuse by offering education and anticipatory guidance about what a healthy relationship looks like, particularly for adolescent girls—but this is true for adult women too.

The following sample script provides more messaging about healthy, safe, and consensual relationships that can be shared with every patient.

Sample Script:

"We have started talking to all of our patients about how you deserve to be treated by the people you go out with and giving them this card—It's kind of like a magazine quiz—Are you in a HEALTHY relationship?"



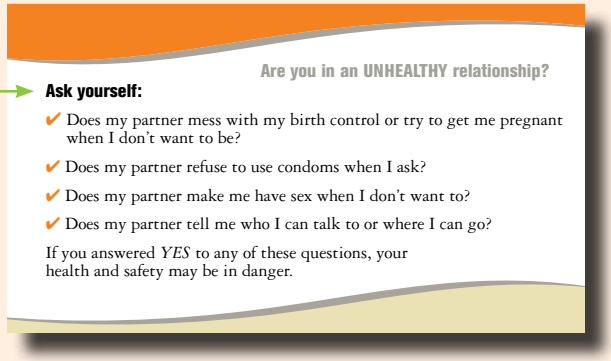
Birth Control Options Counseling

PROVIDER TIP

Before spending valuable time counseling a patient about various contraceptive methods, assess if she is at risk for reproductive coercion. By changing the pronouns in the self-quiz found in the safety card,

Sample Script:

"Before I review all of your birth control options, I want to understand if your partner is supportive of your using birth control. Has your partner ever messed or tampered with your birth control or tried to get you pregnant when you didn't want to be?"



Harm Reduction Strategy:

If her answer is yes, talk with her about contraceptive options that are less vulnerable to being tampered with, such as IUDs, Depo-Provera and Implanon.

Sample Script:

"I'm really glad you told me about what is going on. It happens to a lot of women and it is so stressful to worry about getting pregnant when you don't want to be. I want to talk with you about some methods of birth control your partner doesn't have to know about—take a look at this section of the safety card called "Taking Control."

Although discrepancies may still exist between clinical protocols regarding appropriate timing for use of intrauterine devices (IUDs) in nulliparous women and adolescent girls, recent recommendations clearly state that IUDs offer a safe and appropriate option for nulliparous women and teens. In 2011, The American College of Obstetricians and Gynecologists (ACOG) issued a Practice Bulletin on long-acting, reversible contraception.[73] There are no studies that have demonstrated an increased risk of pelvic inflammatory disease (PID) in nulliparous IUD users and there is no evidence that IUD use is associated with subsequent infertility. As described in the bulletin, the U.S. Medical Eligibility Criteria for Contraceptive Use assigns a Category 1 for contraceptive implant use among nulliparous women and adolescents.

SAFETY FIRST!

It is important to be aware that some controlling partners may monitor bleeding patterns and menstrual cycles. For these women, the safest option may be the Copper T IUD as it does not change their cycle.

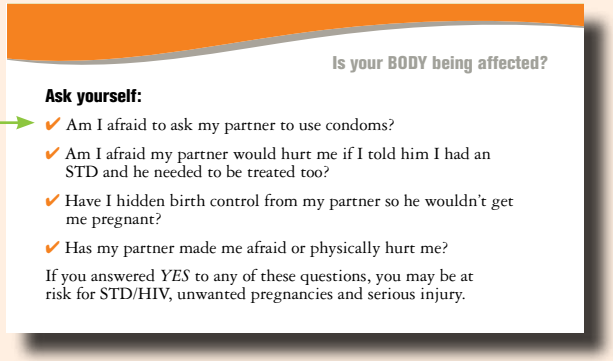
For IUD users, it is also recommended to discuss cutting the strings short in the cervical canal so the device cannot be felt or detected by her partner.

When Condoms Are the Preferred Contraceptive Method

Ask the patient if she is comfortable asking her partner to use condoms and if her partner is supportive of her choice.

Sample Script:

"Anytime someone tells me they use condoms as their main method of contraception—I always ask if using condoms is something that you are able to talk with him about? Does he ever get mad at you for asking? Do they break often?"



What to do if you get a "yes" to difficulty negotiating condoms:

Sample Script:

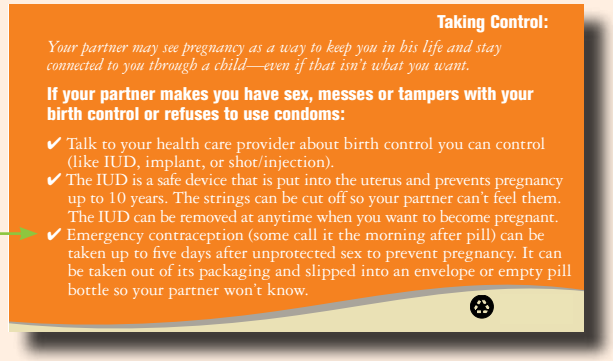
"I have had a lot a patients tell me they are (fill in blank) uncomfortable asking, worried about breakage or not sure what to do when he gets mad. There is another method you might consider that doesn't have hormones that doesn't depend upon him using condoms."

Emergency Contraceptive Visit

Whenever someone comes in for Emergency Contraception (EC) or the morning after pill there are key questions to ask and patient education to provide to help determine whether the sex was consensual or if any contraceptive tampering may be occurring. Due to some patients not feeling comfortable disclosing what is happening to them, it is helpful to review the harm reduction portion of the card so that all EC patients know about this strategy whether they disclose or not.

Sample Script:

"Was the sex you had consensual, something you wanted to do? Are you at all concerned that a partner may be trying to get you pregnant when you don't what to be? Sometimes women have to worry about someone else finding your emergency contraception and throwing it away. If that is an issue for you it may useful for you to try out some of the strategies listed on the card."



PROVIDER TIP

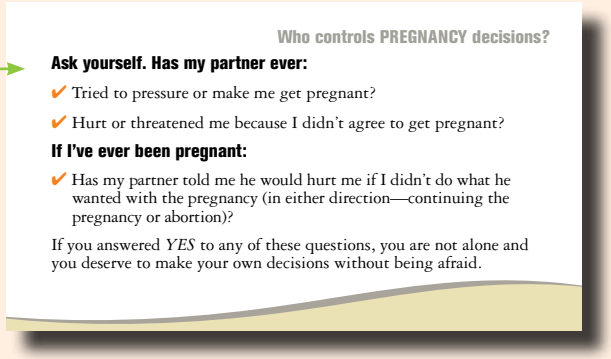
EC Harm Reduction Strategy: Emergency contraception is often packaged in a large box with bold labeling and could easily be discovered in a purse or a backpack by an abusive partner. Consider offering harm reduction strategies such as giving a patient an envelope so that she can remove the EC from the packaging and then conceal it in the envelope so it is less likely to be detected by her partner.

Pregnancy Test Visits

The panel, "Who controls PREGNANCY Decisions?" of the safety card should be reviewed with patients for all positive or negative pregnancy test results. Pregnancy options counseling should also include these key assessment questions.

Sample Script:

"Because this happens to so many women, we ask all of our patients who come in for a pregnancy test if they are able to make decisions about pregnancy and birth control without any threats or fear from a partner. Who makes these decisions in your relationship?"



Harm Reduction Strategy

If a patient discloses that she is afraid of her partner, follow up by offering referrals to local domestic violence programs and reminding her about the National Domestic Violence Hotline shown on the back of the safety card.

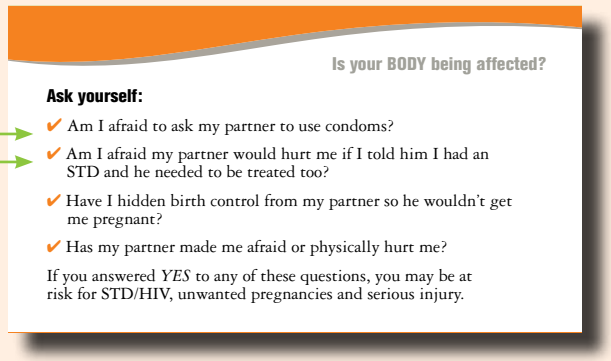
Testing for Sexually Transmitted Infections (STIs)

Because STI/HIV is highly correlated with abusive relationships it is important to make sure she is safe and able to make decisions about condoms.

Sample Script:

"Anytime patients come in for STI/HIV testing, we always ask if they feel comfortable talking to their partners about using condoms."

"Are you afraid to ask your partner to use condoms or does he ever get mad at you for asking?"

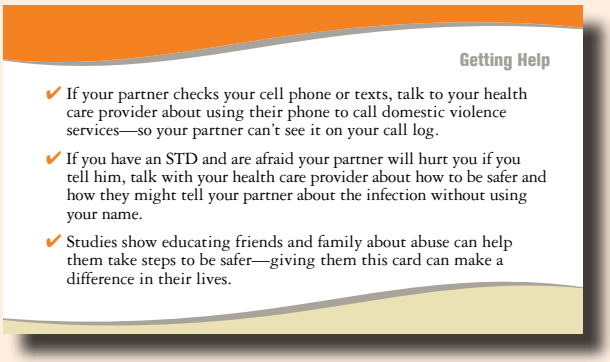


Positive STI Test Result—Seeking Treatment for STI Exposure

Patient-initiated partner notification for treatment of STIs/HIV can compromise a patient's safety if she is in an abusive relationship. Women experiencing physical or sexual IPV are more likely to be afraid to notify their partners of a STI. In a study with a culturally diverse sample of patients seeking care at family planning clinics, female patients exposed to IPV were more likely to have partners who responded to partner notification by saying that the STI was not from them or accusing her of cheating. Some of the women reported threats of harm or actual harm in response to notifying their partner of an STI.

Harm Reduction Strategy

"I want to go over the "Getting Help" panel of the safety card with you… I know this isn't a perfect answer, but often controlling partners have multiple sex partners and it is possible that the STI notification call could be about someone other than you— this may reduce the likelihood that you would be hurt by your partner when he finds out he has an STI. We can have someone call your partner anonymously from the health department saying that someone he has slept with in the past year has (name of STI) and he needs to come and be treated."



If the patient says she is afraid of how her partner may react if she notifies him about the STI, consider calling the partner yourself, especially if asking your health department to make the call is not an option.

ALWAYS FOLLOW UP POSITIVE DISCLOSURES OF REPRODUCTIVE COERCION WITH ADDITIONAL ARA QUESTIONS

Any positive disclosure of reproductive or sexual coercion should be followed up by questions about other abuse in her relationship.

Supported Referral

Sample Script:

"What you are telling me about your relationship makes me wonder if there are other things that make you uncomfortable. Has there ever been a situation where he has hurt you or made you have sex when you didn't want too?"

Another integral part of reproductive health care is called supported referral. This is a strategy for addressing reproductive and sexual coercion and ARA. By offering support to facilitate the referral process, providers can increase the likelihood a patient follows through with a referral. Two key strategies for supported referral are acknowledging a patient's safety concerns and offering options. Additionally, offering a patient use of a phone at the clinic to call a domestic violence hotline or an advocate can be a safer strategy that increases access to services.

A key step in developing supported referral is to connect health providers with existing support services for ARA in the community. Making this connection is mutually beneficial.

- Domestic violence and sexual assault advocates from shelters/advocacy programs are an excellent resource for training and advocacy.
- Domestic violence and sexual assault advocates will become more aware of what reproductive health services are available for young women and girls experiencing ARA.
- Health care providers will become more familiar with what services for ARA are available locally and have a specific name/person to contact when referring patients.

Respect Her Answer

If she says yes to relationship problems but doesn't disclose more than something vague:

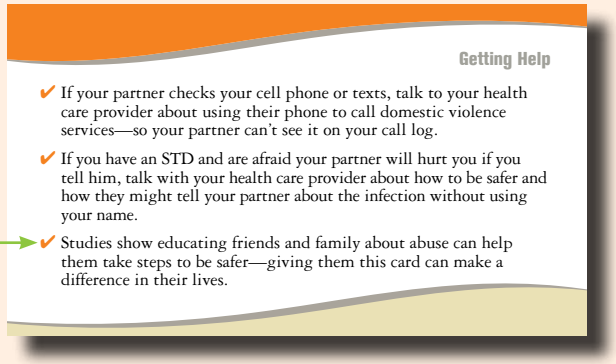
Sample Script:

"You mentioned things are sometimes complicated in your relationship. I just want you to know that sometimes things can get worse. I hope this is never the case, but if you are ever in trouble you can come here for help. I am also going to give you a card with a hotline number on it. You can call the number anytime. The hotline staff really get how complicated it can be when you love someone and sometimes it feels unhealthy or scary. They have contact with lots of women who have experienced this or know about it in a personal way."

What to say when she says: "No, this isn't happening to me."

Sample Script:

"I'm really glad to hear nothing like this is going on for you. We are giving this card to all of our patients so that they will know how to help a friend or a family member having difficulties in their relationship."



Documentation and Follow Up

The following information should be routinely documented in patients' charts:

- Confirmation that the patient was screened for IPV and reproductive and sexual coercion or the reason why screening could not be done and any plans or follow-up actions to ensure that the patient will be screened
- Patient response to screening
- Documentation of resources provided such as safety cards
- Any referrals provided

When a patient discloses victimization or abuse is suspected, a follow-up to ensure continuity of care should be discussed and documented. In addition to offering appropriate referrals and assistance contacting local resources, such as a domestic violence or sexual assault advocate, ask the patient if a follow-up appointment can be scheduled at the present time. It is also helpful to ask the patient for contact information, such as a phone number where it is safe to contact her at, so that any future contact will be done in a way that minimizes risk to the patient.

What about boys and men?

The opportunities for screening, education, and prevention with male patients are similar to those described for female patients. Share pro-active messages with all male patients that emphasize the importance of healthy, safe, and consensual relationships. Counseling about safe sex and STI prevention should include messaging on how condom use can prevent unintended pregnancies and STIs. Male patients need to understand how victimization such as sexual coercion may impact their reproductive and sexual health and risk-taking behaviors.

Find out what resources are available for male patients by contacting local domestic violence and sexual assault programs/shelters or National Hotline.

PART 5: POLICY IMPLICATIONS & SYSTEMS RESPONSE

There are a number of important steps to take to prepare your practice to identify and respond to victims of adolescent relationship abuse (ARA). It is essential that the clinical setting be designed to support the staff to respond effectively and efficiently. In preparing your practice to begin routine inquiry for and response to ARA, it is advisable to obtain support from the leadership and administration at your setting as well as staff input. Finally, as the Joint Commission on the Accreditation of Health Care Organization requires, and the Institute of Medicine recommends, staff should receive initial and on-going training.

Develop Protocols

System wide changes in practices will only be implemented and sustained when there are tangible changes in policies and the infrastructure to support these changes. A formalized protocol is an essential step to institutionalizing a trauma-informed coordinated response addressing ARA. The protocol should include the following elements:

1. Definitions and guiding principles
2. Training requirements for staff
    a. Content of training
    b. Staff proficiencies for knowledge and skills
3. Confidentiality procedures
4. Assessment strategies including setting, frequency, and cultural and language considerations
5. Harm reduction counseling for patients disclosing ARA and/or reproductive coercion
6. Follow-up and referral strategies
7. Documentation
8. Roles and responsibilities of staff

All staff should receive an orientation on the protocol. This protocol should be updated regularly and informed by new knowledge, laws and policies regarding ARA. This protocol should be accessible to all staff.

Provider Resources Should Include:

- "Hanging Out or Hooking Up" and "Did You Know Your Relationship Affects Your Health" safety cards (Available at www.futureswithoutviolence.org/health)
- Posters and practitioner pocket cards (Available at www.futureswithoutviolence.org/health)
- Consultation with on-site or off-site ARA advocates, legal and forensic experts, counselors with expertise in trauma treatment, and community experts from diverse (LGBTIQ, disability, teen, ethnic specific and immigrant) communities
- Documentation (Refer to the *National Consensus Guidelines on Identifying and Responding to Domestic Violence in Health Care Settings* for sample forms, available at www.futureswithoutviolence.org/health)
- Chart prompts in the medical record

Develop a Collaborative Model of Care

Prior to assessment for abuse and violence, practitioners should ensure protocols are in place for a safe and effective response. This means having specified roles and responsibilities within the clinic setting, knowledge of existing resources within the local community (in schools, local domestic violence and rape crisis agencies, mental health agencies, child protective services), and an established system for activating these resources depending on the situation.

- **A Team Approach is Beneficial** – Providers should not feel that they must have "all the answers." In these moments, having a team in place to call upon is necessary so the provider is not left carrying the weight of the situation alone. It is ideal to have an in-person introduction to an advocate or social worker to connect the young person with ongoing support.
- **Emphasize Care as a Team Rather Than Passing Off Care** – The provider's response when a young person shares experiences of control and abuse is crucial for continuing support. Adolescents need to feel they are heard and that the provider, as a trustworthy adult, can handle what they have been through and just disclosed. A provider who seems uncomfortable or who simply tells the adolescent to speak with a social worker about this may be interpreted as uncaring or dismissive.
- **Involve the Young Person in the Team and Decision-making** – While adolescents may initially appear not to want the help of adults, they do desire to be protected and cared for. In the moments following a disclosure, the provider's job is to validate what they have shared, affirm the courage it takes to talk openly of their experiences, in addition to offering a range of options to support healing and intervention. It is natural to want to promise "everything will be okay," but rather than making empty statements, it is important to offer clear and realistic next steps while maintaining boundaries. "We're all going to work together to help you stay safe."
- **Know the Limits of Confidentiality and Mandated Reporting Requirements** – Knowledge of mandated reporting requirements and how to support a minor in the safest way possible requires consultation. Developing connections with colleagues to call to talk through

options and best approaches is essential. Reporting a case to an outside agency without thoughtfully considering safety could put the young person at significantly greater risk for harm and even death.

The resources available to a provider may be within the health system in which s/he works. A social worker or mental health worker within a clinic is often a good first connection. Some health systems have hospital-based domestic violence programs to support providers and offer services to victims. Having a referral list in your network (within both the health system and local resources) will assist you in knowing your allies and creating a collaborative network of resources.

Part of implementing a protocol for assessment and intervention with adolescent relationship abuse should include having first-hand knowledge of these local resources, and integrating these resources directly into the clinical protocol.

Supporting Staff Who May Be Exposed to Violence

Strategies that will help to institutionalize a trauma-informed, coordinated response to ARA include:

- Implement and routinely update workplace policies to:
  - Include language on ensuring a violence-free workplace
  - Offer support for staff exposed to violence including services through employee assistance programs
  - Describe plans for addressing stalking and workplace harassment by an abusive partner
  - For more information please see the Futures Without Violence website on workplace response to abuse at www.workplacesrespond.org
- Promote awareness that life experiences of staff may influence their comfort level and effectiveness with addressing ARA.
- Create a network of clinicians within your organization who have expertise on this issue and will champion the cause.

Continuous Quality Improvement (CQI) Program

Develop program quality improvement goals through a consensus process with staff, and monitor your organization's progress. A quality assurance/quality improvement (QA/QI) tool has been developed for implementing and evaluating a trauma-informed, coordinated response to ARA in the adolescent health care setting. The QA/QI tool (See Appendix B), which uses a checklist format, can help clinics and programs to identify their goals and monitor their progress. Topics addressed in the QA/QI tool are:

- Assessment methods
- Intervention strategies
- Networking and training
- Self care and support
- Data and evaluation
- Education and prevention
- Environment and resources

For a sample protocol, please see Appendix A.

APPENDIX A

THIS IS A SAMPLE PROTOCOL INTENDED TO BE ADAPTED FOR USE IN CLINICAL SETTINGS. THE PROTOCOL SHOULD BE REVIEWED BY CLINIC ADMINISTRATION AND LOCAL DOMESTIC VIOLENCE/SEXUAL ASSAULT EXPERTS FOR CONTENT ACCURACY AND RELEVANCE TO LOCAL JURISDICTIONS.

Protocol for Adolescent Relationship Abuse Prevention and Intervention

SECTION I: INTRODUCTION

Adolescent relationship abuse is prevalent and is associated with multiple poor health outcomes for youth. Adolescents and young adults seeking care in health care settings report higher rates of intimate partner violence victimization. The _____ health center is committed to **preventing adolescent relationship abuse** by promoting healthy relationships, **identifying relationship abuse** and intervening using a safe, patient-centered approach.

The purpose of this protocol is aiding in the promotion of healthy relationships (universal education) with all adolescent patients, as well as encouraging assessment and support for adolescent relationship abuse with sexually active female patients. With one in five (20%) U.S. teen girls reporting ever experiencing physical and/or sexual violence from someone they were dating and one in four (25%) teens in a relationship reporting being called names, harassed, or put down by their partner via cell phone/texting, adolescent relationship abuse is highly prevalent and has major health consequences. Health care providers are often the first or only professionals to come into contact with adolescents in abusive situations. Thus, we have a unique responsibility and opportunity to intervene.

Definitions

Adolescent Relationship Abuse (ARA) is a pattern of repeated acts in which a person physically, sexually, or emotionally abuses another person of the same or opposite sex in the context of a dating or similarly defined relationship, in which one or both partners is a minor. Similar to adult intimate partner violence, the emphasis on repeated controlling and abusive behaviors distinguishes relationship abuse from isolated events (e.g. a single occurrence of sexual assault at a party with two people who did not know each other). Sexual and physical assaults often occur in the context of relationship abuse, but the defining characteristic is a repetitive pattern of behaviors aiming to maintain power and control in a relationship. Such behaviors can include monitoring cell phone usage, telling a partner what s/he can wear, controlling whether the partner goes to school that day, and interfering with contraceptive use.

Reproductive Coercion (RC) involves behaviors aimed to maintain power and control in a relationship related to reproductive health by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent.

Reproductive coercion includes birth control sabotage, pregnancy pressure, and pregnancy coercion.

Birth Control Sabotage is active interference with a partner's contraceptive methods. Examples of birth control sabotage include:

- Hiding, withholding, or destroying a partner's birth control pills
- Breaking or poking holes in a condom on purpose or removing it during sex in an explicit attempt to promote pregnancy

- Not withdrawing when that was the agreed upon method of contraception
- Pulling out vaginal rings
- Tearing off contraceptive patches

Pregnancy Pressure and Coercion involves behaviors that are intended to pressure a female partner to become pregnant when she does not wish to become pregnant. Pregnancy coercion involves coercive behaviors such as threats or acts of violence if she does not comply with her partner's wishes regarding the decision of whether to terminate or continue a pregnancy. Examples of pregnancy pressure and coercion include:

- Threatening to leave a partner if she does not become pregnant
- Threatening to hurt a partner who does not agree to become pregnant
- Forcing a female partner to carry to term against her wishes through threats or acts of violence
- Forcing a female partner to terminate a pregnancy when she does not want to
- Injuring a female partner in a way that she may have a miscarriage

Sexual Coercion includes a range of behaviors that a partner may use related to sexual decision-making to pressure or coerce a person to have sex without using physical force. Examples of sexual coercion include:

- Repeatedly pressuring a partner to have sex when s/he does not want to
- Threatening to end a relationship if a person does not have sex
- Forced non-condom use or not allowing other prophylaxis use
- Intentionally exposing a partner to a STI or HIV
- Threatening retaliation if notified of a positive STI result

Guiding Principles

1. Regard the safety of victims as PRIORITY.
2. Treat patients with dignity, respect, and compassion including sensitivity to age, culture, ethnicity and sexual orientation.
3. Honor victims' right to self-determination by recognizing that the process of leaving an abusive relationship can be complex, long, and gradual.
4. Adapt a collaborative care model to best support patients by attempting to engage patients in long-term continuity of care within the health care system.

Training Requirements

All health center staff that have contact with patients will undergo mandatory Adolescent Relationship Abuse and Sexual Violence training regarding:

- Dynamics of Adolescent Relationship Abuse and Sexual Violence
- Effects of Violence on Health
- Promotion of Healthy Relationships
- Assessment and Intervention
- Updates about Available Resources

Staff members are required to attend two trainings a year on adolescent relationship abuse and sexual violence related issues. Numerous opportunities for trainings will be provided, both in-person and online.

Confidentiality

Our policy, protocol, and practice surrounding the use and disclosure of health information regarding victims of adolescent relationship abuse and sexual violence respects patient autonomy and confidentiality; serving to improve the safety and health of victims. The Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA) apply.

Patient's confidentiality is paramount and must be taken seriously. Therefore, everything discussed with the patient is confidential. Patients should be told that all information is kept private and confidential, unless the patient tells the health care provider they are being hurt by someone, planning on hurting them self (suicidal), or planning on hurting someone else. It is essential to inform patients about mandated reporting requirements.[i]

SECTION II: UNIVERSAL EDUCATION–ANTICIPATORY GUIDANCE ON HEALTHY RELATIONSHIPS

This health center is committed to providing information about healthy relationships to **all** patients. Anticipatory guidance on healthy relationships should occur at least annually and with each new partner. The patient should be seen alone—without partners, parents, or friends present. Every teen regardless of gender or sexual orientation should have the opportunity to talk to their provider about safe, consensual and healthy relationships.

The medical assistants and health educators in the health center will be responsible for ensuring that every patient receives a Hanging Out or Hooking Up safety card. A sample script is provided below:

> *"We want all of the young people who come to our clinic to know that we care a lot about them being in healthy relationships. We are giving this informational card to all of our patients. Please look this over while you're waiting to see the clinician."*

The clinician should follow up with the patient during the health visit. **Remember to discuss the limits of confidentiality before reviewing the card.** Please see pages 23-25 of *Hanging Out or Hooking Up: Clinical Guidelines on Responding to Adolescent Relationship Abuse* for sample scripts that correspond to each panel of the safety card. It is not necessary to review all eight panels. Depending on the type of visit or questions raised during the visit, the clinician can select which panel(s) to focus on. **It is important to discuss the card during the visit rather than simply handing them the card.**

Although NOT the intended goal of universal education, occasionally a patient will make a disclosure of ARA. **Please see Section IV: Documentation and Follow Up for information on steps to take if a patient says s/he is experiencing ARA.**

i Please note that this section will vary state by state, and should be reviewed by a domestic violence and/or sexual assault advocate familiar with all the mandated reporting laws relevant to exposure to relationship abuse and sexual assault.

SECTION III: DIRECT ASSESSMENT WITH SEXUALLY ACTIVE YOUNG WOMEN

Adolescent relationship abuse is highly prevalent among young women seeking reproductive health care. As a result, the health center's policy is to conduct an **integrated assessment for adolescent relationship abuse and reproductive coercion among all adolescent females presenting for a reproductive health concern.**

Who Shall Conduct Assessment:
Assessments will be conducted by a health care professional who has been:

- Educated about the dynamics of adolescent relationship abuse and sexual violence, the safety and autonomy of abused patients, and cultural competency;
- Trained on how to ask about and intervene with identified victims of abuse; and
- Authorized to record in the patient's medical record.

How to Assess:

- When assessing for RC and ARA utilize a private, safe environment. Separate any accompanying persons from the patient. If this cannot be done, postpone assessing for a follow-up visit.
- Explain the limits of confidentiality prior to assessment; patients should be informed of any reporting requirements or other limits to provider/patient confidentiality.
- When unable to converse fluently in the patient's primary language, use a professional interpreter or another health care provider fluent in the patient's language. The patient's family, friends or children should not be used as interpreters when asking about RC and ARA.
- Introduce the assessment using your own words in a non-threatening, non-judgmental way. *"I talk to all my female patients about how they deserve to be treated in a relationship, especially when it comes to decisions about sex."*
    - Use the *Did You Know Your Relationship Affects Your Health?* safety card to ask questions that are integrated into the reason for the visit. See the *Hanging Out or Hooking Up: Clinical Guidelines on Responding to Adolescent Relationship Abuse* (pp. 32-37) for visit-specific sample scripts, follow up questions and harm reduction strategies.
        - Contraception/birth control options counseling visit: Use "Are you in an UNHEALTHY relationship?" panel
        - Pregnancy testing visit: Use "Who controls PREGANCY decisions?" panel
        - STI testing visit: Use "Is your BODY being affected?" panel
        - Emergency contraception visit: Use "Taking control" panel
- Always follow up disclosures of RC with additional questions about ARA. Please see Section IV: Documentation and Follow Up for information on steps to take if a patient discloses ARA.

SECTION IV: DOCUMENTATION OF ASSESSMENT AND FOLLOW-UP

For **every** assessment, the following should be documented in the patients' chart:

- Confirmation that the assessment occurred, or the reason why it did not, and what follow-up actions were taken to ensure that assessment will occur at a future visit

- The patient's response
- Documentation of resources provided, such as safety cards
- Referrals provided

This data will be checked quarterly for compliance by our Management Information Systems professional.

Positive Assessment

- Be supportive of the patient with statements such as:
  - *No one deserves to be abused.*
  - *There is no excuse for relationship abuse.*
  - *You are not alone; there are people you can talk to for support.*
  - *Is there anything else I can do to help?*
- Let the patient know that you will help regardless of whether s/he decides to remain in or leave the abusive relationship.
- Refer the patient to the local Domestic Violence Advocate
- Offer to call the advocate with patient
- Refer the patient to our clinic's social worker/counselor (if available)
  - If the social worker/counselor is in, call directly at _____ (add local phone number here).
  - If the social worker/counselor is out of the office, fill out an orange referral form. Follow up with the social worker/counselor to ensure that the patient has been contacted.
- If the patient does not wish to speak with an advocate
  - Ask if you can make a written referral.
  - Tell the patient that s/he can always call or make a return visit for support or information.
  - Review safety planning information with patient.
  - Provide patient with a safety card with relevant phone numbers and hotline numbers.
- Safety planning
  - Ask: "Do you feel you are in immediate danger?," if s/he answers yes, find out if the person they fear is present at the clinic. If the person is at the clinic,
    - Call security at _____ (add local phone number here). Explain the situation, inform them you are at the clinic and ask them to enter the back door.
    - The goal is to keep everyone safe and not alarm anyone in the waiting room.
    - Our code for employees that security has been called is "Dr. Jones is needed in room X."
  - Call the domestic violence advocate at _____ (add local contact number) for further danger assessment and to discuss next steps.
- Offer to call the police, if s/he would like to press charges.
- Explain to the patient that documentation of past and future incidents with a medical facility or law enforcement may be beneficial to her/him in the event s/he takes legal action in the future.

Please note: If written information is given to the patient, it should be able to fit in his/her pocket and done so only if the patient feels safe accepting it.

Suspected But Unconfirmed ARA

There may be situations in which you suspect ARA is occurring, but the patient does not disclose. *Remember*: Disclosure is NOT the goal; increasing safety and decreasing isolation IS. Simply having conversations about RC and ARA lets patients know that this clinic is a safe place to talk about ARA, if they choose to. Research tells us that many adolescent patients do not disclose to health care providers and rely on their peers for information and support. Therefore, it is critical that we offer safety cards to EVERY patient.

Patient-centered Mandatory Reporting

It is critical that you understand our State laws related to confidentiality and minor consent, physical and sexual abuse, and child abuse. Please refer to our clinic's confidentiality policy and child abuse reporting policy; the same conditions apply.

REMEMBER: Many forms of RC and ARA do not meet the legal requirements for mandatory reporting to child protective services and/or law enforcement.

While the language in the mandated reporting laws state that the person who becomes aware of the abuse should report 'immediately' to the relevant authorities, the focus should **always** be on the care and safety of the young person first. **After** the reason the young person was seeking care has been addressed (such as treatment for a possible STI), the provider should remind the young person of the limits of confidentiality discussed at the start of the visit, then inform the patient of the requirement to report. See patient-centered mandatory reporting scripts, see pages 26-27 of *Hanging Out or Hooking Up: Clinical Guidelines on Responding to Adolescent Relationship Abuse.*

Law Enforcement Intervention

Inform the victim that in the event s/he elects to take legal action in the future, a law enforcement report on record may help their case. If the patient wishes to make a report to the law enforcement, and is not in immediate danger:

- Assist her/him in contacting the Police Department Domestic Violence Unit at _____ (add local number).
- For support during the police interview, offer to stay in the room with the patient until the DV/SA advocate has arrived.
- Medical reports may be given to the officer only with the written consent from the patient.
- Document that a police report was made and obtain the officer's name and badge number.

This policy is to be reviewed and updated by the Clinic Manager on an annual basis.

APPENDIX B

Adolescent Health Programs
Adolescent Relationship Abuse And Sexual Assault
Quality Assessment/Quality Improvement Tool

The following quality assessment tool is intended to provide adolescent health program managers with some guiding questions to assess quality of care related to promotion of healthy relationships and intervention related to adolescent relationship abuse and sexual assault within their programs. The information is to be used as a benchmark for each program to engage in quality improvement efforts.

We hope that this tool will help provide guidance on how to enhance your program to respond to adolescent relationship abuse and sexual assault.

Program:_____

Date: __ __ / __ __ / __ __

Completed by (title only) _____

Assessment Methods				
Does your clinic/program have a written protocol for assessment and response to:	Yes	No	N/A	Don't Know
Adolescent relationship abuse				
Sexual assault				
Reproductive and sexual coercion (birth control sabotage, pregnancy pressure, STI/HIV risk, partner notification risk)				
Does your site provide universal education and anticipatory guidance on healthy relationships during all clinical encounters?				
Does your site provide direct assessment for reproductive coercion during:	Yes	No	N/A	Don't Know
Birth control counseling				
STI/HIV visits				
Emergency contraception visits				
Pregnancy tests				
Are there any written materials available to patients when they check-in for their clinic visit informing them about confidentiality and limits of confidentiality?				

Assessment Methods (Cont.)	Yes	No	N/A	Don't Know
Are there any scripts or instructions on your assessment form that providers can use to inform patients about confidentiality and mandated reporting requirements?				
Are there any scripts or sample questions that providers can use on your assessment forms to ask patients about relationship abuse and sexual assault?				
Are there specific prompts on the intake form (or in the electronic record) to encourage providers to assess for relationship abuse and sexual assault?				
Are there any scripts or sample questions that providers can use on your assessment forms to ask patients about reproductive coercion?				
Is there a private place in your clinic to screen and talk with patients?				
Does your clinic have a policy to ensure that providers ask about relationship abuse, sexual assault, and reproductive coercion when the patient is alone (i.e. no friends, parents, etc. present)?				
Intervention Strategies				
Does your staff have:	**Yes**	**No**	**N/A**	**Don't Know**
Scripted tools/instructions about what to say and do when a patient discloses relationship abuse?				
Scripted tools/instructions on how to do safety planning with patients who disclose current abuse?				
Safety cards/information to give to patients even when abuse is not disclosed or suspected? *(Recommendation: give card to all patients. If they don't need it themselves, tell them you are giving it to them so they know how to help a friend or family member)*				
An on-call advocate or counselor who can provide on-site follow-up with patients who disclose abuse?				
A safe place where a patient can use a phone to talk to a violence advocate/shelter/support services at your facility?				
A clear protocol for what types of behaviors require mandated reporting?				

Assessment Methods (Cont.)				
Does your program have resource lists that:	Yes	No	N/A	Don't Know
Identify referrals/resources (shelters, legal advocacy, housing, etc.) for patients who disclose relationship violence?				
Identify referrals/resources for patients who disclose sexual assault?				
Includes a contact person for each referral agency?				
Has a staff person who is responsible for updating the list?				
Are these lists updated at least once a year?				
Networking and Training				
Has your staff had contact with representatives from any of the following types of agencies in the past year?	Yes	No	N/A	Don't Know
Domestic violence advocates/shelter staff				
Child protective services				
Rape crisis				
Legal advocacy/legal services				
Law enforcement				
Is there anyone on your staff who is especially skilled/comfortable dealing with relationship violence and/or reproductive coercion issues?				
Does your protocol advise staff on what to do if they do not feel comfortable or adequately skilled to help a patient when abuse is disclosed/ suspected? (Example: Can staff 'opt out' if they are survivors of or currently dealing with personal trauma?)				
Does anyone on your staff participate in a local domestic violence task force or related subcommittee?				
Is there a buddy system or internal referral for staff to turn to for assistance when they are overwhelmed or uncomfortable addressing violence with a patient?				
Do new hires receive training on assessment and intervention for relationship abuse and sexual assault during orientation?				

Does your staff receive booster training on assessment and intervention for relationship abuse and sexual assault at least once a year?				
Self-Care and Support				
	Yes	No	N/A	Don't Know
Does your program have a protocol for what to do when a staff person is experiencing intimate partner violence?				
Have you talked with your employee assistance program (EAP) about what resources/help they can provide for staff who disclose current or past victimization?				
Does your program have a protocol for what to do if a perpetrator is on-site and displaying threatening behavior or trying to get information?				
Does staff have the opportunity to meet and discuss challenges and successes with cases involving relationship abuse or sexual assault?				
Data and Evaluation				
	Yes	No	N/A	Don't Know
Does your program record the rate of documented screening for relationship abuse and sexual assault?				
Does your program record the rate of documented disclosures of relationship abuse or sexual assault by patients?				
Does your program conduct an annual review and update of all protocols addressing violence?				
Does your program do any type of consumer satisfaction surveys or patient focus groups that ask patients' opinions about assessment and intervention strategies for violence?				
Does your program provide regular (at least annual) feedback to providers about their performance regarding relationship abuse and sexual assault assessment?				
Education and Prevention				
	Yes	No	N/A	Don't Know
Does your program provide information to patients on how violence can impact their health?				
Does any of the information that you provide to patients address healthy relationships?				
Does your program sponsor any patient or community education to talk about healthy relationships and indicators of abuse?				

Environment and Resources				
	Yes	No	N/A	Don't Know
Are there posters and other written information about what "confidentiality" means and the limits of confidentiality?				
Are there any brochures/cards or other information about relationship abuse and sexual assault designed for teens?				
Are there any posters about healthy and unhealthy relationships displayed at your facility?				
Are materials available specific to LGBTIQ relationship abuse?				
Have these brochures/cards/posters been placed in an easily visible location?				
Have these brochures/cards/posters been reviewed by underserved communities for inclusivity, linguistic and cultural relevance?				
Are there any brochures/cards or other information about reproductive and sexual coercion that are designed for teens?				
Additional Comments and Observations:				

References

1 Silverman JG, Raj A, Mucci LA, Hathaway JE. Dating Violence against Adolescent Girls and Associated Substance Use, Unhealthy Weight Control, Sexual Risk Behavior, Pregnancy, and Suicidality. Journal of the American Medical Association. 2001 Aug 1; 286(5):572-579.

2 Tech Abuse in Teen Relationships Study [Internet]. Liz Claiborne and TRU; 2007. Available from: http://www.loveisnotabuse.com

3 Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, Schoenwald P, Silverman JG. A Family Planning Clinic Partner Violence Intervention to Reduce Risk Associated with Reproductive Coercion. Contraception. 2011 Mar; 83 (3):274-80.

4 Miller E, Decker MR, Reed E, Raj A, Hathaway JE, Silverman JG. Male Partner Pregnancy-promoting Behaviors and Adolescent Partner Violence: Findings from a Qualitative Study with Adolescent Females. Ambulatory Pediatrics. 2007 Oct; 7(5):360-366.

5 Moore AM, Frohwirth L, Miller E. Male reproductive control of women who have experienced intimate partner violence in the United States. Social Science & Medicine. 2010; 70(11): 1737-1744.

6 Miller E. Personal communication, March 2, 2007.

7 Black MD, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, Chen J, Stevens MR. 2011. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

8 Houston E, McKirnan DJ. Intimate Partner Abuse Among /Gay and Bisexual Men: Risk Correlates and Health Outcomes. Journal of Urban Health: Bulletin of the New York Academy of Medicine. 2007; 84(5):681-690.

9 Braun V, Schmidt J, Gavey N, Fenaughty J. Sexual Coercion Among Gay and Bisexual Men in Aoteraroa/New Zealand. Journal of Homosexuality. 2009; 56:336-360.

10 Miller E, Decker MR, Raj A, Reed E, Marable D, Silverman JG. Intimate Partner Violence and Health Care-seeking Patterns among Female Users of Urban Adolescent Clinics. Maternal and Child Health Journal. 2010 Nov; 14(6):910-917.

11 Ashley OS, Foshee VA. Adolescent Help-seeking for Dating Violence: Prevalence, Sociodemographic Correlates, and Sources of Help. Journal of Adolescent Health. 2005 Jan; 36(1):25-31.

12 Schoen C, Davis K, Scott-Collins K, Greenberg L, Des Roches C, Abrams M. The Commonwealth Fund Survey of the Health of Adolescent Girls [Internet]. The Commonwealth Fund; 1997 [cited 2011 Jan 4]. Available from: http://www.commonwealthfund.org/Content/Publications/Fund-Reports/1997/Nov/The-Commonwealth-Fund-Survey-of-the-Health-of-Adolescent-Girls.aspx

13 Miller E, Decker MR, Reed E, Raj A, Hathaway JE, Silverman JG. Male Partner Pregnancy-promoting Behaviors and Adolescent Partner Violence: Findings from a Qualitative Study with Adolescent Females. Ambulatory Pediatrics. 2007 Oct; 7(5):360-366.

14 Raiford JL, DiClemente RJ, Wingood GM. Effects of Fear of Abuse and Possible STI Acquisition on the Sexual Behavior of Young African American Women. American Journal of Public Health. 2009 Jun 1; 99(6):1067-1071.

15 Miller E, Decker MR, Raj A, Reed E, Marable D, Silverman JG. Intimate Partner Violence and Health Care-seeking Patterns among Female Users of Urban Adolescent Clinics. Maternal and Child Health Journal. 2010 Nov; 14(6):910-917.

16 Keeling J, Birch L. The Prevalence Rates of Domestic Abuse in Women Attending a Family Planning Clinic. Journal of Family Planning and Reproductive Health Care. 2004 Apr 1; 30(2):113 -114.

17 Rickert VI, Wiemann CM, Harrykissoon SD, Berenson AB, Kolb E. The Relationship among Demographics Reproductive Characteristics, and Intimate Partner Violence. American Journal of Obstetrics & Gynecology. 2002 Oct; 187(4):1002-1007.

18 Miller E, Decker MR, Raj A, Reed E, Marable D, Silverman JG. Intimate Partner Violence and Health Care-seeking Patterns among Female Users of Urban Adolescent Clinics. Maternal and Child Health Journal. 2010 Nov; 14(6):910-917.

19 Keeling J, Birch L. The Prevalence Rates of Domestic Abuse in Women Attending a Family Planning Clinic. Journal of Family Planning and Reproductive Health Care. 2004 Apr 1; 30(2):113 -114.

20 Rickert VI, Wiemann CM, Harrykissoon SD, Berenson AB, Kolb E. The Relationship among Demographics, Reproductive Characteristics, and Intimate Partner Violence. American Journal of Obstetrics & Gynecology. 2002 Oct; 187(4):1002-1007.

21 Miller E, Decker MR, Raj A, Reed E, Marable D, Silverman JG. Intimate Partner Violence and Health Care-seeking Patterns among Female Users of Urban Adolescent Clinics. Maternal and Child Health Journal. 2010 Nov; 14(6):910-917.

22 Ibid: 910-917.

23 Ashley OS, Foshee VA. Adolescent Help-seeking for Dating Violence: Prevalence, Sociodemographic Correlates, and Sources of Help. Journal of Adolescent Health. 2005 Jan; 36(1):25-31.

24 Juszczak L, Melinkovich P, Kaplan D. Use of Health and Mental Health Services by Adolescents Across Multiple Delivery Sites. Journal of Adolescent Health. 2003 Jun; 32(6 Suppl):108-118.

25 Ibid:108-118.

26 Zimmer-Gembeck MJ, Alexander T, Nystrom RJ. Adolescents Report Their Need For and Use of Health Care Services. Journal of Adolescent Health. 1997 Dec; 21(6):388-399.

27 Britto MT, Klostermann BK, Bonny AE, Altum SA, Hornung RW. Impact of a School-based Intervention on Access to Healthcare for Underserved youth. Journal of Adolescent Health. 2001 Aug; 29(2):116-124.

28 Black MD, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, Chen J, Stevens MR. 2011. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

29 Wolitzky-Taylor KB, Ruggiero KJ, Danielson CK, Resnick HS, Hanson RF, Smith DW, Saunders BE, Kilpatrick DG. Prevalence and Correlates of Dating Violence in a National Sample of Adolescents. Journal of American Academy of Child and Adolescent Psychiatry. 2008; 47(7):755-762.

30 Miller E, Decker MR, Raj A, Reed E, Marable D, Silverman JG. Intimate Partner Violence and Health Care-seeking Patterns among Female Users of Urban Adolescent Clinics. Maternal and Child Health Journal. 2010 Nov; 14(6):910-917.

31 Behnken MP, Le YC, Temple JR, Berenson AB. Forced sexual intercourse, suicidality, and binge drinking among adolescent girls. Addictive Behaviors. 2010;35(5):507-509.

32 Howard DE, Wang MQ, Yan F. Psychosocial Factors Associated with Reports of Physical Dating Violence Victimization among U.S. Adolescent Males. Adolescence. 2008; 43(171):449-460.

33 Bossarte RM, Simon TR, Swahn MH. Clustering of Adolescent Dating Violence, Peer Violence, and Suicidal Behavior. Journal of Interpersonal Violence. 2008 Jun 1; 23(6):815 -833.

34 Ackard DM, Neumark-Sztainer D. Date Violence and Date Rape among Adolescents: Associations with Disordered Eating Behaviors and Psychological Health. Child Abuse & Neglect. 2002 May; 26(5):455-473.

35 Kim-Godwin YS, Clements C, McCuiston AM, Fox JA. Dating Violence among High School Students in Southeastern North Carolina. Journal of School Nursing. 2009 Apr; 25(2):141-151.

36 Ibid:141-151.

37 Miller E. Personal communication, September 30, 2010.

38 Roberts TA, Auinger P, Klein JD. Intimate Partner Abuse and the Reproductive Health of Sexually Active Female Adolescents. Journal of Adolescent Health. 2005 May; 36(5):380-385.

39 Raneri LG, Wiemann CM. Social Ecological Predictors of Repeat Adolescent Pregnancy. Perspectives on Sexual & Reproductive Health. 2007 Mar; 39(1):39-47.

40 Raphael J. Teens Having Babies: The Unexplored Role of Domestic Violence. The Prevention Researcher. 2005; 12(1):15-17.

41 Moore AM, Frohwirth L, Miller E. Male reproductive control of women who have experienced intimate partner violence in the United States. Social Science & Medicine. 2010; 70(11): 1737-1744.

42 Wingood GM, DiClemente R, McCree DH, Harrington K, Davies SL. Dating violence and the sexual health of black adolescent females. Pediatrics. 2001;107(5):1-4.

43 Teitelman AM, Ratcliffe SJ, Morales-Aleman MM. Sexual relationship power, intimate partner violence, and condom use among minority urban girls. Journal of Interpersonal Violence. 2008;23(12):1694-1712.

44 Wu E, El-Bassel N, Witte SS, Gilbert L, Chang M. Intimate partner violence and HIV risk among urban minority women in primary health care settings. AIDS & Behavior. 2003;7:291-301.

45 Bogart LM, Collins RL, Cunningham W, Beckman R, Golinelli D, Eisenman D, et al. The association of partner abuse with risky sexual behaviors among women and men with HIV/AIDS. AIDS & Behavior. 2005;9(3):325-333.

46 Collins RL, Ellickson P, Orlando M, Klein DJ. Isolating the nexus of substance use violence, and sexual risk for HIV infection among young adults in the United States. AIDS & Behavior. 2005;9:73-87.

47 Teitelman AM, Dichter ME, Cederbauma JA, Campbell J. Intimate partner violence, condom use and HIV risk for adolescent girls: gaps in the literature and future directions for research and intervention. Journal of HIV/AIDS Prevention in Children and Youth. 2007;8(2):65-93.

48 Raj A, Reed E, Miller E, Decker MR, Rothman EF, Silverman JG. Contexts of condom use and non-condom use among young adolescent male perpetrators of dating violence. AIDS Care. 2007;19(8):970-973.

49 Wingood GM, DiClemente R, McCree DH, Harrington K, Davies SL. Dating violence and the sexual health of black adolescent females. Pediatrics. 2001;107(5):1-4.

50 Roberts TA, Auinger MS, Klein JD. Intimate partner abuse and the reproductive health of sexually active female adolescents. Journal of Adolescent Health. 2005;36:380-385.

51 Raiford JL, DiClemente RJ, Wingood GM. Effects of Fear of Abuse and Possible STI Acquisition on the Sexual Behavior of Young African American Women. American Journal of Public Health. 2009 Jun 1; 99(6):1067-1071.

52 Wingood GM, DiClemente R, McCree DH, Harrington K, Davies SL. Dating Violence and the Sexual Health of Black Adolescent Females. Pediatrics. 2001; 107(5):1-4.

53 Raiford JL, DiClemente RJ, Wingood GM. Effects of Fear of Abuse and Possible STI Acquisition on the Sexual Behavior of Young African American women. American Journal of Public Health. 2009; 99(6):1067-1071

54 Decker MR, Silverman JG, Raj A. Dating Violence and Sexually Transmitted Disease/HIV Testing and Diagnosis among Adolescent Females. Pediatrics. 2005; 116(2):e272-276.

55 Ibid:e272-276.

56 Silverman JG, Decker MR, Raj A. Immigration-based Disparities in Adolescent Girls' Vulnerability to Dating Violence. Maternal and Child Health Journal. 2007 Jan; 11(1):37-43.

57 Miller E. Personal Communication, March 2, 2007.

58 Champion H, Foley KL, Sigmon-Smith K, Sutfin EL, DuRant RH. Contextual Factors and Health Risk Behaviors Associated with Date Fighting among High School Students. Women Health. 2008; 47(3):1-22.

59 Goldstein AL, Walton MA, Cunningham RM, Resko SM, Duan L. Correlates of Gambling among Youth in an Inner-city Emergency Department. Psychology of Addictive Behaviors. 2009 Mar; 23(1):113-121.

60 Banyard VL, Cross C. Consequences of Teen Dating Violence: Understanding Intervening Variables in Ecological Context. Violence Against Women. 2008 Sep; 14(9):998-1013.

61 Coyne-Beasley T, Moracco KE, Casteel MJ. Adolescent Femicide: A Population-Based Study. Archives of Pediatrics & Adolescent Medicine. 2003 Apr 1; 157(4):355-360.

62 Kim-Godwin YS, Clements C, McCuiston AM, Fox JA. Dating Violence among High School Students in Southeastern North Carolina. Journal of School Nursing. 2009 Apr; 25(2):141-151.

63 Behnken MP, Le YC, Temple JR, Berenson AB. Forced sexual intercourse, suicidality, and binge drinking among adolescent girls. Addictive Behaviors. 2010;35(5):507-509.

64 Howard DE, Wang MQ, Yan F. Psychosocial Factors Associated with Reports of Physical Dating Violence Victimization among U.S. Adolescent Males. Adolescence. 2008; 43(171):449-460.

65 Kim-Godwin YS, Clements C, McCuiston AM, Fox JA. Dating Violence among High School Students in Southeastern North Carolina. Journal of School Nursing. 2009 Apr; 25(2):141-151.

66 Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, Schoenwald P, Silverman JG. A Family Planning Clinic Partner Violence Intervention to Reduce Risk Associated with Reproductive Coercion. Contraception. 2011; 83:274-280.

67 McFarlane J, Parker, B, Soeken, K, Silva, C, & Reel, S. Safety Behaviors of Abused Women Following an Intervention Program offered During Pregnancy. Journal of Obstetrical, Gynecological and Neonatal Nursing. 1998; 27(1):64-69.

68 Parker B, McFarlane J, Soeken K, Silva C, Reel S. (1999). Testing an Intervention to Prevent Further Abuse to Pregnant Women. Research in Nursing and Health. 22:59-66.

69 McFarlane J, Soeken K, Wiist W. An Evaluation of Interventions to Decrease Intimate Partner Violence to Pregnancy Women. Public Health Nursing. 2000; 17(6):443-451.

70 McFarlane J, Groff JY, O'Brien JA, Watson K. Secondary Prevention of Intimate Partner Violence: A Randomized Controlled Trial. Nursing Research. 2006; 55(1):52-61.

71 Weiss KG. "Boys Will Be Boys" and Other Gendered Accounts. Violence Against Women. 2009;15(7):810-834.

72 Raiford JL, DiClemente RJ, Wingood GM. Effects of Fear of Abuse and Possible STI Acquisition on the Sexual Behavior of Young African American Women. American Journal of Public Health. 2009; 99(6):1067-1071.

73 American College of Obstetricians and Gynecologists. Long-Acting Reversible Contraception: Implants and Intrauterine Devices. American College of Obstetricians and Gynecologists Practice Bulletin: Clinical Guidelines for Obstetrician-Gynecologists, Number 121, July, 2011.

NOTES

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NOTES

About the National Health Resource Center on Domestic Violence

For more than two decades, the National Health Resource Center on Domestic Violence has supported health care practitioners, administrators and systems, domestic violence experts, survivors, and policy makers at all levels as they improve health care's response to domestic violence. A project of the Futures Without Violence, and funded by the U.S. Department of Health and Human Services, the Center supports leaders in the field through groundbreaking model professional, education and response programs, cutting-edge advocacy and sophisticated technical assistance. The Center offers a wealth of free culturally competent materials that are appropriate for a variety of public and private health professions, settings and departments.

For free technical assistance, and educational materials:

Visit: **www.FuturesWithoutViolence.org/health**

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Chapter 4 –

Care for Children Ages 0-5

SECTION 1: CARE FOR CHILDREN AGES 0-5 OF ADOLESCENTS AT SBHCs

BACKGROUND

- School-Based Health Centers vary in capacity to serve the children of parenting teens. Some SBHCs have restrictions on the population they can serve to only include students of the school.
- By providing basic care to children of parenting teens, the SBHC can maximize student time in class and decrease unnecessary absenteeism for the adolescent and the child if in pre-school.
- Barriers from accessing care such as transportation, cost, or reliance on other adults, may inhibit youth from seeking care for their child. SBHCs' youth-friendly environment creates a safe, comfortable, and convenient place of care for parenting students to take their children as a first line of triage. This can help reducing unnecessary visits to the Urgent Care or Emergency Room and conversely, encourage parents to seek appropriate care for the child when indeed necessary.

RECOMMENDATIONS

- It is encouraged that if your school has a high number of expectant teens or a child care center on site, that providers at minimum assess children of teen parents and refer for care as appropriate.
- All efforts should be made to help the patient establish a medical home for their child.
- Certain medical equipment may be necessary for your clinic to be able to provide care for children ages 0-5, such as a baby scale. Assess need, purchase, and install/stock proper equipment in among your SBHC.

If your SBHC has capacity to serve children of teen parents or is open to exploring ways to serve this population. Some recommendations are as follows:

- Triage children with acute needs and refer to care at a medical home or urgent care.
    - Support parents to understand the signs/symptoms of their child's illness and where would be an appropriate place to take the child for care.
- Ensure the child is connected to a medial home.
    - Ask the parent if their child is receiving regular well-care for their child. If not, help the student identify a place of care (either family practice or a pediatric practice) that is accessible and cost-effective (accepts their insurance or sliding-scale) and refer appropriately.
    - Provide counseling as to the importance of having a medical home for their child and how a primary care provider will serve them.
    - Work with the GRADS case manager to help link the student's child to regular care.

- If the child is covered by Medicaid, contact their Care Coordinator through their MCO if additional support is needed to identify a medical home for the child and/or to ensure continuity of services.

- Ensure regular well-care for infants and children.
  - The Bright Futures™ schedule should be used as best practice guidelines for providing well-care to the children, including those ages 0-5.

- Assess immunization status.
  - Immunizations are an important part of well-care and can be an opportunity for providers to build on their established relationship with parents by providing immunizations to both parents and their children.
  - Educate parents on the importance of immunizations during infancy and throughout childhood.
  - If your SBHC provides any required/recommended vaccines for children, offer this as an option, while also ensuring that care coordination/communication is occurring with the child's primary care provider to avoid duplication of vaccines.
    - The CDC immunization schedule should be followed for providing vaccinations to infants and children.
  - Providers can support young parents by helping them understand the required immunizations for their child to enter childcare and school.

- Encourage developmental screening and provide possible.
  - The American Academy of Pediatrics recommended developmental screening of young children with standardized screening tool as a routine component of well-child care.
  - Consistent developmental screening allows for early identification, intervention and treatment.
  - The American Academy of Pediatrics recommends that all children be screened for developmental delays and disabilities during regular well-child doctor visits through use of a standardized tool at:
    - 9 months
    - 18 months
    - 24 or 30 months
    - Additional screening might be needed if a child is at high risk for developmental problems due to preterm birth, low birthweight, or other reasons.
      - → There are many different screening tools available, most of which are available for use with purchase.
      - → The Survey of Well-being of Young Children (SWYC)™ is a freely-available, comprehensive screening instrument for children under 5 years of age. See Chapter 4 resources.

- Encourage parents to track their children's development through play, language and behavior, and act early if they have a concern.

CARE FOR CHILDREN AGES 0-5

- Encourage involvement of fathers.
    - Early involvement strengthens the father-child bond and contributes to improved child outcomes.
    - Treating adolescent fathers as peripheral in their parenting role marginalizes an already alienated group and negatively affects the ability of the father to seek future advice and education.
    - Actively involve fathers in growth and development related health care conversations, when possible.
- Refer to school or community resources, such as:
    - Home visiting programs, peer and support groups, mentoring programs
    - Early intervention programs
    - School-based programs, such as GRADS

SECTION 2: RESOURCES FOR SERVING CHILDREN AGES 0-5

Preventive Care

School Immunization Requirements
http://www2a.cdc.gov/nip/schoolsurv/schImmRqmt.asp

Easy-to-Read Immunization Schedules
http://www2a.cdc.gov/nip/schoolsurv/schImmRqmt.asp

AAP Bright Futures™ Preventive Care Recommendations, Periodicity Schedule
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

Child Growth & Development

CDC's Act Early Campaign (materials for parents) http://www.cdc.gov/ncbddd/actearly/

The Survey of Well-being of Young Children™
www.theswyc.org

New Mexico Resources/Referral Sources

NM CYFD, Pull Together
https://pulltogether.org/

Early Learning New Mexico
http://www.earlylearningnm.org/

NM Family, Infant, Toddler Program Agency List
http://archive.nmhealth.org/ddsd/nmfit/documents/NMDOH-DDSD-FIT-ProviderAgencyContactInfo-EN.pdf

INCLUDED RESOURCES

Bright Futures™ Periodicity Schedule

CDC Recommended Immunization Schedule (0 through 18 years)

AAP Algorithm for Developmental Surveillance & Screening

AAP Journal Article: *The Importance of Play in Promoting Healthy Child Development & Maintaining Strong Parent-Child Bond: Focus on Children in Poverty*

CDC Act Early: Tips for Talking with Parents

CDC Act Early: Child Growth Charts

CDC Act Early: Milestone Moments for Parents

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

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.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in *Bright Futures* guidelines (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	**Prenatal**[2]	**Newborn**[3]	**3-5 d**[4]	**By 1 mo**	**2 mo**	**4 mo**	**6 mo**	**9 mo**	**12 mo**	**15 mo**	**18 mo**	**24 mo**	**30 mo**	**3 y**	**4 y**	**5 y**	**6 y**	**7 y**	**8 y**	**9 y**	**10 y**	**11 y**	**12 y**	**13 y**	**14 y**	**15 y**	**16 y**	**17 y**	**18 y**	**19 y**	**20 y**	**21 y**
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																			
Weight for Length		●	●	●	●	●	●	●	●	●	●																				
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																															
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★
Hearing		●[8]	★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	★	★	★	★	★	★	★	★	★	★	★
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																															
Developmental Screening[9]								●			●		●																		
Autism Screening[10]											●	●																			
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment[11]																						★	★	★	★	★	★	★	★	★	★
Depression Screening[12]																						●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[14]																															
Newborn Blood Screening[15]		◄———	●	———►																											
Critical Congenital Heart Defect Screening[16]		●																													
Immunization[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[18]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead Screening[19]							★	★	● or ★[20]		★	● or ★[20]		★	★	★	★															
Tuberculosis Testing[21]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia Screening[22]												★			★		★		★	◄———	●	———►	★	★	★	★	★	★	◄———	●	———►	
STI/HIV Screening[23]																						★	★	★	★	★	◄———	●	———►	★	★	★
Cervical Dysplasia Screening[24]																															●
ORAL HEALTH[25]							★	★	● or ★		● or ★	● or ★	● or ★	●			●														
Fluoride Varnish[26]							◄———				●	———			———►																
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. 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.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per the 2009 AAP statement "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Every infant should have a newborn evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in the 2012 AAP statement "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborn infants discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per the 2010 AAP statement "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per the 2007 AAP statement "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3 year olds. Instrument based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See 2016 AAP statement, "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/1.51) and "Procedures for Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/1.52).
8. All newborns should be screened, per the AAP statement "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. See 2006 AAP statement "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
10. Screening should occur per the 2007 AAP statement "Identification and Evaluation of Children with Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
11. A recommended screening tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.
12. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
13. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See 2011 AAP statement "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
14. These may be modified, depending on entry point into schedule and individual need.
15. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf), establish the criteria for and coverage of newborn screening procedures and programs. Follow-up must be provided, as appropriate, by the pediatrician.
16. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).
17. Schedules, per the AAP Committee on Infectious Diseases, are available at: http://aapredbook.aappublications.org/site/resources/izschedules.xhtml. Every visit should be an opportunity to update and complete a child's immunizations.
18. See 2010 AAP statement "Diagnosis and Prevention of Iron Deficiency and Iron Deficiency Anemia in Infants and Young Children (0-3 Years of Age)" (http://pediatrics.aappublications.org/content/126/5/1040.full).
19. For children at risk of lead exposure, see the 2012 CDC Advisory Committee on Childhood Lead Poisoning Prevention statement "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
20. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
21. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *AAP Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
22. See AAP-endorsed 2011 guidelines from the National Heart Blood and Lung Institute, "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
23. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the *AAP Red Book: Report of the Committee on Infectious Diseases*. Additionally, all adolescents should be screened for HIV according to the AAP statement (http://pediatrics.aappublications.org/content/128/5/1023.full) once between the ages of 16 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
24. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm). Indications for pelvic examinations prior to age 21 are noted in the 2010 AAP statement "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
25. Assess if the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. If primary water source is deficient in fluoride, consider oral fluoride supplementation. Recommend brushing with fluoride toothpaste in the proper dosage for age. See 2009 AAP statement "Oral Health Risk Assessment Timing and Establishment of the Dental Home" (http://pediatrics.aappublications.org/content/111/5/1113.full), 2014 clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626), and 2014 AAP statement "Maintaining and Improving the Oral Health of Young Children (http://pediatrics.aappublications.org/content/134/6/1224.full)."
26. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.htm). Once teeth are present, fluoride varnish may be applied to all children every 3-6 months in the primary care or dental office. Indications for fluoride use are noted in the 2014 AAP clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

KEY ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ◄——— ● ———► = range during which a service may be provided

Summary of changes made to the
Bright Futures/AAP Recommendations for Preventive Pediatric Health Care

(Periodicity Schedule)

This Schedule reflects changes approved in October 2015 and published in January 2016. For updates, visit www.aap.org/periodicityschedule.

Changes made October 2015

- **Vision Screening**- The routine screening at age 18 has been changed to a risk assessment.
- Footnote 7 has been updated to read, "A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3 year olds. Instrument based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See 2016 AAP statement, "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians (http://pediatrics.aappublications.org/content/137/1/1.51) and "Procedures for Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/1.52).

Changes made May 2015

- **Oral Health**- A subheading has been added for fluoride varnish, with a recommendation from 6 months through 5 years.
- Footnote 25 wording has been edited and also includes reference to the 2014 clinical report, "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626) and 2014 policy statement, "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224.full).
- Footnote 26 has been added to the new fluoride varnish subheading: See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.htm). Once teeth are present, fluoride varnish may be applied to all children every 3-6 months in the primary care or dental office. Indications for fluoride use are noted in the 2014 AAP clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

Changes made March 2014

Changes to Developmental/Behavioral Assessment

- **Alcohol and Drug Use Assessment**- Information regarding a recommended screening tool (CRAFFT) was added.
- **Depression**- Screening for depression at ages 11 through 21 has been added, along with suggested screening tools.

Changes to Procedures

- **Dyslipidemia screening**- An additional screening between 9 and 11 years of age has been added. The reference has been updated to the AAP-endorsed National Heart Blood and Lung Institute policy (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
- **Hematocrit or hemoglobin**- A risk assessment has been added at 15 and 30 months. The reference has been updated to the current AAP policy (http://pediatrics.aappublications.org/content/126/5/1040.full).
- **STI/HIV screening**- A screen for HIV has been added between 16 and 18 years. Information on screening adolescents for HIV has been added in the footnotes. STI screening now references recommendations made in the AAP Red Book. This category was previously titled "STI Screening."
- **Cervical dysplasia**- Adolescents should no longer be routinely screened for cervical dysplasia until age 21. Indications for pelvic exams prior to age 21 are noted in the 2010 AAP statement "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
- **Critical Congenital Heart Disease-** Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement, "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).

See www.aap.org/periodicityschedule for additional updates made to footnotes and references in March 2014.

Recommended Immunization Schedules for Persons Aged 0 Through 18 Years
UNITED STATES, 2016

This schedule includes recommendations in effect as of January 1, 2016. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the

Advisory Committee on Immunization Practices
(http://www.cdc.gov/vaccines/acip)

American Academy of Pediatrics
(http://www.aap.org)

American Academy of Family Physicians
(http://www.aafp.org)

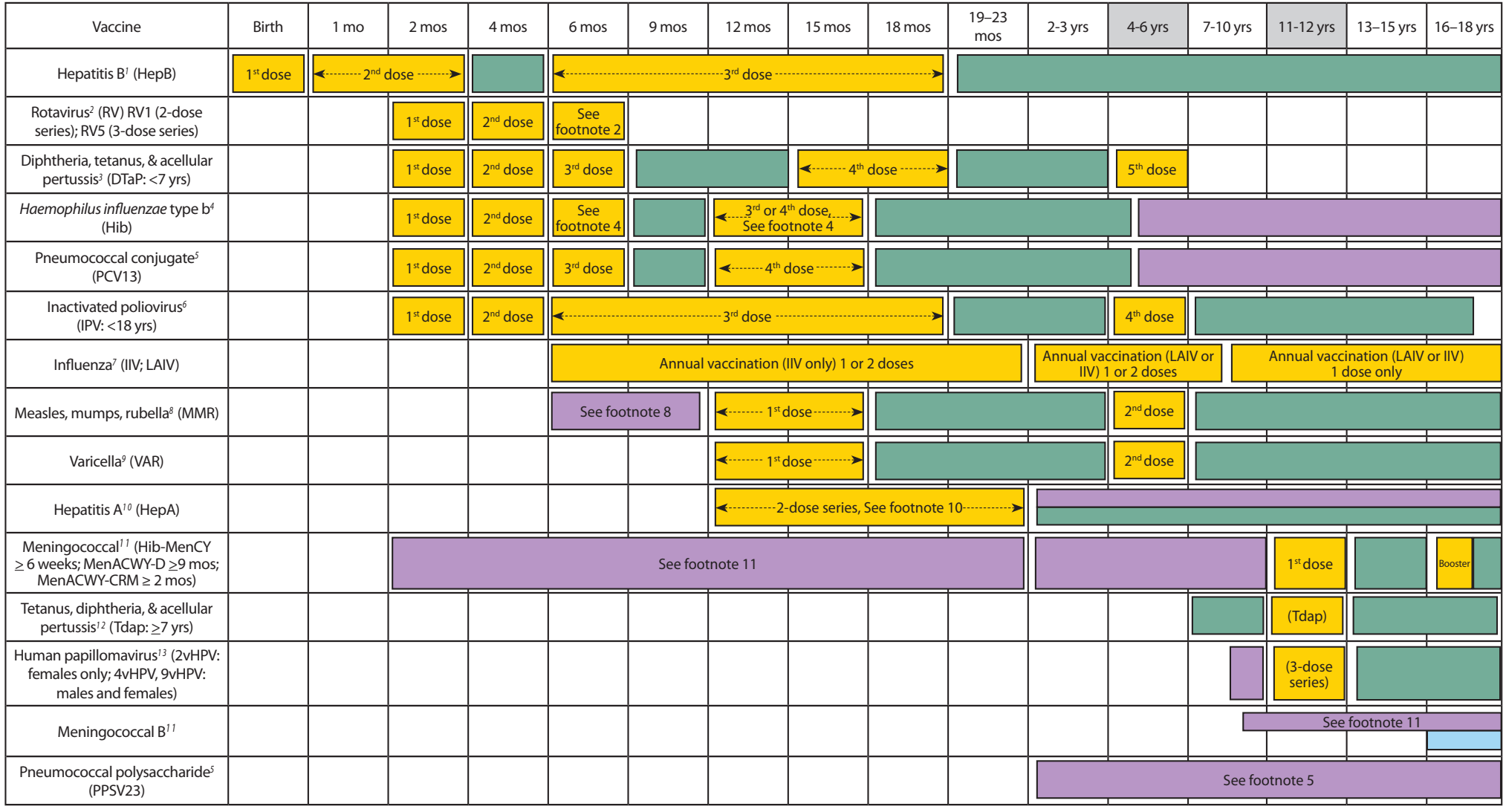
American College of Obstetricians and Gynecologists
(http://www.acog.org)

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Figure 1. Recommended immunization schedule for persons aged 0 through 18 years – United States, 2016.

(FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE [FIGURE 2]).

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are shaded.



Range of recommended ages for all children

Range of recommended ages for catch-up immunization

Range of recommended ages for certain high-risk groups

Range of recommended ages for non-high-risk groups that may receive vaccine, subject to individual clinical decision making

No recommendation

This schedule includes recommendations in effect as of January 1, 2016. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967). Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for vaccination, is available from CDC online (http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm) or by telephone (800-CDC-INFO [800-232-4636]).

This schedule is approved by the Advisory Committee on Immunization Practices (http//www.cdc.gov/vaccines/acip), the American Academy of Pediatrics (http://www.aap.org), the American Academy of Family Physicians (http://www.aafp.org), and the American College of Obstetricians and Gynecologists (http://www.acog.org).

NOTE: The above recommendations must be read along with the footnotes of this schedule.

FIGURE 2. Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind —United States, 2016.

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. Always use this table in conjunction with Figure 1 and the footnotes that follow.

Children age 4 months through 6 years					
Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Hepatitis B[1]	Birth	4 weeks	8 weeks *and* at least 16 weeks after first dose. Minimum age for the final dose is 24 weeks.		
Rotavirus[2]	6 weeks	4 weeks	4 weeks[2]		
Diphtheria, tetanus, and acellular pertussis[3]	6 weeks	4 weeks	4 weeks	6 months	6 months[3]
Haemophilus influenzae type b[4]	6 weeks	4 weeks if first dose was administered before the 1st birthday. 8 weeks (as final dose) if first dose was administered at age 12 through 14 months. No further doses needed if first dose was administered at age 15 months or older.	4 weeks[4] if current age is younger than 12 months **and** first dose was administered at younger than age 7 months, **and** at least 1 previous dose was PRP-T (ActHib, Pentacel) or unknown. 8 weeks *and* age 12 through 59 months (as final dose)[4] • if current age is younger than 12 months **and** first dose was administered at age 7 through 11 months (wait until at least 12 months old); OR • if current age is 12 through 59 months **and** first dose was administered before the 1st birthday, **and** second dose administered at younger than 15 months; OR • if both doses were PRP-OMP (PedvaxHIB; Comvax) **and** were administered before the 1st birthday (wait until at least 12 months old). No further doses needed if previous dose was administered at age 15 months or older.	8 weeks (as final dose) This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal[5]	6 weeks	4 weeks if first dose administered before the 1st birthday. 8 weeks (as final dose for healthy children) if first dose was administered at the 1st birthday or after. No further doses needed for healthy children if first dose administered at age 24 months or older.	4 weeks if current age is younger than 12 months and previous dose given at <7months old. 8 weeks (as final dose for healthy children) if previous dose given between 7-11 months (wait until at least 12 months old); OR if current age is 12 months or older and at least 1 dose was given before age 12 months. No further doses needed for healthy children if previous dose administered at age 24 months or older.	8 weeks (as final dose) This dose only necessary for children aged 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age.	
Inactivated poliovirus[6]	6 weeks	4 weeks[6]	4 weeks[6]	6 months[6] (minimum age 4 years for final dose).	
Measles, mumps, rubella[8]	12 months	4 weeks			
Varicella[9]	12 months	3 months			
Hepatitis A[10]	12 months	6 months			
Meningococcal[11] (Hib-MenCY ≥ 6 weeks; MenACWY-D ≥9 mos; MenACWY-CRM ≥ 2 mos)	6 weeks	8 weeks[11]	See footnote 11	See footnote 11	
Children and adolescents age 7 through 18 years					
Meningococcal[11] (Hib-MenCY ≥ 6 weeks; MenACWY-D ≥9 mos; MenACWY-CRM ≥ 2 mos)	Not Applicable (N/A)	8 weeks[11]			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis[12]	7 years[12]	4 weeks	4 weeks if first dose of DTaP/DT was administered before the 1st birthday. 6 months (as final dose) if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday.	6 months if first dose of DTaP/DT was administered before the 1st birthday.	
Human papillomavirus[13]	9 years	Routine dosing intervals are recommended.[13]			
Hepatitis A[10]	N/A	6 months			
Hepatitis B[1]	N/A	4 weeks	8 weeks **and** at least 16 weeks after first dose.		
Inactivated poliovirus[6]	N/A	4 weeks	4 weeks[6]	6 months[6]	
Measles, mumps, rubella[8]	N/A	4 weeks			
Varicella[9]	N/A	3 months if younger than age 13 years. 4 weeks if age 13 years or older.			

NOTE: The above recommendations must be read along with the footnotes of this schedule.

Footnotes — Recommended immunization schedule for persons aged 0 through 18 years—United States, 2016

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
For vaccine recommendations for persons 19 years of age and older, see the Adult Immunization Schedule.

Additional information

- For contraindications and precautions to use of a vaccine and for additional information regarding that vaccine, vaccination providers should consult the relevant ACIP statement available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For purposes of calculating intervals between doses, 4 weeks = 28 days. Intervals of 4 months or greater are determined by calendar months.
- Vaccine doses administered 4 days or less before the minimum interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum interval or minimum age should not be counted as valid doses and should be repeated as age-appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval. For further details, see *MMWR, General Recommendations on Immunization and Reports* / Vol. 60 / No. 2; Table 1. *Recommended and minimum ages and intervals between vaccine doses* available online at http://www.cdc.gov/mmwr/pdf/rr/rr6002.pdf.
- Information on travel vaccine requirements and recommendations is available at http://wwwnc.cdc.gov/travel/destinations/list.
- For vaccination of persons with primary and secondary immunodeficiencies, see Table 13, *"Vaccination of persons with primary and secondary immunodeficiencies,"* in *General Recommendations on Immunization* (ACIP), available at http://www.cdc.gov/mmwr/pdf/rr/rr6002.pdf.; and American Academy of Pediatrics. "Immunization in Special Clinical Circumstances," in Kimberlin DW, Brady MT, Jackson MA, Long SS eds. *Red Book: 2015 report of the Committee on Infectious Diseases. 30th ed.* Elk Grove Village, IL: American Academy of Pediatrics.

1. Hepatitis B (HepB) vaccine. (Minimum age: birth)

Routine vaccination:

At birth:

- Administer monovalent HepB vaccine to all newborns before hospital discharge.
- For infants born to hepatitis B surface antigen (HBsAg)-positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) at age 9 through 18 months (preferably at the next well-child visit) or 1 to 2 months after completion of the HepB series if the series was delayed; CDC recently recommended testing occur at age 9 through 12 months; see http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6439a6.htm.
- If mother's HBsAg status is unknown, within 12 hours of birth administer HepB vaccine regardless of birth weight. For infants weighing less than 2,000 grams, administer HBIG in addition to HepB vaccine within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if mother is HBsAg-positive, also administer HBIG for infants weighing 2,000 grams or more as soon as possible, but no later than age 7 days.

Doses following the birth dose:

- The second dose should be administered at age 1 or 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
- Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine on a schedule of 0, 1 to 2 months, and 6 months starting as soon as feasible. See Figure 2.
- Administer the second dose 1 to 2 months after the first dose (minimum interval of 4 weeks), administer the third dose at least 8 weeks after the second dose AND at least 16 weeks after the **first** dose. The final (third or fourth) dose in the HepB vaccine series should be administered **no earlier than age 24 weeks**.
- Administration of a total of 4 doses of HepB vaccine is permitted when a combination vaccine containing HepB is administered after the birth dose.

Catch-up vaccination:

- Unvaccinated persons should complete a 3-dose series.
- A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 15 years.
- For other catch-up guidance, see Figure 2.

2. Rotavirus (RV) vaccines. (Minimum age: 6 weeks for both RV1 [Rotarix] and RV5 [RotaTeq])

Routine vaccination:

Administer a series of RV vaccine to all infants as follows:

1. If Rotarix is used, administer a 2-dose series at 2 and 4 months of age.
2. If RotaTeq is used, administer a 3-dose series at ages 2, 4, and 6 months.
3. If any dose in the series was RotaTeq or vaccine product is unknown for any dose in the series, a total of 3 doses of RV vaccine should be administered.

Catch-up vaccination:

- The maximum age for the first dose in the series is 14 weeks, 6 days; vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
- The maximum age for the final dose in the series is 8 months, 0 days.
- For other catch-up guidance, see Figure 2.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks. Exception: DTaP-IPV [Kinrix, Quadracel]: 4 years)

Routine vaccination:

- Administer a 5-dose series of DTaP vaccine at ages 2, 4, 6, 15 through 18 months, and 4 through 6 years. The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
- Inadvertent administration of 4th DTaP dose early: If the fourth dose of DTaP was administered at least 4 months, but less than 6 months, after the third dose of DTaP, it need not be repeated.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine (cont'd)

Catch-up vaccination:

- The fifth dose of DTaP vaccine is not necessary if the fourth dose was administered at age 4 years or older.
- For other catch-up guidance, see Figure 2.

4. *Haemophilus influenzae* type b (Hib) conjugate vaccine. (Minimum age: 6 weeks for PRP-T [ACTHIB, DTaP-IPV/Hib (Pentacel) and Hib-MenCY (MenHibrix)], PRP-OMP [PedvaxHIB or COMVAX], 12 months for PRP-T [Hiberix])

Routine vaccination:

- Administer a 2- or 3-dose Hib vaccine primary series and a booster dose (dose 3 or 4 depending on vaccine used in primary series) at age 12 through 15 months to complete a full Hib vaccine series.
- The primary series with ActHIB, MenHibrix, or Pentacel consists of 3 doses and should be administered at 2, 4, and 6 months of age. The primary series with PedvaxHib or COMVAX consists of 2 doses and should be administered at 2 and 4 months of age; a dose at age 6 months is not indicated.
- One booster dose (dose 3 or 4 depending on vaccine used in primary series) of any Hib vaccine should be administered at age 12 through 15 months. An exception is Hiberix vaccine. Hiberix should only be used for the booster (final) dose in children aged 12 months through 4 years who have received at least 1 prior dose of Hib-containing vaccine.
- For recommendations on the use of MenHibrix in patients at increased risk for meningococcal disease, please refer to the meningococcal vaccine footnotes and also to *MMWR* February 28, 2014 / 63(RR01);1-13, available at http://www.cdc.gov/mmwr/PDF/rr/rr6301.pdf.

Catch-up vaccination:

- If dose 1 was administered at ages 12 through 14 months, administer a second (final) dose at least 8 weeks after dose 1, regardless of Hib vaccine used in the primary series.
- If both doses were PRP-OMP (PedvaxHIB or COMVAX), and were administered before the first birthday, the third (and final) dose should be administered at age 12 through 59 months and at least 8 weeks after the second dose.
- If the first dose was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a third (and final) dose at age 12 through 15 months or 8 weeks after second dose, whichever is later.
- If first dose is administered before the first birthday and second dose administered at younger than 15 months, a third (and final) dose should be administered 8 weeks later.
- For unvaccinated children aged 15 months or older, administer only 1 dose.
- For other catch-up guidance, see Figure 2. For catch-up guidance related to MenHibrix, please see the meningococcal vaccine footnotes and also *MMWR* February 28, 2014 / 63(RR01);1-13, available at http://www.cdc.gov/mmwr/PDF/rr/rr6301.pdf.

Vaccination of persons with high-risk conditions:

- Children aged 12 through 59 months who are at increased risk for Hib disease, including chemotherapy recipients and those with anatomic or functional asplenia (including sickle cell disease), human immunodeficiency virus (HIV) infection, immunoglobulin deficiency, or early component complement deficiency, who have received either no doses or only 1 dose of Hib vaccine before 12 months of age, should receive 2 additional doses of Hib vaccine 8 weeks apart; children who received 2 or more doses of Hib vaccine before 12 months of age should receive 1 additional dose.
- For patients younger than 5 years of age undergoing chemotherapy or radiation treatment who received a Hib vaccine dose(s) within 14 days of starting therapy or during therapy, repeat the dose(s) at least 3 months following therapy completion.
- Recipients of hematopoietic stem cell transplant (HSCT) should be revaccinated with a 3-dose regimen of Hib vaccine starting 6 to 12 months after successful transplant, regardless of vaccination history; doses should be administered at least 4 weeks apart.
- A single dose of any Hib-containing vaccine should be administered to unimmunized* children and adolescents 15 months of age and older undergoing an elective splenectomy; if possible, vaccine should be administered at least 14 days before procedure.

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

4. *Haemophilus influenzae* type b (Hib) conjugate vaccine (cont'd)

- Hib vaccine is not routinely recommended for patients 5 years or older. However, 1 dose of Hib vaccine should be administered to unimmunized* persons aged 5 years or older who have anatomic or functional asplenia (including sickle cell disease) and unvaccinated persons 5 through 18 years of age with HIV infection.

** Patients who have not received a primary series and booster dose or at least 1 dose of Hib vaccine after 14 months of age are considered unimmunized.*

5. Pneumococcal vaccines. (Minimum age: 6 weeks for PCV13, 2 years for PPSV23)

Routine vaccination with PCV13:

- Administer a 4-dose series of PCV13 vaccine at ages 2, 4, and 6 months and at age 12 through 15 months.
- For children aged 14 through 59 months who have received an age-appropriate series of 7-valent PCV (PCV7), administer a single supplemental dose of 13-valent PCV (PCV13).

Catch-up vaccination with PCV13:

- Administer 1 dose of PCV13 to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
- For other catch-up guidance, see Figure 2.

Vaccination of persons with high-risk conditions with PCV13 and PPSV23:

- All recommended PCV13 doses should be administered prior to PPSV23 vaccination if possible.
- For children 2 through 5 years of age with any of the following conditions: chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma if treated with high-dose oral corticosteroid therapy); diabetes mellitus; cerebrospinal fluid leak; cochlear implant; sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; solid organ transplantation; or congenital immunodeficiency:
  1. Administer 1 dose of PCV13 if any incomplete schedule of 3 doses of PCV (PCV7 and/or PCV13) were received previously.
  2. Administer 2 doses of PCV13 at least 8 weeks apart if unvaccinated or any incomplete schedule of fewer than 3 doses of PCV (PCV7 and/or PCV13) were received previously.
  3. Administer 1 supplemental dose of PCV13 if 4 doses of PCV7 or other age-appropriate complete PCV7 series was received previously.
  4. The minimum interval between doses of PCV (PCV7 or PCV13) is 8 weeks.
  5. For children with no history of PPSV23 vaccination, administer PPSV23 at least 8 weeks after the most recent dose of PCV13.
- For children aged 6 through 18 years who have cerebrospinal fluid leak; cochlear implant; sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiencies; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; generalized malignancy; solid organ transplantation; or multiple myeloma:
  1. If neither PCV13 nor PPSV23 has been received previously, administer 1 dose of PCV13 now and 1 dose of PPSV23 at least 8 weeks later.
  2. If PCV13 has been received previously but PPSV23 has not, administer 1 dose of PPSV23 at least 8 weeks after the most recent dose of PCV13.
  3. If PPSV23 has been received but PCV13 has not, administer 1 dose of PCV13 at least 8 weeks after the most recent dose of PPSV23.
- For children aged 6 through 18 years with chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure), chronic lung disease (including asthma if treated with high-dose oral corticosteroid therapy), diabetes mellitus, alcoholism, or chronic liver disease, who have not received PPSV23, administer 1 dose of PPSV23. If PCV13 has been received previously, then PPSV23 should be administered at least 8 weeks after any prior PCV13 dose.
- A single revaccination with PPSV23 should be administered 5 years after the first dose to children with sickle cell disease or other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiencies; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; generalized malignancy; solid organ transplantation; or multiple myeloma.

6. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)

Routine vaccination:

- Administer a 4-dose series of IPV at ages 2, 4, 6 through 18 months, and 4 through 6 years. The final dose in the series should be administered on or after the fourth birthday and at least 6 months after the previous dose.

Catch-up vaccination:

- In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk of imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).
- If 4 or more doses are administered before age 4 years, an additional dose should be administered at age 4 through 6 years and at least 6 months after the previous dose.
- A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.

6. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks) (cont'd)

- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age. If only OPV were administered, and all doses were given prior to 4 years of age, one dose of IPV should be given at 4 years or older, at least 4 weeks after the last OPV dose.
- IPV is not routinely recommended for U.S. residents aged 18 years or older.
- For other catch-up guidance, see Figure 2.

7. Influenza vaccines. (Minimum age: 6 months for inactivated influenza vaccine [IIV], 2 years for live, attenuated influenza vaccine [LAIV])

Routine vaccination:

- Administer influenza vaccine annually to all children beginning at age 6 months. For most healthy, nonpregnant persons aged 2 through 49 years, either LAIV or IIV may be used. However, LAIV should NOT be administered to some persons, including 1) persons who have experienced severe allergic reactions to LAIV, any of its components, or to a previous dose of any other influenza vaccine; 2) children 2 through 17 years receiving aspirin or aspirin-containing products; 3) persons who are allergic to eggs; 4) pregnant women; 5) immunosuppressed persons; 6) children 2 through 4 years of age with asthma or who had wheezing in the past 12 months; or 7) persons who have taken influenza antiviral medications in the previous 48 hours. For all other contraindications and precautions to use of LAIV, see *MMWR* August 7, 2015 / 64(30):818-25 available at http://www.cdc.gov/mmwr/pdf/wk/mm6430.pdf.

For children aged 6 months through 8 years:

- For the 2015-16 season, administer 2 doses (separated by at least 4 weeks) to children who are receiving influenza vaccine for the first time. Some children in this age group who have been vaccinated previously will also need 2 doses. For additional guidance, follow dosing guidelines in the 2015-16 ACIP influenza vaccine recommendations, *MMWR* August 7, 2015 / 64(30):818-25, available at http://www.cdc.gov/mmwr/pdf/wk/mm6430.pdf.
- For the 2016-17 season, follow dosing guidelines in the 2016 ACIP influenza vaccine recommendations.

For persons aged 9 years and older:

- Administer 1 dose.

8. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months for routine vaccination)

Routine vaccination:

- Administer a 2-dose series of MMR vaccine at ages 12 through 15 months and 4 through 6 years. The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
- Administer 1 dose of MMR vaccine to infants aged 6 through 11 months before departure from the United States for international travel. These children should be revaccinated with 2 doses of MMR vaccine, the first at age 12 through 15 months (12 months if the child remains in an area where disease risk is high), and the second dose at least 4 weeks later.
- Administer 2 doses of MMR vaccine to children aged 12 months and older before departure from the United States for international travel. The first dose should be administered on or after age 12 months and the second dose at least 4 weeks later.

Catch-up vaccination:

- Ensure that all school-aged children and adolescents have had 2 doses of MMR vaccine; the minimum interval between the 2 doses is 4 weeks.

9. Varicella (VAR) vaccine. (Minimum age: 12 months)

Routine vaccination:

- Administer a 2-dose series of VAR vaccine at ages 12 through 15 months and 4 through 6 years. The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose. If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

Catch-up vaccination:

- Ensure that all persons aged 7 through 18 years without evidence of immunity (see *MMWR* 2007 / 56 [No. RR-4], available at http://www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have 2 doses of varicella vaccine. For children aged 7 through 12 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons aged 13 years and older, the minimum interval between doses is 4 weeks.

10. Hepatitis A (HepA) vaccine. (Minimum age: 12 months)

Routine vaccination:

- Initiate the 2-dose HepA vaccine series at 12 through 23 months; separate the 2 doses by 6 to 18 months.
- Children who have received 1 dose of HepA vaccine before age 24 months should receive a second dose 6 to 18 months after the first dose.
- For any person aged 2 years and older who has not already received the HepA vaccine series, 2 doses of HepA vaccine separated by 6 to 18 months may be administered if immunity against hepatitis A virus infection is desired.

Catch-up vaccination:

- The minimum interval between the 2 doses is 6 months.

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

10. Hepatitis A (HepA) vaccine (cont'd)

Special populations:

- Administer 2 doses of HepA vaccine at least 6 months apart to previously unvaccinated persons who live in areas where vaccination programs target older children, or who are at increased risk for infection. This includes persons traveling to or working in countries that have high or intermediate endemicity of infection; men having sex with men; users of injection and non-injection illicit drugs; persons who work with HAV-infected primates or with HAV in a research laboratory; persons with clotting-factor disorders; persons with chronic liver disease; and persons who anticipate close personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity. The first dose should be administered as soon as the adoption is planned, ideally 2 or more weeks before the arrival of the adoptee.

11. Meningococcal vaccines. (Minimum age: 6 weeks for Hib-MenCY [MenHibrix], 9 months for MenACWY-D [Menactra], 2 months for MenACWY-CRM [Menveo], 10 years for serogroup B meningococcal [MenB] vaccines: MenB-4C [Bexsero] and MenB-FHbp [Trumenba])

Routine vaccination:

- Administer a single dose of Menactra or Menveo vaccine at age 11 through 12 years, with a booster dose at age 16 years.
- Adolescents aged 11 through 18 years with human immunodeficiency virus (HIV) infection should receive a 2-dose primary series of Menactra or Menveo with at least 8 weeks between doses.
- For children aged 2 months through 18 years with high-risk conditions, see below.

Catch-up vaccination:

- Administer Menactra or Menveo vaccine at age 13 through 18 years if not previously vaccinated.
- If the first dose is administered at age 13 through 15 years, a booster dose should be administered at age 16 through 18 years with a minimum interval of at least 8 weeks between doses.
- If the first dose is administered at age 16 years or older, a booster dose is not needed.
- For other catch-up guidance, see Figure 2.

Clinical discretion:

- Young adults aged 16 through 23 years (preferred age range is 16 through 18 years) may be vaccinated with either a 2-dose series of Bexsero or a 3-dose series of Trumenba vaccine to provide short-term protection against most strains of serogroup B meningococcal disease. The two MenB vaccines are not interchangeable; the same vaccine product must be used for all doses.

Vaccination of persons with high-risk conditions and other persons at increased risk of disease:

Children with anatomic or functional asplenia (including sickle cell disease):

Meningococcal conjugate ACWY vaccines:

1. Menveo
   - *Children who initiate vaccination at 8 weeks:* Administer doses at 2, 4, 6, and 12 months of age.
   - *Unvaccinated children who initiate vaccination at 7 through 23 months:* Administer 2 doses, with the second dose at least 12 weeks after the first dose AND after the first birthday.
   - *Children 24 months and older who have not received a complete series:* Administer 2 primary doses at least 8 weeks apart.
2. MenHibrix
   - *Children who initiate vaccination at 6 weeks:* Administer doses at 2, 4, 6, and 12 through 15 months of age.
   - If the first dose of MenHibrix is given at or after 12 months of age, a total of 2 doses should be given at least 8 weeks apart to ensure protection against serogroups C and Y meningococcal disease.
3. Menactra
   - *Children 24 months and older who have not received a complete series:* Administer 2 primary doses at least 8 weeks apart. If Menactra is administered to a child with asplenia (including sickle cell disease), do not administer Menactra until 2 years of age and at least 4 weeks after the completion of all PCV13 doses.

Meningococcal B vaccines:

1. Bexsero or Trumenba
   - *Persons 10 years or older who have not received a complete series.* Administer a 2-dose series of Bexsero, at least 1 month apart. Or a 3-dose series of Trumenba, with the second dose at least 2 months after the first and the third dose at least 6 months after the first. The two MenB vaccines are not interchangeable; the same vaccine product must be used for all doses.

Children with persistent complement component deficiency (includes persons with inherited or chronic deficiencies in C3, C5-9, properidin, factor D, factor H, or taking eculizumab (Soliriis®):

Meningococcal conjugate ACWY vaccines:

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   - *Children who initiate vaccination at 8 weeks:* Administer doses at 2, 4, 6, and 12 months of age.
   - *Unvaccinated children who initiate vaccination at 7 through 23 months:* Administer 2 doses, with the second dose at least 12 weeks after the first dose AND after the first birthday.
   - *Children 24 months and older who have not received a complete series:* Administer 2 primary doses at least 8 weeks apart.
2. MenHibrix
   - *Children who initiate vaccination 6 weeks:* Administer doses at 2, 4, 6, and 12 through 15 months of age.
   - If the first dose of MenHibrix is given at or after 12 months of age, a total of 2 doses should be given at least 8 weeks apart to ensure protection against serogroups C and Y meningococcal disease.

11. Meningococcal vaccines (cont'd)

3. Menactra
   - *Children 9 through 23 months:* Administer 2 primary doses at least 12 weeks apart.
   - *Children 24 months and older who have not received a complete series:* Administer 2 primary doses at least 8 weeks apart.

Meningococcal B vaccines:

1. Bexsero or Trumenba
   - *Persons 10 years or older who have not received a complete series.* Administer a 2-dose series of Bexsero, at least 1 month apart. Or a 3-dose series of Trumenba, with the second dose at least 2 months after the first and the third dose at least 6 months after the first. The two MenB vaccines are not interchangeable; the same vaccine product must be used for all doses.

For children who travel to or reside in countries in which meningococcal disease is hyperendemic or epidemic, including countries in the African meningitis belt or the Hajj

- administer an age-appropriate formulation and series of Menactra or Menveo for protection against serogroups A and W meningococcal disease. Prior receipt of MenHibrix is not sufficient for children traveling to the meningitis belt or the Hajj because it does not contain serogroups A or W.

For children at risk during a community outbreak attributable to a vaccine serogroup

- administer or complete an age- and formulation-appropriate series of MenHibrix, Menactra, or Menveo, Bexsero or Trumenba.

For booster doses among persons with high-risk conditions, refer to *MMWR* 2013 / 62(RR02);1-22, available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6202a1.htm.

For other catch-up recommendations for these persons, and complete information on use of meningococcal vaccines, including guidance related to vaccination of persons at increased risk of infection, see *MMWR* March 22, 2013 / 62(RR02);1-22, and *MMWR* October 23, 2015 / 64(41); 1171-1176 available at http://www.cdc.gov/mmwr/pdf/rr/rr6202.pdf, and http://www.cdc.gov/mmwr/pdf/wk/mm6441.pdf.

12. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 10 years for both Boostrix and Adacel)

Routine vaccination:

- Administer 1 dose of Tdap vaccine to all adolescents aged 11 through 12 years.
- Tdap may be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.
- Administer 1 dose of Tdap vaccine to pregnant adolescents during each pregnancy (preferred during 27 through 36 weeks gestation) regardless of time since prior Td or Tdap vaccination.

Catch-up vaccination:

- Persons aged 7 years and older who are not fully immunized with DTaP vaccine should receive Tdap vaccine as 1 (preferably the first) dose in the catch-up series; if additional doses are needed, use Td vaccine. For children 7 through 10 years who receive a dose of Tdap as part of the catch-up series, an adolescent Tdap vaccine dose at age 11 through 12 years should NOT be administered. Td should be administered instead 10 years after the Tdap dose.
- Persons aged 11 through 18 years who have not received Tdap vaccine should receive a dose followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter.
- Inadvertent doses of DTaP vaccine:
  - If administered inadvertently to a child aged 7 through 10 years may count as part of the catch-up series. This dose may count as the adolescent Tdap dose, or the child can later receive a Tdap booster dose at age 11 through 12 years.
  - If administered inadvertently to an adolescent aged 11 through 18 years, the dose should be counted as the adolescent Tdap booster.
- For other catch-up guidance, see Figure 2.

13. Human papillomavirus (HPV) vaccines. (Minimum age: 9 years for 2vHPV [Cervarix], 4vHPV [Gardasil] and 9vHPV [Gardasil 9])

Routine vaccination:

- Administer a 3-dose series of HPV vaccine on a schedule of 0, 1-2, and 6 months to all adolescents aged 11 through 12 years. 9vHPV, 4vHPV or 2vHPV may be used for females, and only 9vHPV or 4vHPV may be used for males.
- The vaccine series may be started at age 9 years.
- Administer the second dose 1 to 2 months after the first dose (minimum interval of 4 weeks); administer the third dose 16 weeks after the second dose (minimum interval of 12 weeks) and 24 weeks after the first dose.
- Administer HPV vaccine beginning at age 9 years to children and youth with any history of sexual abuse or assault who have not initiated or completed the 3-dose series.

Catch-up vaccination:

- Administer the vaccine series to females (2vHPV or 4vHPV or 9vHPV) and males (4vHPV or 9vHPV) at age 13 through 18 years if not previously vaccinated.
- Use recommended routine dosing intervals (see Routine vaccination above) for vaccine series catch-up.

Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening

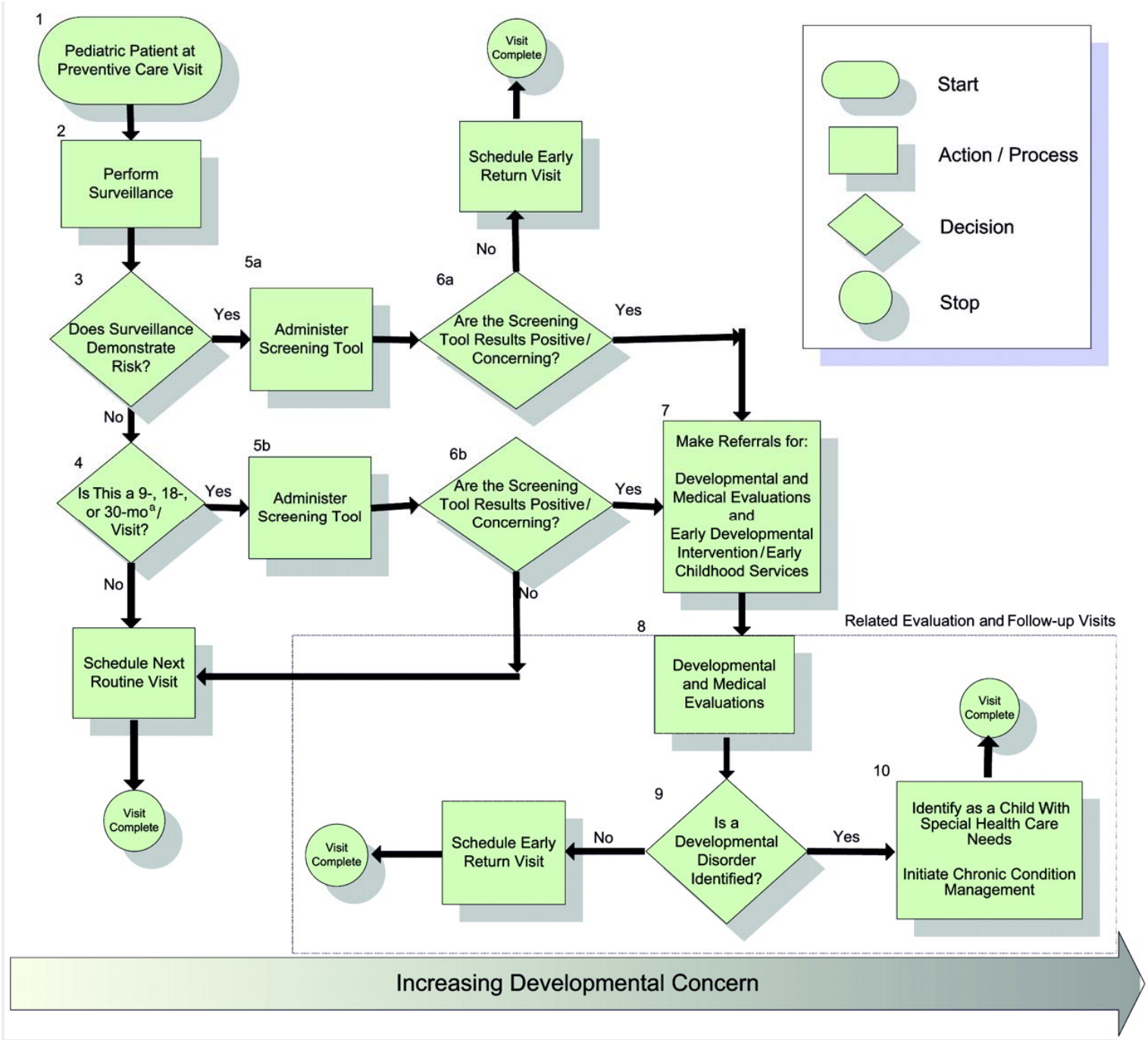

FIGURE 1

Developmental surveillance and screening algorithm within a pediatric preventive care visit. [a] Because the 30-month visit is not yet a part of the preventive care system and is often not reimbursable by third-party payers at this time, developmental screening can be performed at 24 months of age.

Council on Children With Disabilities et al. Pediatrics 2006;118:405-420

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Pediatric Patient at Preventive Care Visit

1. Developmental concerns should be included as one of several health topics addressed at each pediatric preventive care visit throughout the first 5 years of life.[6]

2. ***Developmental surveillance*** is a flexible, longitudinal, continuous, and cumulative process whereby knowledgeable health care professionals identify children who may have developmental problems. There are 5 components of developmental surveillance: eliciting and attending to the parents' concerns about their child's development, documenting and maintaining a developmental history, making accurate observations of the child, identifying the risk and protective factors, and maintaining an accurate record and documenting the process and findings.

Perform Surveillance

Does Surveillance Demonstrate Risk?

3. The concerns of both parents and child health professionals should be included in determining whether surveillance suggests the child may be at risk of developmental delay. If either parents or the child health professional express concern about the child's development, a developmental screening to address the concern specifically should be conducted.

4. All children should receive developmental screening using a standardized test. In the absence of established risk factors or parental or provider concerns, a general developmental screen is recommended at the 9-, 18-, and 30-month[a] visits. Additionally, autism-specific screening is recommended for all children at the 18-month visit.

Is This a 9-, 18-, or 30-mo[a] Visit?

Administer Screening Tool

5a and 5b. ***Developmental screening*** is the administration of a brief standardized tool aiding the identification of children at risk of a developmental disorder. Developmental screening that targets the area of concern is indicated whenever a problem is identified during developmental surveillance.

6a and 6b. When the results of the periodic screening tool are normal, the child health professional can inform the parents and continue with other aspects of the preventive visit. When a screening tool is administered as a result of concerns about development, an early return visit to provide additional developmental surveillance should be scheduled even if the screening tool results do not indicate a risk of delay.

Are the Screening Tool Results Positive/ Concerning?

Make Referrals for:

Developmental and Medical Evaluations and Early Developmental Intervention/Early Childhood Services

Developmental and Medical Evaluations

7–8. If screening results are concerning, the child should be scheduled for developmental and medical evaluations. ***Developmental evaluation*** is aimed at identifying the specific developmental disorder or disorders affecting the child. In addition to the developmental evaluation, a ***medical diagnostic evaluation*** to identify an underlying etiology should be undertaken. ***Early developmental intervention/early childhood services*** can be particularly valuable when a child is first identified to be at high risk of delayed development, because these programs often provide evaluation services and can offer other services to the child and family even before an evaluation is complete.[25] Establishing an effective and efficient partnership with early childhood professionals is an important component of successful care coordination for children.[40]

9. If a developmental disorder is identified, the child should be identified as a child with special health care needs and chronic condition management should be initiated (see No. 10 below). If a developmental disorder is not identified through medical and developmental evaluation, the child should be scheduled for an early return visit for further surveillance. More frequent visits, with particular attention paid to areas of concern, will allow the child to be promptly referred for further evaluation if any further evidence of delayed development or a specific disorder emerges.

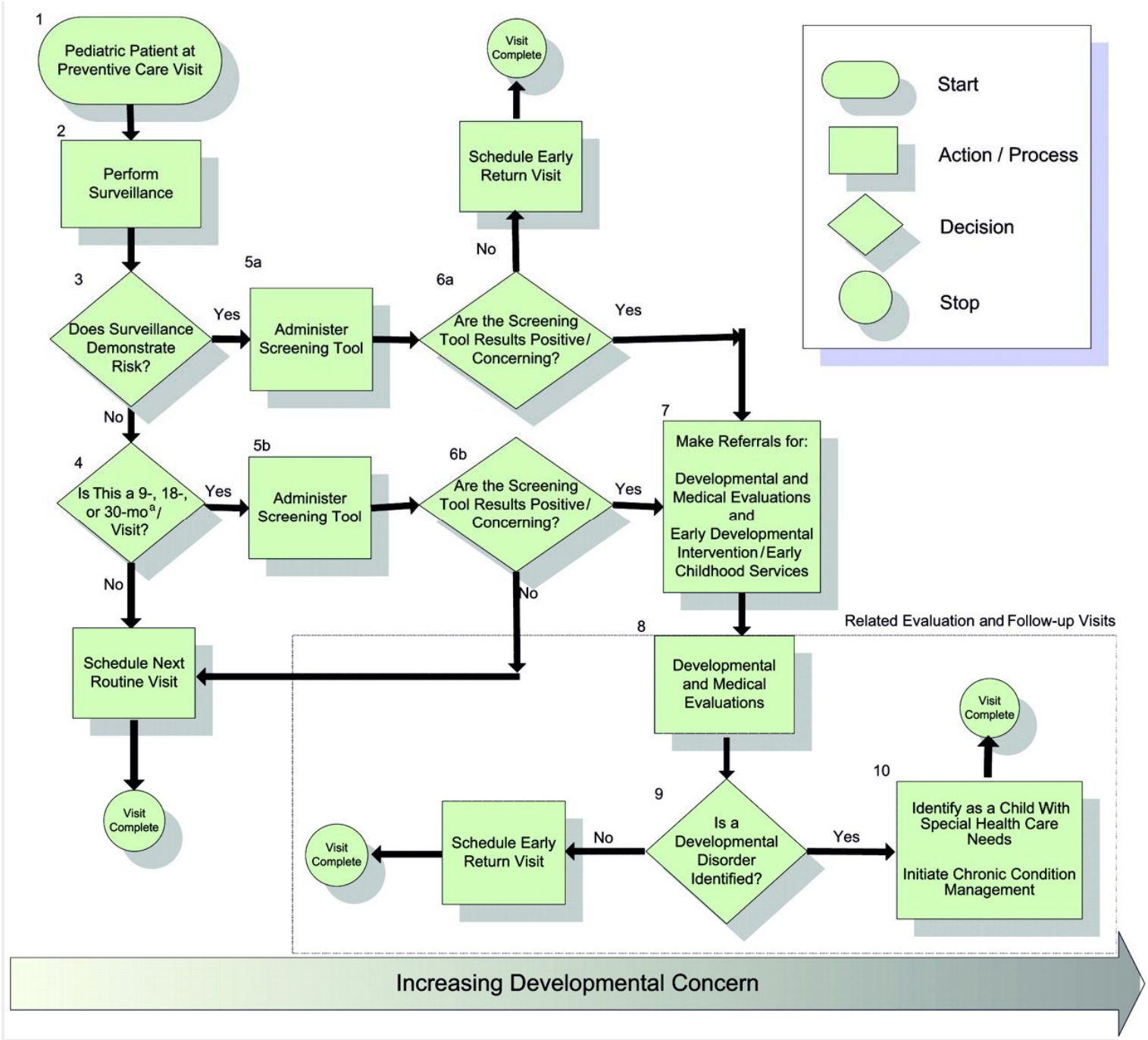
Is a Developmental Disorder Identified?

Identify as a Child With Special Health Care Needs

Initiate Chronic Condition Management

10. When a child is discovered to have a significant developmental disorder, that child becomes a child with special health care needs, even if that child does not have a specific disease etiology identified. Such a child should be identified by the medical home for appropriate chronic condition management and regular monitoring and entered into the practice's children and youth with special health care needs registry.[41]

Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening



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The Importance of Play in Promoting Healthy Child Development and Maintaining Strong Parent-Child Bond: Focus on Children in Poverty

Regina M. Milteer, Kenneth R. Ginsburg, COUNCIL ON COMMUNICATIONS AND MEDIA COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH and Deborah Ann Mulligan

Pediatrics 2012;129;e204; originally published online December 26, 2011;
DOI: 10.1542/peds.2011-2953

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

CLINICAL REPORT

The Importance of Play in Promoting Healthy Child Development and Maintaining Strong Parent-Child Bond: Focus on Children in Poverty

Regina M. Milteer, MD, Kenneth R. Ginsburg, MD, MSEd, and the COUNCIL ON COMMUNICATIONS AND MEDIA and COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH

abstract

FREE

Play is essential to the social, emotional, cognitive, and physical well-being of children beginning in early childhood. It is a natural tool for children to develop resiliency as they learn to cooperate, overcome challenges, and negotiate with others. Play also allows children to be creative. It provides time for parents to be fully engaged with their children, to bond with their children, and to see the world from the perspective of their child. However, children who live in poverty often face socioeconomic obstacles that impede their rights to have playtime, thus affecting their healthy social-emotional development. For children who are underresourced to reach their highest potential, it is essential that parents, educators, and pediatricians recognize the importance of lifelong benefits that children gain from play. *Pediatrics* 2012;129:e204–e213

KEY WORDS
children, development, parents, pediatrician, play, poverty

ABBREVIATIONS
AAP—American Academy of Pediatrics

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More than 15 million children in the United States younger than 18 years live in poverty.[1] These children experience disparities in education, health care, and socioeconomic resources.[2–6] Children living in poverty may also be deprived of the benefits of safe and creative playtime and access to age-appropriate extracurricular activities. The implications of play deprivation may be substantial, because play is essential to the social, emotional, cognitive, and physical well-being of children beginning in early childhood.[7] In addition, play offers an opportunity for parents to view the world from their child's perspective as they engage fully with their children during playtime; all families deserve ready access to this bonding opportunity. Even before the United Nations High Commission for Human Rights cited play as a right of every child, philosophers and psychologists, such as Plato, Piaget, and Friedrich Froebel, recognized the importance of play in healthy child development.[8–10]

This report addresses issues that may deprive children who live in poverty from gaining the maximum benefit from play. Because it follows an earlier report that focused on factors reducing free playtime for children whose families have resources, this report addresses issues specific to children from lower-income families.[7] Although some of the factors covered in the previous report may also apply to children from lower-income and poor families, 3 issues disproportionately affect these children and merit special attention. First, access to recess and other in-school creative and physical

outlets (eg, physical education, art, music), as well as after-school youth development programs are reduced. Second, out-of-school opportunities for play may be compromised by a lack of safe play areas, because parks and playgrounds are less abundant in lower-income areas and, in some cases, may be unsafe because of drug dealing, violence, and vandalism.[11,12] Finally, because lower-income parents have to deal with additional social, emotional, and economic stressors of daily living, they may have less time, energy, and resources available to provide active and creative playtime at the park, playground, or even in the home.

All children deserve the opportunity to reach their highest potential. The optimal developmental milieu for children includes academic enrichment, as well as opportunities for physical, cognitive, social, and emotional growth offered in school, home, and community settings. There are different forms of play—free unstructured play, which uses unlimited creativity, and semistructured play, which is guided play with joint attention by parent and child. It is beyond the scope of this report to define and divide, but poverty may prevent challenges to both unstructured and guided play.

Free unstructured play, as well as creative and physical outlets, contribute to social and emotional growth. This report offers guidance on how pediatricians can advocate for children by helping families, school systems, and communities consider how best to ensure play is protected and promoted as the optimal developmental milieu for positive child and youth development is explored.

THE BENEFITS OF PLAY

It could be argued that active play is so central to child development that it should be included in the very definition of childhood. Play offers more than cherished memories of growing up, it allows children to develop creativity and imagination while developing physical, cognitive, and emotional strengths. A previous manuscript described the benefits of play in fuller detail.[7]

Play enhances physical health by building active, healthy bodies. Physical activity beginning in early childhood prevents obesity.[13] In fact, play may be an exceptional way to increase physical activity levels in children and, therefore, may be included as an important strategy in addressing the obesity epidemic.[14,15]

Play contributes to healthy brain development.[16–18] Children engage and interact with the world around them through play from a very early age. Even in the academic environment, play helps children adjust to the school setting, thereby fostering school engagement, and enhances children's learning readiness, learning behaviors, and problem-solving skills.[19–31] In addition, play and recess may increase children's capacity to store new information, as their cognitive capacity is enhanced when they are offered a drastic change in activity.[19,20]

Play is essential to developing social and emotional ties. First, play helps to build bonds within the family. Children's healthy development is mediated by appropriate nurturing relationships with consistent caregivers.[16] Play allows for a different quality of interaction between parent* and child, one that allows parents to "listen" in a very different, but productive, way. When parents observe their children playing or join them in child-driven play, they can view the world through their child's eyes and, therefore, may learn to communicate or offer guidance more effectively. Less-verbal children may be able to express themselves, including their frustrations, through play, allowing their parents an opportunity to better understand their needs. Above all, the intensive engagement and relaxed interactions that occur while playing tell children that their parents are fully paying attention to them and, thereby, contribute to a strong connection.[17,32,33] Play also helps forge connections between children. It allows them to learn how to share, to negotiate and resolve conflicts, and to learn self-advocacy skills when necessary.[34,35] It teaches them leadership as well as group skills that may be useful in adult life.

Play should be an integral component of school engagement. School engagement is best realized when the educational setting attends to the social and emotional development of children as well as their cognitive development. The challenge is to make each child feel competent in a school setting, because the experience of success forms positive associations with school attendance.[9] Although we hope for each child to demonstrate academic strengths, opportunities to exhibit social, physical, and creative strengths optimizes the chances that children will realize their areas of strength. Play, recess time, and classes that foster creative aptitude and physical fitness allow for peer interactions that contribute both to school engagement and social-emotional learning. Social-emotional learning should not be thought of as distinct from academic learning, because it can creatively be integrated with academic learning and has been shown to enhance children's ability to learn.[36–38]

Play is a natural tool that children can and should use to build their resilience. At its core, the development of resilience is about learning to overcome challenges and adversity. As mentioned, children learn to deal with

*The word "parent" is used in this report to represent the wide range of adult caregivers who raise children.

social challenges and navigate peer relationships on the playground. In addition, even small children use imaginative play and fantasy to take on their fears and create or explore a world they can master. Play allows them to create fantasy heroes that conquer their deepest fears. It allows them to practice adult roles, sometimes while playing with other children and sometimes while play-acting with adults.[34,39–41] Sensitive adults can observe this play and recognize the fears and fantasies that need to be addressed; however, in many cases, play itself helps children meet their own needs. As they experience mastery of the world they create, children develop new competencies that lead to enhanced confidence and the resilience they need to address future challenges.[34,42]

FACTORS THAT REDUCE PLAY FOR CHILDREN IN POVERTY AND THE POTENTIAL IMPLICATIONS

Reduced Access to Play in Schools

There has been a national trend over the past decade of reducing playtime as an integral part of the school day. This trend is most easily observed in the reduction and, in some cases, elimination of recess; however, there are more subtle changes throughout the school day that reduce children's opportunity to play. First, the approach to early education that naturally incorporated play into the school day is shifting toward a more academically oriented instructional approach as new standards for reading readiness have changed for even kindergarten students.[9] Second, in many districts, there is less school time allocated to the creative arts and physical education.[9,43,44] These subjects contribute to a well-rounded education for a variety of reasons but share some of the benefits of play. They allow for a break from the standard academic subjects, foster creative and physical expression, and teach relaxation and stress-reduction skills that will last a lifetime.[9,13] Finally, even after-school activities have shifted away from play and physical activity and toward being an extension of academics and a space for homework completion.[43] This report focuses on reduced recess for illustrative purposes.

Many of these trends are disproportionately affecting underresourced school districts because of targeted efforts to reduce significant academic disparities. It is a national imperative that all children are given the opportunity to reach their academic potential, and efforts to reduce disparities between children with varying levels of resources are urgently needed. It remains important, however, that what is known about child development, including social and emotional learning, remains at the forefront of consideration as policies to raise academic standards and performance for children are created and implemented. Play, in all its forms, needs to be considered as the ideal educational and developmental milieu for children is created. Because poorer children are most dramatically affected by these policies, stakeholders must remain vigilant in ensuring that children do not inadvertently suffer from the diminution of play in their lives while exploring potential solutions to benefit them academically.

A report by the National Center for Education Statistics revealed that children who attend schools with high minority and high poverty rates in urban settings are more likely to have reduced recess time as compared with their peers in more affluent suburban areas.[44–46] Twenty-eight percent of schools with students who have the highest poverty rates had no recess at all.

The No Child Left Behind Act of 2001, designed to decrease the achievement gap of disadvantaged students, allocated additional educational resources and enrichment programs while decreasing recess time to allow more formal educational encounters.[47] At its inception, child development experts, including educators and pediatricians, voiced caution about the demise of playtime for young children with the proposed increased curriculum time of the program.[9] The experts supported the Alliance for Childhood recommendations that children from low-income families be afforded time to learn how to play and time to play.[9] Perhaps in recognition of the importance of the social and emotional development, as well as academic success of children who live at or below the poverty line, the US Department of Education in 2009 announced the Race to the Top Program, an education initiative that financially rewards school districts that support improving social, cognitive, physical, and emotional school readiness of disadvantaged students. In bids to receive the rewards, school districts must demonstrate focused programs that prepare students in the core academic subjects and other subjects that contribute to the development of well-rounded students, such as physical education and the arts.[48] Thus, children who might otherwise not be afforded opportunities for physical activity and enrichment programs outside of the school day have designated time to enhance their total development.

The disparity between access to recess between middle-income and lower-income districts may be explained by factors other than recess time being transferred to reading and math instruction. It has been suggested that reduced recess in poorer areas is reflective of adult concerns that it is not safe for poorer children to have

unstructured time; yet, it has not been proven that recess is unsafe. A time to play is different from the environment in which play occurs. When children have toys and equipment with which to play and attention is paid to helping the children transition back to class, the benefits of recess in terms of expressivity, exercise, and socialization suggest its vital role in the child's school day and overall well-being. Some experts believe the real danger is that the misunderstanding has led to the removal of playtime.[49] The reduction of recess and other in-school opportunities to play affect all children but may have a particularly detrimental effect on poorer children, because they are likely to have fewer opportunities to play outside of school.[11,12] In addition, because school is often the first true socialization environment for vulnerable children, the opportunity for social and emotional learning must not be compromised.

Poor children enter the educational system at a lower level of readiness, averaging 2 years behind their middle- and upper-class peers.[50] This may be explained in part by their increased exposure to social stressors (higher rates of single mothers who lack social supports and financial resources, absent fathers, limited access to early childhood education, unsafe neighborhoods, lack of preventive health care). They mainly enter schools in poor communities that lack financial resources to enhance the educational process.[51] Schools, under pressure to increase academic performance and to decrease the achievement gap of students, have increased direct educational time, including after-school enrichment and tutorial programs. Although it is important to decrease academic disparities, enhanced nonacademic interactions are also essential to prepare children for future success. If the overall goal is to decrease school failure, which could ultimately lead to depression, entry into the juvenile justice system, and continued economic deprivation, a response to the problem has to include efforts to promote school engagement.[49] As previously discussed, opportunities for play and social and emotional learning enhance school engagement. Quite simply, school engagement occurs when children succeed academically, have other nonacademic opportunities for success (creative arts, physical education), and consider school a place in which they feel safe and enjoy spending time.

Play in the school day offers benefits to academic as well as social and emotional learning. A recent report by Barros and others stated that a break during the school day of ≥15 minutes was associated with better teachers' ratings of classroom behavior scores.[19] Good behavior in the classroom is associated with a more productive learning environment secondary to increased attentiveness.[19,20] In addition, children's ability to store new information is increased, because their cognitive capacity is enhanced by a drastic change in activity.[51–53] A change in academic subject and even physical education class may not offer the same benefit as free-play recess.[49] A reduction of time for physical activity may have even greater implications for boys. Schools that use only sedentary styles of learning may be a more difficult environment for boys to navigate successfully and contribute to the discordant academic abilities between boys and girls.[54,55] These findings suggest that decreasing and eliminating recess for students at risk for school failure may be counterproductive.

Finally, it is recognized among educators that recess represents the most powerful strategy to get the most children to participate in physical activity.[56] In its "Physical Activity Guidelines for Americans," the US Department of Health and Human Services recommends 1 hour or more of physical activity per day, with a major part of the hour dedicated to moderate to vigorous physical activity at least 3 times per week for children and adolescents.[57] Physical education curricula should enhance attitudes, habits, and behavioral skills that result in continued physical activity throughout life.[14] Overall, recess offers the most available opportunity for children to play and to engage in physical activity, followed by physical education classes and after-school activities.[58]

Reduced Out-of-School Opportunities for Play

Children cannot play safely outside of the home in many poor communities —urban, suburban, and rural—unless they are under close adult supervision and protection. This is particularly true in areas that are unsafe because of increased violence or where other environmental dangers exist.[11,12] In the past, when neighbors knew each other and often supervised each other's children, there was an extra layer of protection for neighborhood children when they played outside. In today's society, it is not unusual for neighbors not to know one another. Therefore, parents are alone in protecting and supervising their children, which can severely limit outside playtime.

Children who are not engaged in play and physical activity outside of school hours spend time engaged in sedentary activities, such as viewing hours of television, playing video games, or listening to music. This time is often spent in isolation without social interaction and without adult supervision. In sharp contrast to the benefits of

active, creative play, there is substantial evidence that excessive screen time has adverse effects.[59–64] The AAP policy statement on media education presented research that associates media exposure with negative physical and behavioral health problems in children, including obesity, violent and aggressive behavior, depression, anxiety, earlier sexual behaviors, poor academic performance and self-image, nightmares, and tobacco and substance abuse.[63,64]

The sedentary lifestyle is associated with obesity, for which children from low income and minority families are already disproportionally at risk.[65] The AAP and others have reported that children who are obese in early childhood are more likely to be obese adults and to be at risk for the comorbidities associated with obesity, including type 2 diabetes mellitus, hypertension, coronary artery disease, hypercholesterolemia, hyperlipidemia, asthma, and sleep apnea.[14,66,67] In addition to the long-term health effects, obesity may be associated with immediate social and emotional consequences, including low self-esteem, negative body image, depression, teasing and bullying, social marginalization, and discrimination.[63,64,66,67] Obesity can have socioemotional effects on academic achievement and opportunities and can, therefore, thwart educational trajectories associated with long-term success.[66,67]

Family Considerations

Although lower-income parents have the same desires for their children to succeed and reach their full potential as do parents with greater economic and social assets, they must focus primarily on the family's day-to-day survival. When food and shelter are at risk, ensuring time for the children to have free and creative playtime may not be a priority. Economic hardship is a major obstacle for these families, in which the parents are more likely to have a lower educational level or be single heads of households. Minority households (black and Hispanic) and immigrant parents are at increased risk of having children who live in poverty.[1,68] There is more likely to be a history of substance abuse in poorer families. The neighborhoods in which they live lack community resources, such as community centers, parks, and fully equipped supervised playgrounds that offer safe places for children to play and to gather. Children have fewer opportunities to participate in organized sports. Because of fear of violence, families do not venture outside with their children for fun physical activities, such as walking, bike riding, swinging, swimming, playing tennis, or jogging.[11,12,69] In a safe environment with community resources, these activities would not be an additional financial burden to already challenged families.

Poor families may also be at a disadvantage in a material-driven culture in which marketing messages, often claims without proof, abound about what children need to prosper. They may absorb the messages that the best toys are those that are the most expensive or that children are only academically prepared for preschool if exposed to a variety of enrichment tools and activities that claim to produce high-achieving children. Parents who cannot afford these market-driven materials may feel disempowered to actively play with and enrich their children using the most effective known tools—themselves. Children's creativity is enhanced with the most basic (and least expensive) toys, blocks, dolls, and art supplies. Children's academic preparedness may be most developed with low-cost time spent reading with parents. They will learn to love books when they associate quality time with their parents with reading.[70]

Lower-income parents may have fewer resources, including time, to invest in playing with their children. Because play holds so many benefits, including fostering connection between parents and children, less play may be an added, although rarely mentioned, risk of poverty. No one is certain what skills will be needed for our children to be best prepared to lead us into the future, but we do have insight into which character traits will produce children capable of navigating an increasingly complex world. These include confidence, the ability to master the environment, and a connection to others. In addition, to be resilient—to retain hope and to be able to overcome adversity—young people need the added character traits of honesty, generosity, decency, tenacity, and compassion.[71] Children gain these essential traits within a home, when parents and children interact in a supportive manner and share unconditional love.[71–76] Play is a time-tested way for families to have these types of interactions.

WHAT ARE THE SOLUTIONS?

Because there are many causes for the decreased amount of play in the lives of lower-income and poor children, there is no single solution. In addition, simplistic proposed solutions might not take into consideration the complex interplay of factors that have led to decreased play, including the need for safety. For example, if a child does not reside in a safe neighborhood, it may be unwise to simply propose more outdoor child-centered play. Similarly, it may be naïve to insist on more recess without simultaneously coming up with solutions that address the very substantive issue of educational disparities. It is critical, however, that as strategies are developed that

address educational needs and safety, the recognition of children's need to play be strongly advocated, because play is known to promote healthy development and resilience.[46,52,55,58] To effectively preserve play in the lives of economically disadvantaged children, its presence in schools, communities, and homes must be supported.

In schools, the need to support social and emotional learning and healthy child development must be held alongside the need to increase academic scores. Otherwise, school engagement might suffer and efforts at creating a better-prepared generation might fail. The bottom line to school engagement is that schools should be the kind of places that children and adolescents want to be. This means that educators and policy makers must make opportunities for lower-income children to gain the benefits offered from physical education, recess, and the arts so they can reach their highest potential for cognitive, social, and physical development and so children and adolescents will like school. Advocates can also promote programs such as Head Start, the purpose of which is the promotion of school readiness for low-income children. Head Start provides an environment that enhances students' emotional, social, and cognitive development and has demonstrated effectiveness.[77] One of the keys to the success of Head Start has been the involvement of parents in social interaction with their children in playing, reading, and reading-related activities.[78]

Policy makers and community leaders must work together to prioritize the need for safe spaces for families to gather and for children to play. Supervised after-school programs can be critical to children who live in communities where outside playing might be dangerous or unsupervised. Community-based programs that offer a wide variety of services, ranging from homework assistance to athletic programs and from character development to the creative arts can contribute heavily to the positive development of youth. Keeping school facilities open for use by community families in the evenings and on weekends when they are usually closed may increase engagement in these activities. Communities can also offer strategies to link families at or below the poverty level to early education, health care, family support, and parenting education.

Parents of all income levels should use time together at home to engage in both free and structured play with their children. Playtime is bonding time for families. A first step may be education about the value of play that simultaneously refutes false notions that for play to be effective, it must involve expensive toys. Parents from across the economic spectrum need to understand that it is their presence and their attention that enrich their children and that one-on-one play is a time-tested, effective way of being fully present. In parallel, we must be sensitive to the fact that time itself is a commodity when struggling for economic survival. The most comprehensive solutions, therefore, must address broader economic disparities and other factors that create stresses for economically disadvantaged parents.

Certainly, these solutions are broad and societal, going beyond the purview of the pediatrician's office. But as child health professionals committed to the attainment of optimal physical, mental, and social health and well-being for all infants and children, pediatricians have a role in advocating for broad-based solutions that will preserve child play.

ADVICE FOR PEDIATRICIANS

As caring, objective child health professionals, pediatricians have a natural role to advocate for the conditions that allow for the optimal physical, emotional, and social development of children and adolescents. Because play contributes substantially to the healthy development and well-being of children, it is important that pediatricians promote the inclusion of play in homes, schools, and communities.†

- Pediatricians can educate parents about the importance of free, unstructured play in the normal development of children.
- Parents may be influenced by marketing messages that suggest the best toys are those that are financially out of reach. They should be educated that simple, inexpensive toys, such as dolls, jump ropes, blocks, balls, and buckets, are more effective in allowing children to be creative and imaginative than more expensive toys, which can make play a more passive and less physically involved experience.
- Pediatricians can educate parents about the benefits of using play as an opportunity to engage fully with their children. Playtime offers opportunities for parent-child bonding. Playtime offers parents the opportunity to promote healthy social-emotional development in their children through active engagement and shared imagination.
- Pediatricians can encourage parents to use love and understanding to encourage children to try again even when at first they fail. Parents can be informed that

†The guidance in this report is offered by the AAP and, therefore, is targeted to pediatricians. Other health professionals who serve children and adolescents, including other physicians, pediatric and family nurse practitioners, and physician assistants are welcome to consider incorporating this guidance into practice.

positive reinforcement goes further than negative responses as children engage in play alone and with others.

- Pediatricians can use well-child encounters to educate parents about the benefits of play to enhance physical activity that can help prevent childhood obesity. Parents should be educated about the potential for lifelong obesity in obese children, the lifelong health morbidities associated with obesity, and the long-term psychosocial impact of obesity.
- Parents should be encouraged to participate in physical activities with their children that will not have a financial impact on the family.
- Pediatricians can provide parents with information about resources that can provide financial, educational, and mental health assistance to families that have been marginalized by poverty. This may address the underlying stressors that interfere with parents' ability to engage fully in play activities.
- Pediatricians can educate parents about the negative impact of media exposure on children and encourage them to limit screen time and substitute other activities, including playtime and outdoor activities, for screen time. This is an opportunity to educate parents about the AAP recommendations regarding no media time for children younger than 2 years and fewer than 2 hours per day for older children.
- Pediatricians can provide parents and families with information about community resources that provide physical activities for children, such as team sports and camps. They should provide information about organizations that provide "scholarships" or grants that pay for activities that have associated costs.
- Pediatricians can educate parents about the importance of children's play outdoors in nature. Spending unstructured time in nature, surrounded by dirt, trees, grass, rocks, flowers, and insects inspires children's play and offers physical and emotional benefits.
- Pediatricians can advocate for safe play spaces for children who live in communities and attend schools with a high proportion of low-income and poor children by emphasizing that the lifelong success of children is based on their ability to be creative and to apply the lessons learned from playing.
- Pediatricians may consider offering presentations to help educators, community leaders, faith-based groups, and politicians understand the developmental benefits of play to children.
- Pediatricians may advocate for policies that reduce educational disparities while supporting the inclusion of recess, physical outlets, and the creative arts as means to enhance social and emotional learning and school engagement.

CONCLUSIONS

Children who live at or below poverty level in the United States experience educational and health disparities from early childhood. These children deserve additional resources to achieve academically, foster school engagement, and develop their social and emotional competencies. Many children reside in families that face stresses related to daily survival, including whether they will have food or safe shelter, leaving less energy to focus on enrichment opportunities, including play. Some live in neighborhoods where violence may be the norm and children playing on neighborhood playgrounds the exception. School systems are focused on overcoming their academic deficiencies in a safe environment often at the expense of time for arts, recess, physical education classes, and after-school activities that include playing, despite evidence that supports that what happens in play contributes substantially to social and emotional learning, even in the classroom.

Regardless of their socioeconomic status, all children have the right to safe places to play regularly, during which they develop cognitive, communication, problem-solving, negotiation, and leadership skills. They have the right to engage in safe and regular physical activity that will decrease the incidence of lifelong health disparities. The physically and emotionally healthy children of today will become the productive citizens who will contribute positively to society in the future.

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REFERENCES

1. United States Census Bureau. *Current Population Reports: Income, Poverty, and Health Insurance Coverage in the United States: 2009*. Washington, DC: September 2010. Available at: www.census.gov/prod/2010pubs/p60-238.pdf. Accessed June 1, 2011
2. Council on Community Pediatrics and Committee on Native American Child Health. Policy statement—health equity and children's rights. *Pediatrics*. 2010;125(4):838–849
3. Palfrey JS, Tonniges TF, Green M, Richmond J. Introduction: Addressing the millennial morbidity—the context of community pediatrics. *Pediatrics*. 2005;115(4 Suppl):1121–1123
4. Newacheck PW, Stein RE, Bauman L, Hung YY, ; Research Consortium on Children With Chronic Conditions. Disparities in the prevalence of disability between black and white children. *Arch Pediatr Adolesc Med*. 2003;157(3):244–248
5. Children's Defense Fund. *Improving Children's Health—Understanding Children's Health Disparities*. Washington, DC: Children's Defense Fund; 2006. Available at: http://cdf.childrensdefense.org/site/DocServer/CDF_Improving_Childrens_HealthFINAL.pdf?docID=1781. Accessed June 1, 2011
6. Johnson K, Theberge S. National Center for Children in Poverty (NCCP). *Reducing disparities beginning in early childhood*. National Center for Children in Poverty, New York, NY; 2007. Available at www.nccp.org/publications/pub_744.html. Accessed March 31, 2010
7. Ginsburg KR, ; American Academy of Pediatrics Committee on Communications; American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health. The importance of play in promoting healthy child development and maintaining strong parent-child bonds. *Pediatrics*. 2007;119(1):182–191
8. Frost JL, Norquist T. The importance of play. Association Guest Column: International Playground Equipment Manufacturers Association (IPEMA). *Recreation Management Magazine*. 2007. Available at: www.recmanagement.com/200705gc03.php. Accessed June 1, 2011
9. Miller E, Almon J. *Crisis in the Kindergarten: Why Children Need to Play in School*. College Park, MD: Alliance for Childhood; 2009
10. Office of the United Nations High Commissioner for Human Rights. Convention on the Rights of the Child. General Assembly Resolution 44/25 of November 20, 1989. Available at: www.un.org/documents/ga/res/44/a44r025.htm. Accessed June 1, 2011
11. Mowan AJ. *Parks, Playgrounds, and Active Living*. San Diego, CA: Robert Wood Johnson Active Living Research; 2010. Available at: www.activelivingresearch.org/files/Synthesis_Mowen_Feb2010.pdf. Accessed June 1, 2011
12. Scott D, Munson W. Perceived constraints to park usage among individuals with low incomes. *J Park Recreation Admin*. 1994;12:79–96
13. Campbell KJ, Hesketh KD. Strategies which aim to positively impact on weight, physical activity, diet and sedentary behaviours in children from zero to five years. A systematic review of the literature. *Obes Rev*. 2007;8(4):327–338
14. Council on Sports Medicine and Fitness-Council on School Health. Active healthy living: prevention of childhood obesity through increased physical activity. *Pediatrics*. 2006;117(5):1834–1842
15. Cleland V, Venn A. Encouraging physical activity and discouraging sedentary behavior in children and adolescents. *J Adolesc Health*. 2010;47(3):221–222
16. Institute of Medicine, Committee on Integrating the Science of Early Childhood Development, Board on Children, Youth and Families. In: Shonkoff JP, Phillips DA, eds. *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Washington, DC: National Academies Press; 2000
17. Tamis-LeMonda CS, Shannon JD, Cabrera NJ, Lamb ME. Fathers and mothers at play with their 2- and 3-year-olds: contributions to language and cognitive development. *Child Dev*. 2004;75(6):1806–1820
18. Chudacoff H. *Children at Play: An American History*. New York, NY: NYU Press; 2007
19. Barros RM, Silver EJ, Stein RE. School recess and group classroom behavior. *Pediatrics*. 2009;123(2):431–436
20. Robert Wood Johnson Foundation. *The State of Play—Gallup Survey of Principals and School Recess*. Princeton, NJ: Robert Wood Johnson Foundation; 2010
21. Coolahan K, Fantuzzo J, Mendez J, McDermott P. Preschool peer interactions and readiness to learn: relationships between classroom peer play and learning behaviors and conduct. *J Educ Psychol*. 2000;92(3):458–465
22. Raver CC, Ziegler EF. Social competence: an untapped dimension in evaluating Head Start's success. *Early Child Res Q*. 1997;12:363–385
23. Wentzel KR. Socio-emotional processes and interpersonal relationships: implications for understanding motivation at school. *J Educ Psychol*. 1999;91:76–97
24. Fantuzzo J, McWayne C. The relationship between peer play interactions in the family context and dimensions of school readiness for low-income preschool children. *J Educ Psychol*. 2002;94:79–87

25. Coolahan K, Fantuzzo J, Mendez J, McDermott P. Interactive peer play and readiness to learn: relationships between play competencies and classroom learning behaviors and conduct. *J Educ Psychol*. 2000;29:141–152
26. Pellegrini AD, Boyd B. The role of play in early childhood development and education: issues in definition and function. In: Spodek B, ed. *Handbook of Research on the Education of Young Children*. New York, NY: MacMillan; 1993:105–121
27. McWayne CM, Fantuzzo JW, McDermott PA. Preschool competency in context: an investigation of the unique contribution of child competencies to early academic success. *Dev Psychol*. 2004;40(4):633–645
28. Fantuzzo J, Bulotsky R, McDermott P, Mosca S, Lutz MN. A multivariate analysis of emotional and behavioral adjustment and preschool educational outcomes. *School Psych Rev*. 2003;32(2):185–203
29. Fantuzzo J, Sekino Y, Cohen HL. An examination of the contributions of interactive peer play to salient classroom competencies for urban head start children. *Psychol Sch*. 2004;41(3):323–336
30. Ladd GW. Having friends, keeping friends, making friends, and being liked by peers in the classroom: predictors of children's early school adjustment? *Child Dev*. 1990;61(4):1081–1100
31. Fisher EP. The impact of play on development: a meta-analysis. *Play and Culture*. 1992;5:159–181
32. Tsao L. How much do we know about the importance of play in child development? *Child Educ*. 2002;78(4):230–233
33. Cohn DA. Child-mother attachment of six-year-olds and social competence at school. *Child Dev*. 1990;61(1):152–162
34. Hurwitz SC. To be successful—let them play! *Child Education*. 2002-2003;79(2):101–102
35. McElwain NL, Volling BL. Preschool children's interactions with friends and older siblings: relationship specificity and joint contributions to problem behavior. *J Fam Psychol*. 2005;19(4):486–496
36. Elias MJ, Arnold H. *The Educators Guide to Emotional Intelligence and Academic Achievement: Social-Emotional Learning in the Classroom*. Thousand Oaks, CA: Corwin Press; 2006
37. Zins J, Weissberg R, Wang M, Walberg HJ, eds. *Building Academic Success on Social and Emotional Learning: What Does the Research Say?* New York, NY: Teachers College Press; 2004
38. Jarrett OS. Recess in elementary school: what does the research say? *ERIC Digest*. 2002;07:00. Available at: www.eric.ed.gov/PDFS/ED466331.pdf. Accessed June 1, 2011
39. Barnett LA. Developmental benefits of play for children. *Journal of Leisure Research*. 1990;22(2):138–153
40. Pellegrini AD, Smith PK. The development of play during childhood: forms and possible functions. *Child Psychology and Psychiatry Review*. 1998;3(2):51–57
41. Flaxman SG. Play: an endangered species? *Scholastic Inc*. 1999;110(2):39–41
42. Band EB, Weisz JR. How to feel better when it feels bad: children's perspectives on coping with everyday stress. *Dev Psychol*. 1988;24:247–253
43. ED.gov. 21st Century Community Learning Centers. Available at: www.ed.gov/programs/21stcclc/index.html. Accessed June 1, 2011
44. Pasad B, Lewis L. *Calories In, Calories, Out. Food and Exercise in Public Elementary Schools*. Washington, DC: US Department of Education, National Center for Education Statistics; 2006. Publication No. NCES 2006-057
45. Center for Public Education. Time out. Is recess in danger? Available at: www.centerforpubliceducation.org/Main-Menu/Organizing-a-school/Time-out-Is-recess-in-danger Accessed June 1, 2011
46. Ramstetter CL, Murray R, Garner AS. The crucial role of recess in schools. *J Sch Health*. 2010;80(11):517–526
47. US Department of Education. *The No Child Left Behind Act of 2001: Executive Summary*. Washington, DC: US Department of Education; 2002. Available at: www.ed.gov/nclb/overview/intro/execsumm.pdf. Accessed June 1, 2011
48. US Department of Education. *Race to the Top: Executive Summary*. Washington, DC: US Department of Education; 2009. Available at: http://www2.ed.gov/programs/racetothetop/executive-summary.pdf. Accessed June 1, 2011
49. Beresin AR. *Recess Battles: Playing, Fighting, and Story Telling*. Jackson, MS: University of Mississippi Press; 2010
50. Toppino TC, Kasserman JE, Mracek WA. The effect of spacing repetitions on the recognition memory of young children and adults. *J Exp Child Psychol*. 1991;51(1):123–138
51. Children's Defense Fund. *America's Cradle to Prison Pipeline*. Washington, DC: Children's Defense Fund; 2007. Available at: www.childrensdefense.org/child-research-data-publications/data/cradle-prison-pipeline-report-2007-full-highres.pdf. Accessed June 1, 2011
52. Pellegrini AD, Smith K. *Recess: Its Role in Education and Development*. Mahwah, NJ: Erlbaum Associates; 2005
53. Stellino MB, Sinclair CD. Intrinsically motivated, free-time physical activity: considerations for recess. *JOPERD*. 2008;79(4):37–40
54. Gurian M, Stevens K. *The Minds of Boys: Saving Our Sons From Falling Behind in School and Life*. San Francisco, CA: Jossey-Bass Press; 2005
55. Pellegrini AD, Kato K, Blatchford P, Baines E. A short-term longitudinal study of children's playground games across the first year of school: implications for social competence and adjustment to school. *Am Educ Res J*. 2002;39(4):991–1015
56. National Center for Education Statistics, US Department of Education. *Foods and Physical Activity in Public Elementary Schools*. Washington, DC: US Department of Education; 2005
57. US Department of Health and Human Services. *Physical Activity Guidelines for Americans*. Washington, DC: US Department of Health and Human Services; 2008. Available at: www.health.gov/paguidelines/. Accessed June 1, 2011
58. Robert Wood Johnson Foundation. *Recess Rules*. Princeton, NJ: Robert Wood Johnson Foundation; 2007
59. Jago R, Baranowski T, Baranowski JC, Thompson D, Greaves KA. BMI from 3–6 years of age is predicted by TV viewing and physical activity, not diet. *Int J Obes*. 2005;29(6):557–564
60. Browne KD, Hamilton-Giachritsis C. The influence of violent media on children and adolescents: a public-health approach. *Lancet*. 2005;365(9460):702–710
61. Strasburger VC, Donnerstein E. Children, adolescents, and the media: issues and solutions. *Pediatrics*. 1999;103(1):129–139
62. Zimmerman FJ, Christakis DA. Children's television viewing and cognitive outcomes: a longitudinal analysis of national data. *Arch Pediatr Adolesc Med*. 2005;159(7):619–625
63. American Academy of Pediatrics, Council on Communications and Media. Policy statement—media education. *Pediatrics*. 2010;126(5):1012–1017
64. Council on Communications and Media. From the American Academy of Pediatrics: Policy statement—Impact of music, music lyrics, and music videos on children and youth. *Pediatrics*. 2009;124(5):1488–1494
65. Wang Y, Beydoun MA. The obesity epidemic in the United States—gender, age, socioeconomic, racial/ethnic, and geographic characteristics: a systematic review and meta-regression analysis. *Epidemiol Rev*. 2007;29(1):6–28

66. Strauss RS. Childhood obesity and self-esteem. *Pediatrics*. 2000;105(1):e15
67. Schwartz MB, Puhl R. Childhood obesity: a societal problem to solve. *Obes Rev*. 2003; 4(1):57–71
68. Douglas-Hall A, Chau M. *Basic Facts About Low Income Children, Birth to 18*. New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health; 2008. Available at: www.nccp.org/publications/pub_845.html. Accessed June 1, 2011
69. Sheidow AJ, Gorman-Smith D, Tolan PH, Henry DB. Family and community characteristics: risk factors for violence exposure in inner-city youth. *J Community Psychol*. 2001;29(3):345–360
70. Lindsay J. *Learning Point Associates for Reading is Fundamental. Children's Access to Print Material and Education-Related Outcomes*. Naperville, IL: Learning Point Associates; 2010
71. Ginsburg KR, Jablow M. *Building Resilience in Children and Teens: Giving Kids Roots and Wings*. Elk Grove Village, IL: American Academy of Pediatrics; 2011
72. Benson PL. *All Kids Are Our Kids: What Communities Must Do to Raise Caring and Responsible Children and Adolescents*. San Francisco, CA: Jossey-Bass; 1997
73. Power TG. Stress and coping in childhood: the parents' role. *Parent Sci Pract*. 2004;4 (4):271–317
74. Reivich K, Shatte A. *The Resilience Factor: 7 Essential Skills for Overcoming Life's Inevitable Obstacles*. New York, NY: Broadway Books; 2002
75. Simpson AR, Roehlkepartain JL. Asset building in parenting practices and family life. In: Lerner RM, Benson PL, eds. *Developmental Assets and Asset-Building Communities: Implications for Research, Policy, and Practice*. New York, NY: Kluwer Academic/Plenum Publishers; 2003:157–193
76. Ungar M. The importance of parents and other caregivers to the resilience of high-risk adolescents. *Fam Process*. 2004;43(1): 23–41
77. US Department of Health and Human Services, Administration for Children and Families. Head Start Act. Available at: www.acf.hhs.gov/programs/ohs/legislation/HS_act.html. Accessed June 1, 2011
78. Barnett WS, Hudstedt JT. Head start's lasting benefits. *Infants Young Child*. 2005;18 (1):16–24

The Importance of Play in Promoting Healthy Child Development and Maintaining Strong Parent-Child Bond: Focus on Children in Poverty

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Tips for Talking with Parents

If you suspect a child has a developmental delay and believe a parent is unaware of it, this sample conversation can give you ideas of how to talk with the child's parent.

Good afternoon, Ms. Jones. We love having Taylor in class. He really enjoys story time and follows directions well. He is working hard on coloring but is having a difficult time and gets frustrated. I have also noticed a few things about Taylor's social skills that I would like to discuss with you. Do you have a few minutes? *[Cite specific behaviors and when they occurred.]*

Have you noticed any of these at home?

Ms. Jones, here is some information that shows the developmental milestones for a child Taylor's age. Let's plan to meet again next week [set a time] after you've had time to read it and think it over. *[Provide information such as the fact sheets.]*

Ms. Jones, I know this is hard to talk about, and I may be over-reacting, but I think it would also be a good idea to talk to Taylor's doctor about this in the next few weeks. You can take this information with you when you go. The doctor can give Taylor a "developmental screening" which can answer some questions about his progress and whether you need to do anything else. Maybe there is no problem, but getting help early can make a big difference if there is, so it's really important to find out for sure. Let me know if you need anything from me for that doctor's appointment!

Thank you for agreeing to talk with me today. We'll all do our best to help Taylor. He is a great kid!

If a parent approaches you with concerns about his or her child, this might help you respond.

Mrs. Smith, you wanted to speak with me privately about Taylor?

[Listen to her concerns. See if she has noticed the same behaviors you have, and share examples that are the same as or different from hers.]

I am glad to know we are both on the same page. I have some information that might help you when you're watching Taylor at home this week. This fact sheet shows the developmental milestones for his age. Each child develops at his or her own pace, so Taylor might not have met all these milestones; it's worth taking a closer look. Let's meet again next *[set a date]* after you've had time to read this and think about it.

I also think it would be a good idea to talk to Taylor's doctor about this in the next few weeks. You can take this information with when you go. The doctor can give Taylor a "developmental screening" which can answer some questions about his progress and whether you need to do anything else. Let me know if you need anything from me for that doctor's appointment. Thank you for talking with me today. We'll all do our best to help Taylor. He is a great kid!

Tips for these conversations with parents:

- Highlight some of the child's strengths, letting the parent know what the child does well.
- Use materials like the "Learn the Signs. Act Early." fact sheets. This will help the parent know that you are basing your comments on facts and not just feelings.
- Talk about specific behaviors that you have observed in caring for the child. Use the milestones fact sheets as a guide. Example: If you are telling the parent "I have noticed that Taylor does not play pretend games with the other children," you could show the parent the line on the milestones fact sheet for a four-year-old that says that a child that age "engages in fantasy play."
- Try to make it a discussion. Pause a lot, giving the parent time to think and to respond.
- Expect that if the child is the oldest in the family, the parent might not have experience to know the milestones the child should be reaching.
- Listen to and watch the parent to decide on how to proceed. Pay attention to tone of voice and body language.
- This might be the first time the parent has become aware that the child might have a delay. Give the parent time to think about this and even speak with the child's other caregivers.
- Let the parent know that he or she should talk with the child's health care professional (doctor or nurse) soon if there are any concerns or more information is needed.
- Remind the parent that you do your job because you love and care for children, and that you want to make sure that the child does his or her very best. It is also okay to say that you "may be overly concerned," but that it is best to check with the child's doctor or nurse to be sure since early action is so important if there is a real delay.

www.cdc.gov/actearly

It's time to change how we view a child's growth.

4 feet
47″
46″
45″
44″
43″
42″
41″
40″
39″
38″
37″
3 feet
35″
34″
33″
32″
31″
30″
29″
28″
27″
26″
25″
2 feet
23″
22″
21″
20″
19″
18″
17″
16″
15″
14″
13″
1 foot

5 years

Speaks very clearly

Wants to please friends and wants to be like friends

Counts 10 or more things

Can tell what's real and what's make-believe

4 years

Tells stories

Understands the ideas of "same" and "different"

Plays "Mom" or "Dad"

Cooperates with other children

3 years

Says name, age, and sex

Says words like "I," "me," "we" and "you" and some plurals (cars, dogs, cats)

Does puzzles with 3 or 4 pieces

Plays make-believe with dolls, animals, and people

Copies adults and friends

2 years

Points to things or pictures when they are named

Says sentences with 2 to 4 words

Follows simple instructions

Gets excited when with other children

Begins to run

18 months

Plays simple pretend, such as feeding a doll

Points to show others something interesting

Likes to hand things to others as play

Says several single words

Says and shakes head "no"

1 year

Uses simple gestures, like shaking head "no" or waving "bye-bye"

Copies gestures

Plays games such as "peek-a-boo" or "pat-a-cake"

Says "mama" and "dada"

Responds to simple spoken requests

www.cdc.gov/actearly
1-800-CDC-INFO

Learn the Signs. Act Early.

999309
Chapter 4: Care for Children 0-5

Es hora de cambian nuestra forma de ver el crecimiento del niño.

120 cm
118 cm
116 cm
114 cm
112 cm
110 cm
108 cm
106 cm
104 cm
102 cm
100 cm
98 cm
96 cm
94 cm
92 cm
90 cm
88 cm
86 cm
84 cm
82 cm
80 cm
78 cm
76 cm
74 cm
72 cm
70 cm
68 cm
66 cm
64 cm
62 cm
60 cm
58 cm
56 cm
54 cm
52 cm
50 cm
48 cm
46 cm
44 cm
42 cm
40 cm
38 cm
36 cm
34 cm
32 cm
30 cm

5 años

Habla con mucha claridad

Quiere complacer a los amigos y quiere ser como los amigos

Cuenta 10 o más cosas

Puede distinguir entre la fantasía y la realidad

4 años

Relata cuentos

Entienda los conceptos de “igual” y “diferente”

Juega al “papá” o a la “mamá”

Colabora con otros niños

3 años

Puede decir su nombre, edad y sexo

Dice palabras como “yo”, “mi”, “nosotros”, “tú”, y algunos plurales (autos, perros, gatos)

Arma rompecabezas con 3 y 4 piezas

Juega imaginativamente con muñecas, animales y personas

Copia a los adultos y los amigos

2 años

Señala a objetos o ilustraciones cuando se los nombra

Dice frases de 2 a 4 palabras

Sigue instrucciones sencillas

Se entusiasma cuando está con otros niños

Empieza a correr

18 meses

Juega a imitar cosas sencillas, como alimentar a una muñeca

Señala para mostrar algo que le llama la atención

Le gusta alcanzarle cosas a los demás como un juego

Puede decir varias palabras sueltas

Dice “no” y sacude la cabeza como negación

1 año

Usa gestos simples como sacudir la cabeza “no” o despedirse con la mano

Imita gestos

Juega a esconder la carita y a las palmaditas con las manos

Dice “mamá” y “papá”

Responde cuando se le pide que haga algo sencillo

www.cdc.gov/pronto
1-800-CDC-INFO

Aprenda los signos. Reaccione pronto.

It's time to change how we view a child's growth.

As they grow, children are always learning new things. Below are just some of the things you should look for as your child grows. Use this as a guide, and if you have any concerns, talk with your child's doctor and call **1-800-CDC-INFO** to get connected with your community's early childhood intervention system.

At 6 months, many children

- respond to own name
- respond to other people's emotions and often seem happy
- copy sounds
- like to play with others, especially parents

At 1 year (12 months), many children

- use simple gestures, like shaking head "no" or waving "bye-bye"
- say "mama" and "dada" and exclamations like "uh-oh!"
- copy gestures
- respond to simple spoken requests

At 1 ½ years (18 months), many children

- play simple pretend, such as feeding a doll
- point to show others something interesting
- show a full range of emotions, such as happy, sad, angry
- say several single words

At 2 years (24 months), many children

- say sentences with 2 to 4 words
- follow simple instructions
- get excited when with other children
- point to things or pictures when they are named

At 3 years (36 months), many children

- show affection for friends without prompting
- carry on a conversation using 2 to 3 sentences
- copy adults and friends
- play make-believe with dolls, animals, and people

At 4 years (48 months), many children

- tell stories
- would rather play with other children than by themselves
- play cooperatively with others

Questions to ask your child's doctor:

- Is my child's development on track for his or her age?
- How can I track my child's development?
- What should I do if I'm worried about my child's progress?
- Where can I get more information?

Adapted from CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Fifth Edition, edited by Steven Shelov and Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 by the American Academy of Pediatrics and BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, Third Edition, edited by Joseph Hagan, Jr., Judith S. Shaw, and Paula M. Duncan, 2008, Elk Grove Village, IL: American Academy of Pediatrics.

www.cdc.gov/actearly

1-800-CDC-INFO

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CDC Centers for Disease Control and Prevention

Learn the Signs. Act Early.

Es tiempo de ver el crecimiento de los niños de manera diferente.

A medida que crecen, los niños siempre están aprendiendo cosas nuevas. Los siguientes son solo algunos de los aspectos del crecimiento de su hijo en los que usted debe fijarse. Use esta lista como una guía y, si algo le preocupa, consulte con el médico de su hijo y llame al **1-800-CDC-INFO** para recibir información acerca del sistema de ayuda para la intervención infantil temprana de su comunidad.

A los 6 meses, la mayoría de los niños

- responden cuando se les llama por su nombre
- reaccionan ante las emociones de otras personas y por lo general parecen felices
- imitan sonidos
- disfrutan jugando con otras personas, especialmente con sus padres

Al año (12 meses), la mayoría de los niños

- usan gestos simples, como mover la cabeza de lado a lado para decir "no" o despedirse con la mano
- dicen "mamá" y "papá" y exclamaciones como "¡oh-oh!"
- imitan gestos
- responden a pedidos sencillos

Al año y medio (18 meses), la mayoría de los niños

- juegan a imitar cosas sencillas, como alimentar a una muñeca
- señalan para mostrar algo que les llama la atención
- expresan una gran variedad de emociones como felicidad, tristeza o enojo
- pueden decir varias palabras sueltas

A los 2 años (24 meses), la mayoría de los niños

- dicen frases de 2 a 4 palabras
- siguen instrucciones sencillas
- se entusiasman cuando están con otros niños
- señalan objetos o imágenes cuando se los nombra

A los 3 años (36 meses), la mayoría de los niños

- demuestran afecto espontáneo por sus amigos
- pueden conversar usando 2 o 3 frases
- imitan a adultos y compañeros
- juegan imaginativamente con muñecas, animales y personas

A los 4 años (48 meses), la mayoría de los niños

- pueden contar cuentos
- prefieren jugar con otros niños que jugar solos
- juegan con los demás de manera cooperativa

Preguntas para hacerle al médico de su hijo:

- ¿Está bien el desarrollo de mi hijo para la edad que tiene?
- ¿Cómo puedo seguir el desarrollo de mi hijo?
- ¿Qué debo hacer si me preocupa el progreso de mi hijo?
- ¿Dónde puedo obtener más información?

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www.cdc.gov/pronto

1-800-CDC-INFO

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CDC CENTERS FOR DISEASE CONTROL AND PREVENTION

Aprenda los signos. Reaccione pronto.

Milestone Moments

Learn the Signs. Act Early.

Learn the Signs. Act Early.

www.cdc.gov/milestones

1-800-CDC-INFO








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Centers for Disease Control and Prevention

www.cdc.gov/milestones

1-800-CDC-INFO

You can follow your child's development by watching how he or she plays, learns, speaks, and acts.

Look inside for milestones to watch for in your child and how you can help your child learn and grow.

Centers for Disease Control and Prevention

www.cdc.gov/milestones

1-800-CDC-INFO

Milestone Moments

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

The lists that follow have milestones to look for when your child is:

Check the milestones your child has reached at each age.

Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

For more information, go to www.cdc.gov/milestones

Your Baby at 2 Months

Talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What babies do at this age

Social/Emotional

- ❑ Can briefly calm himself (may bring hands to mouth and suck on hand)
- ❑ Begins to smile at people
- ❑ Tries to look at parent

Language/Communication

- ❑ Coos, makes gurgling sounds
- ❑ Turns head toward sounds

Cognitive (learning, thinking, problem-solving)

- ❑ Pays attention to faces
- ❑ Begins to follow things with eyes and recognize people at a distance
- ❑ Begins to act bored (cries, fussy) if activity doesn't change

How you can help your baby's development

- → Cuddle, talk, and play with your baby during feeding, dressing, and bathing.
- → Help your baby learn to calm herself. It's okay for her to suck on her fingers.
- → Begin to help your baby get into a routine, such as sleeping at night more than in the day, and have regular schedules.
- → Getting in tune with your baby's likes and dislikes can help you feel more comfortable and confident.
- → Act excited and smile when your baby makes sounds.
- → Copy your baby's sounds sometimes, but also use clear language.
- → Pay attention to your baby's different cries so that you learn to know what he wants.
- → Talk, read, and sing to your baby.
- → Play peek-a-boo. Help your baby play peek-a-boo, too.
- → Place a baby-safe mirror in your baby's crib so she can look at herself.

Movement/Physical Development

- ❑ Can hold head up and begins to push up when lying on tummy
- ❑ Makes smoother movements with arms and legs

How you can help your baby's development

- ➔ Look at pictures with your baby and talk about them.
- ➔ Lay your baby on his tummy when he is awake and put toys near him.
- ➔ Encourage your baby to lift his head by holding toys at eye level in front of him.
- ➔ Hold a toy or rattle above your baby's head and encourage her to reach for it.
- ➔ Hold your baby upright with his feet on the floor. Sing or talk to your baby as he is upright.

Act early by talking to your child's doctor if your child:

- ❑ Doesn't respond to loud sounds
- ❑ Doesn't watch things as they move
- ❑ Doesn't smile at people
- ❑ Doesn't bring hands to mouth
- ❑ Can't hold head up when pushing up when on tummy

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned**.

Your Baby at 4 Months

Talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What babies do at this age

Social/Emotional

- ❑ Smiles spontaneously, especially at people
- ❑ Copies some movements and facial expressions, like smiling or frowning
- ❑ Likes to play with people and might cry when playing stops

Language/Communication

- ❑ Begins to babble
- ❑ Babbles with expression and copies sounds he hears
- ❑ Cries in different ways to show hunger, pain, or being tired

How you can help your baby's development

- ➔ Hold and talk to your baby; smile and be cheerful while you do.
- ➔ Set steady routines for sleeping and feeding.
- ➔ Pay close attention to what your baby likes and doesn't like; you will know how best to meet his needs and what you can do to make your baby happy.
- ➔ Copy your baby's sounds.
- ➔ Act excited and smile when your baby makes sounds.
- ➔ Have quiet play times when you read or sing to your baby.
- ➔ Give age-appropriate toys to play with, such as rattles or colorful pictures.
- ➔ Play games such as peek-a-boo.
- ➔ Provide safe opportunities for your baby to reach for toys and explore his surroundings.
- ➔ Put toys near your baby so that she can reach for them or kick her feet.

Cognitive (learning, thinking, problem-solving)

- ❑ Lets you know if she is happy or sad
- ❑ Responds to affection
- ❑ Reaches for toy with one hand
- ❑ Uses hands and eyes together, such as seeing a toy and reaching for it
- ❑ Follows moving things with eyes from side to side
- ❑ Watches faces closely
- ❑ Recognizes familiar people and things at a distance

Movement/Physical Development

- ❑ Holds head steady, unsupported
- ❑ Pushes down on legs when feet are on a hard surface
- ❑ May be able to roll over from tummy to back
- ❑ Can hold a toy and shake it and swing at dangling toys
- ❑ Brings hands to mouth
- ❑ When lying on stomach, pushes up to elbows

How you can help your baby's development

- ➔ Put toys or rattles in your baby's hand and help him to hold them.
- ➔ Hold your baby upright with feet on the floor, and sing or talk to your baby as she "stands" with support.

Act early by talking to your child's doctor if your child:

- ❑ Doesn't watch things as they move
- ❑ Doesn't smile at people
- ❑ Can't hold head steady
- ❑ Doesn't coo or make sounds
- ❑ Doesn't bring things to mouth
- ❑ Doesn't push down with legs when feet are placed on a hard surface
- ❑ Has trouble moving one or both eyes in all directions

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned**.

Your Baby at 6 Months

Talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What babies do at this age

Social/Emotional

- ❑ Knows familiar faces and begins to know if someone is a stranger
- ❑ Likes to play with others, especially parents
- ❑ Responds to other people's emotions and often seems happy
- ❑ Likes to look at self in a mirror

Language/Communication

- ❑ Responds to sounds by making sounds
- ❑ Strings vowels together when babbling ("ah," "eh," "oh") and likes taking turns with parent while making sounds
- ❑ Responds to own name
- ❑ Makes sounds to show joy and displeasure
- ❑ Begins to say consonant sounds (jabbering with "m," "b")

How you can help your baby's development

- ➔ Play on the floor with your baby every day.
- ➔ Learn to read your baby's moods. If he's happy, keep doing what you are doing. If he's upset, take a break and comfort your baby.
- ➔ Show your baby how to comfort herself when she's upset. She may suck on her fingers to self soothe.
- ➔ Use "reciprocal" play—when he smiles, you smile; when he makes sounds, you copy them.
- ➔ Repeat your child's sounds and say simple words with those sounds. For example, if your child says "bah," say "bottle" or "book."
- ➔ Read books to your child every day. Praise her when she babbles and "reads" too.
- ➔ When your baby looks at something, point to it and talk about it.
- ➔ When he drops a toy on the floor, pick it up and give it back. This game helps him learn cause and effect.
- ➔ Read colorful picture books to your baby.

Cognitive (learning, thinking, problem-solving)

- ❑ Looks around at things nearby
- ❑ Shows curiosity about things and tries to get things that are out of reach
- ❑ Brings things to mouth
- ❑ Begins to pass things from one hand to the other

Movement/Physical Development

- ❑ Rolls over in both directions (front to back, back to front)
- ❑ When standing, supports weight on legs and might bounce
- ❑ Begins to sit without support
- ❑ Rocks back and forth, sometimes crawling backward before moving forward

How you can help your baby's development

- ➔ Point out new things to your baby and name them.
- ➔ Show your baby bright pictures in a magazine and name them.
- ➔ Hold your baby up while she sits or support her with pillows. Let her look around and give her toys to look at while she balances.
- ➔ Put your baby on his tummy or back and put toys just out of reach. Encourage him to roll over to reach the toys.

Act early by talking to your child's doctor if your child:

- ❑ Doesn't try to get things that are in reach
- ❑ Shows no affection for caregivers
- ❑ Doesn't respond to sounds around him
- ❑ Has difficulty getting things to mouth
- ❑ Seems very floppy, like a rag doll
- ❑ Doesn't make vowel sounds ("ah", "eh", "oh")
- ❑ Doesn't roll over in either direction
- ❑ Doesn't laugh or make squealing sounds
- ❑ Seems very stiff, with tight muscles

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned**.

Your Baby at 9 Months

Talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What babies do at this age

Social/Emotional

- ❑ May be afraid of strangers
- ❑ May be clingy with familiar adults
- ❑ Has favorite toys

Language/Communication

- ❑ Understands "no"
- ❑ Makes a lot of different sounds like "mamamama" and "babababababa"
- ❑ Copies sounds and gestures of others
- ❑ Uses fingers to point at things

How you can help your baby's development

- ➔ Pay attention to the way he reacts to new situations and people; try to continue to do things that make your baby happy and comfortable.
- ➔ As she moves around more, stay close so she knows that you are near.
- ➔ Continue with routines; they are especially important now.
- ➔ Play games with "my turn, your turn."
- ➔ Say what you think your baby is feeling. For example, say, "You are so sad, let's see if we can make you feel better."
- ➔ Describe what your baby is looking at; for example, "red, round ball."
- ➔ Talk about what your baby wants when he points at something.
- ➔ Copy your baby's sounds and words.
- ➔ Ask for behaviors that you want. For example, instead of saying "don't stand," say "time to sit."
- ➔ Teach cause-and-effect by rolling balls back and forth, pushing toy cars and trucks, and putting blocks in and out of a container.

Cognitive (learning, thinking, problem-solving)

- ❑ Watches the path of something as it falls
- ❑ Looks for things he sees you hide
- ❑ Plays peek-a-boo
- ❑ Puts things in her mouth
- ❑ Moves things smoothly from one hand to the other
- ❑ Picks up things like cereal o's between thumb and index finger

Movement/Physical Development

- ❑ Stands, holding on
- ❑ Sits without support
- ❑ Crawls
- ❑ Can get into sitting position
- ❑ Pulls to stand

How you can help your baby's development

- ➔ Play peek-a-boo and hide-and-seek.
- ➔ Read and talk to your baby.
- ➔ Provide lots of room for your baby to move and explore in a safe area.
- ➔ Put your baby close to things that she can pull up on safely.

Act early by talking to your child's doctor if your child:

- ❑ Doesn't bear weight on legs with support
- ❑ Doesn't sit with help
- ❑ Doesn't babble ("mama", "baba", "dada")
- ❑ Doesn't play any games involving back-and-forth play
- ❑ Doesn't respond to own name
- ❑ Doesn't seem to recognize familiar people
- ❑ Doesn't look where you point
- ❑ Doesn't transfer toys from one hand to the other

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned**.

The American Academy of Pediatrics recommends that all children be screened for general development at the 9-month visit. Ask your child's doctor about your child's developmental screening.

Your Child at 1 Year

Talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What children do at this age

Social/Emotional

- ❑ Is shy or nervous with strangers
- ❑ Cries when mom or dad leaves
- ❑ Has favorite things and people
- ❑ Shows fear in some situations
- ❑ Hands you a book when he wants to hear a story
- ❑ Repeats sounds or actions to get attention
- ❑ Puts out arm or leg to help with dressing
- ❑ Plays games such as "peek-a-boo" and "pat-a-cake"

Language/Communication

- ❑ Responds to simple spoken requests
- ❑ Uses simple gestures, like shaking head "no" or waving "bye-bye"
- ❑ Makes sounds with changes in tone (sounds more like speech)
- ❑ Says "mama" and "dada" and exclamations like "uh-oh!"
- ❑ Tries to say words you say

How you can help your child's development

- → Give your child time to get to know a new caregiver. Bring a favorite toy, stuffed animal, or blanket to help comfort your child.
- → In response to unwanted behaviors, say "no" firmly. Do not yell, spank, or give long explanations. A time out for 30 seconds to 1 minute might help redirect your child.
- → Give your child lots of hugs, kisses, and praise for good behavior.
- → Spend a lot more time encouraging wanted behaviors than punishing unwanted behaviors (4 times as much encouragement for wanted behaviors as redirection for unwanted behaviors).
- → Talk to your child about what you're doing. For example, "Mommy is washing your hands with a washcloth."
- → Read with your child every day. Have your child turn the pages. Take turns labeling pictures with your child.
- → Build on what your child says or tries to say, or what he points to. If he points to a truck and says "t" or "truck," say, "Yes, that's a big, blue truck."

Cognitive (learning, thinking, problem-solving)

- ❑ Explores things in different ways, like shaking, banging, throwing
- ❑ Finds hidden things easily
- ❑ Looks at the right picture or thing when it's named
- ❑ Copies gestures
- ❑ Puts things in a container, takes things out of a container
- ❑ Bangs two things together
- ❑ Starts to use things correctly; for example, drinks from a cup, brushes hair
- ❑ Lets things go without help
- ❑ Pokes with index (pointer) finger
- ❑ Follows simple directions like "pick up the toy"

Movement/Physical Development

- ❑ Gets to a sitting position without help
- ❑ Pulls up to stand, walks holding on to furniture ("cruising")
- ❑ May take a few steps without holding on
- ❑ May stand alone

How you can help your child's development

- → Give your child crayons and paper, and let your child draw freely. Show your child how to draw lines up and down and across the page. Praise your child when she tries to copy them.
- → Play with blocks, shape sorters, and other toys that encourage your child to use his hands.
- → Hide small toys and other things and have your child find them.
- → Ask your child to label body parts or things you see while driving in the car.
- → Sing songs with actions, like "The Itsy Bitsy Spider" and "Wheels on the Bus." Help your child do the actions with you.
- → Give your child pots and pans or a small musical instrument like a drum or cymbals. Encourage your child to make noise.
- → Provide lots of safe places for your toddler to explore. (Toddler-proof your home. Lock away products for cleaning, laundry, lawn care, and car care. Use a safety gate and lock doors to the outside and the basement.)
- → Give your child push toys like a wagon or "kiddie push car."

Act early by talking to your child's doctor if your child:

- ❑ Doesn't crawl
- ❑ Can't stand when supported
- ❑ Doesn't search for things that she sees you hide
- ❑ Doesn't point to things
- ❑ Doesn't learn gestures like waving or shaking head
- ❑ Doesn't say single words like "mama" or "dada"
- ❑ Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned**.

Your Child at 18 Months

Talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What children do at this age

Social/Emotional

- ❑ Likes to hand things to others as play
- ❑ May have temper tantrums
- ❑ May be afraid of strangers
- ❑ Shows affection to familiar people
- ❑ Plays simple pretend, such as feeding a doll
- ❑ May cling to caregivers in new situations
- ❑ Points to show others something interesting
- ❑ Explores alone but with parent close by

Language/Communication

- ❑ Says several single words
- ❑ Says and shakes head "no"
- ❑ Points to show someone what he wants

How you can help your child's development

- → Provide a safe, loving environment. It's important to be consistent and predictable.
- → Praise good behaviors more than you punish bad behaviors (use only very brief time outs).
- → Describe her emotions. For example, say, "You are happy when we read this book."
- → Encourage pretend play.
- → Encourage empathy. For example, when he sees a child who is sad, encourage him to hug or pat the other child.
- → Read books and talk about the pictures using simple words.
- → Copy your child's words.
- → Use words that describe feelings and emotions.
- → Use simple, clear phrases.
- → Ask simple questions.

Cognitive (learning, thinking, problem-solving)

- ❑ Knows what ordinary things are for; for example, telephone, brush, spoon
- ❑ Points to one body part
- ❑ Shows interest in a doll or stuffed animal by pretending to feed
- ❑ Points to get the attention of others
- ❑ Scribbles on his own
- ❑ Can follow 1-step verbal commands without any gestures; for example, sits when you say "sit down"

Movement/Physical Development

- ❑ Walks alone
- ❑ May walk up steps and run
- ❑ Pulls toys while walking
- ❑ Can help undress herself
- ❑ Drinks from a cup
- ❑ Eats with a spoon

How you can help your child's development

- ➔ Hide things under blankets and pillows and encourage him to find them.
- ➔ Play with blocks, balls, puzzles, books, and toys that teach cause and effect and problem solving.
- ➔ Name pictures in books and body parts.
- ➔ Provide toys that encourage pretend play; for example, dolls, play telephones.
- ➔ Provide safe areas for your child to walk and move around in.
- ➔ Provide toys that she can push or pull safely.
- ➔ Provide balls for her to kick, roll, and throw.
- ➔ Encourage him to drink from his cup and use a spoon, no matter how messy.
- ➔ Blow bubbles and let your child pop them.

Act early by talking to your child's doctor if your child:

- ❑ Doesn't point to show things to others
- ❑ Can't walk
- ❑ Doesn't know what familiar things are for
- ❑ Doesn't copy others
- ❑ Doesn't gain new words
- ❑ Doesn't have at least 6 words
- ❑ Doesn't notice or mind when a caregiver leaves or returns
- ❑ Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned**.

The American Academy of Pediatrics recommends that all children be screened for general development and autism at the 18-month visit. Ask your child's doctor about your child's developmental screening.

Your Child at 2 Years

Talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What children do at this age

Social/Emotional

- ❑ Copies others, especially adults and older children
- ❑ Gets excited when with other children
- ❑ Shows more and more independence
- ❑ Shows defiant behavior (doing what he has been told not to)
- ❑ Plays mainly beside other children, but is beginning to include other children, such as in chase games

Language/Communication

- ❑ Points to things or pictures when they are named
- ❑ Knows names of familiar people and body parts
- ❑ Says sentences with 2 to 4 words
- ❑ Follows simple instructions
- ❑ Repeats words overheard in conversation
- ❑ Points to things in a book

How you can help your child's development

- ➔ Encourage your child to help with simple chores at home, like sweeping and making dinner. Praise your child for being a good helper.
- ➔ At this age, children still play next to (not with) each other and don't share well. For play dates, give the children lots of toys to play with. Watch the children closely and step in if they fight or argue.
- ➔ Give your child attention and praise when he follows instructions. Limit attention for defiant behavior. Spend a lot more time praising good behaviors than punishing bad ones.
- ➔ Teach your child to identify and say body parts, animals, and other common things.
- ➔ Do not correct your child when he says words incorrectly. Rather, say it correctly. For example, "That is a *ball*."
- ➔ Encourage your child to say a word instead of pointing. If your child can't say the whole word ("milk"), give her the first sound ("m") to help. Over time, you can prompt your child to say the whole sentence — "I want milk."

Cognitive (learning, thinking, problem-solving)

- ❑ Finds things even when hidden under two or three covers
- ❑ Begins to sort shapes and colors
- ❑ Completes sentences and rhymes in familiar books
- ❑ Plays simple make-believe games
- ❑ Builds towers of 4 or more blocks
- ❑ Might use one hand more than the other
- ❑ Follows two-step instructions such as "Pick up your shoes and put them in the closet."
- ❑ Names items in a picture book such as a cat, bird, or dog

Movement/Physical Development

- ❑ Stands on tiptoe
- ❑ Kicks a ball
- ❑ Begins to run
- ❑ Walks up and down stairs holding on
- ❑ Climbs onto and down from furniture without help
- ❑ Throws ball overhand
- ❑ Makes or copies straight lines and circles

How you can help your child's development

- ➔ Hide your child's toys around the room and let him find them.
- ➔ Help your child do puzzles with shapes, colors, or farm animals. Name each piece when your child puts it in place.
- ➔ Encourage your child to play with blocks. Take turns building towers and knocking them down.
- ➔ Do art projects with your child using crayons, paint, and paper. Describe what your child makes and hang it on the wall or refrigerator.
- ➔ Ask your child to help you open doors and drawers and turn pages in a book or magazine.
- ➔ Once your child walks well, ask her to carry small things for you.
- ➔ Kick a ball back and forth with your child. When your child is good at that, encourage him to run and kick.
- ➔ Take your child to the park to run and climb on equipment or walk on nature trails. Watch your child closely.

Act early by talking to your child's doctor if your child:

- ❑ Doesn't know what to do with common things, like a brush, phone, fork, spoon
- ❑ Doesn't copy actions and words
- ❑ Doesn't follow simple instructions
- ❑ Doesn't use 2-word phrases (for example, "drink milk")
- ❑ Doesn't walk steadily
- ❑ Loses skills she once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned**.

The American Academy of Pediatrics recommends that all children be screened for general development and autism at the 24-month visit. Ask your child's doctor about your child's developmental screening.

Your Child at 3 Years

Talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What children do at this age

Social/Emotional

- ❑ Copies adults and friends
- ❑ Shows affection for friends without prompting
- ❑ Takes turns in games
- ❑ Shows concern for a crying friend
- ❑ Dresses and undresses self
- ❑ Understands the idea of "mine" and "his" or "hers"
- ❑ Shows a wide range of emotions
- ❑ Separates easily from mom and dad
- ❑ May get upset with major changes in routine

Language/Communication

- ❑ Follows instructions with 2 or 3 steps
- ❑ Can name most familiar things
- ❑ Understands words like "in," "on," and "under"
- ❑ Says first name, age, and sex
- ❑ Names a friend
- ❑ Talks well enough for strangers to understand most of the time
- ❑ Says words like "I," "me," "we," and "you" and some plurals (cars, dogs, cats)
- ❑ Carries on a conversation using 2 to 3 sentences

How you can help your child's development

- → Go to play groups with your child or other places where there are other children, to encourage getting along with others.
- → Work with your child to solve the problem when he is upset.
- → Talk about your child's emotions. For example, say, "I can tell you feel mad because you threw the puzzle piece." Encourage your child to identify feelings in books.
- → Set rules and limits for your child, and stick to them. If your child breaks a rule, give him a time out for 30 seconds to 1 minute in a chair or in his room. Praise your child for following the rules.
- → Give your child instructions with 2 or 3 steps. For example, "Go to your room and get your shoes and coat."
- → Read to your child every day. Ask your child to point to things in the pictures and repeat words after you.
- → Give your child an "activity box" with paper, crayons, and coloring books. Color and draw lines and shapes with your child.

Cognitive (learning, thinking, problem-solving)

- ❑ Can work toys with buttons, levers, and moving parts
- ❑ Plays make-believe with dolls, animals, and people
- ❑ Does puzzles with 3 or 4 pieces
- ❑ Understands what "two" means
- ❑ Copies a circle with pencil or crayon
- ❑ Turns book pages one at a time
- ❑ Builds towers of more than 6 blocks
- ❑ Screws and unscrews jar lids or turns door handle

Movement/Physical Development

- ❑ Climbs well
- ❑ Runs easily
- ❑ Pedals a tricycle (3-wheel bike)
- ❑ Walks up and down stairs, one foot on each step

How you can help your child's development

- → Play matching games. Ask your child to find objects in books or around the house that are the same.
- → Play counting games. Count body parts, stairs, and other things you use or see every day.
- → Hold your child's hand going up and down stairs. When she can go up and down easily, encourage her to use the railing.
- → Play outside with your child. Go to the park or hiking trail. Allow your child to play freely and without structured activities.

Act early by talking to your child's doctor if your child:

- ❑ Falls down a lot or has trouble with stairs
- ❑ Drools or has very unclear speech
- ❑ Can't work simple toys (such as peg boards, simple puzzles, turning a handle)
- ❑ Doesn't understand simple instructions
- ❑ Doesn't speak in sentences
- ❑ Doesn't make eye contact
- ❑ Doesn't play pretend or make-believe
- ❑ Doesn't want to play with other children or with toys
- ❑ Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your local public school. For more information, go to **www.cdc.gov/concerned**.

Your Child at 4 Years

Talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What children do at this age

Social/Emotional

- ❑ Enjoys doing new things
- ❑ Is more and more creative with make-believe play
- ❑ Would rather play with other children than by himself
- ❑ Cooperates with other children
- ❑ Plays "Mom" or "Dad"
- ❑ Often can't tell what's real and what's make-believe
- ❑ Talks about what she likes and what she is interested in

Language/Communication

- ❑ Tells stories
- ❑ Sings a song or says a poem from memory such as the "Itsy Bitsy Spider" or the "Wheels on the Bus"
- ❑ Knows some basic rules of grammar, such as correctly using "he" and "she"
- ❑ Can say first and last name

How you can help your child's development

- → Play make-believe with your child. Let her be the leader and copy what she is doing.
- → Suggest your child pretend play an upcoming event that might make him nervous, like going to preschool or staying overnight at a grandparent's house.
- → Give your child simple choices whenever you can. Let your child choose what to wear, play, or eat for a snack. Limit choices to 2 or 3.
- → During play dates, let your child solve her own problems with friends, but be nearby to help out if needed.
- → Encourage your child to use words, share toys, and take turns playing games of one another's choice.
- → Give your child toys to build imagination, like dress-up clothes, kitchen sets, and blocks.
- → Use good grammar when speaking to your child. Instead of "Mommy wants you to come here," say, "I want you to come here."

Cognitive (learning, thinking, problem-solving)

- ❑ Names some colors and some numbers
- ❑ Understands the idea of counting
- ❑ Starts to understand time
- ❑ Remembers parts of a story
- ❑ Understands the idea of "same" and "different"
- ❑ Draws a person with 2 to 4 body parts
- ❑ Uses scissors
- ❑ Starts to copy some capital letters
- ❑ Plays board or card games
- ❑ Tells you what he thinks is going to happen next in a book

Movement/Physical Development

- ❑ Hops and stands on one foot up to 2 seconds
- ❑ Pours, cuts with supervision, and mashes own food
- ❑ Catches a bounced ball most of the time

How you can help your child's development

- → Use words like "first," "second," and "finally" when talking about everyday activities. This will help your child learn about sequence of events.
- → Take time to answer your child's "why" questions. If you don't know the answer, say "I don't know," or help your child find the answer in a book, on the Internet, or from another adult.
- → When you read with your child, ask him to tell you what happened in the story as you go.
- → Say colors in books, pictures, and things at home. Count common items, like the number of snack crackers, stairs, or toy trains.
- → Teach your child to play outdoor games like tag, follow the leader, and duck, duck, goose.
- → Play your child's favorite music and dance with your child. Take turns copying each other's moves.

Act early by talking to your child's doctor if your child:

- ❑ Can't jump in place
- ❑ Has trouble scribbling
- ❑ Shows no interest in interactive games or make-believe
- ❑ Ignores other children or doesn't respond to people outside the family
- ❑ Resists dressing, sleeping, and using the toilet
- ❑ Doesn't understand "same" and "different"
- ❑ Doesn't use "me" and "you" correctly
- ❑ Doesn't follow 3-part commands
- ❑ Can't retell a favorite story
- ❑ Speaks unclearly
- ❑ Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your local public school. For more information, go to **www.cdc.gov/concerned**.

Your Child at 5 Years

Talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What children do at this age

Social/Emotional

- ❑ Wants to please friends
- ❑ Wants to be like friends
- ❑ More likely to agree with rules
- ❑ Likes to sing, dance, and act
- ❑ Is aware of gender
- ❑ Can tell what's real and what's make-believe
- ❑ Shows more independence (for example, may visit a next-door neighbor by himself [adult supervision is still needed])
- ❑ Is sometimes demanding and sometimes very cooperative

Language/Communication

- ❑ Speaks very clearly
- ❑ Tells a simple story using full sentences
- ❑ Uses future tense; for example, "Grandma will be here."
- ❑ Says name and address

How you can help your child's development

- ➔ Continue to arrange play dates, trips to the park, or play groups. Give your child more freedom to choose activities to play with friends, and let your child work out problems on her own.
- ➔ Your child might start to talk back or use profanity (swear words) as a way to feel independent. Do not give a lot of attention to this talk, other than a brief time out. Instead, praise your child when he asks for things nicely and calmly takes "no" for an answer.
- ➔ This is a good time to talk to your child about safe touch. No one should touch "private parts" except doctors or nurses during an exam or parents when they are trying to keep the child clean.
- ➔ Teach your child her address and phone number.
- ➔ When reading to your child, ask him to predict what will happen next in the story.
- ➔ Encourage your child to "read" by looking at the pictures and telling the story.

Cognitive (learning, thinking, problem-solving)

- ❑ Counts 10 or more things
- ❑ Can draw a person with at least 6 body parts
- ❑ Copies a triangle and other shapes
- ❑ Can print some letters or numbers
- ❑ Knows about things used every day, like money and food

Movement/Physical Development

- ❑ Stands on one foot for 10 seconds or longer
- ❑ Hops; may be able to skip
- ❑ Can do a somersault
- ❑ Uses a fork and spoon and sometimes a table knife
- ❑ Can use the toilet on her own
- ❑ Swings and climbs

How you can help your child's development

- → Teach your child time concepts like morning, afternoon, evening, today, tomorrow, and yesterday. Start teaching the days of the week.
- → Explore your child's interests in your community. For example, if your child loves animals, visit the zoo or petting farm. Go to the library or look on the Internet to learn about these topics.
- → Keep a handy box of crayons, paper, paint, child scissors, and paste. Encourage your child to draw and make art projects with different supplies.
- → Play with toys that encourage your child to put things together.
- → Teach your child how to pump her legs back and forth on a swing.
- → Help your child climb on the monkey bars.
- → Go on walks with your child, do a scavenger hunt in your neighborhood or park, help him ride a bike with training wheels (wearing a helmet).

Act early by talking to your child's doctor if your child:

- ❑ Doesn't show a wide range of emotions
- ❑ Shows extreme behavior (unusually fearful, aggressive, shy, or sad)
- ❑ Unusually withdrawn and not active
- ❑ Is easily distracted, has trouble focusing on one activity for more than 5 minutes
- ❑ Doesn't respond to people, or responds only superficially
- ❑ Can't tell what's real and what's make-believe
- ❑ Doesn't play a variety of games and activities
- ❑ Can't give first and last name
- ❑ Doesn't draw pictures
- ❑ Doesn't talk about daily activities or experiences
- ❑ Doesn't use plurals or past tense properly
- ❑ Can't brush teeth, wash and dry hands, or get undressed without help
- ❑ Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your local public school. For more information, go to **www.cdc.gov/concerned**.

Questions for my Child's Doctor




2 Months

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Indicadores del Desarrollo

Aprenda los signos. Reaccione pronto.

www.cdc.gov/pronto
1-800-CDC-INFO








Tomado de CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Quinta Edición, editado por Steven Shelov y Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 por la Academia Americana de Pediatría y BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, tercera edición, editado por Joseph Hagan, Jr., Judith S. Shaw y Paula M. Duncan, 2008, Elk Grove Village, IL: Academia Americana de Pediatría.

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Centros para el Control y la Prevención de Enfermedades
www.cdc.gov/pronto
1-800-CDC-INFO

Puede hacerle seguimiento al desarrollo de su hijo si observa cómo juega, aprende, habla y actúa en general.

En estas páginas encontrará los indicadores a los que debe prestar atención y la forma en que puede ayudar a su hijo a aprender y crecer.

Centros para el Control y la Prevención de Enfermedades
www.cdc.gov/pronto
1-800-CDC-INFO

Indicadores del Desarrollo

La manera en que su hijo juega, aprende, habla y actúa nos ofrece pistas importantes sobre cómo se está desarrollando el niño. Los indicadores del desarrollo son las cosas que la mayoría de los niños pueden hacer a una edad determinada.

La lista a continuación tiene los indicadores a los que debe estar atento si su hijo tiene:

Marque los indicadores que su hijo ha alcanzado en cada etapa.

En cada visita médica de su hijo, lleve esta información y hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

Para obtener más información, consulte www.cdc.gov/pronto

Su Bebé a los 2 Meses

En cada visita médica de su hijo, hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los bebés a esta edad?

Áreas social y emocional

- ❑ Puede calmarse sin ayuda por breves momentos (se pone los dedos en la boca y se chupa la mano)
- ❑ Empieza a sonreírle a las personas
- ❑ Trata de mirar a sus padres

Áreas del habla y la comunicación

- ❑ Hace sonidos como de arrullo o gorjeos
- ❑ Mueve la cabeza para buscar los sonidos

Área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Se interesa en las caras
- ❑ Comienza a seguir las cosas con los ojos y reconoce a las personas a la distancia
- ❑ Comienza a demostrar aburrimiento si no cambian las actividades (llora, se inquieta)

Cómo puede ayudar al desarrollo de su bebé

- ➔ Abrácelo, háblele y juegue con su bebé a la hora de comer, cuando le viste y cuando le baña.
- ➔ Ayude a su bebé a que aprenda a calmarse solo. Está bien que se chupe el dedo.
- ➔ Establezca una rutina con su bebé, por ejemplo que duerma más de noche que de día y que tenga regularidad en sus horarios.
- ➔ Estar en sintonía con las cosas que le gustan y las que no le gustan a su bebé le hará sentir más cómoda y confiada.
- ➔ Demuestre su entusiasmo y sonría cuando su bebé “habla”.
- ➔ De vez en cuando, copie los sonidos que hace el bebé, pero también utilice un lenguaje claro.
- ➔ Preste atención a los diferentes llantos de su bebé, para poder aprender a distinguir qué es lo que quiere.
- ➔ Háblele, léale y cántele a su bebé.

Áreas motora y de desarrollo físico

- ❑ Puede mantener la cabeza alzada y trata de alzar el cuerpo cuando está boca abajo
- ❑ Mueve las piernas y los brazos con mayor suavidad

Cómo puede ayudar al desarrollo de su bebé

- ➔ Juegue a esconder la cara detrás de sus manos. Enseñe a su bebé a que juegue a esconder su carita también.
- ➔ Coloque un espejo para bebés en la cuna, para que pueda mirarse en él.
- ➔ Miren ilustraciones juntos y háblele al bebé sobre lo que ven en ellas.
- ➔ Acueste al bebé boca abajo cuando está despierto y coloque juguetes a su alrededor.
- ➔ Sostenga juguetes frente al bebé, para que los vea y así alentarle a alzar la cabeza.
- ➔ Sostenga un juguete o un sonajero por encima de la cabeza del bebé, para alentarle a alcanzarlo.
- ➔ Sostenga al bebé de pie, con los pies apoyados en el piso. Cántele o háblele a su bebé mientras está así, parado.

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No responde ante ruidos fuertes
- ❑ No sigue con la vista a las cosas que se mueven
- ❑ No le sonríe a las personas
- ❑ No se lleva las manos a la boca
- ❑ No puede sostener la cabeza en alto cuando empuja el cuerpo hacia arriba estando boca abajo

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado**.

Su Bebé a los 4 Meses

En cada visita médica de su hijo, hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los bebés a esta edad?

Áreas social y emocional

- ❑ Sonríe espontáneamente, especialmente a las personas
- ❑ Le gusta jugar con la gente y puede ser que hasta llore cuando se terminan los juegos
- ❑ Copia algunos movimientos y gestos faciales, como sonreír o fruncir el ceño

Áreas del habla y la comunicación

- ❑ Empieza a balbucear
- ❑ Balbucea con entonación y copia los sonidos que escucha
- ❑ Llora de diferentes maneras para mostrar cuando tiene hambre, siente dolor o está cansado

Cómo puede ayudar al desarrollo de su bebé

- ➔ Cargue a su bebé en brazos y háblele, hágalo con sonrisas y demostrando alegría.
- ➔ Establezca una rutina fija para las horas de dormir y de comer.
- ➔ Preste mucha atención a las cosas que le gustan a su bebé y las que no, así podrá saber cómo satisfacer sus necesidades de la mejor manera y qué puede hacer para que su bebé sea feliz.
- ➔ Copie los sonidos que hace su bebé.
- ➔ Demuestre su entusiasmo y sonría cuando su bebé “habla”.
- ➔ Dedique momentos de tranquilidad para leerle o cantarle a su bebé.
- ➔ Dele juguetes adecuados para la edad del bebé, como sonajeros o ilustraciones coloridas.
- ➔ Juegue por ejemplo a esconder su cara detrás de las manos.
- ➔ Con las medidas de seguridad adecuadas, provea oportunidades para que su bebé pueda alcanzar juguetes y explorar lo que le rodea.

Área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Responde ante las demostraciones de afecto
- ❑ Trata de alcanzar los juguetes con la mano
- ❑ Coordina las manos y los ojos, por ejemplo, ve un juguete y lo trata de alcanzar
- ❑ Le deja saber si está contento o triste
- ❑ Sigue con la vista a las cosas que se mueven, moviendo los ojos de lado a lado
- ❑ Observa las caras con atención
- ❑ Reconoce objetos y personas conocidas desde lejos

Áreas motora y de desarrollo físico

- ❑ Mantiene la cabeza fija, sin necesidad de soporte
- ❑ Se empuja con las piernas cuando tiene los pies sobre una superficie firme
- ❑ Cuando está boca abajo puede darse vuelta y quedar boca arriba
- ❑ Puede sostener un juguete y sacudirlo y golpear a juguetes que estén colgando
- ❑ Se lleva las manos a la boca
- ❑ Cuando está boca abajo, levanta el cuerpo hasta apoyarse en los codos

Cómo puede ayudar al desarrollo de su bebé

- ➔ Ponga juguetes cerca de su bebé para que trate de agarrarlos o patearlos.
- ➔ Ponga juguetes o sonajeros en la mano del bebé y ayúdelo a agarrarlos.
- ➔ Sostenga al bebé de pie, con los pies apoyados en el piso, y cántele o háblele mientras él está “parado” con apoyo.

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No sigue con la vista a las cosas que se mueven
- ❑ No le sonríe a las personas
- ❑ No puede sostener la cabeza con firmeza
- ❑ No se lleva las cosas a la boca
- ❑ No gorjea ni hace sonidos con la boca
- ❑ No empuja con los pies cuando le apoyan sobre una superficie dura
- ❑ Tiene dificultad para mover uno o los dos ojos en todas las direcciones

Dígale al pediatra o la enfermera si nota cualquiera de estos signos de posible retraso del desarrollo para la edad de su hijo, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado**.

Su Bebé a los 6 Meses

En cada visita médica de su hijo, hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los bebés a esta edad?

Áreas social y emocional

- ❑ Reconoce las caras familiares y comienza a darse cuenta si alguien es un desconocido
- ❑ Le gusta jugar con los demás, especialmente con sus padres
- ❑ Responde antes las emociones de otras personas y generalmente se muestra feliz
- ❑ Le gusta mirarse en el espejo

Áreas del habla y la comunicación

- ❑ Reacciona a los sonidos con sus propios sonidos
- ❑ Une varias vocales cuando balbucea (“a”, “e”, “o”) y le gusta hacer sonidos por turno con los padres
- ❑ Reacciona cuando se menciona su nombre
- ❑ Hace sonidos para demostrar alegría o descontento
- ❑ Comienza a emitir sonidos de consonantes (parlotea usando la “m” o la “b”)

Cómo puede ayudar al desarrollo de su bebé

- ➔ Juegue con su bebé en el piso todos los días.
- ➔ Aprenda a conocer los estados de ánimo de su bebé. Si está contento, siga haciendo lo mismo. Si está molesto, deje lo que está haciendo y consuele al bebé.
- ➔ Muéstrele a su bebé cómo consolarse a sí mismo cuando está molesto. Se puede chupar el dedo para calmarse.
- ➔ Juegue a hacer lo mismo, es decir cuando él sonríe, usted sonríe, cuando él hace sonidos, usted los copia.
- ➔ Repita los sonidos que hace su hijo y diga palabras sencillas utilizándolos. Por ejemplo, si su hijo dice “ba”, diga “barco” o “balón”.
- ➔ Léale libros a su hijo todos los días. Felicítelo cuando balbucee y también cuando “lea”.
- ➔ Cuando su bebé mire hacia algo, señálelo y descríbalo.
- ➔ Cuando el bebé deje caer un juguete al suelo, levántelo y devuélvaselo. Este juego le ayuda a aprender el fenómeno de causa y efecto.

Área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Observa a su alrededor las cosas que están cerca
- ❑ Demuestra curiosidad sobre las cosas y trata de agarrar las cosas que están fuera de su alcance
- ❑ Se lleva la cosas a la boca
- ❑ Comienza a pasar cosas de una mano a la otra

Áreas motora y de desarrollo físico

- ❑ Se da vuelta para ambos lados (se pone boca arriba y boca abajo)
- ❑ Comienza a sentarse sin apoyo
- ❑ Cuando se para, se apoya en sus piernas y hasta puede ser que salte
- ❑ Se mece hacia adelante y hacia atrás, a veces gatea primero hacia atrás y luego hacia adelante

Cómo puede ayudar al desarrollo de su bebé

- ➔ Léale libros con ilustraciones coloridas.
- ➔ Señale cosas nuevas y dígale cómo se llaman.
- ➔ Muéstrele a su bebé las ilustraciones brillantes de las revistas y dígale qué son.
- ➔ Sostenga al bebé mientras está sentado o póngale almohadas como sostén. Déjele observar a su alrededor y dele juguetes para mirar mientras se mantiene sentado.
- ➔ Ponga al bebé boca abajo o boca arriba y coloque juguetes cerca pero fuera de su alcance. Anímelo a que se dé vuelta para agarrar los juguetes.

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No trata de agarrar cosas que están a su alcance
- ❑ No demuestra afecto por quienes le cuidan
- ❑ No reacciona ante los sonidos de alrededor
- ❑ Tiene dificultad para llevarse cosas a la boca
- ❑ No se ríe ni hace sonidos de placer
- ❑ No rueda en ninguna dirección para darse vuelta
- ❑ No emite sonidos de vocales (“a”, “e”, “o”)
- ❑ Se ve rígido y con los músculos tensos
- ❑ Se ve sin fuerza como un muñeco de trapo

Dígale al pediatra o la enfermera si nota cualquiera de estos signos de posible retraso del desarrollo para la edad de su hijo, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado**.

Su Bebé a los 9 Meses

En cada visita médica de su hijo, hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los bebés a esta edad?

Áreas social y emocional

- ❑ Puede ser que le tenga miedo a los desconocidos
- ❑ Puede ser que se aferre a los adultos conocidos todo el tiempo
- ❑ Tiene juguetes preferidos

Áreas del habla y la comunicación

- ❑ Entiende cuando se le dice “no”
- ❑ Hace muchos sonidos diferentes como “mamamama” y “tatatatata”
- ❑ Imita los sonidos y los gestos de otros
- ❑ Señala objetos con los dedos

Cómo puede ayudar al desarrollo de su bebé

- ➔ Preste atención a la manera en que su bebé reacciona ante situaciones nuevas o personas desconocidas, trate de continuar haciendo las mismas cosas que lo hacen sentir cómodo y feliz.
- ➔ Cuando comience a moverse más a su alrededor no se aleje, para que sepa que usted está cerca.
- ➔ Continúe con las rutinas, ahora son especialmente importantes.
- ➔ Juegue a tomar turnos.
- ➔ Diga en voz alta lo que le parece que su bebé esté sintiendo. Por ejemplo, diga “Estás triste, vamos a ver qué podemos hacer para que te sientas mejor”.
- ➔ Describa lo que su bebé esté mirando; por ejemplo, “pelota redonda y roja”.
- ➔ Describa lo que su bebé quiere cuando señala algo.
- ➔ Copie los sonidos y las palabras que emite su bebé.
- ➔ Dígale lo que desea que haga. Por ejemplo, en lugar de decir “no te pares”, diga “es hora de sentarse”.

Área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Observa el recorrido de las cosas al caer
- ❑ Va en busca de las cosas que usted esconde
- ❑ Juega a esconder su carita detrás de las manos
- ❑ Transfiere objetos de una mano a la otra con facilidad
- ❑ Se pone las cosas en la boca
- ❑ Levanta cosas como cereales en forma de "o" entre el dedo índice y el pulgar

Áreas motora y de desarrollo físico

- ❑ Se para sosteniéndose en algo
- ❑ Puede sentarse solo
- ❑ Se sienta sin apoyo
- ❑ Se parar sosteniéndose de algo
- ❑ Gatea

Cómo puede ayudar al desarrollo de su bebé

- ➔ Enséñele causa y efecto haciendo rodar balones para atrás y para adelante, empujando autos y camioncitos y metiendo y sacando bloquecitos de un recipiente.
- ➔ Juegue a esconder la cara detrás de las manos y a las escondidas.
- ➔ Léale y háblele a su bebé.
- ➔ Prepare muchos lugares donde su bebé pueda moverse y explorar en forma segura.
- ➔ Ponga al bebé cerca de cosas donde se pueda apoyar y pararse sin peligro.

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No se sostiene en las piernas con apoyo
- ❑ No se sienta con ayuda
- ❑ No balbucea ("mamá", "tata", "papá")
- ❑ No juega a nada que sea por turnos como "me toca a mí, te toca a ti"
- ❑ No responde cuando le llaman por su nombre
- ❑ No parece reconocer a las personas conocidas
- ❑ No mira hacia donde usted señala
- ❑ No pasa juguetes de una mano a la otra

Dígale al pediatra o la enfermera si nota cualquiera de estos signos de posible retraso del desarrollo para la edad de su hijo, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado**.

La Academia Americana de Pediatría recomienda que se evalúe el desarrollo general de los niños en la consulta de los 9 meses. Pregúntele al médico de su hijo si hay que hacerle la evaluación del desarrollo.

Su Hijo de 1 Año

En cada visita médica de su hijo, hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los niños a esta edad?

Áreas social y emocional

- ❑ Actúa con timidez o se pone nervioso en presencia de desconocidos
- ❑ Llora cuando la mamá o el papá se aleja
- ❑ Tiene cosas y personas preferidas
- ❑ Demuestra miedo en algunas situaciones
- ❑ Le alcanza un libro cuando quiere escuchar un cuento
- ❑ Repite sonidos o acciones para llamar la atención
- ❑ Levanta un brazo o una pierna para ayudar a vestirse
- ❑ Juega a esconder la carita y a las palmaditas con las manos

Áreas del habla y la comunicación

- ❑ Actúa cuando se le pide que haga algo sencillo
- ❑ Usa gestos simples, como mover la cabeza de lado a lado para decir "no" o despedirse con la mano
- ❑ Dice "mamá" y "papá" y exclamaciones como "oh-oh"
- ❑ Hace sonidos con cambios de entonación (se parece más al lenguaje normal)
- ❑ Trata de repetir las palabras que usted dice

Cómo puede ayudar al desarrollo de su hijo

- ➔ Dele tiempo a su hijo para que se acostumbre a la nueva persona que lo va a cuidar. Para que su hijo se sienta cómodo, tráigale el juguete, muñeco de peluche o mantita preferida.
- ➔ Cuando haga algo que no debe, diga "no" con firmeza. No le grite o le pegue, ni tampoco le dé largas explicaciones. Castigar al niño sin dejar que realice ninguna actividad por 30 segundos a 1 minuto puede ayudarle a que se distraiga y haga otras cosas.
- ➔ Dele a su hijo muchos abrazos, besos y felicitaciones cuando se porta bien.
- ➔ Dedique más tiempo a alentar los comportamientos que usted desea ver que a castigar los que no desea (anime los comportamientos deseados 4 veces más de lo que reorienta la atención ante comportamientos no deseados).
- ➔ Converse con su hijo sobre lo que usted está haciendo. Por ejemplo, "Mamá está lavándote las manos con una toallita".
- ➔ Léale a su hijo todos los días. Deje que su hijo sea quien pase las páginas. Tome turnos con su hijo para identificar las ilustraciones.
- ➔ Agregue más detalles acerca de lo que su hijo dice, trata de decir, o señala. Si señala a un camión y dice "c" o "camión" diga, "Sí, es un camión grande y es azul".

Área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Explora los objetos de diferentes maneras (los sacude, los golpea o los tira)
- ❑ Cuando se nombra algo mira en dirección a la ilustración o cosa que se nombró
- ❑ Imita gestos
- ❑ Comienza a usar las cosas correctamente, por ejemplo, bebe de una taza, se cepilla el pelo
- ❑ Golpea un objeto contra otro
- ❑ Mete cosas dentro de un recipiente, las saca del recipiente
- ❑ Suelta las cosas sin ayuda
- ❑ Pincha con el dedo índice
- ❑ Sigue instrucciones sencillas como "recoge el juguete"
- ❑ Encuentra fácilmente objetos escondidos

Áreas motora y de desarrollo físico

- ❑ Se sienta sin ayuda
- ❑ Se para sosteniéndose de algo, camina apoyándose en los muebles, la pared, etc.
- ❑ Puede ser que hasta dé unos pasos sin apoyarse
- ❑ Puede ser que se pare solo

Cómo puede ayudar al desarrollo de su hijo

- ➔ Dele a su hijo papel y crayones y déjelo dibujar libremente. Muéstrele a su hijo cómo dibujar líneas de arriba a abajo y de lado a lado de la página. Felicite a su hijo cuando trata de copiarlas.
- ➔ Juegue con bloques, juguetes para clasificar según su forma y otro tipo de juguetes que animen a su hijo a usar las manos.
- ➔ Esconda juguetes pequeños y otras cosas y pídale a su hijo que las encuentre.
- ➔ Pídale a su hijo que nombre partes del cuerpo o cosas que ven cuando van en el auto.
- ➔ Entone canciones que describan acciones, como "La araña pequeñita" y "Las ruedas de los autobuses". Ayúdelo a mover las manos a la par de la canción.
- ➔ Dele a su hijo ollas y sartenes o un instrumento musical pequeño como un tambor o platillos. Anime a su hijo a hacer ruido.
- ➔ Provea muchos lugares seguros para que su niño pequeño pueda explorar. (Tome precauciones en su hogar para proteger a su niño pequeño. Guarde bajo llave los productos de limpieza, lavandería, jardinería y cuidados del auto. Utilice cerrojos de seguridad y cierre las puertas de la calle y el sótano con llave).
- ➔ Dele a su hijo juguetes para empujar como un vagón o un "carrito para niños".

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No gatea
- ❑ No puede permanecer de pie con ayuda
- ❑ No busca las cosas que la ve esconder
- ❑ Pierde habilidades que había adquirido
- ❑ No aprende a usar gestos como saludar con la mano o mover la cabeza
- ❑ No señala cosas
- ❑ No dice palabras sencillas como "mamá" o "papá"

Dígale al pediatra o la enfermera si nota cualquiera de estos signos de posible retraso del desarrollo para la edad de su hijo, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado**.

Su Hijo de 18 Meses

En cada visita médica de su hijo, hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los niños a esta edad?

Áreas social y emocional

- ❑ Le gusta alcanzarle cosas a los demás como un juego
- ❑ Puede tener rabietas
- ❑ Puede ser que le tenga miedo a los desconocidos
- ❑ Le demuestra afecto a las personas conocidas
- ❑ Juega a imitar cosas sencillas, como alimentar a una muñeca
- ❑ Se aferra a la persona que le cuida en situaciones nuevas
- ❑ Señala para mostrar algo que le llama la atención
- ❑ Explora solo, pero con la presencia cercana de los padres

Áreas del habla y la comunicación

- ❑ Puede decir palabras sueltas
- ❑ Dice “no” y sacude la cabeza como negación
- ❑ Señala para mostrarle a otra persona lo que quiere

Cómo puede ayudar al desarrollo de su hijo

- ➔ Provea un ambiente seguro y lleno de cariño. Es importante ser constante y predecible.
- ➔ Felicite al niño cuando se porta bien más de lo que lo castiga cuando se porta mal (no le deje hacer nada por un rato como castigo).
- ➔ Describa sus emociones. Por ejemplo, dígale “Te pones contento cuando leemos este libro”.
- ➔ Aliente los juegos de imitación.
- ➔ Fomente que sea comprensivo con los demás. Por ejemplo, cuando ven a un niño que está triste, aliente a su hijo a darle un abrazo o una palmadita en la espalda.
- ➔ Lea libros y hable acerca de las ilustraciones usando palabras sencillas.
- ➔ Copie las palabras que dice su hijo.
- ➔ Use palabras para describir sentimientos y emociones.
- ➔ Use frases claras y sencillas.
- ➔ Haga preguntas sencillas.

Área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Sabe para qué sirven las cosas comunes, como teléfono, cepillo, cuchara
- ❑ Señala para llamar la atención de otras personas
- ❑ Demuestra interés en una muñeca o animal de peluche y hace de cuenta que le da de comer
- ❑ Señala una parte del cuerpo
- ❑ Hace garabatos sin ayuda
- ❑ Puede seguir instrucciones verbales de un solo paso que no se acompañan de gestos; por ejemplo, se sienta cuando se le dice “siéntate”

Áreas motora y de desarrollo físico

- ❑ Camina solo
- ❑ Jala juguetes detrás de él mientras camina
- ❑ Puede subir las escaleras y correr
- ❑ Puede ayudar a desvestirse
- ❑ Bebe de una taza
- ❑ Come con cuchara

Cómo puede ayudar al desarrollo de su hijo

- ➔ Esconda objetos debajo de las mantas y almohadas y anímelo a encontrarlos.
- ➔ Juegue con bloquecitos, pelotas, rompecabezas, libros y juguetes que enseñan causa y efecto y cómo resolver problemas.
- ➔ Nombre las ilustraciones de los libros y las partes del cuerpo.
- ➔ Dele juguetes que fomentan los juegos de imitación; por ejemplo, muñecos, teléfonos de juguete.
- ➔ Proporcione áreas seguras donde su hijo pueda caminar y moverse sin peligro.
- ➔ Dele juguetes para que pueda empujar o jalar sin peligro.
- ➔ Tenga pelotas para que el niño pueda patearlas, tirarlas y hacerlas rodar.
- ➔ Aliente a su hijo a beber de una taza y usar la cuchara, sin importar el reguero que haga.
- ➔ Juegue con burbujas y déjelo estallarlas.

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No señala cosas para mostrárselas a otras personas
- ❑ No puede caminar
- ❑ No sabe para qué sirven las cosas familiares
- ❑ No copia lo que hacen las demás personas
- ❑ No aprende nuevas palabras
- ❑ No sabe por lo menos 6 palabras
- ❑ No se da cuenta ni parece importarle si la persona que le cuida se va a o regresa
- ❑ Pierde habilidades que había adquirido

Dígale al pediatra o la enfermera si nota cualquiera de estos signos de posible retraso del desarrollo para la edad de su hijo, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado**.

La Academia Americana de Pediatría recomienda que se evalúe el desarrollo general de los niños y los posibles signos de autismo en la consulta de los 18 meses. Pregúntele al médico de su hijo si hay que hacerle la evaluación del desarrollo.

Su Hijo de 2 Años

En cada visita médica de su hijo, hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los niños a esta edad?

Áreas social y emocional

- ❑ Copia a otras personas, especialmente a adultos y niños mayores
- ❑ Se entusiasma cuando está con otros niños
- ❑ Demuestra ser cada vez más independiente
- ❑ Demuestra un comportamiento desafiante (hace lo que se le ha dicho que no haga)
- ❑ Por lo general juega con otros niños sin interactuar mucho, pero empieza a incluirlos en sus juegos, como jugar a perseguirlos

Áreas del habla y la comunicación

- ❑ Señala a objetos o ilustraciones cuando se los nombra
- ❑ Sabe los nombres de personas conocidas y partes del cuerpo
- ❑ Dice frases de 2 a 4 palabras
- ❑ Sigue instrucciones sencillas
- ❑ Repite palabras que escuchó en alguna conversación
- ❑ Señala las cosas que aparecen en un libro

Cómo puede ayudar al desarrollo de su hijo

- ➔ Deje que su hijo ayude con tareas sencillas en el hogar, como barrer o preparar la cena. Felicítelo por ser un buen ayudante.
- ➔ A esta edad, los niños todavía no interactúan con otros niños al jugar (aunque estén juntos) y no saben compartir. Cuando vienen amiguitos a jugar, deles muchos juguetes. Observe siempre a los niños e intervenga si hay una pelea o discusión.
- ➔ Preste mucha atención a su hijo y felicítelo cuando sigue las instrucciones. Evite prestarle atención cuando se comporta en forma desafiante. Dedique más tiempo a felicitarlo por su buen comportamiento que a castigarlo cuando no se porta bien.
- ➔ Enséñele a su hijo a identificar y nombrar partes del cuerpo, animales y otras cosas comunes.
- ➔ No corrija a su hijo cuando dice una palabra en forma incorrecta. En su lugar, dígala usted correctamente. Por ejemplo, “eso es una *pelota*.”
- ➔ Anime a su hijo a usar la palabra en vez de señalar las cosas. Si su hijo no puede decir la palabra entera (“leche”), ayúdelo con el sonido de la primera letra (“l”). Con el tiempo, puede guiarlo para que diga toda la oración: “yo quiero leche”.

Área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Encuentra cosas aun cuando están escondidas debajo de dos o tres sábanas
- ❑ Empieza a clasificar por formas y colores
- ❑ Completa las frases y las rimas de los cuentos que conoce
- ❑ Juega con su imaginación de manera sencilla
- ❑ Construye torres de 4 bloques o más
- ❑ Puede que use una mano más que la otra
- ❑ Sigue instrucciones para hacer dos cosas como por ejemplo, “levanta tus zapatos y ponlos en su lugar”
- ❑ Nombra las ilustraciones de los libros como un gato, pájaro o perro

Áreas motora y de desarrollo físico

- ❑ Se para en las puntas de los dedos
- ❑ Patea una pelota
- ❑ Empieza a correr
- ❑ Se trepa y baja de muebles sin ayuda
- ❑ Sube y baja las escaleras agarrándose
- ❑ Tira la pelota por encima de la cabeza
- ❑ Dibuja o copia líneas rectas y círculos

Cómo puede ayudar al desarrollo de su hijo

- ➔ Esconda los juguetes del niño en la sala y deje que los encuentre.
- ➔ Ayude a su hijo a armar rompecabezas que tengan formas, colores o animales de granja. Nombre cada pieza cuando su hijo la coloca en su lugar.
- ➔ Anime a su hijo a que juegue con bloquecitos. Tome turnos con él para construir torres y derrumbarlas.
- ➔ Haga proyectos de arte con su hijo usando papel, crayones y pintura. Describa lo que su hijo hace y ponga sus dibujos en la pared o en el refrigerador.
- ➔ Pídale a su hijo que le ayude a abrir puertas y cajones y a pasar las páginas de los libros y revistas.
- ➔ Cuando ya camine bien, pídale a su hijo que le ayude cargando cosas pequeñas.
- ➔ Juegue a patear la pelota con su hijo, pasándola una y otra vez. Cuando su hijo haya aprendido, anímelo a correr y patear.
- ➔ Lleve a su hijo al parque para correr y treparse en los juegos o caminar por los senderos naturales. Supervise a su hijo con mucha atención.

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No usa frases de 2 palabras (por ejemplo, “toma leche”)
- ❑ No sabe cómo utilizar objetos de uso común, como un cepillo, teléfono, tenedor o cuchara
- ❑ No copia acciones ni palabras
- ❑ No puede seguir instrucciones sencillas
- ❑ No camina con estabilidad
- ❑ Pierde habilidades que había logrado

Dígale al pediatra o la enfermera si nota cualquiera de estos signos de posible retraso del desarrollo para la edad de su hijo, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado**.

La Academia Americana de Pediatría recomienda que se evalúen el desarrollo general de los niños y los posibles signos de autismo en la consulta de los 24 meses. Pregúntele al médico de su hijo si hay que hacerle la evaluación del desarrollo.

Su Hijo de 3 Años

En cada visita médica de su hijo, hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los niños a esta edad?

Áreas social y emocional

- ❑ Copia a los adultos y los amigos
- ❑ Demuestra afecto por sus amigos espontáneamente
- ❑ Espera su turno en los juegos
- ❑ Se preocupa si ve un amigo llorando
- ❑ Entiende la idea de lo que "es mío", "de él" o "de ella"
- ❑ Expresa una gran variedad de emociones
- ❑ Se separa de su mamá y su papá con facilidad
- ❑ Se molesta con los cambios de rutina grandes
- ❑ Se viste y desviste

Áreas del habla y la comunicación

- ❑ Sigue instrucciones de 2 o 3 pasos
- ❑ Sabe el nombre de la mayoría de las cosas conocidas
- ❑ Entiende palabras como "adentro", "arriba" o "debajo"
- ❑ Puede decir su nombre, edad y sexo
- ❑ Sabe el nombre de un amigo
- ❑ Dice palabras como "yo", "mi", "nosotros", "tú" y algunos plurales (autos, perros, gatos)
- ❑ Habla bien de manera que los desconocidos pueden entender la mayor parte de lo que dice
- ❑ Puede conversar usando 2 o 3 oraciones

Cómo puede ayudar al desarrollo de su hijo

- → Reúnase a jugar en grupos con su hijo o vaya a otros lugares donde hay más niños, para enseñarle a que se lleve bien con los demás.
- → Ayude a su hijo a tratar de resolver los problemas cuando está molesto.
- → Hable sobre las emociones de su hijo. Por ejemplo, dígale "me doy cuenta de que estás enojado porque tiraste la pieza del rompecabezas". Anime a su hijo a identificar sentimientos en los libros.
- → Fije reglas y límites para su hijo y respételas. Si su hijo no respeta una regla, déjelo de 30 segundos a 1 minuto sentado en una silla o dentro de su habitación como castigo. Felicite a su hijo cuando sigue las reglas.
- → Dele a su hijo instrucciones de 2 o 3 pasos. Por ejemplo, "ve a tu habitación y trae tus zapatos y tu abrigo".
- → Léale a su hijo todos los días. Pídale a su hijo que señale cosas en las ilustraciones y que repita las palabras después de usted.
- → Dele a su hijo una "caja con útiles" con papel, crayones y libros para colorear. Coloree y dibuje líneas y formas con su hijo.

Área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Puede operar juguetes con botones, palancas y piezas móviles
- ❑ Juega imaginativamente con muñecas, animales y personas
- ❑ Arma rompecabezas de 3 y 4 piezas
- ❑ Entiende lo que significa “dos”
- ❑ Copia un círculo con lápiz o crayón
- ❑ Pasa las hojas de los libros una a la vez
- ❑ Arma torres de más de 6 bloquecitos
- ❑ Enrosca y desenrosca las tapas de jarras o abre la manija de la puerta

Áreas motora y de desarrollo físico

- ❑ Trepa bien
- ❑ Puede pedalear un triciclo (bicicleta de 3 ruedas)
- ❑ Corre fácilmente
- ❑ Sube y baja escaleras, un pie por escalón

Cómo puede ayudar al desarrollo de su hijo

- ➔ Juegue a encontrar figuras iguales. Pídale a su hijo que encuentre objetos iguales en libros o en la casa.
- ➔ Juegue a contar. Cuente las partes del cuerpo, los escalones y otras cosas que usa o ve todos los días.
- ➔ Dele la mano a su hijo para subir o bajar las escaleras. Cuando pueda subir y bajar con facilidad, anímelo a tomarse del pasamanos.
- ➔ Juegue con su hijo afuera de la casa. Vaya al parque o a caminar por un sendero. Deje que su hijo juegue con libertad y sin actividades estructuradas.

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ Se cae mucho o tiene problemas para subir y bajar escaleras
- ❑ No mira a las personas a los ojos
- ❑ No puede operar juguetes sencillos (tableros de piezas para encajar, rompecabezas sencillos, girar una manija)
- ❑ No usa oraciones para hablar
- ❑ No entiende instrucciones sencillas
- ❑ No imita ni usa la imaginación en sus juegos
- ❑ No quiere jugar con otros niños ni con juguetes
- ❑ Pierde habilidades que había adquirido
- ❑ Se babea o no se le entiende cuando habla

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo la escuela pública más cercana. Para obtener más información, consulte **www.cdc.gov/preocupado**.

Su Hijo de 4 Años

En cada visita médica de su hijo, hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los niños a esta edad?

Áreas social y emocional

- ❑ Disfruta haciendo cosas nuevas
- ❑ Juega al “papá” o a la “mamá”
- ❑ Cada vez se muestra más creativo en los juegos de imaginación
- ❑ Le gusta más jugar con otros niños que solo
- ❑ Colabora con otros niños
- ❑ Generalmente no puede distinguir la fantasía de la realidad
- ❑ Describe lo que le gusta y lo que le interesa

Áreas del habla y la comunicación

- ❑ Sabe algunas reglas básicas de gramática, como el uso correcto de “él” y “ella”
- ❑ Relata cuentos
- ❑ Puede decir su nombre y apellido
- ❑ Canta una canción o recita un poema de memoria como “La araña pequeñita” o “Las ruedas de los autobuses”

Cómo puede ayudar al desarrollo de su hijo

- ➔ Juegue con su hijo usando la imaginación. Deje que sea el líder y copie todo lo que hace.
- ➔ Sugiera que jueguen a hacer de cuenta que están en una situación que le pone nervioso, como empezar el preescolar o quedarse por la noche en la casa de los abuelitos.
- ➔ Siempre que pueda, dele a su hijo opciones sencillas para que escoja. Deje que escoja la ropa, los juegos o algo de comer entre las comidas. Limítese a no más de 2 o 3 opciones.
- ➔ Cuando juega con sus amigos, deje que su hijo resuelva los problemas con los otros niños, pero esté atenta para ayudar si es necesario.
- ➔ Anime a su hijo a usar palabras, compartir juguetes y turnarse con sus amigos para elegir los juegos.
- ➔ Dele a su hijo juguetes que aviven la imaginación, como disfraces, juegos de cocina y bloquecitos.
- ➔ Cuando hable con su hijo use la gramática correcta. En lugar de decirle “mamá quiere que vengas aquí”, dígale “yo quiero que vengas aquí”.

Área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Nombra algunos colores y números
- ❑ Entiende la idea de contar
- ❑ Comienza a entender el concepto de tiempo
- ❑ Recuerda partes de un cuento
- ❑ Entiende el concepto de "igual" y "diferente"
- ❑ Sabe usar tijeras
- ❑ Dibuja una persona con 2 o 4 partes del cuerpo
- ❑ Empieza a copiar algunas letras mayúsculas
- ❑ Juega juegos infantiles de mesa o de cartas
- ❑ Le dice lo que le parece que va a suceder en un libro a continuación

Áreas motora y de desarrollo físico

- ❑ Brinca y se sostiene en un pie hasta por 2 segundos
- ❑ La mayoría de las veces agarra una pelota que rebota
- ❑ Se sirve los alimentos, los hace papilla y los corta (mientras usted lo vigila)

Cómo puede ayudar al desarrollo de su hijo

- ➔ Use palabras como "primero," "segundo" y "al final" cuando hable de sus actividades cotidianas. Esto le va a ayudar a su hijo a aprender sobre la secuencia de eventos.
- ➔ Responda con tranquilidad a las preguntas de su hijo sobre los "porqué de las cosas". Si no sabe la respuesta, diga "no lo sé" o ayude a su hijo a encontrar la respuesta en un libro, en Internet o preguntándole a otro adulto.
- ➔ Cuando lea con su hijo, pídale que le cuente qué pasó durante el relato.
- ➔ Nombre los colores de los libros, las ilustraciones y las cosas de la casa. Cuente los artículos comunes, como la cantidad de galletitas, escalones o trenes de juguete.
- ➔ Enséñele a su hijo a jugar afuera a juegos como el "corre que te alcanzo", "seguir al líder" y "pato, pato, ganso".
- ➔ Escuche la música preferida de su hijo y baile con él. Tomen turnos copiándose lo que cada uno hace.

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No puede saltar en el mismo sitio
- ❑ Tiene dificultades para hacer garabatos
- ❑ No muestra interés en los juegos interactivos o de imaginación
- ❑ Ignora a otros niños o no responde a las personas que no son de la familia
- ❑ Rehúsa vestirse, dormir y usar el baño
- ❑ No puede relatar su cuento favorito
- ❑ No sigue instrucciones de 3 partes
- ❑ No entiende lo que quieren decir "igual" y "diferente"
- ❑ Habla con poca claridad
- ❑ No usa correctamente las palabras "yo" y "tú"
- ❑ Pierde habilidades que había adquirido

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo la escuela pública más cercana. Para obtener más información, consulte **www.cdc.gov/preocupado**.

Su Hijo de 5 Años

En cada visita médica de su hijo, hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los niños a esta edad?

Áreas social y emocional

- ❑ Quiere complacer a los amigos
- ❑ Quiere parecerse a los amigos
- ❑ Es posible que haga más caso a las reglas
- ❑ Está consciente de la diferencia de los sexos
- ❑ Puede distinguir la fantasía de la realidad
- ❑ Le gusta cantar, bailar y actuar
- ❑ Es más independiente (por ejemplo, puede ir solo a visitar a los vecinos de al lado) [para esto todavía necesita la supervisión de un adulto]
- ❑ A veces es muy exigente y a veces muy cooperador

Áreas del habla y la comunicación

- ❑ Habla con mucha claridad
- ❑ Puede contar una historia sencilla usando oraciones completas
- ❑ Puede usar el tiempo futuro; por ejemplo, “la abuelita va a venir”
- ❑ Dice su nombre y dirección

Cómo puede ayudar al desarrollo de su hijo

- ➔ Continúe organizando citas para jugar con los amiguitos, paseos al parque o grupos de juego. Dele a su hijo más libertad para elegir actividades para jugar con amigos, y deje que resuelva los problemas por sí mismo.
- ➔ Es posible que su hijo comience a “contestar” o a usar malas palabras como una forma de sentirse independiente. No le preste demasiada atención a este tipo de comportamiento verbal, más allá de no dejarle hacer nada por un tiempo breve como castigo. En lugar de ello, felicite a su hijo cuando pide las cosas con cortesía y cuando acepta un “no” con tranquilidad.
- ➔ Este es un buen momento para hablar con su hijo acerca de cuándo está bien que lo toquen. Nadie debe tocarle las partes íntimas excepto los médicos o enfermeras durante un examen o los padres cuando está bañando o limpiando al niño.
- ➔ Enséñele a su hijo la dirección y el teléfono de su casa.
- ➔ Cuando le lea a su hijo, pídale que adivine qué va a pasar en la historia a continuación.
- ➔ Enséñele a su hijo conceptos como mañana, tarde, noche, hoy, mañana y ayer. Comience a enseñarle los días de la semana.

Área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Cuenta 10 o más cosas
- ❑ Puede dibujar una persona con al menos 6 partes del cuerpo
- ❑ Puede escribir algunas letras o números
- ❑ Dibuja triángulos y otras figuras
- ❑ Conoce las cosas de uso diario como el dinero y la comida

Áreas motora y de desarrollo físico

- ❑ Se para en un pie por 10 segundos o más
- ❑ Brinca y puede ser que dé saltos de lado
- ❑ Puede dar volteretas en el aire
- ❑ Usa tenedor y cuchara y, a veces, cuchillo
- ❑ Puede ir al baño solo
- ❑ Se columpia y trepa

Cómo puede ayudar al desarrollo de su hijo

- ➔ Anime a su hijo a "leer" mirando las ilustraciones y contando la historia.
- ➔ Fomente el interés de su hijo en su comunidad. Por ejemplo, si a su hijo le encantan los animales, visite el zoológico o granjas donde se permite tocar a los animales. Vaya a la biblioteca o busque información en Internet sobre estos temas.
- ➔ Tenga siempre a mano una caja de crayones, papel, pintura, tijeras para niños y goma de pegar. Anime a su hijo a dibujar y terminar proyectos de arte con diferentes materiales.
- ➔ Juegue con juguetes que lo animan a poner cosas juntas.
- ➔ Enséñele a su hijo a mover las piernas y a impulsarse en el columpio con los pies.
- ➔ Ayude a su hijo a colgarse de las barras del juego infantil de pasamanos.
- ➔ Salga a caminar con su hijo, organice una "búsqueda del tesoro en el vecindario o el parque", ayúdelo a andar en bicicleta con rueditas de auxilio (usando casco).

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No expresa una gran variedad de emociones
- ❑ Tiene comportamientos extremos (demasiado miedo, agresión, timidez o tristeza)
- ❑ Es demasiado retraído y pasivo
- ❑ Se distrae con facilidad, tiene problemas para concentrarse en una actividad por más de 5 minutes
- ❑ No le responde a las personas o lo hace solo superficialmente
- ❑ No puede distinguir la fantasía de la realidad
- ❑ No juega a una variedad de juegos y actividades
- ❑ No puede decir su nombre y apellido
- ❑ No usa correctamente los plurales y el tiempo pasado
- ❑ No habla de sus actividades o experiencias diarias
- ❑ Pierde habilidades que había adquirido
- ❑ No puede cepillarse los dientes, lavarse y secarse las manos o desvestirse sin ayuda
- ❑ No dibuja

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo la escuela pública más cercana. Para obtener más información, consulte **www.cdc.gov/preocupado**.

Preguntas Para el Médico de Mi Hijo




2 Meses

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4 Meses

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18 Meses (1 Año y Medio)

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5 Años

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Resources

"Learn the Signs. Act Early." Web: www.cdc.gov/actearly

GOVERNMENT RESOURCES

- Centers for Disease Control and Prevention (CDC), National Center on Birth Defects and Developmental Disabilities (NCBDDD)
  Phone: 1-800-232-4636 Web: www.cdc.gov/ncbddd
- National Dissemination Center for Children with Disabilities
  Web: www.nichcy.org/states.htm
- Department of Education Web: www.ed.gov/index.html
- National Institute of Mental Health
  Phone: 1-866-615-6464 Web: www.nimh.nih.gov
- State Health Insurance Program (SCHIP)
  Phone: 1-877-543-7669 Web: www.insurekidsnow.gov

SPECIAL RESOURCES

- American Academy of Pediatrics (AAP)
  Phone: 1-847-434-4000 Web: www.aap.org
- Parent to Parent-USA Web: www.p2pusa.org

AUTISM SPECTRUM DISORDERS (ASD)

- Autism Society of America (ASA)
  Phone: 1-800-328-8476 Web: www.autism-society.org
- Autism Speaks
  Phone: 1-888-288-4762 Web: www.autismspeaks.org
- First Signs
  Phone: 1-978-346-4380 Web: www.firstsigns.org
- Organization for Autism Research (OAR)
  Phone: 1-703-243-9710 Web: www.researchautism.org
- Asperger Syndrome Education Network (ASPEN)
  Phone: 1-732-321-0880 Web: www.aspennj.org
- MAAP Services for Autism, Asperger Syndrome, and PDD
  Phone: 1-219-662-1311 Web: www.maapservices.org
- CDC's Resources on Vaccines and Autism
  Web: www.cdc.gov/ncbddd/autism/vaccines.htm

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD)

- Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD)
  Phone: 1-800-233-4050 Web: www.chadd.org
- Attention Deficit Disorder Association (ADDA)
  Phone: 1-800-939-1019 Web: www.add.org

CEREBRAL PALSY

- United Cerebral Palsy (UCP)
  Phone: 1-800-872-5827 Web: www.ucp.org
- National Institute of Neurological Disorders and Stroke (NINDS)
  Phone: 1-800-352-9424 Web: www.ninds.nih.gov
- Reaching for the Stars
  Phone: 1-877-561-7387
  Web: www.reachingforthestars.org

INTELLECTUAL DISABILITY (also known as Mental Retardation)

- American Association of Intellectual and Developmental Disabilities (formerly American Association on Mental Retardation)
  Phone: 1-800-424-3688 Web: www.aaidd.org
- The Arc of the United States
  Phone: 1-800-433-5255 Web: www.thearc.org

HEARING LOSS

- Centers for Disease Control and Prevention (CDC), Early Hearing Detection and Intervention Program (EHDI)
  Phone: 1-800-232-4636
  Web: www.cdc.gov/ncbddd/ehdi
- American Academy of Audiology (AAA)
  Phone: 1-800-222-2336 Web: www.audiology.org
- American Academy of Pediatrics Bright Futures
  Phone: 1-847-434-4000
  Web: brightfutures.aap.org/web
- American Speech-Language-Hearing Association (ASHA)
  Phone: 1-800-638-8255 Web: www.asha.org

VISION LOSS

- National Federation of the Blind (NFB)
  Phone: 1-410-659-9314 Web: www.nfb.org
- American Council of the Blind (ACB)
  Phone: 1-800-424-8666 Web: www.acb.org
- American Foundation for the Blind (AFB)
  Phone: 1-800-232-5463 Web: www.afb.org

FETAL ALCOHOL SYNDROME DISORDER (FASD)

- Centers for Disease Control and Prevention (CDC), Fetal Alcohol Syndrome Program
  Phone: 1-800-232-4636 Web: www.cdc.gov/ncbddd/fas
- National Organization on Fetal Alcohol Syndrome (NOFAS)
  Phone: 1-800-666-6327 Web: www.nofas.org

www.cdc.gov/actearly

SAFER • HEALTHIER • PEOPLE™

Learn the Signs. Act Early.

Recursos

Aprenda los signos. Reaccione pronto. Sitio electrónico: www.cdc.gov/pronto

RECURSOS GUBERNAMENTALES

- Centros para el Control y la Prevención de Enfermedades (Centers for Disease Control and Prevention, CDC)
  Teléfono: 1-800-232-4636
  Sitio electrónico: www.cdc.gov/spanish
- Centro Nacional de Defectos Congénitos y Deficiencias del Desarrollo (National Center on Birth Defects and Developmental Disabilities, NCBDDD)
  Sitio electrónico: www.cdc.gov/ncbddd/defaultspan.htm
- Centro Nacional de Diseminación de Información para Niños con Discapacidades (National Dissemination Center for Children with Disabilities)
  Sitio electrónico: www.nichcy.org/spanish.htm
- Departamento de Educación de los Estados Unidos (US Department of Education)
  Teléfono: 1-800-872-5327
  Sitio electrónico: www.ed.gov/espanol
- Programas Estatales de Seguro Médico (State Health Insurance Program, SCHIP)
  Teléfono: 1-877-543-7669
  Sitio electrónico: www.insurekidsnow.gov/espanol

TRASTORNO DEL ESPECTRO AUTISTA (AUTISM SPECTRUM DISORDER, ASD)

- Autismo Habla (Autism Speaks)
  Sitio electrónico: www.autismspeaks.org/espanol
- Organización para la Investigación del Autismo (Organization for Autism Research, OAR)
  Sitio electrónico:
  www.researchautism.org/resources/reading/spanishguides.asp
- Sociedad Autista Estadounidense (Autism Society of America, ASA)
  Teléfono: 1-800-328-8476
  Sitio electrónico: www.autism-society.org/autismo
- Sitio electrónico del Programa Nacional de Inmunización "CDC: Vacunas y Autismo" (CDC's National Immunization Program's "Vaccines and Autism" Internet Site)
  Sitio electrónico: www.cdc.gov/spanish/inmunizacion/autismo.html

TRASTORNO POR DÉFICIT DE ATENCIÓN E HIPERACTIVIDAD (ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER, ADHD)

- Niños y Adultos con Trastorno de Déficit de Atención con Hiperactividad (Children and Adults with Attention Deficit/Hyperactivity Disorder, CHADD)
  Teléfono: 1-800-233-4050
  Sitio electrónico: www.help4adhd.org/espanol.cfm
- Asociación del Trastorno por Déficit de Atención (Attention Deficit Disorder Association, ADDA)
  Sitio electrónico: www.add.org/help/faqs-esp.html

PARÁLISIS CEREBRAL

- Instituto Nacional de Trastornos Neurológicos y Accidentes Cerebrovasculares (National Institute of Neurological Disorders and Stroke, NINDS)
  Sitio electrónico:
  www.ninds.nih.gov/health_and_medical/spanishindex.htm
- Asociación para la Parálisis Cerebral (United Cerebral Palsy, UCP)
  Sitio electrónico: www.ucp.org/ucp_general.cfm/1/11788

DISCAPACIDAD INTELECTUAL (también conocido como retraso mental)

- Sociedad Nacional del Síndrome de Down (National Down Syndrome Society, NDSS)
  Teléfono: 1-800-221-4602
  Sitio electrónico: www.esp.ndss.org

PÉRDIDA DE LA AUDICIÓN

- Centros para el Control y la Prevención de Enfermedades Programa de Detección Auditiva e Intervención Temprana (Centers for Disease Control and Prevention, Early Hearing Detection and Intervention Program)
  Teléfono: 1-800-232-4636
  Sitio electrónico: www.cdc.gov/ncbddd/ehdi/spanish
- Clínica John Tracy (John Tracy Clinic)
  Teléfono: 1-213-748-5481
  Sitio electrónico: www.clinicajohntracy.org
- Criando Niños Sordos (Raising Deaf Kids)
  Sitio electrónico: www.raisingdeafkids.org/spanish

PÉRDIDA DE LA VISIÓN

- Consorcio Nacional sobre la Sordera-Ceguera (National Consortium on Deaf-Blindness, NCDB)
  Teléfono: 1-800-438-9376
  Sitio electrónico: nationaldb.org/ISespanol.php
- Federación Americana para Ciegos (American Federation for the Blind, AFB)
  Sitio electrónico: www.afb.org/section.asp?sectionID=59

TRASTORNOS DEL ESPECTRO ALCOHOLICO FETAL (FASD)

- Centros para el Control y la Prevención de Enfermedades Programa de Trastornos del Espectro Alcoholico Fetal (Centers for Disease Control and Prevention, Fetal Alcohol Syndrome Program)
  Teléfono: 1-800-232-4636
  Sitio electrónico: www.cdc.gov/ncbddd/spanish/fas

www.cdc.gov/pronto

Aprenda los signos. Reaccione pronto.

Tips for Talking with Parents

If you suspect a child has a developmental delay and believe a parent is unaware of it, this sample conversation can give you ideas of how to talk with the child's parent.

Good afternoon, Ms. Jones. We love having Taylor in class. He really enjoys story time and follows directions well. He is working hard on coloring but is having a difficult time and gets frustrated. I have also noticed a few things about Taylor's social skills that I would like to discuss with you. Do you have a few minutes? *[Cite specific behaviors and when they occurred.]*

Have you noticed any of these at home?

Ms. Jones, here is some information that shows the developmental milestones for a child Taylor's age. Let's plan to meet again next week [set a time] after you've had time to read it and think it over. *[Provide information such as the fact sheets.]*

Ms. Jones, I know this is hard to talk about, and I may be over-reacting, but I think it would also be a good idea to talk to Taylor's doctor about this in the next few weeks. You can take this information with you when you go. The doctor can give Taylor a "developmental screening" which can answer some questions about his progress and whether you need to do anything else. Maybe there is no problem, but getting help early can make a big difference if there is, so it's really important to find out for sure. Let me know if you need anything from me for that doctor's appointment!

Thank you for agreeing to talk with me today. We'll all do our best to help Taylor. He is a great kid!

If a parent approaches you with concerns about his or her child, this might help you respond.

Mrs. Smith, you wanted to speak with me privately about Taylor?

[Listen to her concerns. See if she has noticed the same behaviors you have, and share examples that are the same as or different from hers.]

I am glad to know we are both on the same page. I have some information that might help you when you're watching Taylor at home this week. This fact sheet shows the developmental milestones for his age. Each child develops at his or her own pace, so Taylor might not have met all these milestones; it's worth taking a closer look. Let's meet again next *[set a date]* after you've had time to read this and think about it.

I also think it would be a good idea to talk to Taylor's doctor about this in the next few weeks. You can take this information with when you go. The doctor can give Taylor a "developmental screening" which can answer some questions about his progress and whether you need to do anything else. Let me know if you need anything from me for that doctor's appointment. Thank you for talking with me today. We'll all do our best to help Taylor. He is a great kid!

Tips for these conversations with parents:

- Highlight some of the child's strengths, letting the parent know what the child does well.
- Use materials like the "Learn the Signs. Act Early." fact sheets. This will help the parent know that you are basing your comments on facts and not just feelings.
- Talk about specific behaviors that you have observed in caring for the child. Use the milestones fact sheets as a guide. Example: If you are telling the parent "I have noticed that Taylor does not play pretend games with the other children," you could show the parent the line on the milestones fact sheet for a four-year-old that says that a child that age "engages in fantasy play."
- Try to make it a discussion. Pause a lot, giving the parent time to think and to respond.
- Expect that if the child is the oldest in the family, the parent might not have experience to know the milestones the child should be reaching.
- Listen to and watch the parent to decide on how to proceed. Pay attention to tone of voice and body language.
- This might be the first time the parent has become aware that the child might have a delay. Give the parent time to think about this and even speak with the child's other caregivers.
- Let the parent know that he or she should talk with the child's health care professional (doctor or nurse) soon if there are any concerns or more information is needed.
- Remind the parent that you do your job because you love and care for children, and that you want to make sure that the child does his or her very best. It is also okay to say that you "may be overly concerned," but that it is best to check with the child's doctor or nurse to be sure since early action is so important if there is a real delay.

www.cdc.gov/actearly

It's time to change how we view a child's growth.

4 feet
47″
46″
45″
44″
43″
42″
41″
40″
39″
38″
37″
3 feet
35″
34″
33″
32″
31″
30″
29″
28″
27″
26″
25″
2 feet
23″
22″
21″
20″
19″
18″
17″
16″
15″
14″
13″
1 foot

5 years

Speaks very clearly

Wants to please friends and wants to be like friends

Counts 10 or more things

Can tell what's real and what's make-believe

4 years

Tells stories

Understands the ideas of "same" and "different"

Plays "Mom" or "Dad"

Cooperates with other children

3 years

Says name, age, and sex

Says words like "I," "me," "we" and "you" and some plurals (cars, dogs, cats)

Does puzzles with 3 or 4 pieces

Plays make-believe with dolls, animals, and people

Copies adults and friends

2 years

Points to things or pictures when they are named

Says sentences with 2 to 4 words

Follows simple instructions

Gets excited when with other children

Begins to run

18 months

Plays simple pretend, such as feeding a doll

Points to show others something interesting

Likes to hand things to others as play

Says several single words

Says and shakes head "no"

1 year

Uses simple gestures, like shaking head "no" or waving "bye-bye"

Copies gestures

Plays games such as "peek-a-boo" or "pat-a-cake"

Says "mama" and "dada"

Responds to simple spoken requests

www.cdc.gov/actearly
1-800-CDC-INFO

Learn the Signs. Act Early.

999309
Chapter 4: Care for Children 0-5

Es hora de cambian nuestra forma de ver el crecimiento del niño.

120 cm
118 cm
116 cm
114 cm
112 cm
110 cm
108 cm
106 cm
104 cm
102 cm
100 cm
98 cm
96 cm
94 cm
92 cm
90 cm
88 cm
86 cm
84 cm
82 cm
80 cm
78 cm
76 cm
74 cm
72 cm
70 cm
68 cm
66 cm
64 cm
62 cm
60 cm
58 cm
56 cm
54 cm
52 cm
50 cm
48 cm
46 cm
44 cm
42 cm
40 cm
38 cm
36 cm
34 cm
32 cm
30 cm

5 años

Habla con mucha claridad

Quiere complacer a los amigos y quiere ser como los amigos

Cuenta 10 o más cosas

Puede distinguir entre la fantasía y la realidad

4 años

Relata cuentos

Entienda los conceptos de “igual” y “diferente”

Juega al “papá” o a la “mamá”

Colabora con otros niños

3 años

Puede decir su nombre, edad y sexo

Dice palabras como “yo”, “mi”, “nosotros”, “tú”, y algunos plurales (autos, perros, gatos)

Arma rompecabezas con 3 y 4 piezas

Juega imaginativamente con muñecas, animales y personas

Copia a los adultos y los amigos

2 años

Señala a objetos o ilustraciones cuando se los nombra

Dice frases de 2 a 4 palabras

Sigue instrucciones sencillas

Se entusiasma cuando está con otros niños

Empieza a correr

18 meses

Juega a imitar cosas sencillas, como alimentar a una muñeca

Señala para mostrar algo que le llama la atención

Le gusta alcanzarle cosas a los demás como un juego

Puede decir varias palabras sueltas

Dice “no” y sacude la cabeza como negación

1 año

Usa gestos simples como sacudir la cabeza “no” o despedirse con la mano

Imita gestos

Juega a esconder la carita y a las palmaditas con las manos

Dice “mamá” y “papá”

Responde cuando se le pide que haga algo sencillo

www.cdc.gov/pronto
1-800-CDC-INFO

Aprenda los signos. Reaccione pronto.

It's time to change how we view a child's growth.

As they grow, children are always learning new things. Below are just some of the things you should look for as your child grows. Use this as a guide, and if you have any concerns, talk with your child's doctor and call **1-800-CDC-INFO** to get connected with your community's early childhood intervention system.

At 6 months, many children

- respond to own name
- respond to other people's emotions and often seem happy
- copy sounds
- like to play with others, especially parents

At 1 year (12 months), many children

- use simple gestures, like shaking head "no" or waving "bye-bye"
- say "mama" and "dada" and exclamations like "uh-oh!"
- copy gestures
- respond to simple spoken requests

At 1 ½ years (18 months), many children

- play simple pretend, such as feeding a doll
- point to show others something interesting
- show a full range of emotions, such as happy, sad, angry
- say several single words

At 2 years (24 months), many children

- say sentences with 2 to 4 words
- follow simple instructions
- get excited when with other children
- point to things or pictures when they are named

At 3 years (36 months), many children

- show affection for friends without prompting
- carry on a conversation using 2 to 3 sentences
- copy adults and friends
- play make-believe with dolls, animals, and people

At 4 years (48 months), many children

- tell stories
- would rather play with other children than by themselves
- play cooperatively with others

Questions to ask your child's doctor:

- Is my child's development on track for his or her age?
- How can I track my child's development?
- What should I do if I'm worried about my child's progress?
- Where can I get more information?

Adapted from CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Fifth Edition, edited by Steven Shelov and Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 by the American Academy of Pediatrics and BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, Third Edition, edited by Joseph Hagan, Jr., Judith S. Shaw, and Paula M. Duncan, 2008, Elk Grove Village, IL: American Academy of Pediatrics.

www.cdc.gov/actearly

1-800-CDC-INFO

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CDC Centers for Disease Control and Prevention

Learn the Signs. Act Early.

Es tiempo de ver el crecimiento de los niños de manera diferente.

A medida que crecen, los niños siempre están aprendiendo cosas nuevas. Los siguientes son solo algunos de los aspectos del crecimiento de su hijo en los que usted debe fijarse. Use esta lista como una guía y, si algo le preocupa, consulte con el médico de su hijo y llame al **1-800-CDC-INFO** para recibir información acerca del sistema de ayuda para la intervención infantil temprana de su comunidad.

A los 6 meses, la mayoría de los niños

- responden cuando se les llama por su nombre
- reaccionan ante las emociones de otras personas y por lo general parecen felices
- imitan sonidos
- disfrutan jugando con otras personas, especialmente con sus padres

Al año (12 meses), la mayoría de los niños

- usan gestos simples, como mover la cabeza de lado a lado para decir "no" o despedirse con la mano
- dicen "mamá" y "papá" y exclamaciones como "¡oh-oh!"
- imitan gestos
- responden a pedidos sencillos

Al año y medio (18 meses), la mayoría de los niños

- juegan a imitar cosas sencillas, como alimentar a una muñeca
- señalan para mostrar algo que les llama la atención
- expresan una gran variedad de emociones como felicidad, tristeza o enojo
- pueden decir varias palabras sueltas

A los 2 años (24 meses), la mayoría de los niños

- dicen frases de 2 a 4 palabras
- siguen instrucciones sencillas
- se entusiasman cuando están con otros niños
- señalan objetos o imágenes cuando se los nombra

A los 3 años (36 meses), la mayoría de los niños

- demuestran afecto espontáneo por sus amigos
- pueden conversar usando 2 o 3 frases
- imitan a adultos y compañeros
- juegan imaginativamente con muñecas, animales y personas

A los 4 años (48 meses), la mayoría de los niños

- pueden contar cuentos
- prefieren jugar con otros niños que jugar solos
- juegan con los demás de manera cooperativa

Preguntas para hacerle al médico de su hijo:

- ¿Está bien el desarrollo de mi hijo para la edad que tiene?
- ¿Cómo puedo seguir el desarrollo de mi hijo?
- ¿Qué debo hacer si me preocupa el progreso de mi hijo?
- ¿Dónde puedo obtener más información?

Tomado de CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Fifth Edition, edited by Steven Shelov and Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 by the American Academy of Pediatrics and BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, Third Edition, edited by Joseph Hagan, Jr., Judith S. Shaw, and Paula M. Duncan, 2008, Elk Grove Village, IL: Academia Americana de Pediatría.

www.cdc.gov/pronto

1-800-CDC-INFO

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CDC CENTERS FOR DISEASE CONTROL AND PREVENTION

Aprenda los signos. Reaccione pronto.

Milestone Moments

Learn the Signs. Act Early.

Learn the Signs. Act Early.

www.cdc.gov/milestones

1-800-CDC-INFO








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Centers for Disease Control and Prevention

www.cdc.gov/milestones

1-800-CDC-INFO

You can follow your child's development by watching how he or she plays, learns, speaks, and acts.

Look inside for milestones to watch for in your child and how you can help your child learn and grow.

Centers for Disease Control and Prevention

www.cdc.gov/milestones

1-800-CDC-INFO

Milestone Moments

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

The lists that follow have milestones to look for when your child is:

Check the milestones your child has reached at each age.

Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

For more information, go to www.cdc.gov/milestones

Your Baby at 2 Months

Talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What babies do at this age

Social/Emotional

- ❑ Can briefly calm himself (may bring hands to mouth and suck on hand)
- ❑ Begins to smile at people
- ❑ Tries to look at parent

Language/Communication

- ❑ Coos, makes gurgling sounds
- ❑ Turns head toward sounds

Cognitive (learning, thinking, problem-solving)

- ❑ Pays attention to faces
- ❑ Begins to follow things with eyes and recognize people at a distance
- ❑ Begins to act bored (cries, fussy) if activity doesn't change

How you can help your baby's development

- → Cuddle, talk, and play with your baby during feeding, dressing, and bathing.
- → Help your baby learn to calm herself. It's okay for her to suck on her fingers.
- → Begin to help your baby get into a routine, such as sleeping at night more than in the day, and have regular schedules.
- → Getting in tune with your baby's likes and dislikes can help you feel more comfortable and confident.
- → Act excited and smile when your baby makes sounds.
- → Copy your baby's sounds sometimes, but also use clear language.
- → Pay attention to your baby's different cries so that you learn to know what he wants.
- → Talk, read, and sing to your baby.
- → Play peek-a-boo. Help your baby play peek-a-boo, too.
- → Place a baby-safe mirror in your baby's crib so she can look at herself.

Movement/Physical Development

- ❑ Can hold head up and begins to push up when lying on tummy
- ❑ Makes smoother movements with arms and legs

How you can help your baby's development

- ➔ Look at pictures with your baby and talk about them.
- ➔ Lay your baby on his tummy when he is awake and put toys near him.
- ➔ Encourage your baby to lift his head by holding toys at eye level in front of him.
- ➔ Hold a toy or rattle above your baby's head and encourage her to reach for it.
- ➔ Hold your baby upright with his feet on the floor. Sing or talk to your baby as he is upright.

Act early by talking to your child's doctor if your child:

- ❑ Doesn't respond to loud sounds
- ❑ Doesn't watch things as they move
- ❑ Doesn't smile at people
- ❑ Doesn't bring hands to mouth
- ❑ Can't hold head up when pushing up when on tummy

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned**.

Your Baby at 4 Months

Talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What babies do at this age

Social/Emotional

- ❑ Smiles spontaneously, especially at people
- ❑ Copies some movements and facial expressions, like smiling or frowning
- ❑ Likes to play with people and might cry when playing stops

Language/Communication

- ❑ Begins to babble
- ❑ Babbles with expression and copies sounds he hears
- ❑ Cries in different ways to show hunger, pain, or being tired

How you can help your baby's development

- ➔ Hold and talk to your baby; smile and be cheerful while you do.
- ➔ Set steady routines for sleeping and feeding.
- ➔ Pay close attention to what your baby likes and doesn't like; you will know how best to meet his needs and what you can do to make your baby happy.
- ➔ Copy your baby's sounds.
- ➔ Act excited and smile when your baby makes sounds.
- ➔ Have quiet play times when you read or sing to your baby.
- ➔ Give age-appropriate toys to play with, such as rattles or colorful pictures.
- ➔ Play games such as peek-a-boo.
- ➔ Provide safe opportunities for your baby to reach for toys and explore his surroundings.
- ➔ Put toys near your baby so that she can reach for them or kick her feet.

Cognitive (learning, thinking, problem-solving)

- ❑ Lets you know if she is happy or sad
- ❑ Responds to affection
- ❑ Reaches for toy with one hand
- ❑ Uses hands and eyes together, such as seeing a toy and reaching for it
- ❑ Follows moving things with eyes from side to side
- ❑ Watches faces closely
- ❑ Recognizes familiar people and things at a distance

Movement/Physical Development

- ❑ Holds head steady, unsupported
- ❑ Pushes down on legs when feet are on a hard surface
- ❑ May be able to roll over from tummy to back
- ❑ Can hold a toy and shake it and swing at dangling toys
- ❑ Brings hands to mouth
- ❑ When lying on stomach, pushes up to elbows

How you can help your baby's development

- ➔ Put toys or rattles in your baby's hand and help him to hold them.
- ➔ Hold your baby upright with feet on the floor, and sing or talk to your baby as she "stands" with support.

Act early by talking to your child's doctor if your child:

- ❑ Doesn't watch things as they move
- ❑ Doesn't smile at people
- ❑ Can't hold head steady
- ❑ Doesn't coo or make sounds
- ❑ Doesn't bring things to mouth
- ❑ Doesn't push down with legs when feet are placed on a hard surface
- ❑ Has trouble moving one or both eyes in all directions

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned**.

Your Baby at 6 Months

Talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What babies do at this age

Social/Emotional

- ❑ Knows familiar faces and begins to know if someone is a stranger
- ❑ Likes to play with others, especially parents
- ❑ Responds to other people's emotions and often seems happy
- ❑ Likes to look at self in a mirror

Language/Communication

- ❑ Responds to sounds by making sounds
- ❑ Strings vowels together when babbling ("ah," "eh," "oh") and likes taking turns with parent while making sounds
- ❑ Responds to own name
- ❑ Makes sounds to show joy and displeasure
- ❑ Begins to say consonant sounds (jabbering with "m," "b")

How you can help your baby's development

- ➔ Play on the floor with your baby every day.
- ➔ Learn to read your baby's moods. If he's happy, keep doing what you are doing. If he's upset, take a break and comfort your baby.
- ➔ Show your baby how to comfort herself when she's upset. She may suck on her fingers to self soothe.
- ➔ Use "reciprocal" play—when he smiles, you smile; when he makes sounds, you copy them.
- ➔ Repeat your child's sounds and say simple words with those sounds. For example, if your child says "bah," say "bottle" or "book."
- ➔ Read books to your child every day. Praise her when she babbles and "reads" too.
- ➔ When your baby looks at something, point to it and talk about it.
- ➔ When he drops a toy on the floor, pick it up and give it back. This game helps him learn cause and effect.
- ➔ Read colorful picture books to your baby.

Cognitive (learning, thinking, problem-solving)

- ❑ Looks around at things nearby
- ❑ Shows curiosity about things and tries to get things that are out of reach
- ❑ Brings things to mouth
- ❑ Begins to pass things from one hand to the other

Movement/Physical Development

- ❑ Rolls over in both directions (front to back, back to front)
- ❑ When standing, supports weight on legs and might bounce
- ❑ Begins to sit without support
- ❑ Rocks back and forth, sometimes crawling backward before moving forward

How you can help your baby's development

- ➔ Point out new things to your baby and name them.
- ➔ Show your baby bright pictures in a magazine and name them.
- ➔ Hold your baby up while she sits or support her with pillows. Let her look around and give her toys to look at while she balances.
- ➔ Put your baby on his tummy or back and put toys just out of reach. Encourage him to roll over to reach the toys.

Act early by talking to your child's doctor if your child:

- ❑ Doesn't try to get things that are in reach
- ❑ Shows no affection for caregivers
- ❑ Doesn't respond to sounds around him
- ❑ Has difficulty getting things to mouth
- ❑ Seems very floppy, like a rag doll
- ❑ Doesn't make vowel sounds ("ah", "eh", "oh")
- ❑ Doesn't roll over in either direction
- ❑ Doesn't laugh or make squealing sounds
- ❑ Seems very stiff, with tight muscles

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned**.

Your Baby at 9 Months

Talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What babies do at this age

Social/Emotional

- ❑ May be afraid of strangers
- ❑ May be clingy with familiar adults
- ❑ Has favorite toys

Language/Communication

- ❑ Understands "no"
- ❑ Makes a lot of different sounds like "mamamama" and "babababababa"
- ❑ Copies sounds and gestures of others
- ❑ Uses fingers to point at things

How you can help your baby's development

- ➔ Pay attention to the way he reacts to new situations and people; try to continue to do things that make your baby happy and comfortable.
- ➔ As she moves around more, stay close so she knows that you are near.
- ➔ Continue with routines; they are especially important now.
- ➔ Play games with "my turn, your turn."
- ➔ Say what you think your baby is feeling. For example, say, "You are so sad, let's see if we can make you feel better."
- ➔ Describe what your baby is looking at; for example, "red, round ball."
- ➔ Talk about what your baby wants when he points at something.
- ➔ Copy your baby's sounds and words.
- ➔ Ask for behaviors that you want. For example, instead of saying "don't stand," say "time to sit."
- ➔ Teach cause-and-effect by rolling balls back and forth, pushing toy cars and trucks, and putting blocks in and out of a container.

Cognitive (learning, thinking, problem-solving)

- ❑ Watches the path of something as it falls
- ❑ Looks for things he sees you hide
- ❑ Plays peek-a-boo
- ❑ Puts things in her mouth
- ❑ Moves things smoothly from one hand to the other
- ❑ Picks up things like cereal o's between thumb and index finger

Movement/Physical Development

- ❑ Stands, holding on
- ❑ Sits without support
- ❑ Crawls
- ❑ Can get into sitting position
- ❑ Pulls to stand

How you can help your baby's development

- ➔ Play peek-a-boo and hide-and-seek.
- ➔ Read and talk to your baby.
- ➔ Provide lots of room for your baby to move and explore in a safe area.
- ➔ Put your baby close to things that she can pull up on safely.

Act early by talking to your child's doctor if your child:

- ❑ Doesn't bear weight on legs with support
- ❑ Doesn't sit with help
- ❑ Doesn't babble ("mama", "baba", "dada")
- ❑ Doesn't play any games involving back-and-forth play
- ❑ Doesn't respond to own name
- ❑ Doesn't seem to recognize familiar people
- ❑ Doesn't look where you point
- ❑ Doesn't transfer toys from one hand to the other

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned**.

The American Academy of Pediatrics recommends that all children be screened for general development at the 9-month visit. Ask your child's doctor about your child's developmental screening.

Your Child at 1 Year

Talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What children do at this age

Social/Emotional

- ❑ Is shy or nervous with strangers
- ❑ Cries when mom or dad leaves
- ❑ Has favorite things and people
- ❑ Shows fear in some situations
- ❑ Hands you a book when he wants to hear a story
- ❑ Repeats sounds or actions to get attention
- ❑ Puts out arm or leg to help with dressing
- ❑ Plays games such as "peek-a-boo" and "pat-a-cake"

Language/Communication

- ❑ Responds to simple spoken requests
- ❑ Uses simple gestures, like shaking head "no" or waving "bye-bye"
- ❑ Makes sounds with changes in tone (sounds more like speech)
- ❑ Says "mama" and "dada" and exclamations like "uh-oh!"
- ❑ Tries to say words you say

How you can help your child's development

- → Give your child time to get to know a new caregiver. Bring a favorite toy, stuffed animal, or blanket to help comfort your child.
- → In response to unwanted behaviors, say "no" firmly. Do not yell, spank, or give long explanations. A time out for 30 seconds to 1 minute might help redirect your child.
- → Give your child lots of hugs, kisses, and praise for good behavior.
- → Spend a lot more time encouraging wanted behaviors than punishing unwanted behaviors (4 times as much encouragement for wanted behaviors as redirection for unwanted behaviors).
- → Talk to your child about what you're doing. For example, "Mommy is washing your hands with a washcloth."
- → Read with your child every day. Have your child turn the pages. Take turns labeling pictures with your child.
- → Build on what your child says or tries to say, or what he points to. If he points to a truck and says "t" or "truck," say, "Yes, that's a big, blue truck."

Cognitive (learning, thinking, problem-solving)

- ❑ Explores things in different ways, like shaking, banging, throwing
- ❑ Finds hidden things easily
- ❑ Looks at the right picture or thing when it's named
- ❑ Copies gestures
- ❑ Puts things in a container, takes things out of a container
- ❑ Bangs two things together
- ❑ Starts to use things correctly; for example, drinks from a cup, brushes hair
- ❑ Lets things go without help
- ❑ Pokes with index (pointer) finger
- ❑ Follows simple directions like "pick up the toy"

Movement/Physical Development

- ❑ Gets to a sitting position without help
- ❑ Pulls up to stand, walks holding on to furniture ("cruising")
- ❑ May take a few steps without holding on
- ❑ May stand alone

How you can help your child's development

- → Give your child crayons and paper, and let your child draw freely. Show your child how to draw lines up and down and across the page. Praise your child when she tries to copy them.
- → Play with blocks, shape sorters, and other toys that encourage your child to use his hands.
- → Hide small toys and other things and have your child find them.
- → Ask your child to label body parts or things you see while driving in the car.
- → Sing songs with actions, like "The Itsy Bitsy Spider" and "Wheels on the Bus." Help your child do the actions with you.
- → Give your child pots and pans or a small musical instrument like a drum or cymbals. Encourage your child to make noise.
- → Provide lots of safe places for your toddler to explore. (Toddler-proof your home. Lock away products for cleaning, laundry, lawn care, and car care. Use a safety gate and lock doors to the outside and the basement.)
- → Give your child push toys like a wagon or "kiddie push car."

Act early by talking to your child's doctor if your child:

- ❑ Doesn't crawl
- ❑ Can't stand when supported
- ❑ Doesn't search for things that she sees you hide
- ❑ Doesn't point to things
- ❑ Doesn't learn gestures like waving or shaking head
- ❑ Doesn't say single words like "mama" or "dada"
- ❑ Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned**.

Your Child at 18 Months

Talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What children do at this age

Social/Emotional

- ❑ Likes to hand things to others as play
- ❑ May have temper tantrums
- ❑ May be afraid of strangers
- ❑ Shows affection to familiar people
- ❑ Plays simple pretend, such as feeding a doll
- ❑ May cling to caregivers in new situations
- ❑ Points to show others something interesting
- ❑ Explores alone but with parent close by

Language/Communication

- ❑ Says several single words
- ❑ Says and shakes head "no"
- ❑ Points to show someone what he wants

How you can help your child's development

- → Provide a safe, loving environment. It's important to be consistent and predictable.
- → Praise good behaviors more than you punish bad behaviors (use only very brief time outs).
- → Describe her emotions. For example, say, "You are happy when we read this book."
- → Encourage pretend play.
- → Encourage empathy. For example, when he sees a child who is sad, encourage him to hug or pat the other child.
- → Read books and talk about the pictures using simple words.
- → Copy your child's words.
- → Use words that describe feelings and emotions.
- → Use simple, clear phrases.
- → Ask simple questions.

Cognitive (learning, thinking, problem-solving)

- ❑ Knows what ordinary things are for; for example, telephone, brush, spoon
- ❑ Points to one body part
- ❑ Shows interest in a doll or stuffed animal by pretending to feed
- ❑ Points to get the attention of others
- ❑ Scribbles on his own
- ❑ Can follow 1-step verbal commands without any gestures; for example, sits when you say "sit down"

Movement/Physical Development

- ❑ Walks alone
- ❑ May walk up steps and run
- ❑ Pulls toys while walking
- ❑ Can help undress herself
- ❑ Drinks from a cup
- ❑ Eats with a spoon

How you can help your child's development

- ➔ Hide things under blankets and pillows and encourage him to find them.
- ➔ Play with blocks, balls, puzzles, books, and toys that teach cause and effect and problem solving.
- ➔ Name pictures in books and body parts.
- ➔ Provide toys that encourage pretend play; for example, dolls, play telephones.
- ➔ Provide safe areas for your child to walk and move around in.
- ➔ Provide toys that she can push or pull safely.
- ➔ Provide balls for her to kick, roll, and throw.
- ➔ Encourage him to drink from his cup and use a spoon, no matter how messy.
- ➔ Blow bubbles and let your child pop them.

Act early by talking to your child's doctor if your child:

- ❑ Doesn't point to show things to others
- ❑ Can't walk
- ❑ Doesn't know what familiar things are for
- ❑ Doesn't copy others
- ❑ Doesn't gain new words
- ❑ Doesn't have at least 6 words
- ❑ Doesn't notice or mind when a caregiver leaves or returns
- ❑ Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned**.

The American Academy of Pediatrics recommends that all children be screened for general development and autism at the 18-month visit. Ask your child's doctor about your child's developmental screening.

Your Child at 2 Years

Talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What children do at this age

Social/Emotional

- ❑ Copies others, especially adults and older children
- ❑ Gets excited when with other children
- ❑ Shows more and more independence
- ❑ Shows defiant behavior (doing what he has been told not to)
- ❑ Plays mainly beside other children, but is beginning to include other children, such as in chase games

Language/Communication

- ❑ Points to things or pictures when they are named
- ❑ Knows names of familiar people and body parts
- ❑ Says sentences with 2 to 4 words
- ❑ Follows simple instructions
- ❑ Repeats words overheard in conversation
- ❑ Points to things in a book

How you can help your child's development

- ➔ Encourage your child to help with simple chores at home, like sweeping and making dinner. Praise your child for being a good helper.
- ➔ At this age, children still play next to (not with) each other and don't share well. For play dates, give the children lots of toys to play with. Watch the children closely and step in if they fight or argue.
- ➔ Give your child attention and praise when he follows instructions. Limit attention for defiant behavior. Spend a lot more time praising good behaviors than punishing bad ones.
- ➔ Teach your child to identify and say body parts, animals, and other common things.
- ➔ Do not correct your child when he says words incorrectly. Rather, say it correctly. For example, "That is a *ball*."
- ➔ Encourage your child to say a word instead of pointing. If your child can't say the whole word ("milk"), give her the first sound ("m") to help. Over time, you can prompt your child to say the whole sentence — "I want milk."

Cognitive (learning, thinking, problem-solving)

- ❑ Finds things even when hidden under two or three covers
- ❑ Begins to sort shapes and colors
- ❑ Completes sentences and rhymes in familiar books
- ❑ Plays simple make-believe games
- ❑ Builds towers of 4 or more blocks
- ❑ Might use one hand more than the other
- ❑ Follows two-step instructions such as "Pick up your shoes and put them in the closet."
- ❑ Names items in a picture book such as a cat, bird, or dog

Movement/Physical Development

- ❑ Stands on tiptoe
- ❑ Kicks a ball
- ❑ Begins to run
- ❑ Walks up and down stairs holding on
- ❑ Climbs onto and down from furniture without help
- ❑ Throws ball overhand
- ❑ Makes or copies straight lines and circles

How you can help your child's development

- ➔ Hide your child's toys around the room and let him find them.
- ➔ Help your child do puzzles with shapes, colors, or farm animals. Name each piece when your child puts it in place.
- ➔ Encourage your child to play with blocks. Take turns building towers and knocking them down.
- ➔ Do art projects with your child using crayons, paint, and paper. Describe what your child makes and hang it on the wall or refrigerator.
- ➔ Ask your child to help you open doors and drawers and turn pages in a book or magazine.
- ➔ Once your child walks well, ask her to carry small things for you.
- ➔ Kick a ball back and forth with your child. When your child is good at that, encourage him to run and kick.
- ➔ Take your child to the park to run and climb on equipment or walk on nature trails. Watch your child closely.

Act early by talking to your child's doctor if your child:

- ❑ Doesn't know what to do with common things, like a brush, phone, fork, spoon
- ❑ Doesn't copy actions and words
- ❑ Doesn't follow simple instructions
- ❑ Doesn't use 2-word phrases (for example, "drink milk")
- ❑ Doesn't walk steadily
- ❑ Loses skills she once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned**.

The American Academy of Pediatrics recommends that all children be screened for general development and autism at the 24-month visit. Ask your child's doctor about your child's developmental screening.

Your Child at 3 Years

Talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What children do at this age

Social/Emotional

- ❑ Copies adults and friends
- ❑ Shows affection for friends without prompting
- ❑ Takes turns in games
- ❑ Shows concern for a crying friend
- ❑ Dresses and undresses self
- ❑ Understands the idea of "mine" and "his" or "hers"
- ❑ Shows a wide range of emotions
- ❑ Separates easily from mom and dad
- ❑ May get upset with major changes in routine

Language/Communication

- ❑ Follows instructions with 2 or 3 steps
- ❑ Can name most familiar things
- ❑ Understands words like "in," "on," and "under"
- ❑ Says first name, age, and sex
- ❑ Names a friend
- ❑ Talks well enough for strangers to understand most of the time
- ❑ Says words like "I," "me," "we," and "you" and some plurals (cars, dogs, cats)
- ❑ Carries on a conversation using 2 to 3 sentences

How you can help your child's development

- → Go to play groups with your child or other places where there are other children, to encourage getting along with others.
- → Work with your child to solve the problem when he is upset.
- → Talk about your child's emotions. For example, say, "I can tell you feel mad because you threw the puzzle piece." Encourage your child to identify feelings in books.
- → Set rules and limits for your child, and stick to them. If your child breaks a rule, give him a time out for 30 seconds to 1 minute in a chair or in his room. Praise your child for following the rules.
- → Give your child instructions with 2 or 3 steps. For example, "Go to your room and get your shoes and coat."
- → Read to your child every day. Ask your child to point to things in the pictures and repeat words after you.
- → Give your child an "activity box" with paper, crayons, and coloring books. Color and draw lines and shapes with your child.

Cognitive (learning, thinking, problem-solving)

- ❑ Can work toys with buttons, levers, and moving parts
- ❑ Plays make-believe with dolls, animals, and people
- ❑ Does puzzles with 3 or 4 pieces
- ❑ Understands what "two" means
- ❑ Copies a circle with pencil or crayon
- ❑ Turns book pages one at a time
- ❑ Builds towers of more than 6 blocks
- ❑ Screws and unscrews jar lids or turns door handle

Movement/Physical Development

- ❑ Climbs well
- ❑ Runs easily
- ❑ Pedals a tricycle (3-wheel bike)
- ❑ Walks up and down stairs, one foot on each step

How you can help your child's development

- → Play matching games. Ask your child to find objects in books or around the house that are the same.
- → Play counting games. Count body parts, stairs, and other things you use or see every day.
- → Hold your child's hand going up and down stairs. When she can go up and down easily, encourage her to use the railing.
- → Play outside with your child. Go to the park or hiking trail. Allow your child to play freely and without structured activities.

Act early by talking to your child's doctor if your child:

- ❑ Falls down a lot or has trouble with stairs
- ❑ Drools or has very unclear speech
- ❑ Can't work simple toys (such as peg boards, simple puzzles, turning a handle)
- ❑ Doesn't understand simple instructions
- ❑ Doesn't speak in sentences
- ❑ Doesn't make eye contact
- ❑ Doesn't play pretend or make-believe
- ❑ Doesn't want to play with other children or with toys
- ❑ Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your local public school. For more information, go to **www.cdc.gov/concerned**.

Your Child at 4 Years

Talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What children do at this age

Social/Emotional

- ❑ Enjoys doing new things
- ❑ Is more and more creative with make-believe play
- ❑ Would rather play with other children than by himself
- ❑ Cooperates with other children
- ❑ Plays "Mom" or "Dad"
- ❑ Often can't tell what's real and what's make-believe
- ❑ Talks about what she likes and what she is interested in

Language/Communication

- ❑ Tells stories
- ❑ Sings a song or says a poem from memory such as the "Itsy Bitsy Spider" or the "Wheels on the Bus"
- ❑ Knows some basic rules of grammar, such as correctly using "he" and "she"
- ❑ Can say first and last name

How you can help your child's development

- → Play make-believe with your child. Let her be the leader and copy what she is doing.
- → Suggest your child pretend play an upcoming event that might make him nervous, like going to preschool or staying overnight at a grandparent's house.
- → Give your child simple choices whenever you can. Let your child choose what to wear, play, or eat for a snack. Limit choices to 2 or 3.
- → During play dates, let your child solve her own problems with friends, but be nearby to help out if needed.
- → Encourage your child to use words, share toys, and take turns playing games of one another's choice.
- → Give your child toys to build imagination, like dress-up clothes, kitchen sets, and blocks.
- → Use good grammar when speaking to your child. Instead of "Mommy wants you to come here," say, "I want you to come here."

Cognitive (learning, thinking, problem-solving)

- ❑ Names some colors and some numbers
- ❑ Understands the idea of counting
- ❑ Starts to understand time
- ❑ Remembers parts of a story
- ❑ Understands the idea of "same" and "different"
- ❑ Draws a person with 2 to 4 body parts
- ❑ Uses scissors
- ❑ Starts to copy some capital letters
- ❑ Plays board or card games
- ❑ Tells you what he thinks is going to happen next in a book

Movement/Physical Development

- ❑ Hops and stands on one foot up to 2 seconds
- ❑ Pours, cuts with supervision, and mashes own food
- ❑ Catches a bounced ball most of the time

How you can help your child's development

- → Use words like "first," "second," and "finally" when talking about everyday activities. This will help your child learn about sequence of events.
- → Take time to answer your child's "why" questions. If you don't know the answer, say "I don't know," or help your child find the answer in a book, on the Internet, or from another adult.
- → When you read with your child, ask him to tell you what happened in the story as you go.
- → Say colors in books, pictures, and things at home. Count common items, like the number of snack crackers, stairs, or toy trains.
- → Teach your child to play outdoor games like tag, follow the leader, and duck, duck, goose.
- → Play your child's favorite music and dance with your child. Take turns copying each other's moves.

Act early by talking to your child's doctor if your child:

- ❑ Can't jump in place
- ❑ Has trouble scribbling
- ❑ Shows no interest in interactive games or make-believe
- ❑ Ignores other children or doesn't respond to people outside the family
- ❑ Resists dressing, sleeping, and using the toilet
- ❑ Doesn't understand "same" and "different"
- ❑ Doesn't use "me" and "you" correctly
- ❑ Doesn't follow 3-part commands
- ❑ Can't retell a favorite story
- ❑ Speaks unclearly
- ❑ Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your local public school. For more information, go to **www.cdc.gov/concerned**.

Your Child at 5 Years

Talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What children do at this age

Social/Emotional

- ❑ Wants to please friends
- ❑ Wants to be like friends
- ❑ More likely to agree with rules
- ❑ Likes to sing, dance, and act
- ❑ Is aware of gender
- ❑ Can tell what's real and what's make-believe
- ❑ Shows more independence (for example, may visit a next-door neighbor by himself [adult supervision is still needed])
- ❑ Is sometimes demanding and sometimes very cooperative

Language/Communication

- ❑ Speaks very clearly
- ❑ Tells a simple story using full sentences
- ❑ Uses future tense; for example, "Grandma will be here."
- ❑ Says name and address

How you can help your child's development

- ➔ Continue to arrange play dates, trips to the park, or play groups. Give your child more freedom to choose activities to play with friends, and let your child work out problems on her own.
- ➔ Your child might start to talk back or use profanity (swear words) as a way to feel independent. Do not give a lot of attention to this talk, other than a brief time out. Instead, praise your child when he asks for things nicely and calmly takes "no" for an answer.
- ➔ This is a good time to talk to your child about safe touch. No one should touch "private parts" except doctors or nurses during an exam or parents when they are trying to keep the child clean.
- ➔ Teach your child her address and phone number.
- ➔ When reading to your child, ask him to predict what will happen next in the story.
- ➔ Encourage your child to "read" by looking at the pictures and telling the story.

Cognitive (learning, thinking, problem-solving)

- ❑ Counts 10 or more things
- ❑ Can draw a person with at least 6 body parts
- ❑ Copies a triangle and other shapes
- ❑ Can print some letters or numbers
- ❑ Knows about things used every day, like money and food

Movement/Physical Development

- ❑ Stands on one foot for 10 seconds or longer
- ❑ Hops; may be able to skip
- ❑ Can do a somersault
- ❑ Uses a fork and spoon and sometimes a table knife
- ❑ Can use the toilet on her own
- ❑ Swings and climbs

How you can help your child's development

- → Teach your child time concepts like morning, afternoon, evening, today, tomorrow, and yesterday. Start teaching the days of the week.
- → Explore your child's interests in your community. For example, if your child loves animals, visit the zoo or petting farm. Go to the library or look on the Internet to learn about these topics.
- → Keep a handy box of crayons, paper, paint, child scissors, and paste. Encourage your child to draw and make art projects with different supplies.
- → Play with toys that encourage your child to put things together.
- → Teach your child how to pump her legs back and forth on a swing.
- → Help your child climb on the monkey bars.
- → Go on walks with your child, do a scavenger hunt in your neighborhood or park, help him ride a bike with training wheels (wearing a helmet).

Act early by talking to your child's doctor if your child:

- ❑ Doesn't show a wide range of emotions
- ❑ Shows extreme behavior (unusually fearful, aggressive, shy, or sad)
- ❑ Unusually withdrawn and not active
- ❑ Is easily distracted, has trouble focusing on one activity for more than 5 minutes
- ❑ Doesn't respond to people, or responds only superficially
- ❑ Can't tell what's real and what's make-believe
- ❑ Doesn't play a variety of games and activities
- ❑ Can't give first and last name
- ❑ Doesn't draw pictures
- ❑ Doesn't talk about daily activities or experiences
- ❑ Doesn't use plurals or past tense properly
- ❑ Can't brush teeth, wash and dry hands, or get undressed without help
- ❑ Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your local public school. For more information, go to **www.cdc.gov/concerned**.

Questions for my Child's Doctor




2 Months

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Indicadores del Desarrollo

Aprenda los signos. Reaccione pronto.

www.cdc.gov/pronto
1-800-CDC-INFO








Tomado de CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Quinta Edición, editado por Steven Shelov y Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 por la Academia Americana de Pediatría y BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, tercera edición, editado por Joseph Hagan, Jr., Judith S. Shaw y Paula M. Duncan, 2008, Elk Grove Village, IL: Academia Americana de Pediatría.

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Centros para el Control y la Prevención de Enfermedades
www.cdc.gov/pronto
1-800-CDC-INFO

Puede hacerle seguimiento al desarrollo de su hijo si observa cómo juega, aprende, habla y actúa en general.

En estas páginas encontrará los indicadores a los que debe prestar atención y la forma en que puede ayudar a su hijo a aprender y crecer.

Centros para el Control y la Prevención de Enfermedades
www.cdc.gov/pronto
1-800-CDC-INFO

Indicadores del Desarrollo

La manera en que su hijo juega, aprende, habla y actúa nos ofrece pistas importantes sobre cómo se está desarrollando el niño. Los indicadores del desarrollo son las cosas que la mayoría de los niños pueden hacer a una edad determinada.

La lista a continuación tiene los indicadores a los que debe estar atento si su hijo tiene:

Marque los indicadores que su hijo ha alcanzado en cada etapa.

En cada visita médica de su hijo, lleve esta información y hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

Para obtener más información, consulte www.cdc.gov/pronto

Su Bebé a los 2 Meses

En cada visita médica de su hijo, hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los bebés a esta edad?

Áreas social y emocional

- ❑ Puede calmarse sin ayuda por breves momentos (se pone los dedos en la boca y se chupa la mano)
- ❑ Empieza a sonreírle a las personas
- ❑ Trata de mirar a sus padres

Áreas del habla y la comunicación

- ❑ Hace sonidos como de arrullo o gorjeos
- ❑ Mueve la cabeza para buscar los sonidos

Área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Se interesa en las caras
- ❑ Comienza a seguir las cosas con los ojos y reconoce a las personas a la distancia
- ❑ Comienza a demostrar aburrimiento si no cambian las actividades (llora, se inquieta)

Cómo puede ayudar al desarrollo de su bebé

- ➔ Abrácelo, háblele y juegue con su bebé a la hora de comer, cuando le viste y cuando le baña.
- ➔ Ayude a su bebé a que aprenda a calmarse solo. Está bien que se chupe el dedo.
- ➔ Establezca una rutina con su bebé, por ejemplo que duerma más de noche que de día y que tenga regularidad en sus horarios.
- ➔ Estar en sintonía con las cosas que le gustan y las que no le gustan a su bebé le hará sentir más cómoda y confiada.
- ➔ Demuestre su entusiasmo y sonría cuando su bebé “habla”.
- ➔ De vez en cuando, copie los sonidos que hace el bebé, pero también utilice un lenguaje claro.
- ➔ Preste atención a los diferentes llantos de su bebé, para poder aprender a distinguir qué es lo que quiere.
- ➔ Háblele, léale y cántele a su bebé.

Áreas motora y de desarrollo físico

- ❑ Puede mantener la cabeza alzada y trata de alzar el cuerpo cuando está boca abajo
- ❑ Mueve las piernas y los brazos con mayor suavidad

Cómo puede ayudar al desarrollo de su bebé

- ➔ Juegue a esconder la cara detrás de sus manos. Enseñe a su bebé a que juegue a esconder su carita también.
- ➔ Coloque un espejo para bebés en la cuna, para que pueda mirarse en él.
- ➔ Miren ilustraciones juntos y háblele al bebé sobre lo que ven en ellas.
- ➔ Acueste al bebé boca abajo cuando está despierto y coloque juguetes a su alrededor.
- ➔ Sostenga juguetes frente al bebé, para que los vea y así alentarle a alzar la cabeza.
- ➔ Sostenga un juguete o un sonajero por encima de la cabeza del bebé, para alentarle a alcanzarlo.
- ➔ Sostenga al bebé de pie, con los pies apoyados en el piso. Cántele o háblele a su bebé mientras está así, parado.

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No responde ante ruidos fuertes
- ❑ No sigue con la vista a las cosas que se mueven
- ❑ No le sonríe a las personas
- ❑ No se lleva las manos a la boca
- ❑ No puede sostener la cabeza en alto cuando empuja el cuerpo hacia arriba estando boca abajo

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado**.

Su Bebé a los 4 Meses

En cada visita médica de su hijo, hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los bebés a esta edad?

Áreas social y emocional

- ❑ Sonríe espontáneamente, especialmente a las personas
- ❑ Le gusta jugar con la gente y puede ser que hasta llore cuando se terminan los juegos
- ❑ Copia algunos movimientos y gestos faciales, como sonreír o fruncir el ceño

Áreas del habla y la comunicación

- ❑ Empieza a balbucear
- ❑ Balbucea con entonación y copia los sonidos que escucha
- ❑ Llora de diferentes maneras para mostrar cuando tiene hambre, siente dolor o está cansado

Cómo puede ayudar al desarrollo de su bebé

- ➔ Cargue a su bebé en brazos y háblele, hágalo con sonrisas y demostrando alegría.
- ➔ Establezca una rutina fija para las horas de dormir y de comer.
- ➔ Preste mucha atención a las cosas que le gustan a su bebé y las que no, así podrá saber cómo satisfacer sus necesidades de la mejor manera y qué puede hacer para que su bebé sea feliz.
- ➔ Copie los sonidos que hace su bebé.
- ➔ Demuestre su entusiasmo y sonría cuando su bebé “habla”.
- ➔ Dedique momentos de tranquilidad para leerle o cantarle a su bebé.
- ➔ Dele juguetes adecuados para la edad del bebé, como sonajeros o ilustraciones coloridas.
- ➔ Juegue por ejemplo a esconder su cara detrás de las manos.
- ➔ Con las medidas de seguridad adecuadas, provea oportunidades para que su bebé pueda alcanzar juguetes y explorar lo que le rodea.

Área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Responde ante las demostraciones de afecto
- ❑ Trata de alcanzar los juguetes con la mano
- ❑ Coordina las manos y los ojos, por ejemplo, ve un juguete y lo trata de alcanzar
- ❑ Le deja saber si está contento o triste
- ❑ Sigue con la vista a las cosas que se mueven, moviendo los ojos de lado a lado
- ❑ Observa las caras con atención
- ❑ Reconoce objetos y personas conocidas desde lejos

Áreas motora y de desarrollo físico

- ❑ Mantiene la cabeza fija, sin necesidad de soporte
- ❑ Se empuja con las piernas cuando tiene los pies sobre una superficie firme
- ❑ Cuando está boca abajo puede darse vuelta y quedar boca arriba
- ❑ Puede sostener un juguete y sacudirlo y golpear a juguetes que estén colgando
- ❑ Se lleva las manos a la boca
- ❑ Cuando está boca abajo, levanta el cuerpo hasta apoyarse en los codos

Cómo puede ayudar al desarrollo de su bebé

- ➔ Ponga juguetes cerca de su bebé para que trate de agarrarlos o patearlos.
- ➔ Ponga juguetes o sonajeros en la mano del bebé y ayúdelo a agarrarlos.
- ➔ Sostenga al bebé de pie, con los pies apoyados en el piso, y cántele o háblele mientras él está “parado” con apoyo.

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No sigue con la vista a las cosas que se mueven
- ❑ No le sonríe a las personas
- ❑ No puede sostener la cabeza con firmeza
- ❑ No se lleva las cosas a la boca
- ❑ No gorjea ni hace sonidos con la boca
- ❑ No empuja con los pies cuando le apoyan sobre una superficie dura
- ❑ Tiene dificultad para mover uno o los dos ojos en todas las direcciones

Dígale al pediatra o la enfermera si nota cualquiera de estos signos de posible retraso del desarrollo para la edad de su hijo, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado**.

Su Bebé a los 6 Meses

En cada visita médica de su hijo, hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los bebés a esta edad?

Áreas social y emocional

- ❑ Reconoce las caras familiares y comienza a darse cuenta si alguien es un desconocido
- ❑ Le gusta jugar con los demás, especialmente con sus padres
- ❑ Responde antes las emociones de otras personas y generalmente se muestra feliz
- ❑ Le gusta mirarse en el espejo

Áreas del habla y la comunicación

- ❑ Reacciona a los sonidos con sus propios sonidos
- ❑ Une varias vocales cuando balbucea (“a”, “e”, “o”) y le gusta hacer sonidos por turno con los padres
- ❑ Reacciona cuando se menciona su nombre
- ❑ Hace sonidos para demostrar alegría o descontento
- ❑ Comienza a emitir sonidos de consonantes (parlotea usando la “m” o la “b”)

Cómo puede ayudar al desarrollo de su bebé

- ➔ Juegue con su bebé en el piso todos los días.
- ➔ Aprenda a conocer los estados de ánimo de su bebé. Si está contento, siga haciendo lo mismo. Si está molesto, deje lo que está haciendo y consuele al bebé.
- ➔ Muéstrele a su bebé cómo consolarse a sí mismo cuando está molesto. Se puede chupar el dedo para calmarse.
- ➔ Juegue a hacer lo mismo, es decir cuando él sonríe, usted sonríe, cuando él hace sonidos, usted los copia.
- ➔ Repita los sonidos que hace su hijo y diga palabras sencillas utilizándolos. Por ejemplo, si su hijo dice “ba”, diga “barco” o “balón”.
- ➔ Léale libros a su hijo todos los días. Felicítelo cuando balbucee y también cuando “lea”.
- ➔ Cuando su bebé mire hacia algo, señálelo y descríbalo.
- ➔ Cuando el bebé deje caer un juguete al suelo, levántelo y devuélvaselo. Este juego le ayuda a aprender el fenómeno de causa y efecto.

Área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Observa a su alrededor las cosas que están cerca
- ❑ Demuestra curiosidad sobre las cosas y trata de agarrar las cosas que están fuera de su alcance
- ❑ Se lleva la cosas a la boca
- ❑ Comienza a pasar cosas de una mano a la otra

Áreas motora y de desarrollo físico

- ❑ Se da vuelta para ambos lados (se pone boca arriba y boca abajo)
- ❑ Comienza a sentarse sin apoyo
- ❑ Cuando se para, se apoya en sus piernas y hasta puede ser que salte
- ❑ Se mece hacia adelante y hacia atrás, a veces gatea primero hacia atrás y luego hacia adelante

Cómo puede ayudar al desarrollo de su bebé

- ➔ Léale libros con ilustraciones coloridas.
- ➔ Señale cosas nuevas y dígale cómo se llaman.
- ➔ Muéstrele a su bebé las ilustraciones brillantes de las revistas y dígale qué son.
- ➔ Sostenga al bebé mientras está sentado o póngale almohadas como sostén. Déjele observar a su alrededor y dele juguetes para mirar mientras se mantiene sentado.
- ➔ Ponga al bebé boca abajo o boca arriba y coloque juguetes cerca pero fuera de su alcance. Anímelo a que se dé vuelta para agarrar los juguetes.

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No trata de agarrar cosas que están a su alcance
- ❑ No demuestra afecto por quienes le cuidan
- ❑ No reacciona ante los sonidos de alrededor
- ❑ Tiene dificultad para llevarse cosas a la boca
- ❑ No se ríe ni hace sonidos de placer
- ❑ No rueda en ninguna dirección para darse vuelta
- ❑ No emite sonidos de vocales (“a”, “e”, “o”)
- ❑ Se ve rígido y con los músculos tensos
- ❑ Se ve sin fuerza como un muñeco de trapo

Dígale al pediatra o la enfermera si nota cualquiera de estos signos de posible retraso del desarrollo para la edad de su hijo, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado**.

Su Bebé a los 9 Meses

En cada visita médica de su hijo, hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los bebés a esta edad?

Áreas social y emocional

- ❑ Puede ser que le tenga miedo a los desconocidos
- ❑ Puede ser que se aferre a los adultos conocidos todo el tiempo
- ❑ Tiene juguetes preferidos

Áreas del habla y la comunicación

- ❑ Entiende cuando se le dice “no”
- ❑ Hace muchos sonidos diferentes como “mamamama” y “tatatatata”
- ❑ Imita los sonidos y los gestos de otros
- ❑ Señala objetos con los dedos

Cómo puede ayudar al desarrollo de su bebé

- ➔ Preste atención a la manera en que su bebé reacciona ante situaciones nuevas o personas desconocidas, trate de continuar haciendo las mismas cosas que lo hacen sentir cómodo y feliz.
- ➔ Cuando comience a moverse más a su alrededor no se aleje, para que sepa que usted está cerca.
- ➔ Continúe con las rutinas, ahora son especialmente importantes.
- ➔ Juegue a tomar turnos.
- ➔ Diga en voz alta lo que le parece que su bebé esté sintiendo. Por ejemplo, diga “Estás triste, vamos a ver qué podemos hacer para que te sientas mejor”.
- ➔ Describa lo que su bebé esté mirando; por ejemplo, “pelota redonda y roja”.
- ➔ Describa lo que su bebé quiere cuando señala algo.
- ➔ Copie los sonidos y las palabras que emite su bebé.
- ➔ Dígale lo que desea que haga. Por ejemplo, en lugar de decir “no te pares”, diga “es hora de sentarse”.

Área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Observa el recorrido de las cosas al caer
- ❑ Va en busca de las cosas que usted esconde
- ❑ Juega a esconder su carita detrás de las manos
- ❑ Transfiere objetos de una mano a la otra con facilidad
- ❑ Se pone las cosas en la boca
- ❑ Levanta cosas como cereales en forma de "o" entre el dedo índice y el pulgar

Áreas motora y de desarrollo físico

- ❑ Se para sosteniéndose en algo
- ❑ Puede sentarse solo
- ❑ Se sienta sin apoyo
- ❑ Se parar sosteniéndose de algo
- ❑ Gatea

Cómo puede ayudar al desarrollo de su bebé

- ➔ Enséñele causa y efecto haciendo rodar balones para atrás y para adelante, empujando autos y camioncitos y metiendo y sacando bloquecitos de un recipiente.
- ➔ Juegue a esconder la cara detrás de las manos y a las escondidas.
- ➔ Léale y háblele a su bebé.
- ➔ Prepare muchos lugares donde su bebé pueda moverse y explorar en forma segura.
- ➔ Ponga al bebé cerca de cosas donde se pueda apoyar y pararse sin peligro.

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No se sostiene en las piernas con apoyo
- ❑ No se sienta con ayuda
- ❑ No balbucea ("mamá", "tata", "papá")
- ❑ No juega a nada que sea por turnos como "me toca a mí, te toca a ti"
- ❑ No responde cuando le llaman por su nombre
- ❑ No parece reconocer a las personas conocidas
- ❑ No mira hacia donde usted señala
- ❑ No pasa juguetes de una mano a la otra

Dígale al pediatra o la enfermera si nota cualquiera de estos signos de posible retraso del desarrollo para la edad de su hijo, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado**.

La Academia Americana de Pediatría recomienda que se evalúe el desarrollo general de los niños en la consulta de los 9 meses. Pregúntele al médico de su hijo si hay que hacerle la evaluación del desarrollo.

Su Hijo de 1 Año

En cada visita médica de su hijo, hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los niños a esta edad?

Áreas social y emocional

- ❑ Actúa con timidez o se pone nervioso en presencia de desconocidos
- ❑ Llora cuando la mamá o el papá se aleja
- ❑ Tiene cosas y personas preferidas
- ❑ Demuestra miedo en algunas situaciones
- ❑ Le alcanza un libro cuando quiere escuchar un cuento
- ❑ Repite sonidos o acciones para llamar la atención
- ❑ Levanta un brazo o una pierna para ayudar a vestirse
- ❑ Juega a esconder la carita y a las palmaditas con las manos

Áreas del habla y la comunicación

- ❑ Actúa cuando se le pide que haga algo sencillo
- ❑ Usa gestos simples, como mover la cabeza de lado a lado para decir "no" o despedirse con la mano
- ❑ Dice "mamá" y "papá" y exclamaciones como "oh-oh"
- ❑ Hace sonidos con cambios de entonación (se parece más al lenguaje normal)
- ❑ Trata de repetir las palabras que usted dice

Cómo puede ayudar al desarrollo de su hijo

- ➔ Dele tiempo a su hijo para que se acostumbre a la nueva persona que lo va a cuidar. Para que su hijo se sienta cómodo, tráigale el juguete, muñeco de peluche o mantita preferida.
- ➔ Cuando haga algo que no debe, diga "no" con firmeza. No le grite o le pegue, ni tampoco le dé largas explicaciones. Castigar al niño sin dejar que realice ninguna actividad por 30 segundos a 1 minuto puede ayudarle a que se distraiga y haga otras cosas.
- ➔ Dele a su hijo muchos abrazos, besos y felicitaciones cuando se porta bien.
- ➔ Dedique más tiempo a alentar los comportamientos que usted desea ver que a castigar los que no desea (anime los comportamientos deseados 4 veces más de lo que reorienta la atención ante comportamientos no deseados).
- ➔ Converse con su hijo sobre lo que usted está haciendo. Por ejemplo, "Mamá está lavándote las manos con una toallita".
- ➔ Léale a su hijo todos los días. Deje que su hijo sea quien pase las páginas. Tome turnos con su hijo para identificar las ilustraciones.
- ➔ Agregue más detalles acerca de lo que su hijo dice, trata de decir, o señala. Si señala a un camión y dice "c" o "camión" diga, "Sí, es un camión grande y es azul".

Área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Explora los objetos de diferentes maneras (los sacude, los golpea o los tira)
- ❑ Cuando se nombra algo mira en dirección a la ilustración o cosa que se nombró
- ❑ Imita gestos
- ❑ Comienza a usar las cosas correctamente, por ejemplo, bebe de una taza, se cepilla el pelo
- ❑ Golpea un objeto contra otro
- ❑ Mete cosas dentro de un recipiente, las saca del recipiente
- ❑ Suelta las cosas sin ayuda
- ❑ Pincha con el dedo índice
- ❑ Sigue instrucciones sencillas como "recoge el juguete"
- ❑ Encuentra fácilmente objetos escondidos

Áreas motora y de desarrollo físico

- ❑ Se sienta sin ayuda
- ❑ Se para sosteniéndose de algo, camina apoyándose en los muebles, la pared, etc.
- ❑ Puede ser que hasta dé unos pasos sin apoyarse
- ❑ Puede ser que se pare solo

Cómo puede ayudar al desarrollo de su hijo

- ➔ Dele a su hijo papel y crayones y déjelo dibujar libremente. Muéstrele a su hijo cómo dibujar líneas de arriba a abajo y de lado a lado de la página. Felicite a su hijo cuando trata de copiarlas.
- ➔ Juegue con bloques, juguetes para clasificar según su forma y otro tipo de juguetes que animen a su hijo a usar las manos.
- ➔ Esconda juguetes pequeños y otras cosas y pídale a su hijo que las encuentre.
- ➔ Pídale a su hijo que nombre partes del cuerpo o cosas que ven cuando van en el auto.
- ➔ Entone canciones que describan acciones, como "La araña pequeñita" y "Las ruedas de los autobuses". Ayúdelo a mover las manos a la par de la canción.
- ➔ Dele a su hijo ollas y sartenes o un instrumento musical pequeño como un tambor o platillos. Anime a su hijo a hacer ruido.
- ➔ Provea muchos lugares seguros para que su niño pequeño pueda explorar. (Tome precauciones en su hogar para proteger a su niño pequeño. Guarde bajo llave los productos de limpieza, lavandería, jardinería y cuidados del auto. Utilice cerrojos de seguridad y cierre las puertas de la calle y el sótano con llave).
- ➔ Dele a su hijo juguetes para empujar como un vagón o un "carrito para niños".

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No gatea
- ❑ No puede permanecer de pie con ayuda
- ❑ No busca las cosas que la ve esconder
- ❑ Pierde habilidades que había adquirido
- ❑ No aprende a usar gestos como saludar con la mano o mover la cabeza
- ❑ No señala cosas
- ❑ No dice palabras sencillas como "mamá" o "papá"

Dígale al pediatra o la enfermera si nota cualquiera de estos signos de posible retraso del desarrollo para la edad de su hijo, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado**.

Su Hijo de 18 Meses

En cada visita médica de su hijo, hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los niños a esta edad?

Áreas social y emocional

- ❑ Le gusta alcanzarle cosas a los demás como un juego
- ❑ Puede tener rabietas
- ❑ Puede ser que le tenga miedo a los desconocidos
- ❑ Le demuestra afecto a las personas conocidas
- ❑ Juega a imitar cosas sencillas, como alimentar a una muñeca
- ❑ Se aferra a la persona que le cuida en situaciones nuevas
- ❑ Señala para mostrar algo que le llama la atención
- ❑ Explora solo, pero con la presencia cercana de los padres

Áreas del habla y la comunicación

- ❑ Puede decir palabras sueltas
- ❑ Dice “no” y sacude la cabeza como negación
- ❑ Señala para mostrarle a otra persona lo que quiere

Cómo puede ayudar al desarrollo de su hijo

- ➔ Provea un ambiente seguro y lleno de cariño. Es importante ser constante y predecible.
- ➔ Felicite al niño cuando se porta bien más de lo que lo castiga cuando se porta mal (no le deje hacer nada por un rato como castigo).
- ➔ Describa sus emociones. Por ejemplo, dígale “Te pones contento cuando leemos este libro”.
- ➔ Aliente los juegos de imitación.
- ➔ Fomente que sea comprensivo con los demás. Por ejemplo, cuando ven a un niño que está triste, aliente a su hijo a darle un abrazo o una palmadita en la espalda.
- ➔ Lea libros y hable acerca de las ilustraciones usando palabras sencillas.
- ➔ Copie las palabras que dice su hijo.
- ➔ Use palabras para describir sentimientos y emociones.
- ➔ Use frases claras y sencillas.
- ➔ Haga preguntas sencillas.

Área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Sabe para qué sirven las cosas comunes, como teléfono, cepillo, cuchara
- ❑ Señala para llamar la atención de otras personas
- ❑ Demuestra interés en una muñeca o animal de peluche y hace de cuenta que le da de comer
- ❑ Señala una parte del cuerpo
- ❑ Hace garabatos sin ayuda
- ❑ Puede seguir instrucciones verbales de un solo paso que no se acompañan de gestos; por ejemplo, se sienta cuando se le dice “siéntate”

Áreas motora y de desarrollo físico

- ❑ Camina solo
- ❑ Jala juguetes detrás de él mientras camina
- ❑ Puede subir las escaleras y correr
- ❑ Puede ayudar a desvestirse
- ❑ Bebe de una taza
- ❑ Come con cuchara

Cómo puede ayudar al desarrollo de su hijo

- ➔ Esconda objetos debajo de las mantas y almohadas y anímelo a encontrarlos.
- ➔ Juegue con bloquecitos, pelotas, rompecabezas, libros y juguetes que enseñan causa y efecto y cómo resolver problemas.
- ➔ Nombre las ilustraciones de los libros y las partes del cuerpo.
- ➔ Dele juguetes que fomentan los juegos de imitación; por ejemplo, muñecos, teléfonos de juguete.
- ➔ Proporcione áreas seguras donde su hijo pueda caminar y moverse sin peligro.
- ➔ Dele juguetes para que pueda empujar o jalar sin peligro.
- ➔ Tenga pelotas para que el niño pueda patearlas, tirarlas y hacerlas rodar.
- ➔ Aliente a su hijo a beber de una taza y usar la cuchara, sin importar el reguero que haga.
- ➔ Juegue con burbujas y déjelo estallarlas.

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No señala cosas para mostrárselas a otras personas
- ❑ No puede caminar
- ❑ No sabe para qué sirven las cosas familiares
- ❑ No copia lo que hacen las demás personas
- ❑ No aprende nuevas palabras
- ❑ No sabe por lo menos 6 palabras
- ❑ No se da cuenta ni parece importarle si la persona que le cuida se va a o regresa
- ❑ Pierde habilidades que había adquirido

Dígale al pediatra o la enfermera si nota cualquiera de estos signos de posible retraso del desarrollo para la edad de su hijo, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado**.

La Academia Americana de Pediatría recomienda que se evalúe el desarrollo general de los niños y los posibles signos de autismo en la consulta de los 18 meses. Pregúntele al médico de su hijo si hay que hacerle la evaluación del desarrollo.

Su Hijo de 2 Años

En cada visita médica de su hijo, hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los niños a esta edad?

Áreas social y emocional

- ❑ Copia a otras personas, especialmente a adultos y niños mayores
- ❑ Se entusiasma cuando está con otros niños
- ❑ Demuestra ser cada vez más independiente
- ❑ Demuestra un comportamiento desafiante (hace lo que se le ha dicho que no haga)
- ❑ Por lo general juega con otros niños sin interactuar mucho, pero empieza a incluirlos en sus juegos, como jugar a perseguirlos

Áreas del habla y la comunicación

- ❑ Señala a objetos o ilustraciones cuando se los nombra
- ❑ Sabe los nombres de personas conocidas y partes del cuerpo
- ❑ Dice frases de 2 a 4 palabras
- ❑ Sigue instrucciones sencillas
- ❑ Repite palabras que escuchó en alguna conversación
- ❑ Señala las cosas que aparecen en un libro

Cómo puede ayudar al desarrollo de su hijo

- ➔ Deje que su hijo ayude con tareas sencillas en el hogar, como barrer o preparar la cena. Felicítelo por ser un buen ayudante.
- ➔ A esta edad, los niños todavía no interactúan con otros niños al jugar (aunque estén juntos) y no saben compartir. Cuando vienen amiguitos a jugar, deles muchos juguetes. Observe siempre a los niños e intervenga si hay una pelea o discusión.
- ➔ Preste mucha atención a su hijo y felicítelo cuando sigue las instrucciones. Evite prestarle atención cuando se comporta en forma desafiante. Dedique más tiempo a felicitarlo por su buen comportamiento que a castigarlo cuando no se porta bien.
- ➔ Enséñele a su hijo a identificar y nombrar partes del cuerpo, animales y otras cosas comunes.
- ➔ No corrija a su hijo cuando dice una palabra en forma incorrecta. En su lugar, dígala usted correctamente. Por ejemplo, “eso es una *pelota*.”
- ➔ Anime a su hijo a usar la palabra en vez de señalar las cosas. Si su hijo no puede decir la palabra entera (“leche”), ayúdelo con el sonido de la primera letra (“l”). Con el tiempo, puede guiarlo para que diga toda la oración: “yo quiero leche”.

Área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Encuentra cosas aun cuando están escondidas debajo de dos o tres sábanas
- ❑ Empieza a clasificar por formas y colores
- ❑ Completa las frases y las rimas de los cuentos que conoce
- ❑ Juega con su imaginación de manera sencilla
- ❑ Construye torres de 4 bloques o más
- ❑ Puede que use una mano más que la otra
- ❑ Sigue instrucciones para hacer dos cosas como por ejemplo, “levanta tus zapatos y ponlos en su lugar”
- ❑ Nombra las ilustraciones de los libros como un gato, pájaro o perro

Áreas motora y de desarrollo físico

- ❑ Se para en las puntas de los dedos
- ❑ Patea una pelota
- ❑ Empieza a correr
- ❑ Se trepa y baja de muebles sin ayuda
- ❑ Sube y baja las escaleras agarrándose
- ❑ Tira la pelota por encima de la cabeza
- ❑ Dibuja o copia líneas rectas y círculos

Cómo puede ayudar al desarrollo de su hijo

- ➔ Esconda los juguetes del niño en la sala y deje que los encuentre.
- ➔ Ayude a su hijo a armar rompecabezas que tengan formas, colores o animales de granja. Nombre cada pieza cuando su hijo la coloca en su lugar.
- ➔ Anime a su hijo a que juegue con bloquecitos. Tome turnos con él para construir torres y derrumbarlas.
- ➔ Haga proyectos de arte con su hijo usando papel, crayones y pintura. Describa lo que su hijo hace y ponga sus dibujos en la pared o en el refrigerador.
- ➔ Pídale a su hijo que le ayude a abrir puertas y cajones y a pasar las páginas de los libros y revistas.
- ➔ Cuando ya camine bien, pídale a su hijo que le ayude cargando cosas pequeñas.
- ➔ Juegue a patear la pelota con su hijo, pasándola una y otra vez. Cuando su hijo haya aprendido, anímelo a correr y patear.
- ➔ Lleve a su hijo al parque para correr y treparse en los juegos o caminar por los senderos naturales. Supervise a su hijo con mucha atención.

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No usa frases de 2 palabras (por ejemplo, “toma leche”)
- ❑ No sabe cómo utilizar objetos de uso común, como un cepillo, teléfono, tenedor o cuchara
- ❑ No copia acciones ni palabras
- ❑ No puede seguir instrucciones sencillas
- ❑ No camina con estabilidad
- ❑ Pierde habilidades que había logrado

Dígale al pediatra o la enfermera si nota cualquiera de estos signos de posible retraso del desarrollo para la edad de su hijo, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado**.

La Academia Americana de Pediatría recomienda que se evalúen el desarrollo general de los niños y los posibles signos de autismo en la consulta de los 24 meses. Pregúntele al médico de su hijo si hay que hacerle la evaluación del desarrollo.

Su Hijo de 3 Años

En cada visita médica de su hijo, hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los niños a esta edad?

Áreas social y emocional

- ❑ Copia a los adultos y los amigos
- ❑ Demuestra afecto por sus amigos espontáneamente
- ❑ Espera su turno en los juegos
- ❑ Se preocupa si ve un amigo llorando
- ❑ Entiende la idea de lo que "es mío", "de él" o "de ella"
- ❑ Expresa una gran variedad de emociones
- ❑ Se separa de su mamá y su papá con facilidad
- ❑ Se molesta con los cambios de rutina grandes
- ❑ Se viste y desviste

Áreas del habla y la comunicación

- ❑ Sigue instrucciones de 2 o 3 pasos
- ❑ Sabe el nombre de la mayoría de las cosas conocidas
- ❑ Entiende palabras como "adentro", "arriba" o "debajo"
- ❑ Puede decir su nombre, edad y sexo
- ❑ Sabe el nombre de un amigo
- ❑ Dice palabras como "yo", "mi", "nosotros", "tú" y algunos plurales (autos, perros, gatos)
- ❑ Habla bien de manera que los desconocidos pueden entender la mayor parte de lo que dice
- ❑ Puede conversar usando 2 o 3 oraciones

Cómo puede ayudar al desarrollo de su hijo

- → Reúnase a jugar en grupos con su hijo o vaya a otros lugares donde hay más niños, para enseñarle a que se lleve bien con los demás.
- → Ayude a su hijo a tratar de resolver los problemas cuando está molesto.
- → Hable sobre las emociones de su hijo. Por ejemplo, dígale "me doy cuenta de que estás enojado porque tiraste la pieza del rompecabezas". Anime a su hijo a identificar sentimientos en los libros.
- → Fije reglas y límites para su hijo y respételas. Si su hijo no respeta una regla, déjelo de 30 segundos a 1 minuto sentado en una silla o dentro de su habitación como castigo. Felicite a su hijo cuando sigue las reglas.
- → Dele a su hijo instrucciones de 2 o 3 pasos. Por ejemplo, "ve a tu habitación y trae tus zapatos y tu abrigo".
- → Léale a su hijo todos los días. Pídale a su hijo que señale cosas en las ilustraciones y que repita las palabras después de usted.
- → Dele a su hijo una "caja con útiles" con papel, crayones y libros para colorear. Coloree y dibuje líneas y formas con su hijo.

Área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Puede operar juguetes con botones, palancas y piezas móviles
- ❑ Juega imaginativamente con muñecas, animales y personas
- ❑ Arma rompecabezas de 3 y 4 piezas
- ❑ Entiende lo que significa “dos”
- ❑ Copia un círculo con lápiz o crayón
- ❑ Pasa las hojas de los libros una a la vez
- ❑ Arma torres de más de 6 bloquecitos
- ❑ Enrosca y desenrosca las tapas de jarras o abre la manija de la puerta

Áreas motora y de desarrollo físico

- ❑ Trepa bien
- ❑ Puede pedalear un triciclo (bicicleta de 3 ruedas)
- ❑ Corre fácilmente
- ❑ Sube y baja escaleras, un pie por escalón

Cómo puede ayudar al desarrollo de su hijo

- ➔ Juegue a encontrar figuras iguales. Pídale a su hijo que encuentre objetos iguales en libros o en la casa.
- ➔ Juegue a contar. Cuente las partes del cuerpo, los escalones y otras cosas que usa o ve todos los días.
- ➔ Dele la mano a su hijo para subir o bajar las escaleras. Cuando pueda subir y bajar con facilidad, anímelo a tomarse del pasamanos.
- ➔ Juegue con su hijo afuera de la casa. Vaya al parque o a caminar por un sendero. Deje que su hijo juegue con libertad y sin actividades estructuradas.

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ Se cae mucho o tiene problemas para subir y bajar escaleras
- ❑ No mira a las personas a los ojos
- ❑ No puede operar juguetes sencillos (tableros de piezas para encajar, rompecabezas sencillos, girar una manija)
- ❑ No usa oraciones para hablar
- ❑ No entiende instrucciones sencillas
- ❑ No imita ni usa la imaginación en sus juegos
- ❑ No quiere jugar con otros niños ni con juguetes
- ❑ Pierde habilidades que había adquirido
- ❑ Se babea o no se le entiende cuando habla

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo la escuela pública más cercana. Para obtener más información, consulte **www.cdc.gov/preocupado**.

Su Hijo de 4 Años

En cada visita médica de su hijo, hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los niños a esta edad?

Áreas social y emocional

- ❑ Disfruta haciendo cosas nuevas
- ❑ Juega al “papá” o a la “mamá”
- ❑ Cada vez se muestra más creativo en los juegos de imaginación
- ❑ Le gusta más jugar con otros niños que solo
- ❑ Colabora con otros niños
- ❑ Generalmente no puede distinguir la fantasía de la realidad
- ❑ Describe lo que le gusta y lo que le interesa

Áreas del habla y la comunicación

- ❑ Sabe algunas reglas básicas de gramática, como el uso correcto de “él” y “ella”
- ❑ Relata cuentos
- ❑ Puede decir su nombre y apellido
- ❑ Canta una canción o recita un poema de memoria como “La araña pequeñita” o “Las ruedas de los autobuses”

Cómo puede ayudar al desarrollo de su hijo

- ➔ Juegue con su hijo usando la imaginación. Deje que sea el líder y copie todo lo que hace.
- ➔ Sugiera que jueguen a hacer de cuenta que están en una situación que le pone nervioso, como empezar el preescolar o quedarse por la noche en la casa de los abuelitos.
- ➔ Siempre que pueda, dele a su hijo opciones sencillas para que escoja. Deje que escoja la ropa, los juegos o algo de comer entre las comidas. Limítese a no más de 2 o 3 opciones.
- ➔ Cuando juega con sus amigos, deje que su hijo resuelva los problemas con los otros niños, pero esté atenta para ayudar si es necesario.
- ➔ Anime a su hijo a usar palabras, compartir juguetes y turnarse con sus amigos para elegir los juegos.
- ➔ Dele a su hijo juguetes que aviven la imaginación, como disfraces, juegos de cocina y bloquecitos.
- ➔ Cuando hable con su hijo use la gramática correcta. En lugar de decirle “mamá quiere que vengas aquí”, dígale “yo quiero que vengas aquí”.

Área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Nombra algunos colores y números
- ❑ Entiende la idea de contar
- ❑ Comienza a entender el concepto de tiempo
- ❑ Recuerda partes de un cuento
- ❑ Entiende el concepto de "igual" y "diferente"
- ❑ Sabe usar tijeras
- ❑ Dibuja una persona con 2 o 4 partes del cuerpo
- ❑ Empieza a copiar algunas letras mayúsculas
- ❑ Juega juegos infantiles de mesa o de cartas
- ❑ Le dice lo que le parece que va a suceder en un libro a continuación

Áreas motora y de desarrollo físico

- ❑ Brinca y se sostiene en un pie hasta por 2 segundos
- ❑ La mayoría de las veces agarra una pelota que rebota
- ❑ Se sirve los alimentos, los hace papilla y los corta (mientras usted lo vigila)

Cómo puede ayudar al desarrollo de su hijo

- ➔ Use palabras como "primero," "segundo" y "al final" cuando hable de sus actividades cotidianas. Esto le va a ayudar a su hijo a aprender sobre la secuencia de eventos.
- ➔ Responda con tranquilidad a las preguntas de su hijo sobre los "porqué de las cosas". Si no sabe la respuesta, diga "no lo sé" o ayude a su hijo a encontrar la respuesta en un libro, en Internet o preguntándole a otro adulto.
- ➔ Cuando lea con su hijo, pídale que le cuente qué pasó durante el relato.
- ➔ Nombre los colores de los libros, las ilustraciones y las cosas de la casa. Cuente los artículos comunes, como la cantidad de galletitas, escalones o trenes de juguete.
- ➔ Enséñele a su hijo a jugar afuera a juegos como el "corre que te alcanzo", "seguir al líder" y "pato, pato, ganso".
- ➔ Escuche la música preferida de su hijo y baile con él. Tomen turnos copiándose lo que cada uno hace.

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No puede saltar en el mismo sitio
- ❑ Tiene dificultades para hacer garabatos
- ❑ No muestra interés en los juegos interactivos o de imaginación
- ❑ Ignora a otros niños o no responde a las personas que no son de la familia
- ❑ Rehúsa vestirse, dormir y usar el baño
- ❑ No puede relatar su cuento favorito
- ❑ No sigue instrucciones de 3 partes
- ❑ No entiende lo que quieren decir "igual" y "diferente"
- ❑ Habla con poca claridad
- ❑ No usa correctamente las palabras "yo" y "tú"
- ❑ Pierde habilidades que había adquirido

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo la escuela pública más cercana. Para obtener más información, consulte **www.cdc.gov/preocupado**.

Su Hijo de 5 Años

En cada visita médica de su hijo, hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los niños a esta edad?

Áreas social y emocional

- ❑ Quiere complacer a los amigos
- ❑ Quiere parecerse a los amigos
- ❑ Es posible que haga más caso a las reglas
- ❑ Está consciente de la diferencia de los sexos
- ❑ Puede distinguir la fantasía de la realidad
- ❑ Le gusta cantar, bailar y actuar
- ❑ Es más independiente (por ejemplo, puede ir solo a visitar a los vecinos de al lado) [para esto todavía necesita la supervisión de un adulto]
- ❑ A veces es muy exigente y a veces muy cooperador

Áreas del habla y la comunicación

- ❑ Habla con mucha claridad
- ❑ Puede contar una historia sencilla usando oraciones completas
- ❑ Puede usar el tiempo futuro; por ejemplo, “la abuelita va a venir”
- ❑ Dice su nombre y dirección

Cómo puede ayudar al desarrollo de su hijo

- ➔ Continúe organizando citas para jugar con los amiguitos, paseos al parque o grupos de juego. Dele a su hijo más libertad para elegir actividades para jugar con amigos, y deje que resuelva los problemas por sí mismo.
- ➔ Es posible que su hijo comience a “contestar” o a usar malas palabras como una forma de sentirse independiente. No le preste demasiada atención a este tipo de comportamiento verbal, más allá de no dejarle hacer nada por un tiempo breve como castigo. En lugar de ello, felicite a su hijo cuando pide las cosas con cortesía y cuando acepta un “no” con tranquilidad.
- ➔ Este es un buen momento para hablar con su hijo acerca de cuándo está bien que lo toquen. Nadie debe tocarle las partes íntimas excepto los médicos o enfermeras durante un examen o los padres cuando está bañando o limpiando al niño.
- ➔ Enséñele a su hijo la dirección y el teléfono de su casa.
- ➔ Cuando le lea a su hijo, pídale que adivine qué va a pasar en la historia a continuación.
- ➔ Enséñele a su hijo conceptos como mañana, tarde, noche, hoy, mañana y ayer. Comience a enseñarle los días de la semana.

Área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Cuenta 10 o más cosas
- ❑ Puede dibujar una persona con al menos 6 partes del cuerpo
- ❑ Puede escribir algunas letras o números
- ❑ Dibuja triángulos y otras figuras
- ❑ Conoce las cosas de uso diario como el dinero y la comida

Áreas motora y de desarrollo físico

- ❑ Se para en un pie por 10 segundos o más
- ❑ Brinca y puede ser que dé saltos de lado
- ❑ Puede dar volteretas en el aire
- ❑ Usa tenedor y cuchara y, a veces, cuchillo
- ❑ Puede ir al baño solo
- ❑ Se columpia y trepa

Cómo puede ayudar al desarrollo de su hijo

- ➔ Anime a su hijo a "leer" mirando las ilustraciones y contando la historia.
- ➔ Fomente el interés de su hijo en su comunidad. Por ejemplo, si a su hijo le encantan los animales, visite el zoológico o granjas donde se permite tocar a los animales. Vaya a la biblioteca o busque información en Internet sobre estos temas.
- ➔ Tenga siempre a mano una caja de crayones, papel, pintura, tijeras para niños y goma de pegar. Anime a su hijo a dibujar y terminar proyectos de arte con diferentes materiales.
- ➔ Juegue con juguetes que lo animan a poner cosas juntas.
- ➔ Enséñele a su hijo a mover las piernas y a impulsarse en el columpio con los pies.
- ➔ Ayude a su hijo a colgarse de las barras del juego infantil de pasamanos.
- ➔ Salga a caminar con su hijo, organice una "búsqueda del tesoro en el vecindario o el parque", ayúdelo a andar en bicicleta con rueditas de auxilio (usando casco).

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No expresa una gran variedad de emociones
- ❑ Tiene comportamientos extremos (demasiado miedo, agresión, timidez o tristeza)
- ❑ Es demasiado retraído y pasivo
- ❑ Se distrae con facilidad, tiene problemas para concentrarse en una actividad por más de 5 minutes
- ❑ No le responde a las personas o lo hace solo superficialmente
- ❑ No puede distinguir la fantasía de la realidad
- ❑ No juega a una variedad de juegos y actividades
- ❑ No puede decir su nombre y apellido
- ❑ No usa correctamente los plurales y el tiempo pasado
- ❑ No habla de sus actividades o experiencias diarias
- ❑ Pierde habilidades que había adquirido
- ❑ No puede cepillarse los dientes, lavarse y secarse las manos o desvestirse sin ayuda
- ❑ No dibuja

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo la escuela pública más cercana. Para obtener más información, consulte **www.cdc.gov/preocupado**.

Preguntas Para el Médico de Mi Hijo




2 Meses

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4 Meses

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18 Meses (1 Año y Medio)

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4 Años

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5 Años

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Resources

"Learn the Signs. Act Early." Web: www.cdc.gov/actearly

GOVERNMENT RESOURCES

- Centers for Disease Control and Prevention (CDC), National Center on Birth Defects and Developmental Disabilities (NCBDDD)
  Phone: 1-800-232-4636 Web: www.cdc.gov/ncbddd
- National Dissemination Center for Children with Disabilities
  Web: www.nichcy.org/states.htm
- Department of Education Web: www.ed.gov/index.html
- National Institute of Mental Health
  Phone: 1-866-615-6464 Web: www.nimh.nih.gov
- State Health Insurance Program (SCHIP)
  Phone: 1-877-543-7669 Web: www.insurekidsnow.gov

SPECIAL RESOURCES

- American Academy of Pediatrics (AAP)
  Phone: 1-847-434-4000 Web: www.aap.org
- Parent to Parent-USA Web: www.p2pusa.org

AUTISM SPECTRUM DISORDERS (ASD)

- Autism Society of America (ASA)
  Phone: 1-800-328-8476 Web: www.autism-society.org
- Autism Speaks
  Phone: 1-888-288-4762 Web: www.autismspeaks.org
- First Signs
  Phone: 1-978-346-4380 Web: www.firstsigns.org
- Organization for Autism Research (OAR)
  Phone: 1-703-243-9710 Web: www.researchautism.org
- Asperger Syndrome Education Network (ASPEN)
  Phone: 1-732-321-0880 Web: www.aspennj.org
- MAAP Services for Autism, Asperger Syndrome, and PDD
  Phone: 1-219-662-1311 Web: www.maapservices.org
- CDC's Resources on Vaccines and Autism
  Web: www.cdc.gov/ncbddd/autism/vaccines.htm

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD)

- Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD)
  Phone: 1-800-233-4050 Web: www.chadd.org
- Attention Deficit Disorder Association (ADDA)
  Phone: 1-800-939-1019 Web: www.add.org

CEREBRAL PALSY

- United Cerebral Palsy (UCP)
  Phone: 1-800-872-5827 Web: www.ucp.org
- National Institute of Neurological Disorders and Stroke (NINDS)
  Phone: 1-800-352-9424 Web: www.ninds.nih.gov
- Reaching for the Stars
  Phone: 1-877-561-7387
  Web: www.reachingforthestars.org

INTELLECTUAL DISABILITY (also known as Mental Retardation)

- American Association of Intellectual and Developmental Disabilities (formerly American Association on Mental Retardation)
  Phone: 1-800-424-3688 Web: www.aaidd.org
- The Arc of the United States
  Phone: 1-800-433-5255 Web: www.thearc.org

HEARING LOSS

- Centers for Disease Control and Prevention (CDC), Early Hearing Detection and Intervention Program (EHDI)
  Phone: 1-800-232-4636
  Web: www.cdc.gov/ncbddd/ehdi
- American Academy of Audiology (AAA)
  Phone: 1-800-222-2336 Web: www.audiology.org
- American Academy of Pediatrics Bright Futures
  Phone: 1-847-434-4000
  Web: brightfutures.aap.org/web
- American Speech-Language-Hearing Association (ASHA)
  Phone: 1-800-638-8255 Web: www.asha.org

VISION LOSS

- National Federation of the Blind (NFB)
  Phone: 1-410-659-9314 Web: www.nfb.org
- American Council of the Blind (ACB)
  Phone: 1-800-424-8666 Web: www.acb.org
- American Foundation for the Blind (AFB)
  Phone: 1-800-232-5463 Web: www.afb.org

FETAL ALCOHOL SYNDROME DISORDER (FASD)

- Centers for Disease Control and Prevention (CDC), Fetal Alcohol Syndrome Program
  Phone: 1-800-232-4636 Web: www.cdc.gov/ncbddd/fas
- National Organization on Fetal Alcohol Syndrome (NOFAS)
  Phone: 1-800-666-6327 Web: www.nofas.org

www.cdc.gov/actearly

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Recursos

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RECURSOS GUBERNAMENTALES

- Centros para el Control y la Prevención de Enfermedades (Centers for Disease Control and Prevention, CDC)
  Teléfono: 1-800-232-4636
  Sitio electrónico: www.cdc.gov/spanish
- Centro Nacional de Defectos Congénitos y Deficiencias del Desarrollo (National Center on Birth Defects and Developmental Disabilities, NCBDDD)
  Sitio electrónico: www.cdc.gov/ncbddd/defaultspan.htm
- Centro Nacional de Diseminación de Información para Niños con Discapacidades (National Dissemination Center for Children with Disabilities)
  Sitio electrónico: www.nichcy.org/spanish.htm
- Departamento de Educación de los Estados Unidos (US Department of Education)
  Teléfono: 1-800-872-5327
  Sitio electrónico: www.ed.gov/espanol
- Programas Estatales de Seguro Médico (State Health Insurance Program, SCHIP)
  Teléfono: 1-877-543-7669
  Sitio electrónico: www.insurekidsnow.gov/espanol

TRASTORNO DEL ESPECTRO AUTISTA (AUTISM SPECTRUM DISORDER, ASD)

- Autismo Habla (Autism Speaks)
  Sitio electrónico: www.autismspeaks.org/espanol
- Organización para la Investigación del Autismo (Organization for Autism Research, OAR)
  Sitio electrónico:
  www.researchautism.org/resources/reading/spanishguides.asp
- Sociedad Autista Estadounidense (Autism Society of America, ASA)
  Teléfono: 1-800-328-8476
  Sitio electrónico: www.autism-society.org/autismo
- Sitio electrónico del Programa Nacional de Inmunización "CDC: Vacunas y Autismo" (CDC's National Immunization Program's "Vaccines and Autism" Internet Site)
  Sitio electrónico: www.cdc.gov/spanish/inmunizacion/autismo.html

TRASTORNO POR DÉFICIT DE ATENCIÓN E HIPERACTIVIDAD (ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER, ADHD)

- Niños y Adultos con Trastorno de Déficit de Atención con Hiperactividad (Children and Adults with Attention Deficit/Hyperactivity Disorder, CHADD)
  Teléfono: 1-800-233-4050
  Sitio electrónico: www.help4adhd.org/espanol.cfm
- Asociación del Trastorno por Déficit de Atención (Attention Deficit Disorder Association, ADDA)
  Sitio electrónico: www.add.org/help/faqs-esp.html

PARÁLISIS CEREBRAL

- Instituto Nacional de Trastornos Neurológicos y Accidentes Cerebrovasculares (National Institute of Neurological Disorders and Stroke, NINDS)
  Sitio electrónico:
  www.ninds.nih.gov/health_and_medical/spanishindex.htm
- Asociación para la Parálisis Cerebral (United Cerebral Palsy, UCP)
  Sitio electrónico: www.ucp.org/ucp_general.cfm/1/11788

DISCAPACIDAD INTELECTUAL (también conocido como retraso mental)

- Sociedad Nacional del Síndrome de Down (National Down Syndrome Society, NDSS)
  Teléfono: 1-800-221-4602
  Sitio electrónico: www.esp.ndss.org

PÉRDIDA DE LA AUDICIÓN

- Centros para el Control y la Prevención de Enfermedades Programa de Detección Auditiva e Intervención Temprana (Centers for Disease Control and Prevention, Early Hearing Detection and Intervention Program)
  Teléfono: 1-800-232-4636
  Sitio electrónico: www.cdc.gov/ncbddd/ehdi/spanish
- Clínica John Tracy (John Tracy Clinic)
  Teléfono: 1-213-748-5481
  Sitio electrónico: www.clinicajohntracy.org
- Criando Niños Sordos (Raising Deaf Kids)
  Sitio electrónico: www.raisingdeafkids.org/spanish

PÉRDIDA DE LA VISIÓN

- Consorcio Nacional sobre la Sordera-Ceguera (National Consortium on Deaf-Blindness, NCDB)
  Teléfono: 1-800-438-9376
  Sitio electrónico: nationaldb.org/ISespanol.php
- Federación Americana para Ciegos (American Federation for the Blind, AFB)
  Sitio electrónico: www.afb.org/section.asp?sectionID=59

TRASTORNOS DEL ESPECTRO ALCOHOLICO FETAL (FASD)

- Centros para el Control y la Prevención de Enfermedades Programa de Trastornos del Espectro Alcoholico Fetal (Centers for Disease Control and Prevention, Fetal Alcohol Syndrome Program)
  Teléfono: 1-800-232-4636
  Sitio electrónico: www.cdc.gov/ncbddd/spanish/fas

www.cdc.gov/pronto

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Chapter 5 –

Adolescent Well-Care

SECTION 1: ADOLESCENT WELL-CARE

BACKGROUND

Adolescents are among the least likely age group to access health care. They have the lowest rates of primary care use and tend not to receive preventive health care services, with even higher rates for adolescents of low-income backgrounds. Consequently, adolescents typically have unmet physical and behavioral health care needs.[32]

- Adolescents are less likely to be insured than younger children and are likely to forego health care services or face challenges in accessing care. [32]
- More than 11% of children aged 6-17 did not have a health care visit to a doctor's office, emergency department, or home visit in the past 12 months. [32]
- SBHCs have a strong focus on well-care, particularly through comprehensive well-exams (CWEs) or EPSDT and comprehensive risk screening.
- As adolescents, particularly young parents, transition toward adulthood and begin health decisions on their own and for their children, SBHCs can help them gain knowledge and skills to prevent or reduce health risks by focusing on preventive care.

RECOMMENDATIONS

While special considerations may be made for parenting teens, American Academy of Pediatrics Bright Futures™ recommendations for adolescent care should be followed. Some specific areas to consider

- Begin the visit by establishing trust, being transparent, and explaining confidentiality and its limitations.
- Ask your patient what their priority is for the visit.
    - Address any questions or concerns they may have.
    - For complex situations, triage the highest need to be addressed during the current visit; schedule follow-up visits to address any less urgent concerns.
- Administer the SHQ/eSHQ, review with the patient, and address risk(s).
    - As per OSAH standards, the SHQ must be completed on the student's first visit of the school year, regardless of the visit type, or at a scheduled visit within 30 days if the student is acutely ill or in crisis.
    - The SHQ should be reviewed by the provider with the student on the date that it is administered and then signed and dated.
    - Risk(s) should be assessed and addressed during the SHQ review process; refer accordingly.
- Assess immunization status.
    - Follow the CDC Recommended Immunization schedule.

- For adolescents who start late or are more than 1 month behind on immunizations, follow the CDC Catch-Up Immunization Schedule.
- Educate parents on the importance of being up-to-date on their immunizations as protection for their child, too.

- Assess for dental home.
  - Assess whether the student has a dental home and/or has had a teeth cleaning within the past 6 months.
  - If the patient does not have a dental home, refer the student for dental care or have the student schedule a dental appointment at the SBHC or your sponsor entity's main clinic, if available.
  - Provide counseling on the importance of oral health, especially as it relates to overall health.
- Screen sexually active patients for STIs.
  - STI screening should be provided to all sexually active as part of their routine well-care.
  - For full STI screening guidelines, see Chapter 1.
- Screen for behavioral health risk.
  - Screening for depression/anxiety should be included in all adolescent well-visits as part of the SHQ/eSHQ. This is especially important for parenting teens who may be experiencing more demands and stressors than non-parents.
  - A positive screen for anxiety should trigger the use of an anxiety assessment tool, such as the SCARED.
  - A positive screen for depression should trigger the use of a depression assessment tool, such as the PHQ-9 modified for teens.
- Identify strengths during the visit.
  - Start by acknowledging what is going well.
  - Praise small successes.
  - Validate the positive and reflect back.
- Assess insurance status.
  - Refer to PE/MOSAA determiner if the patient is uninsured.
- Assess for medial home.
  - Ask the patient if they are receiving regular well-care outside of the SBHC. If not, help the student identify a place of care that is accessible and cost-effective (accepts their insurance or sliding-scale) and refer.
    - Consider referring to a family practice where the patient and their child can both access care
  - Provide counseling as to the importance of having a medical home for their child and how a Primary Care Provider will serve them.
  - Work with the GRADS case manager to help link the patient to regular care.

- If the patient is covered by Medicaid, contact their Care Coordinator through their MCO if additional support is needed to identify a medical home for the child and/or to ensure continuity of services.

SECTION 2: ADOLESCENT WELL-CARE RESOURCES

Clinical Tools

EPSDT Handbook
http://www.envisionnm.org/xpdf/EPSDT_Resource_Handbook.pdf

Student Health Questionnaire
http://www.nmasbhc.org/sbhc-documents.html

Bright Futures™ Adolescent Tools
https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/adolescence-tools.aspx

Bright Futures™ Adolescent Health Supervision
https://brightfutures.aap.org/Bright%20Futures%20Documents/18-Adolescence.pdf

CDC Vaccine Schedules
http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html

Bright Futures™ Medical Screening Reference Table
https://brightfutures.aap.org/Bright%20Futures%20Documents/MSRTable_AdolVisits.pdf

AAP Coding Guidance for ICD-10
https://www.aap.org/en-us/professional-resources/practicesupport/Coding-at-the-AAP/Pages/ICD-10-CM-implementation.aspx

Support for Uninsured or Underinsured Patients

NM Center on Law & Poverty
http://www.nmpovertylaw.org/

NM Immigrant Law Center
http://nmilc.org/

INCLUDED RESOURCES

SCARED Anxiety Assessment Tool (English & Spanish)

PHQ-9 Depression Assessment Tool (English & Spanish)

CDC Recommended Immunization Schedule (0 through 18 years)

Depression/Anxiety Screening, Assessment, Treatment Best Practice Flow Chart

Bright Futures™ Periodicity Schedule

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

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.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in *Bright Futures* guidelines (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	**Prenatal**[2]	**Newborn**[3]	**3-5 d**[4]	**By 1 mo**	**2 mo**	**4 mo**	**6 mo**	**9 mo**	**12 mo**	**15 mo**	**18 mo**	**24 mo**	**30 mo**	**3 y**	**4 y**	**5 y**	**6 y**	**7 y**	**8 y**	**9 y**	**10 y**	**11 y**	**12 y**	**13 y**	**14 y**	**15 y**	**16 y**	**17 y**	**18 y**	**19 y**	**20 y**	**21 y**
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																			
Weight for Length		●	●	●	●	●	●	●	●	●	●																				
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																															
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★
Hearing		●[8]	★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	★	★	★	★	★	★	★	★	★	★	★
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																															
Developmental Screening[9]								●			●		●																		
Autism Screening[10]											●	●																			
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment[11]																						★	★	★	★	★	★	★	★	★	★
Depression Screening[12]																						●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[14]																															
Newborn Blood Screening[15]		◄———	●	———►																											
Critical Congenital Heart Defect Screening[16]		●																													
Immunization[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[18]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead Screening[19]							★	★	● or ★[20]		★	● or ★[20]		★	★	★	★															
Tuberculosis Testing[21]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia Screening[22]												★			★		★		★	◄———	●	———►	★	★	★	★	★	★	◄———	●	———►
STI/HIV Screening[23]																						★	★	★	★	★	◄———	●	———►	★	★	★
Cervical Dysplasia Screening[24]																															●
ORAL HEALTH[25]							★	★	● or ★		● or ★	● or ★	● or ★	●			●														
Fluoride Varnish[26]							◄———				●	———	———	———	———►																
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. 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.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per the 2009 AAP statement "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Every infant should have a newborn evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in the 2012 AAP statement "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborn infants discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per the 2010 AAP statement "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per the 2007 AAP statement "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3 year olds. Instrument based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See 2016 AAP statement, "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/1.51) and "Procedures for Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/1.52).
8. All newborns should be screened, per the AAP statement "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. See 2006 AAP statement "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
10. Screening should occur per the 2007 AAP statement "Identification and Evaluation of Children with Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
11. A recommended screening tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.
12. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
13. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See 2011 AAP statement "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
14. These may be modified, depending on entry point into schedule and individual need.
15. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf), establish the criteria for and coverage of newborn screening procedures and programs. Follow-up must be provided, as appropriate, by the pediatrician.
16. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).
17. Schedules, per the AAP Committee on Infectious Diseases, are available at: http://aapredbook.aappublications.org/site/resources/izschedules.xhtml. Every visit should be an opportunity to update and complete a child's immunizations.
18. See 2010 AAP statement "Diagnosis and Prevention of Iron Deficiency and Iron Deficiency Anemia in Infants and Young Children (0-3 Years of Age)" (http://pediatrics.aappublications.org/content/126/5/1040.full).
19. For children at risk of lead exposure, see the 2012 CDC Advisory Committee on Childhood Lead Poisoning Prevention statement "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
20. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
21. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *AAP Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
22. See AAP-endorsed 2011 guidelines from the National Heart Blood and Lung Institute, "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
23. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the *AAP Red Book: Report of the Committee on Infectious Diseases*. Additionally, all adolescents should be screened for HIV according to the AAP statement (http://pediatrics.aappublications.org/content/128/5/1023.full) once between the ages of 16 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
24. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm). Indications for pelvic examinations prior to age 21 are noted in the 2010 AAP statement "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
25. Assess if the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. If primary water source is deficient in fluoride, consider oral fluoride supplementation. Recommend brushing with fluoride toothpaste in the proper dosage for age. See 2009 AAP statement "Oral Health Risk Assessment Timing and Establishment of the Dental Home" (http://pediatrics.aappublications.org/content/111/5/1113.full), 2014 clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626), and 2014 AAP statement "Maintaining and Improving the Oral Health of Young Children (http://pediatrics.aappublications.org/content/134/6/1224.full)."
26. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.htm). Once teeth are present, fluoride varnish may be applied to all children every 3-6 months in the primary care or dental office. Indications for fluoride use are noted in the 2014 AAP clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

KEY ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ◄——— ● ———► = range during which a service may be provided

Summary of changes made to the
Bright Futures/AAP Recommendations for Preventive Pediatric Health Care

(Periodicity Schedule)

This Schedule reflects changes approved in October 2015 and published in January 2016. For updates, visit www.aap.org/periodicityschedule.

Changes made October 2015

- **Vision Screening**- The routine screening at age 18 has been changed to a risk assessment.
- Footnote 7 has been updated to read, "A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3 year olds. Instrument based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See 2016 AAP statement, "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians (http://pediatrics.aappublications.org/content/137/1/1.51) and "Procedures for Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/1.52).

Changes made May 2015

- **Oral Health**- A subheading has been added for fluoride varnish, with a recommendation from 6 months through 5 years.
- Footnote 25 wording has been edited and also includes reference to the 2014 clinical report, "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626) and 2014 policy statement, "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224.full).
- Footnote 26 has been added to the new fluoride varnish subheading: See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.htm). Once teeth are present, fluoride varnish may be applied to all children every 3-6 months in the primary care or dental office. Indications for fluoride use are noted in the 2014 AAP clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

Changes made March 2014

Changes to Developmental/Behavioral Assessment

- **Alcohol and Drug Use Assessment**- Information regarding a recommended screening tool (CRAFFT) was added.
- **Depression**- Screening for depression at ages 11 through 21 has been added, along with suggested screening tools.

Changes to Procedures

- **Dyslipidemia screening**- An additional screening between 9 and 11 years of age has been added. The reference has been updated to the AAP-endorsed National Heart Blood and Lung Institute policy (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
- **Hematocrit or hemoglobin**- A risk assessment has been added at 15 and 30 months. The reference has been updated to the current AAP policy (http://pediatrics.aappublications.org/content/126/5/1040.full).
- **STI/HIV screening**- A screen for HIV has been added between 16 and 18 years. Information on screening adolescents for HIV has been added in the footnotes. STI screening now references recommendations made in the AAP Red Book. This category was previously titled "STI Screening."
- **Cervical dysplasia**- Adolescents should no longer be routinely screened for cervical dysplasia until age 21. Indications for pelvic exams prior to age 21 are noted in the 2010 AAP statement "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
- **Critical Congenital Heart Disease-** Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement, "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).

See www.aap.org/periodicityschedule for additional updates made to footnotes and references in March 2014.

Recommended Immunization Schedules for Persons Aged 0 Through 18 Years
UNITED STATES, 2016

This schedule includes recommendations in effect as of January 1, 2016. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the

Advisory Committee on Immunization Practices
(http://www.cdc.gov/vaccines/acip)

American Academy of Pediatrics
(http://www.aap.org)

American Academy of Family Physicians
(http://www.aafp.org)

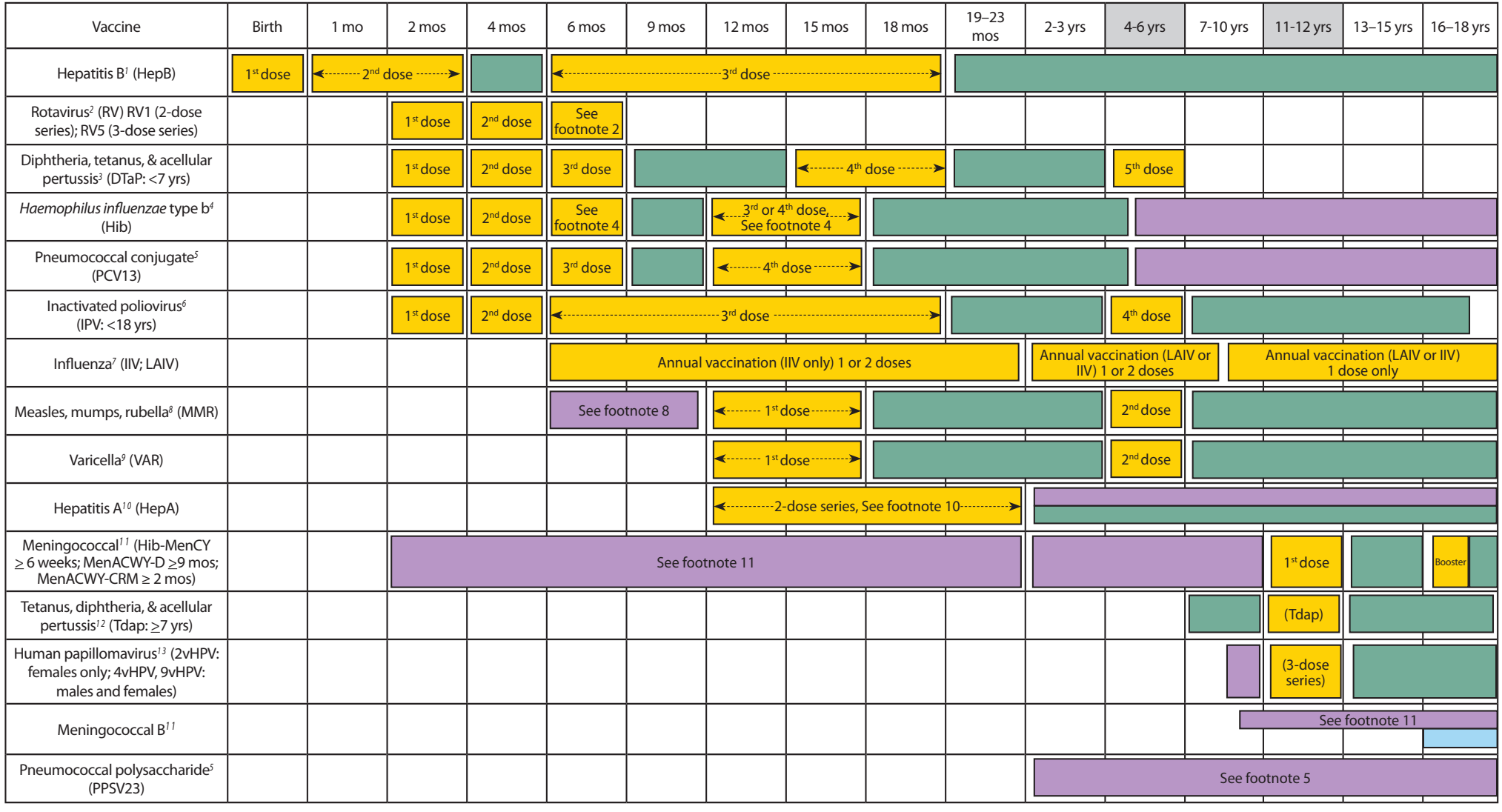
American College of Obstetricians and Gynecologists
(http://www.acog.org)

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Figure 1. Recommended immunization schedule for persons aged 0 through 18 years – United States, 2016.

(FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE [FIGURE 2]).

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are shaded.



Range of recommended ages for all children

Range of recommended ages for catch-up immunization

Range of recommended ages for certain high-risk groups

Range of recommended ages for non-high-risk groups that may receive vaccine, subject to individual clinical decision making

No recommendation

This schedule includes recommendations in effect as of January 1, 2016. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967). Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for vaccination, is available from CDC online (http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm) or by telephone (800-CDC-INFO [800-232-4636]).

This schedule is approved by the Advisory Committee on Immunization Practices (http//www.cdc.gov/vaccines/acip), the American Academy of Pediatrics (http://www.aap.org), the American Academy of Family Physicians (http://www.aafp.org), and the American College of Obstetricians and Gynecologists (http://www.acog.org).

NOTE: The above recommendations must be read along with the footnotes of this schedule.

FIGURE 2. Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind —United States, 2016.

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. Always use this table in conjunction with Figure 1 and the footnotes that follow.

Children age 4 months through 6 years					
Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Hepatitis B[1]	Birth	4 weeks	8 weeks *and* at least 16 weeks after first dose. Minimum age for the final dose is 24 weeks.		
Rotavirus[2]	6 weeks	4 weeks	4 weeks[2]		
Diphtheria, tetanus, and acellular pertussis[3]	6 weeks	4 weeks	4 weeks	6 months	6 months[3]
Haemophilus influenzae type b[4]	6 weeks	4 weeks if first dose was administered before the 1st birthday. 8 weeks (as final dose) if first dose was administered at age 12 through 14 months. No further doses needed if first dose was administered at age 15 months or older.	4 weeks[4] if current age is younger than 12 months **and** first dose was administered at younger than age 7 months, **and** at least 1 previous dose was PRP-T (ActHib, Pentacel) or unknown. 8 weeks *and* age 12 through 59 months (as final dose)[4] • if current age is younger than 12 months **and** first dose was administered at age 7 through 11 months (wait until at least 12 months old); OR • if current age is 12 through 59 months **and** first dose was administered before the 1st birthday, **and** second dose administered at younger than 15 months; OR • if both doses were PRP-OMP (PedvaxHIB; Comvax) **and** were administered before the 1st birthday (wait until at least 12 months old). No further doses needed if previous dose was administered at age 15 months or older.	8 weeks (as final dose) This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal[5]	6 weeks	4 weeks if first dose administered before the 1st birthday. 8 weeks (as final dose for healthy children) if first dose was administered at the 1st birthday or after. No further doses needed for healthy children if first dose administered at age 24 months or older.	4 weeks if current age is younger than 12 months and previous dose given at <7months old. 8 weeks (as final dose for healthy children) if previous dose given between 7-11 months (wait until at least 12 months old); OR if current age is 12 months or older and at least 1 dose was given before age 12 months. No further doses needed for healthy children if previous dose administered at age 24 months or older.	8 weeks (as final dose) This dose only necessary for children aged 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age.	
Inactivated poliovirus[6]	6 weeks	4 weeks[6]	4 weeks[6]	6 months[6] (minimum age 4 years for final dose).	
Measles, mumps, rubella[8]	12 months	4 weeks			
Varicella[9]	12 months	3 months			
Hepatitis A[10]	12 months	6 months			
Meningococcal[11] (Hib-MenCY ≥ 6 weeks; MenACWY-D ≥9 mos; MenACWY-CRM ≥ 2 mos)	6 weeks	8 weeks[11]	See footnote 11	See footnote 11	
Children and adolescents age 7 through 18 years					
Meningococcal[11] (Hib-MenCY ≥ 6 weeks; MenACWY-D ≥9 mos; MenACWY-CRM ≥ 2 mos)	Not Applicable (N/A)	8 weeks[11]			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis[12]	7 years[12]	4 weeks	4 weeks if first dose of DTaP/DT was administered before the 1st birthday. 6 months (as final dose) if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday.	6 months if first dose of DTaP/DT was administered before the 1st birthday.	
Human papillomavirus[13]	9 years	Routine dosing intervals are recommended.[13]			
Hepatitis A[10]	N/A	6 months			
Hepatitis B[1]	N/A	4 weeks	8 weeks **and** at least 16 weeks after first dose.		
Inactivated poliovirus[6]	N/A	4 weeks	4 weeks[6]	6 months[6]	
Measles, mumps, rubella[8]	N/A	4 weeks			
Varicella[9]	N/A	3 months if younger than age 13 years. 4 weeks if age 13 years or older.			

NOTE: The above recommendations must be read along with the footnotes of this schedule.

Footnotes — Recommended immunization schedule for persons aged 0 through 18 years—United States, 2016

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
For vaccine recommendations for persons 19 years of age and older, see the Adult Immunization Schedule.

Additional information

- For contraindications and precautions to use of a vaccine and for additional information regarding that vaccine, vaccination providers should consult the relevant ACIP statement available online at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For purposes of calculating intervals between doses, 4 weeks = 28 days. Intervals of 4 months or greater are determined by calendar months.
- Vaccine doses administered 4 days or less before the minimum interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum interval or minimum age should not be counted as valid doses and should be repeated as age-appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval. For further details, see *MMWR, General Recommendations on Immunization and Reports* / Vol. 60 / No. 2; Table 1. *Recommended and minimum ages and intervals between vaccine doses* available online at http://www.cdc.gov/mmwr/pdf/rr/rr6002.pdf.
- Information on travel vaccine requirements and recommendations is available at http://wwwnc.cdc.gov/travel/destinations/list.
- For vaccination of persons with primary and secondary immunodeficiencies, see Table 13, *"Vaccination of persons with primary and secondary immunodeficiencies,"* in *General Recommendations on Immunization* (ACIP), available at http://www.cdc.gov/mmwr/pdf/rr/rr6002.pdf.; and American Academy of Pediatrics. "Immunization in Special Clinical Circumstances," in Kimberlin DW, Brady MT, Jackson MA, Long SS eds. *Red Book: 2015 report of the Committee on Infectious Diseases. 30th ed.* Elk Grove Village, IL: American Academy of Pediatrics.

1. Hepatitis B (HepB) vaccine. (Minimum age: birth)

Routine vaccination:

At birth:

- Administer monovalent HepB vaccine to all newborns before hospital discharge.
- For infants born to hepatitis B surface antigen (HBsAg)-positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) at age 9 through 18 months (preferably at the next well-child visit) or 1 to 2 months after completion of the HepB series if the series was delayed; CDC recently recommended testing occur at age 9 through 12 months; see http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6439a6.htm.
- If mother's HBsAg status is unknown, within 12 hours of birth administer HepB vaccine regardless of birth weight. For infants weighing less than 2,000 grams, administer HBIG in addition to HepB vaccine within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if mother is HBsAg-positive, also administer HBIG for infants weighing 2,000 grams or more as soon as possible, but no later than age 7 days.

Doses following the birth dose:

- The second dose should be administered at age 1 or 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
- Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine on a schedule of 0, 1 to 2 months, and 6 months starting as soon as feasible. See Figure 2.
- Administer the second dose 1 to 2 months after the first dose (minimum interval of 4 weeks), administer the third dose at least 8 weeks after the second dose AND at least 16 weeks after the **first** dose. The final (third or fourth) dose in the HepB vaccine series should be administered **no earlier than age 24 weeks**.
- Administration of a total of 4 doses of HepB vaccine is permitted when a combination vaccine containing HepB is administered after the birth dose.

Catch-up vaccination:

- Unvaccinated persons should complete a 3-dose series.
- A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 15 years.
- For other catch-up guidance, see Figure 2.

2. Rotavirus (RV) vaccines. (Minimum age: 6 weeks for both RV1 [Rotarix] and RV5 [RotaTeq])

Routine vaccination:

Administer a series of RV vaccine to all infants as follows:

1. If Rotarix is used, administer a 2-dose series at 2 and 4 months of age.
2. If RotaTeq is used, administer a 3-dose series at ages 2, 4, and 6 months.
3. If any dose in the series was RotaTeq or vaccine product is unknown for any dose in the series, a total of 3 doses of RV vaccine should be administered.

Catch-up vaccination:

- The maximum age for the first dose in the series is 14 weeks, 6 days; vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
- The maximum age for the final dose in the series is 8 months, 0 days.
- For other catch-up guidance, see Figure 2.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks. Exception: DTaP-IPV [Kinrix, Quadracel]: 4 years)

Routine vaccination:

- Administer a 5-dose series of DTaP vaccine at ages 2, 4, 6, 15 through 18 months, and 4 through 6 years. The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
- Inadvertent administration of 4th DTaP dose early: If the fourth dose of DTaP was administered at least 4 months, but less than 6 months, after the third dose of DTaP, it need not be repeated.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine (cont'd)

Catch-up vaccination:

- The fifth dose of DTaP vaccine is not necessary if the fourth dose was administered at age 4 years or older.
- For other catch-up guidance, see Figure 2.

4. *Haemophilus influenzae* type b (Hib) conjugate vaccine. (Minimum age: 6 weeks for PRP-T [ACTHIB, DTaP-IPV/Hib (Pentacel) and Hib-MenCY (MenHibrix)], PRP-OMP [PedvaxHIB or COMVAX], 12 months for PRP-T [Hiberix])

Routine vaccination:

- Administer a 2- or 3-dose Hib vaccine primary series and a booster dose (dose 3 or 4 depending on vaccine used in primary series) at age 12 through 15 months to complete a full Hib vaccine series.
- The primary series with ActHIB, MenHibrix, or Pentacel consists of 3 doses and should be administered at 2, 4, and 6 months of age. The primary series with PedvaxHib or COMVAX consists of 2 doses and should be administered at 2 and 4 months of age; a dose at age 6 months is not indicated.
- One booster dose (dose 3 or 4 depending on vaccine used in primary series) of any Hib vaccine should be administered at age 12 through 15 months. An exception is Hiberix vaccine. Hiberix should only be used for the booster (final) dose in children aged 12 months through 4 years who have received at least 1 prior dose of Hib-containing vaccine.
- For recommendations on the use of MenHibrix in patients at increased risk for meningococcal disease, please refer to the meningococcal vaccine footnotes and also to *MMWR* February 28, 2014 / 63(RR01);1-13, available at http://www.cdc.gov/mmwr/PDF/rr/rr6301.pdf.

Catch-up vaccination:

- If dose 1 was administered at ages 12 through 14 months, administer a second (final) dose at least 8 weeks after dose 1, regardless of Hib vaccine used in the primary series.
- If both doses were PRP-OMP (PedvaxHIB or COMVAX), and were administered before the first birthday, the third (and final) dose should be administered at age 12 through 59 months and at least 8 weeks after the second dose.
- If the first dose was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a third (and final) dose at age 12 through 15 months or 8 weeks after second dose, whichever is later.
- If first dose is administered before the first birthday and second dose administered at younger than 15 months, a third (and final) dose should be administered 8 weeks later.
- For unvaccinated children aged 15 months or older, administer only 1 dose.
- For other catch-up guidance, see Figure 2. For catch-up guidance related to MenHibrix, please see the meningococcal vaccine footnotes and also *MMWR* February 28, 2014 / 63(RR01);1-13, available at http://www.cdc.gov/mmwr/PDF/rr/rr6301.pdf.

Vaccination of persons with high-risk conditions:

- Children aged 12 through 59 months who are at increased risk for Hib disease, including chemotherapy recipients and those with anatomic or functional asplenia (including sickle cell disease), human immunodeficiency virus (HIV) infection, immunoglobulin deficiency, or early component complement deficiency, who have received either no doses or only 1 dose of Hib vaccine before 12 months of age, should receive 2 additional doses of Hib vaccine 8 weeks apart; children who received 2 or more doses of Hib vaccine before 12 months of age should receive 1 additional dose.
- For patients younger than 5 years of age undergoing chemotherapy or radiation treatment who received a Hib vaccine dose(s) within 14 days of starting therapy or during therapy, repeat the dose(s) at least 3 months following therapy completion.
- Recipients of hematopoietic stem cell transplant (HSCT) should be revaccinated with a 3-dose regimen of Hib vaccine starting 6 to 12 months after successful transplant, regardless of vaccination history; doses should be administered at least 4 weeks apart.
- A single dose of any Hib-containing vaccine should be administered to unimmunized* children and adolescents 15 months of age and older undergoing an elective splenectomy; if possible, vaccine should be administered at least 14 days before procedure.

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

4. ***Haemophilus influenzae*** **type b (Hib) conjugate vaccine (cont'd)**
   - Hib vaccine is not routinely recommended for patients 5 years or older. However, 1 dose of Hib vaccine should be administered to unimmunized* persons aged 5 years or older who have anatomic or functional asplenia (including sickle cell disease) and unvaccinated persons 5 through 18 years of age with HIV infection.

   ** Patients who have not received a primary series and booster dose or at least 1 dose of Hib vaccine after 14 months of age are considered unimmunized.*

5. **Pneumococcal vaccines. (Minimum age: 6 weeks for PCV13, 2 years for PPSV23)**

   Routine vaccination with PCV13:
   - Administer a 4-dose series of PCV13 vaccine at ages 2, 4, and 6 months and at age 12 through 15 months.
   - For children aged 14 through 59 months who have received an age-appropriate series of 7-valent PCV (PCV7), administer a single supplemental dose of 13-valent PCV (PCV13).

   Catch-up vaccination with PCV13:
   - Administer 1 dose of PCV13 to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
   - For other catch-up guidance, see Figure 2.

   Vaccination of persons with high-risk conditions with PCV13 and PPSV23:
   - All recommended PCV13 doses should be administered prior to PPSV23 vaccination if possible.
   - For children 2 through 5 years of age with any of the following conditions: chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma if treated with high-dose oral corticosteroid therapy); diabetes mellitus; cerebrospinal fluid leak; cochlear implant; sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; solid organ transplantation; or congenital immunodeficiency:
     1. Administer 1 dose of PCV13 if any incomplete schedule of 3 doses of PCV (PCV7 and/or PCV13) were received previously.
     2. Administer 2 doses of PCV13 at least 8 weeks apart if unvaccinated or any incomplete schedule of fewer than 3 doses of PCV (PCV7 and/or PCV13) were received previously.
     3. Administer 1 supplemental dose of PCV13 if 4 doses of PCV7 or other age-appropriate complete PCV7 series was received previously.
     4. The minimum interval between doses of PCV (PCV7 or PCV13) is 8 weeks.
     5. For children with no history of PPSV23 vaccination, administer PPSV23 at least 8 weeks after the most recent dose of PCV13.
   - For children aged 6 through 18 years who have cerebrospinal fluid leak; cochlear implant; sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiencies; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; generalized malignancy; solid organ transplantation; or multiple myeloma:
     1. If neither PCV13 nor PPSV23 has been received previously, administer 1 dose of PCV13 now and 1 dose of PPSV23 at least 8 weeks later.
     2. If PCV13 has been received previously but PPSV23 has not, administer 1 dose of PPSV23 at least 8 weeks after the most recent dose of PCV13.
     3. If PPSV23 has been received but PCV13 has not, administer 1 dose of PCV13 at least 8 weeks after the most recent dose of PPSV23.
   - For children aged 6 through 18 years with chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure), chronic lung disease (including asthma if treated with high-dose oral corticosteroid therapy), diabetes mellitus, alcoholism, or chronic liver disease, who have not received PPSV23, administer 1 dose of PPSV23. If PCV13 has been received previously, then PPSV23 should be administered at least 8 weeks after any prior PCV13 dose.
   - A single revaccination with PPSV23 should be administered 5 years after the first dose to children with sickle cell disease or other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiencies; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; generalized malignancy; solid organ transplantation; or multiple myeloma.

6. **Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)**

   Routine vaccination:
   - Administer a 4-dose series of IPV at ages 2, 4, 6 through 18 months, and 4 through 6 years. The final dose in the series should be administered on or after the fourth birthday and at least 6 months after the previous dose.

   Catch-up vaccination:
   - In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk of imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).
   - If 4 or more doses are administered before age 4 years, an additional dose should be administered at age 4 through 6 years and at least 6 months after the previous dose.
   - A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.

6. **Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks) (cont'd)**
   - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age. If only OPV were administered, and all doses were given prior to 4 years of age, one dose of IPV should be given at 4 years or older, at least 4 weeks after the last OPV dose.
   - IPV is not routinely recommended for U.S. residents aged 18 years or older.
   - For other catch-up guidance, see Figure 2.

7. **Influenza vaccines. (Minimum age: 6 months for inactivated influenza vaccine [IIV], 2 years for live, attenuated influenza vaccine [LAIV])**

   Routine vaccination:
   - Administer influenza vaccine annually to all children beginning at age 6 months. For most healthy, nonpregnant persons aged 2 through 49 years, either LAIV or IIV may be used. However, LAIV should NOT be administered to some persons, including 1) persons who have experienced severe allergic reactions to LAIV, any of its components, or to a previous dose of any other influenza vaccine; 2) children 2 through 17 years receiving aspirin or aspirin-containing products; 3) persons who are allergic to eggs; 4) pregnant women; 5) immunosuppressed persons; 6) children 2 through 4 years of age with asthma or who had wheezing in the past 12 months; or 7) persons who have taken influenza antiviral medications in the previous 48 hours. For all other contraindications and precautions to use of LAIV, see *MMWR* August 7, 2015 / 64(30):818-25 available at http://www.cdc.gov/mmwr/pdf/wk/mm6430.pdf.

   For children aged 6 months through 8 years:
   - For the 2015-16 season, administer 2 doses (separated by at least 4 weeks) to children who are receiving influenza vaccine for the first time. Some children in this age group who have been vaccinated previously will also need 2 doses. For additional guidance, follow dosing guidelines in the 2015-16 ACIP influenza vaccine recommendations, *MMWR* August 7, 2015 / 64(30):818-25, available at http://www.cdc.gov/mmwr/pdf/wk/mm6430.pdf.
   - For the 2016-17 season, follow dosing guidelines in the 2016 ACIP influenza vaccine recommendations.

   For persons aged 9 years and older:
   - Administer 1 dose.

8. **Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months for routine vaccination)**

   Routine vaccination:
   - Administer a 2-dose series of MMR vaccine at ages 12 through 15 months and 4 through 6 years. The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
   - Administer 1 dose of MMR vaccine to infants aged 6 through 11 months before departure from the United States for international travel. These children should be revaccinated with 2 doses of MMR vaccine, the first at age 12 through 15 months (12 months if the child remains in an area where disease risk is high), and the second dose at least 4 weeks later.
   - Administer 2 doses of MMR vaccine to children aged 12 months and older before departure from the United States for international travel. The first dose should be administered on or after age 12 months and the second dose at least 4 weeks later.

   Catch-up vaccination:
   - Ensure that all school-aged children and adolescents have had 2 doses of MMR vaccine; the minimum interval between the 2 doses is 4 weeks.

9. **Varicella (VAR) vaccine. (Minimum age: 12 months)**

   Routine vaccination:
   - Administer a 2-dose series of VAR vaccine at ages 12 through 15 months and 4 through 6 years. The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose. If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

   Catch-up vaccination:
   - Ensure that all persons aged 7 through 18 years without evidence of immunity (see *MMWR* 2007 / 56 [No. RR-4], available at http://www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have 2 doses of varicella vaccine. For children aged 7 through 12 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons aged 13 years and older, the minimum interval between doses is 4 weeks.

10. **Hepatitis A (HepA) vaccine. (Minimum age: 12 months)**

    Routine vaccination:
    - Initiate the 2-dose HepA vaccine series at 12 through 23 months; separate the 2 doses by 6 to 18 months.
    - Children who have received 1 dose of HepA vaccine before age 24 months should receive a second dose 6 to 18 months after the first dose.
    - For any person aged 2 years and older who has not already received the HepA vaccine series, 2 doses of HepA vaccine separated by 6 to 18 months may be administered if immunity against hepatitis A virus infection is desired.

    Catch-up vaccination:
    - The minimum interval between the 2 doses is 6 months.

For further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

10. Hepatitis A (HepA) vaccine (cont'd)

Special populations:

- Administer 2 doses of HepA vaccine at least 6 months apart to previously unvaccinated persons who live in areas where vaccination programs target older children, or who are at increased risk for infection. This includes persons traveling to or working in countries that have high or intermediate endemicity of infection; men having sex with men; users of injection and non-injection illicit drugs; persons who work with HAV-infected primates or with HAV in a research laboratory; persons with clotting-factor disorders; persons with chronic liver disease; and persons who anticipate close personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity. The first dose should be administered as soon as the adoption is planned, ideally 2 or more weeks before the arrival of the adoptee.

11. Meningococcal vaccines. (Minimum age: 6 weeks for Hib-MenCY [MenHibrix], 9 months for MenACWY-D [Menactra], 2 months for MenACWY-CRM [Menveo], 10 years for serogroup B meningococcal [MenB] vaccines: MenB-4C [Bexsero] and MenB-FHbp [Trumenba])

Routine vaccination:

- Administer a single dose of Menactra or Menveo vaccine at age 11 through 12 years, with a booster dose at age 16 years.
- Adolescents aged 11 through 18 years with human immunodeficiency virus (HIV) infection should receive a 2-dose primary series of Menactra or Menveo with at least 8 weeks between doses.
- For children aged 2 months through 18 years with high-risk conditions, see below.

Catch-up vaccination:

- Administer Menactra or Menveo vaccine at age 13 through 18 years if not previously vaccinated.
- If the first dose is administered at age 13 through 15 years, a booster dose should be administered at age 16 through 18 years with a minimum interval of at least 8 weeks between doses.
- If the first dose is administered at age 16 years or older, a booster dose is not needed.
- For other catch-up guidance, see Figure 2.

Clinical discretion:

- Young adults aged 16 through 23 years (preferred age range is 16 through 18 years) may be vaccinated with either a 2-dose series of Bexsero or a 3-dose series of Trumenba vaccine to provide short-term protection against most strains of serogroup B meningococcal disease. The two MenB vaccines are not interchangeable; the same vaccine product must be used for all doses.

Vaccination of persons with high-risk conditions and other persons at increased risk of disease:

Children with anatomic or functional asplenia (including sickle cell disease):

Meningococcal conjugate ACWY vaccines:

1. Menveo
   - *Children who initiate vaccination at 8 weeks:* Administer doses at 2, 4, 6, and 12 months of age.
   - *Unvaccinated children who initiate vaccination at 7 through 23 months:* Administer 2 doses, with the second dose at least 12 weeks after the first dose AND after the first birthday.
   - *Children 24 months and older who have not received a complete series:* Administer 2 primary doses at least 8 weeks apart.
2. MenHibrix
   - *Children who initiate vaccination at 6 weeks:* Administer doses at 2, 4, 6, and 12 through 15 months of age.
   - If the first dose of MenHibrix is given at or after 12 months of age, a total of 2 doses should be given at least 8 weeks apart to ensure protection against serogroups C and Y meningococcal disease.
3. Menactra
   - *Children 24 months and older who have not received a complete series:* Administer 2 primary doses at least 8 weeks apart. If Menactra is administered to a child with asplenia (including sickle cell disease), do not administer Menactra until 2 years of age and at least 4 weeks after the completion of all PCV13 doses.

Meningococcal B vaccines:

1. Bexsero or Trumenba
   - *Persons 10 years or older who have not received a complete series.* Administer a 2-dose series of Bexsero, at least 1 month apart. Or a 3-dose series of Trumenba, with the second dose at least 2 months after the first and the third dose at least 6 months after the first. The two MenB vaccines are not interchangeable; the same vaccine product must be used for all doses.

Children with persistent complement component deficiency (includes persons with inherited or chronic deficiencies in C3, C5-9, properidin, factor D, factor H, or taking eculizumab (Soliriis®):

Meningococcal conjugate ACWY vaccines:

1. Menveo
   - *Children who initiate vaccination at 8 weeks:* Administer doses at 2, 4, 6, and 12 months of age.
   - *Unvaccinated children who initiate vaccination at 7 through 23 months:* Administer 2 doses, with the second dose at least 12 weeks after the first dose AND after the first birthday.
   - *Children 24 months and older who have not received a complete series:* Administer 2 primary doses at least 8 weeks apart.
2. MenHibrix
   - *Children who initiate vaccination 6 weeks:* Administer doses at 2, 4, 6, and 12 through 15 months of age.
   - If the first dose of MenHibrix is given at or after 12 months of age, a total of 2 doses should be given at least 8 weeks apart to ensure protection against serogroups C and Y meningococcal disease.

11. Meningococcal vaccines (cont'd)

3. Menactra
   - *Children 9 through 23 months:* Administer 2 primary doses at least 12 weeks apart.
   - *Children 24 months and older who have not received a complete series:* Administer 2 primary doses at least 8 weeks apart.

Meningococcal B vaccines:

1. Bexsero or Trumenba
   - *Persons 10 years or older who have not received a complete series.* Administer a 2-dose series of Bexsero, at least 1 month apart. Or a 3-dose series of Trumenba, with the second dose at least 2 months after the first and the third dose at least 6 months after the first. The two MenB vaccines are not interchangeable; the same vaccine product must be used for all doses.

For children who travel to or reside in countries in which meningococcal disease is hyperendemic or epidemic, including countries in the African meningitis belt or the Hajj

- administer an age-appropriate formulation and series of Menactra or Menveo for protection against serogroups A and W meningococcal disease. Prior receipt of MenHibrix is not sufficient for children traveling to the meningitis belt or the Hajj because it does not contain serogroups A or W.

For children at risk during a community outbreak attributable to a vaccine serogroup

- administer or complete an age- and formulation-appropriate series of MenHibrix, Menactra, or Menveo, Bexsero or Trumenba.

For booster doses among persons with high-risk conditions, refer to *MMWR* 2013 / 62(RR02);1-22, available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6202a1.htm.

For other catch-up recommendations for these persons, and complete information on use of meningococcal vaccines, including guidance related to vaccination of persons at increased risk of infection, see *MMWR* March 22, 2013 / 62(RR02);1-22, and *MMWR* October 23, 2015 / 64(41); 1171-1176 available at http://www.cdc.gov/mmwr/pdf/rr/rr6202.pdf, and http://www.cdc.gov/mmwr/pdf/wk/mm6441.pdf.

12. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 10 years for both Boostrix and Adacel)

Routine vaccination:

- Administer 1 dose of Tdap vaccine to all adolescents aged 11 through 12 years.
- Tdap may be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.
- Administer 1 dose of Tdap vaccine to pregnant adolescents during each pregnancy (preferred during 27 through 36 weeks gestation) regardless of time since prior Td or Tdap vaccination.

Catch-up vaccination:

- Persons aged 7 years and older who are not fully immunized with DTaP vaccine should receive Tdap vaccine as 1 (preferably the first) dose in the catch-up series; if additional doses are needed, use Td vaccine. For children 7 through 10 years who receive a dose of Tdap as part of the catch-up series, an adolescent Tdap vaccine dose at age 11 through 12 years should NOT be administered. Td should be administered instead 10 years after the Tdap dose.
- Persons aged 11 through 18 years who have not received Tdap vaccine should receive a dose followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter.
- Inadvertent doses of DTaP vaccine:
  - If administered inadvertently to a child aged 7 through 10 years may count as part of the catch-up series. This dose may count as the adolescent Tdap dose, or the child can later receive a Tdap booster dose at age 11 through 12 years.
  - If administered inadvertently to an adolescent aged 11 through 18 years, the dose should be counted as the adolescent Tdap booster.
- For other catch-up guidance, see Figure 2.

13. Human papillomavirus (HPV) vaccines. (Minimum age: 9 years for 2vHPV [Cervarix], 4vHPV [Gardasil] and 9vHPV [Gardasil 9])

Routine vaccination:

- Administer a 3-dose series of HPV vaccine on a schedule of 0, 1-2, and 6 months to all adolescents aged 11 through 12 years. 9vHPV, 4vHPV or 2vHPV may be used for females, and only 9vHPV or 4vHPV may be used for males.
- The vaccine series may be started at age 9 years.
- Administer the second dose 1 to 2 months after the first dose (minimum interval of 4 weeks); administer the third dose 16 weeks after the second dose (minimum interval of 12 weeks) and 24 weeks after the first dose.
- Administer HPV vaccine beginning at age 9 years to children and youth with any history of sexual abuse or assault who have not initiated or completed the 3-dose series.

Catch-up vaccination:

- Administer the vaccine series to females (2vHPV or 4vHPV or 9vHPV) and males (4vHPV or 9vHPV) at age 13 through 18 years if not previously vaccinated.
- Use recommended routine dosing intervals (see Routine vaccination above) for vaccine series catch-up.

PHQ-9: Modified for Teens

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) **Not At All**	*(1)* **Several Days**	*(2)* **More Than Half the Days**	*(3)* **Nearly Every Day**
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
[ ] Yes [ ] No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

[ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?
[ ] Yes [ ] No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?
[ ] Yes [ ] No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: Severity score: _____

Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)

CUESTIONARIO SOBRE LA SALUD DEL PACIENTE-9:

Modificado

Nombre: _____ Clinico: _____Fecha: _____

Instrucciones: ¿Qué tan a menudo ha sentido cada uno de los siguientes síntomas durante las **dos ultimas semanas**? Por cada síntoma escriba una "X" en el cuadro que mehor describe como se siente.

	(0) **Ninguno**	*(1)* **Varios Días**	*(2)* **Mas de la Mitad de los Días**	*(3)* **Casi Todos los Días**
1. ¿Se seinte deprimido, irritado, o sin esperanza?				
2. ¿Poco interés or placer para hacer cosas?				
3. ¿Tiene dificultad para dormirse, quedarse dormido, o duerme demasiado?				
4. ¿Poco apetito, perdida de peso, o come demasiado?				
5. ¿Se siente cansado o tiene poca energía?				
6. ¿Se seinte mal por usted mismo-o siente que es un fracasado, o que le ha fallado a su familia y a usted mismo?				
7. ¿Tiene problema para concetrarse en cosas tales como tareas escolares, leer, o ver televisión?				
8. ¿Se mueve o habla tan lentamente que las otras personas pueden notarlo? ¿O al contrario-esta tan inquieto que se mueve mas de lo usual?				
9. ¿Pensamientos que estaría mejor muerto o de hacerse daño usted mismo de alguna manera ?				

¿En el año pasado se ha sentido deprimido o triste la mayoría de los días, aun cuando se siente bien algunas veces?

[ ] Si [ ] No

Si usted esta pasando por cualquiera de los problemas mencionados en este formulario, ¿qué tan difícil estos problemas le causan para hacer su trabajo, hacer las cosas de la casa, o relacionarse con las demás personas?

[ ] No difícil [ ] Un poco difícil [ ] Muy difícil [ ] Sumamente difícil

¿En el mes pasado hubo algún momento donde usted pensó seriamente en terminar con su vida?

[ ] Si [ ] No

¿Alguna vez en su vida, trato de matarse o trato de suicidarse?

[ ] Si [ ] No

***Si usted piensa que estaría mejor muerto o piensa hacerse daño de alguna manera, por favor hable sobre esto con el Clinico de Atencion de Salud, o vaya a la sala de emergencia de un hospital o llame al 911.*

Para uso de la oficina solamente: Severity score: _____

Translated by the Asian/American Center of Queens College with funds provided by the Queens Borough President Helen Marshall.
Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)

Scoring the PHQ-9 modified for Teens

Scoring the PHQ-9 modified for teens is easy but involves thinking about several different aspects of depression.

To use the PHQ-9 as a diagnostic aid for Major Depressive Disorder:

- Questions 1 and/or 2 need to be endorsed as a "2" or "3"
- Need five or more positive symptoms (positive is defined by a "2" or "3" in questions 1-8 and by a "1", "2", or "3" in question 9).
- The functional impairment question (How difficult….) needs to be rated at least as "somewhat difficult."

To use the PHQ-9 to screen for all types of depression or other mental illness:

- All positive answers (positive is defined by a "2" or "3" in questions 1-8 and by a "1", "2", or "3" in question 9) should be followed up by interview.
- A total PHQ-9 score $\geq$ 10 (see below for instructions on how to obtain a total score) has a good sensitivity and specificity for MDD.

To use the PHQ-9 to aid in the diagnosis of dysthymia:

- The dysthymia question (In the past year…) should be endorsed as "yes."

To use the PHQ-9 to screen for suicide risk:

- All positive answers to question 9 as well as the two additional suicide items MUST be followed up by a clinical interview.

To use the PHQ-9 to obtain a total score and assess depressive severity:

- Add up the numbers endorsed for questions 1-9 and obtain a total score.
- See Table below:

Total Score	**Depression Severity**
0-4	No or Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 1 of 2 (to be filled out by the CHILD)

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh *(October, 1995)*. *E-mail:* birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(10), 1230–6.

Name: _____ Date: _____

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then, for each sentence, fill in one circle that corresponds to the response that seems to describe you *for the last 3 months*.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When I feel frightened, it is hard to breathe	O	O	O	**PN**
2. I get headaches when I am at school.	O	O	O	**SH**
3. I don't like to be with people I don't know well.	O	O	O	**SC**
4. I get scared if I sleep away from home.	O	O	O	**SP**
5. I worry about other people liking me.	O	O	O	**GD**
6. When I get frightened, I feel like passing out.	O	O	O	**PN**
7. I am nervous.	O	O	O	**GD**
8. I follow my mother or father wherever they go.	O	O	O	**SP**
9. People tell me that I look nervous.	O	O	O	**PN**
10. I feel nervous with people I don't know well.	O	O	O	**SC**
11. I get stomachaches at school.	O	O	O	**SH**
12. When I get frightened, I feel like I am going crazy.	O	O	O	**PN**
13. I worry about sleeping alone.	O	O	O	**SP**
14. I worry about being as good as other kids.	O	O	O	**GD**
15. When I get frightened, I feel like things are not real.	O	O	O	**PN**
16. I have nightmares about something bad happening to my parents.	O	O	O	**SP**
17. I worry about going to school.	O	O	O	**SH**
18. When I get frightened, my heart beats fast.	O	O	O	**PN**
19. I get shaky.	O	O	O	**PN**
20. I have nightmares about something bad happening to me.	O	O	O	**SP**

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 2 of 2 (to be filled out by the CHILD)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. I worry about things working out for me.	O	O	O	**GD**
22. When I get frightened, I sweat a lot.	O	O	O	**PN**
23. I am a worrier.	O	O	O	**GD**
24. I get really frightened for no reason at all.	O	O	O	**PN**
25. I am afraid to be alone in the house.	O	O	O	**SP**
26. It is hard for me to talk with people I don't know well.	O	O	O	**SC**
27. When I get frightened, I feel like I am choking.	O	O	O	**PN**
28. People tell me that I worry too much.	O	O	O	**GD**
29. I don't like to be away from my family.	O	O	O	**SP**
30. I am afraid of having anxiety (or panic) attacks.	O	O	O	**PN**
31. I worry that something bad might happen to my parents.	O	O	O	**SP**
32. I feel shy with people I don't know well.	O	O	O	**SC**
33. I worry about what is going to happen in the future.	O	O	O	**GD**
34. When I get frightened, I feel like throwing up.	O	O	O	**PN**
35. I worry about how well I do things.	O	O	O	**GD**
36. I am scared to go to school.	O	O	O	**SH**
37. I worry about things that have already happened.	O	O	O	**GD**
38. When I get frightened, I feel dizzy.	O	O	O	**PN**
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport).	O	O	O	**SC**
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.	O	O	O	**SC**
41. I am shy.	O	O	O	**SC**

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. **TOTAL =**

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**. **PN =**

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**. **GD =**

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety SOC**. **SP =**

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**. **SC =**

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**. **SH =**

For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.

The SCARED is available at no cost at www.wpic.pitt.edu/research under tools and assessments, or at www.pediatric bipolar.pitt.edu under instruments.

March 27, 2012

SELF-REPORT FOR CHILDHOOD ANXIETY RELATED DISORDERS (SCAReD)*
AUTO-REPORTE PARA DESÓRDENES RELACIONADOS CON LA ANSIEDAD EN LA INFANCIA

FORMA PARA NIÑOS (8 años o mayores)**

Nombre:_____ Fecha:

Identificación #:

Esta es una lista de cosas que describen como se siente usted. Marque el **0** si casi nunca o nunca es cierto. Marque el **1** si es cierto algunas veces. Marque el **2** si casi siempre o siempre es cierto. Por favor conteste las preguntas lo mejor que pueda.

0 = Casi nunca o nunca es cierto
1 = Es cierto algunas veces
2 = Casi siempre o siempre es cierto

1.	Cuando tengo miedo, no puedo respirar bien.	0 1 2
2.	Cuando estoy en la escuela me duele la cabeza.	0 1 2
3.	No me gusta estar con personas que no conozco bien.	0 1 2
4.	Cuando duermo en una casa que no es la mía me siento con miedo.	0 1 2
5.	Me preocupa saber si le caigo bien a la gente.	0 1 2
6.	Cuando tengo miedo, siento que me voy a desmayar.	0 1 2
7.	Soy una persona nerviosa.	0 1 2
8.	Sigo a mis padres a donde ellos van.	0 1 2
9.	La gente me dice que me veo nervioso(a).	0 1 2
10.	Me pongo nervioso(a) cuando estoy con personas que no conozco bien.	0 1 2
11.	Cuando estoy en la escuela me duele el estómago (panza).	0 1 2
12.	Cuando tengo mucho miedo, me siento como si me fuera a enloquecer.	0 1 2
13.	Me preocupo cuando tengo que dormir solo(a).	0 1 2
14.	Me preocupo de ser tan bueno(a) como los otros niños (por ejemplo: en mis estudios o deportes).	0 1 2
15.	Cuando tengo mucho miedo, siento como si las cosas fueran diferentes o no reales.	0 1 2
16.	En las noches sueño que cosas malas le van a pasar a mis padres.	0 1 2
17.	Me preocupo cuando tengo que ir a la escuela.	0 1 2

POR FAVOR COMPLETE LA PROXIMA PÁGINA

0= Casi nunca o nunca es cierto **1= Es cierto algunas veces**

18.	Cuando tengo mucho miedo, el corazón me late muy rápido.	0 1 2
19.	Cuando tengo mucho miedo, yo tiemblo.	0 1 2
20.	En las noches tengo pesadillas de que me va a pasar algo malo.	0 1 2
21.	Me preocupa pensar como me van a salir las cosas.	0 1 2
22.	Sudo mucho cuando tengo miedo.	0 1 2
23.	Me preocupo demasiado.	0 1 2
24.	Me preocupo sin motivo.	0 1 2
25.	Me da miedo estar solo(a) en la casa.	0 1 2
26.	Me cuesta trabajo hablar con personas que no conozco.	0 1 2
27.	Cuando tengo miedo, siento como si no pudiera tragar.	0 1 2
28.	Las personas me dicen que yo me preocupo demasiado.	0 1 2
29.	No me gusta estar lejos de mi familia.	0 1 2
30.	Tengo miedo de tener ataques de nervios (pánico).	0 1 2
31.	Me preocupa pensar que algo malo le va a pasar a mis padres.	0 1 2
32.	Me da vergüenza cuando estoy con personas que no conozco.	0 1 2
33.	Me preocupa que me pasara cuando sea grande.	0 1 2
34.	Cuando tengo miedo me dan ganas de vomitar.	0 1 2
35.	Me preocupa saber si hago las cosas bien.	0 1 2
36.	Tengo miedo de ir al colegio.	0 1 2
37.	Me preocupan las cosas que ya han pasado.	0 1 2
38.	Cuando tengo miedo, me siento mareado(a).	0 1 2
39.	Me siento nervioso(a) cuando tengo que hacer algo delante de otros niños o adultos (ejemplos: leer en voz alta, hablar, jugar)	0 1 2
40.	Me siento nervioso(a) de ir a fiestas, bailes, o alguna parte donde hay gente que no conozco.	0 1 2
41	Soy tímido(a)	0 1 2

*****Hecho por Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David A. Brent, M.D., and Sandra McKenzie, Ph.D., Instituto Siquiátrico de la Universidad de Pittsburgh (11/95). E-mail: boris@camp.wpic.pitt.edu

*****Se recomienda que a los niños de 8 a 11 años se les explique bien el contenido de este cuestionario o que contesten el cuestionario al lado de un adulto en caso de que tengan algunas preguntas***.

NAME: _____ DATE: _____

SCORING THE SCARED

SCREEN FOR CHILD ANXIETY RELATED EMOTIONAL DISORDERS

BIRMAHER, BORIS M.D.; BRENT, DAVID A. M.D.; CHIAPPETTA, LAUREL B.S.; BRIDGE, JEFFREY B.S.; MONGA, SUNEETA M.D.; BAUGHER, MARIANNE M.A.

SCALE	MAX	Significant	SCORE
TOTAL ANXIETY	82	25	
Panic/Somatic	26	7	
Generalized Anxiety	18	9	
Separation Anxiety	16	5	
Social Anxiety	14	8	
School Avoidance	8	3	

SCORING:

A total score of **> 25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific.

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicated **Panic Disorder** or **Significant Somatic Symptoms**.

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**.

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety Disorder**.

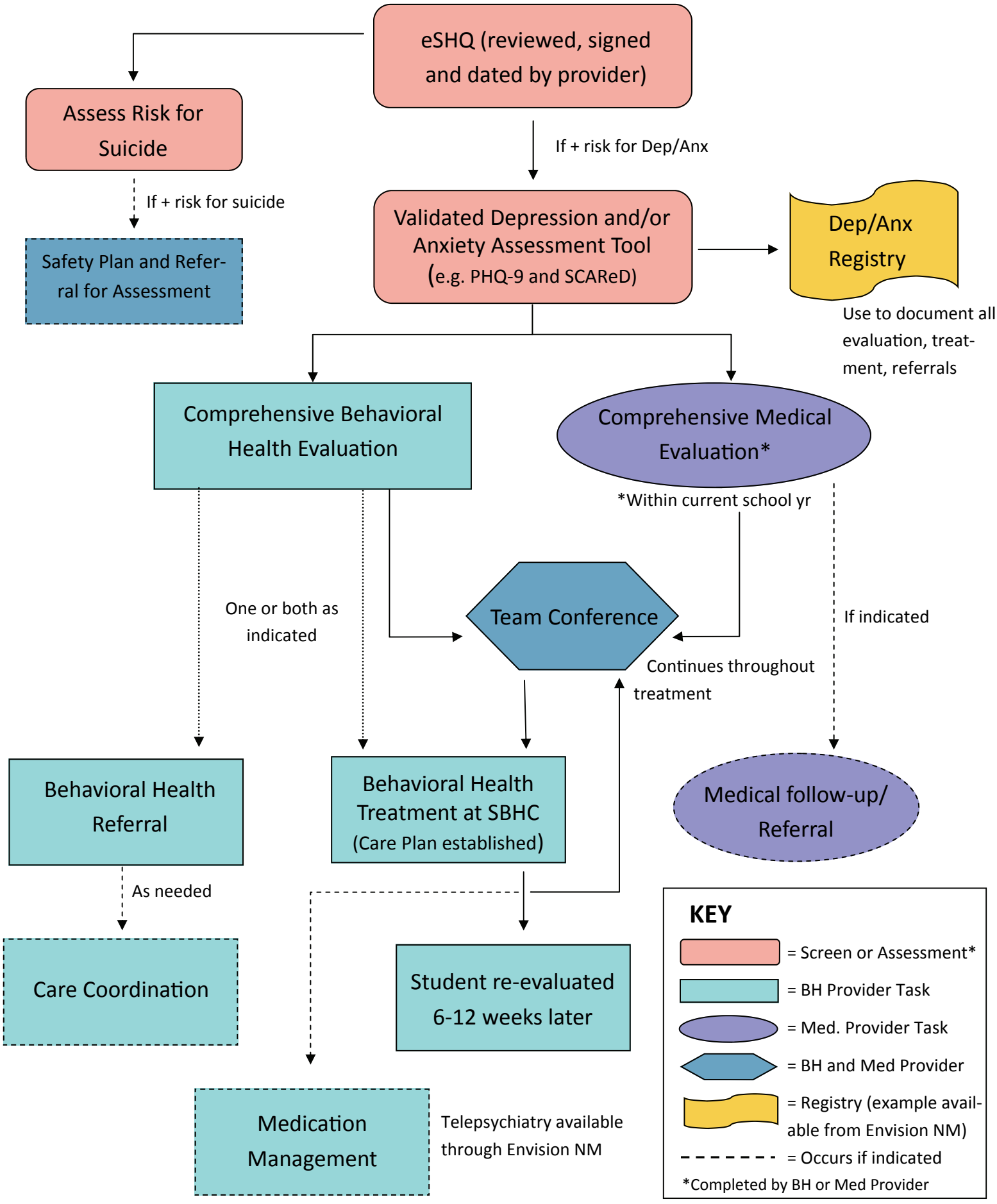
A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**.

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**.

NOTE: Items # 24, 25, 28,36, and 41 comprise the abbreviated 5-item scale.

Scale is scored on a scale from 0 to 2; 0 = not true or hardly ever true, 1 = sometimes true, and 2 = true or often true.

Depression/Anxiety Screening, Assessment, Treatment Best Practice Flow Chart



Chapter 6 –

Consent & Confidentiality

SECTION 1: MINORS' CONSENT & CONFIDENTIALITY FOR HEALTH CARE SERVICES

BACKGROUND

Consent is the legal term for agreeing to health care services. In order to consent to health care, an individual must be able to understand the condition and the risks and benefits of the treatment proposed by the provider.

Confidentiality is a requirement on health care provider to not release information about the patient except as allowed by law. Laws that affect minors' rights to confidentiality include HIPAA (healthcare settings), FERPA (educational settings), and state laws.

Under HIPAA, a parent/guardian generally has access to their child's medical records however exceptions are made when: **a) a minor consents to care and consent of parent not required under state law,** b) a minor obtains care at direction of a court, or c) a minor's parent/guardian agrees to confidential relationship (45 CFR § 164.502(g)).[17]

Minors (under age 18) in New Mexico have the right to consent without their parent's permission to certain health care services, including[18] :

- Sexual/Reproductive Health Care
  - STI testing/treatment
  - Contraception
  - Pregnancy testing, counseling and prenatal care

  ** For sexual/reproductive health care, New Mexico law specifically addresses consent to services and is silent as to confidentiality.*

- Mental Health Care
  - Therapy/counseling
  - Some medications
  - Alcohol/drug use support

  ** For mental health care, New Mexico law specifically addresses consent to services and is explicit as to confidentiality.*

- Medically necessary care for youth aged 14 or older who are living away from home or the parent of a child (Uniform Health Care Decisions Act)
  ** The Uniform Health Care Decisions Act in New Mexico specifically addresses consent to services and is silent as to confidentiality.*

- All health care for a minor parent's child

In alignment with the exception made under HIPAA, New Mexico providers generally take the position that **if the minor can consent for the service, then they have the right to confidentiality and control access to and disclosure of medical records for those services.** Though minors can consent for these services, some limitations exist. These are fully described in the resource attachment of this chapter.

RECOMMENDATIONS

- Providers should be cognizant of the laws, ensure patient confidentiality, and inform adolescents of their rights to consent and confidentiality.
    - In situations where the state law does not explicitly address confidentiality (ie. minor living away from home/parent of a child), providers must use judgement.
- When talking with your patients, clarify the laws and limits of confidentiality, explaining situations where confidentiality may have to be breached, such as in cases of reported abuse.
- Ensure there is a system in place within your sponsoring entity and/or electronic health record (EHR) to keep records from confidential visits separate from other records. It is critical that these records are records are not inadvertently released to a parent upon their request. However:
    - In New Mexico, parents/guardians of minors *may* have access to records for STI results in the event that they were to ask for the records, but it does not require release of records (§ 24-1-9.4 NMSA 1978) as long as doing so is consistent with the confidentiality policies of your practice.[18]
- Ensure clinic staff are also aware of how results for reproductive/sexual health visits will be delivered to ensure patient confidentiality.
- In the absence of contraindications, patient choice should be the principal factor in prescribing one method of contraception over another, and adolescents have the right to decline any method of contraception.

SECTION 2: CONSENT & CONFIDENTIALITY RESOURCES

Consent & Confidentiality Laws

Guttmacher Institute:
www.guttmacher.org/statecenter/adolescents.html

Pegasus Legal Services for Children (New Mexico):
www.pegasuslaw.org

Physicians for Reproductive Health
https://prh.org/teen-reproductive-health/minors-access-cards/minors-access-to-confidential-reproductive-healthcare-in-new-mexico/

INCLUDED RESOURCES

Minors' Consent for Services in New Mexico

Minors' Consent for Health Care Services in New Mexico

As addressed in the New Mexico Statutes Annotated (NMSA)

Under HIPAA (45 CFR § 164.502(g)), a parent/guardian generally has access to their child's medical records. However, an exception is made if the minor consents to care that does not require parental/guardian consent under state law. Most providers take the position that if the minor can consent for the service, then they have the right to confidentiality and control access to and disclosure of medical records for those services (as below).

§ 24-1-9 NMSA 1978 … Sexually transmitted disease

Any person regardless of age has the capacity to consent to an examination and treatment by a licensed physician for any sexually transmitted disease. *Test results for sexually transmitted diseases may be released to the subject's legally authorized representative, guardian or legal custodian upon request (NMSA § 24-1-9.4), but it is not required.*

§ 24-1-13.1 NMSA 1978 … Pregnancy

A health care provider shall have the authority, within the limits of his license, to provide prenatal, delivery and postnatal care to a female minor. A minor is presumed to have the capacity to consent to prenatal, delivery and postnatal care by a licensed health care provider.

§ 24-8-5 NMSA 1978 … Contraception

Neither the state… nor any health facility furnishing family planning services shall subject any person to any standard or requirement as a prerequisite for receipt of any requested family planning service…[exceptions do not address age of client].

§24-10-2 NMSA 1978 … Emergency Conditions

… in cases of emergency in which a minor is in need of immediate hospitalization, medical attention or surgery and the parents of the minor cannot be located for the purpose of consenting…after reasonable efforts have been made…, consent can be given by any person standing in locus parentis to the minor. But see also §24-7A-6.2 NMSA 1978 below

§32A-6A-14, 15 NMSA 1978 … Mental Health (including substance abuse) **[Rev. 2007]**

A child under the age of fourteen years may consent to initial assessment and early intervention services, limited to verbal therapy, not to exceed a two-week period. After the initial period, parental consent is required.

A child fourteen years of age or older has the right to consent to and receive individual psychotherapy, group psychotherapy, guidance counseling or other forms of verbal therapy and information regarding such counseling is confidential. A child fourteen years of age or older has the right to consent to psychotropic medication with notice to the parent/legal guardian. A child fourteen years of age or older has the exclusive right to consent to disclosure of their mental health records.

§24-7A-6.2 NMSA 1978 … Consent for Certain Minors Fourteen Years or Older (homeless youth or parent of a child)

An unemancipated minor fourteen years of age or older has the right to consent to and receive medically necessary health care - clinical and rehabilitative, physical, mental, or behavioral health services that are essential to prevent, diagnose or treat medical conditions. The minor must be living apart from the minor's parents/ legal guardian, or the parent of child. The healthcare must be provided within professionally accepted standards of practice and national guidelines.

For complete statutes, visit: http://www.nmonesource.com/nmnxtadmin/nmpublic.aspx Rev. July, 2016

REFERENCES

1 CDC 2014 NVSS Vol 64, Number 12, http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_12.pdf

2 US Dept. of Health and Human Services, Office of Adolescent Health. http://www.hhs.gov/ash/oah/adolescent-health- topics/reproductive-health/teen-pregnancy/

3 New Mexico Department of Health, Indicator-Based Information System for Public Health. http://ibis.health.state.nm.us

4 2013 New Mexico Youth Risk and Resiliency Survey. http://www.youthrisk.org/

5 AAP Committee on Adolescence. Contraception for adolescents. Pediatrics. 2014;134:e1244-e1256. https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/AAP-Updates-Recommendations-on-Teen-Pregnancy- Prevention.aspx

6 Adolescents and long-acting reversible contraception: implants and intrauterine devices. Committee Opinion No. 539. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012;120:983–8.

7 Myths and Misconceptions About Long-Acting Reversible Contraception (LARC). Russo, Jennifer A. et al. Journal of Adolescent Health , Volume 52 , Issue 4 , S14 - S21

8 U.S. Selected Practice Recommendations for Contraceptive Use. Centers for Disease Control and Prevention. 2013. http://www.cdc.gov/mmwr/pdf/rr/rr6205.pdf

9 CDC Vital Signs (2013). Preventing repeat teen pregnancies. http://www.cdc.gov/vitalsigns/teenpregnancy/

10 Office of Adolescent Health, New Mexico Adolescent Reproductive Health Facts. www.hhs.gov/ash/oah/adolescent-health-topics/reproductive-health/states/nm.html

11 AAP Committee on Adolescence and Committee on Early Childhood (2012). Care for adolescent patients and their children. Pediatrics,130(6):e1743-e1756.

12 Centers for Disease Control and Prevention. Taking a Sexual History. http://www.cdc.gov/std/treatment/sexualhistory.pdf

13 Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2010. MMWR 2010;59(No. RR-12):1-110. http://www.cdc.gov/std/treatment/2010/

14 Centers for Disease Control and Prevention. Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. MMWR 2006;55(No. RR-14): 1-. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm

15 APHL/CDC Expert Consultation Meeting Summary Report: Laboratory Diagnostic Testing for Chlamydia trachomatis and Neisseria gonorrhea. January 2009. Atlanta, GA; http://www.aphl.org/aphlprograms/infectious/std/Pages/stdtestingguidelines.aspx/2009

16 The Commission of Public Records, Administrative Law Division. New Mexico Administrative Code. http://164.64.110.239/nmac/parts/title07/07.004.0003.htm

17 45 CFR 164.502 - Uses and disclosures of protected health information: General rules. Cornell University Law School, Legal Information Institute. https://www.law.cornell.edu/cfr/text/45/164.502

18 New Mexico Compilation Commission. New Mexico Public Access Law- Statutes and Court Rule (unannotated). http://www.nmonesource.com/nmnxtadmin/nmpublic.aspx

[19] Pregnancy Options Counseling with Adolescents (2015). Adolescent Reproductive and Sexual Health Education Program (ARSHEP). Physicians for Reproductive Choice. https://prh.org/teen-reproductive-health/arshep-downloads/

[20] Caring for pregnant and parenting adolescents. Adolescent Reproductive and Sexual Health Education Program (ARSHEP). Physicians for Reproductive Health. https://prh.org/teen-reproductive-health/arshep-explained/

[21] Oral health care during pregnancy and through the lifespan. Committee Opinion No. 569. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013;122:417–22.

[22] Surround babies with protection. Pregnancy and whooping cough. Centers for Disease Control and Prevention (2015). http://www.cdc.gov/pertussis/pregnant/mom/protection.html

[23] AAP Section on Breastfeeding (2012). Breastfeeding and the use of human milk. Pediatrics,129(3):e827-e841.

[24] Sipsma, HL, Jones, KL, & Cole-Lewis, H (2014). Breastfeeding among adolescents mothers: A systematic review of interventions from high-income countries. Journal of Human Lactation, 31(2):221-229.

[25] Grassley, JS (2010). Adolescent mothers' breastfeeding social support needs. JOGNN (39): 713-722.

[26] O'Hara, MW & McCabe, JE (2013). Postpartum depression: Current status and future directions. Annual Review of Clinical Psychology, 9:379-407.

[27] Kleiber, BV & Dimidjian, S (2014). Postpartum depression among adolescent mothers: A comprehensive review of prevalence, course, correlates, consequences, and interventions. Clinical Psychology Science and Practice, 21:48-66.

[28] Reid, V & Meadows-Oliver, M (2007). Postpartum depression in adolescent mothers: An integrative review of the literature. Journal of Pediatric Health Care, 21(5):289-298.

[29] Venkatesh, KK, et al. (2014). Accuracy of brief screening tools for identifying postpartum depression among adolescent mothers. Pediatrics (133): e45-e53.

[30] Miller, E & Levenson, R (2013). Hanging out or hooking up: Clinical Guidelines on Responding to Adolescent Relationship Abuse. https://www.futureswithoutviolence.org/userfiles/file/HealthCare/Adolescent%20Health%20Guide.pdf

[31] Cappelletti, M., Gatimu, J., & Shaw, G (2014). Exposing Reproductive Coercion: A Toolkit for Awareness-Raising, Assessment, and Intervention. FWHC, NCADV, NOMAS. https://www.ncadv.org/files/RCtoolkit.pdf

[32] School-Based Health Center Improvement Project (2015). Right Place, Right Time: School-Based Health Centers Improve Care for Adolescents. https://www.colorado.gov/pacific/sites/default/files/School-Based%20Health%20Center%20Improvement%20Final%20Report%20February%202015_1.pdf

[33] *Counseling the adolescent about pregnancy options. AAP Committee on Adolescents (1998). Pediatrics, 101(5):e938-e940.*