

The Update is a bi-weekly web newsletter published by the Iowa Department of Public Health's Bureau of Family Health. It is posted the second and fourth week of every month, and provides useful job resource information for departmental health care professionals, information on training opportunities, intradepartmental reports and meetings, and additional information pertinent to health care professionals.

In this issue...

1 Eat and Play the 5-2-1 Way

2 December/January Edition of The Check-Up

2 Dr. Mariannette Miller-Meeks

2 2011 Iowa Governor's Conference on Public Health

3-7 Spotlight on Scott County Health Department

7 Healthy Lifestyles Conference

8 Delta Dental of Iowa Statewide Public Health Campaign

9 2011 Childhood Immunization Schedules

10 National Public Health Week

11 Calendar of Events

12 Directory

13-16 Additional Information

Eat and Play the 5-2-1 Way

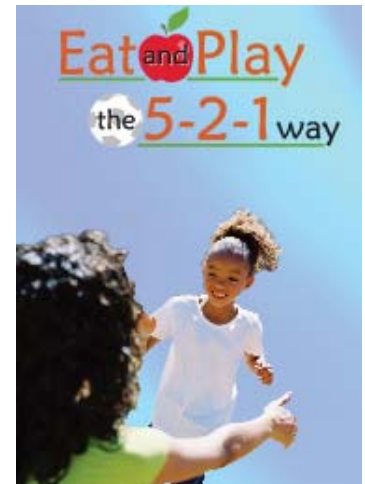
The Iowa Department of Public Health and Iowa Health Systems have collaborated to develop www.eatplay521.com, an online pediatric obesity prevention toolkit for Iowa health care providers.

Components of the toolkit include:

- free continuing education online module on motivational interviewing and supporting patients in health behavior change
- community resource referral link to "Find a Registered Dietitian in Your Area"
- brochures for patients and families centered around creative nutrition and physical activity ideas
- quick links to AAP recommendations on childhood obesity prevention
- "Kids, Teens and Families" link for you to give patients and families that includes tips on nutrition and physical activity, feeding picky eaters and eating healthy on a budget
- quick guide to Iowa provider reimbursement codes for overweight and obesity - *coming soon*

The goal of Eat and Play the 5-2-1 Way is to assist providers in addressing childhood overweight and obesity in the real-time clinical setting. Please pass this information along to colleagues, family and friends interested in decreasing childhood obesity in Iowa.

For more information, go to <http://www.eatplay521.com/index.html>.



December/January Edition of The Check-Up

The Check-Up is a monthly health care reform newsletter designed to keep interested Iowans up to date on the progress of health reform initiatives.

The Check-Up will feature updates on activities of the health reform councils as authorized by HF 2539 (2008) including the Legislative Health Care Coverage Commission, activities related to the Federal Patient Protection and Affordable Care Act (HR 3590), and other activities related to the focus of the councils.

The Check-Up will be archived on the main IDPH health care reform website at www.idph.state.ia.us/hcr_committees.

To view the December/January edition of The Check-Up, go to www.idph.state.ia.us/ldphArchive/Archive.aspx?channel=CheckUp.

IDPH Director - Dr. Mariannette Miller-Meeks, MD



Dr. Mariannette Miller-Meeks, MD, was appointed director of the Iowa Department of Public Health (IDPH) by Governor Terry Branstad in December 2010. With experience in both academic and practical medicine, as well as leadership roles in numerous medical and service organizations, Dr. Miller-Meeks understands the challenges of promoting and protecting the health of Iowans. Under Dr. Miller-Meeks' leadership, the department will work with the legislature, public health organizations, health care providers and the community to maintain and advance the health of all Iowans.

Dr. Miller-Meeks completed her undergraduate degree in nursing at Texas Christian University, master's degree education from University of Southern California, and her M.D. from The University of Texas Health Science Center before completing her specialization in ophthalmology. She served as the first woman president of the Iowa Medical Society, was the first woman on faculty in the Department of Ophthalmology at The University of Iowa, and was a councilor for Iowa to the American Academy of Ophthalmology. Dr. Miller-Meeks is a 24-year veteran of the United States Army, both active and reserve service, and retired after 24 years as a lieutenant colonel.

Dr. Miller-Meeks volunteered at a free medical clinic in Cedar Rapids helping families who have fallen on hard times and is also a CASA volunteer. She and her husband, Curt, have two adult children.

2011 Iowa Governor's Conference on Public Health

Registration is now open for the 2011 Iowa Governor's Conference on Public Health, April 5-6 the Scheman Conference Center in Ames.

To download a registration form, go to www.iowapha.org/Resources/Documents2011%20Iowa%20Governor's%20Conference%20on%20Public%20Health%20Conference%20Brochure.pdf.



Spotlight on: Scott County Health Dept.

How many state contracts does Scott County Health Department (SCHD) hold?

SCHD, located in Davenport, holds ten state contracts, including Breastfeeding Peer Counseling, Care for Yourself, EMS System Development, farmer's market, Grants to Counties, immunization services, lead, Local public health services, tobacco, and WIC.

How many programs does SCHD administer?

SCHD administers three programs - child health, dental health, the I-Smile™ program and subcontracts for the *hawk-i* program.

How many counties (rural/urban) does SCHD service in its various programs?

Scott County Health Department provides services for Scott County.

How many people does the SCHD employ?

Sixty.

A little history about SCHD ...and how long has SCHD been a Title V MH or CH contractor?

The City of Davenport Board of Health and the Scott County Board of Health merged in 1968 to become one. The SCHD was formed after this merger, in April of 1969, and has a 41 year history of service and is the health department for all of Scott County.

The newly formed SCHD assumed responsibility for many environmental and clinical related services in Scott County. As the need arose, the board of health adopted regulations for setting guidelines and enforcement procedures for public health programs.

More recently, the SCHD has realigned its operation to provide essential public health services as defined under the Core Public Health Functions. Along with Administrative Services, there are five service areas: Clinical; Community Relations, Information and Planning; Environmental; Correctional Health; and Public Health Services.

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Spotlight on Scott County Health Department *continued*

The SCHED is governed by the Scott County Board of Health, which consists of five members appointed by the Board of Supervisors. The five members include a clinical research coordinator, internal medicine physician, retired PhD nurse faculty member, pediatrician and a veterinarian.

SCHED became the Title V MCH provider for Scott County in 2000. The maternal health services were subcontracted to Edgerton Women's Health Center from 2000 until

September 30, 2010. The child health services were subcontracted to Community Health Care, Inc. from 2000 to 2008. Presently the SCHED operates the child health program, including Care for Kids, Early ACCESS, I-Smile™ and Dental Direct Services. The *hawk-i* component of the child health program is subcontracted to Community Health Care, Inc.



L to R: Edward Rivers (Executive Director); JaNan Less (Project Director, CH Coordinator); Teri Arnold (Fiscal); Tiffany Kennedy (CAREs Administrator)

What populations does SCHED serve?

Our child health program serves children birth through twenty years who live in Scott County. The majority of our clients are enrolled in Medicaid. While the children we serve live in Scott County, being a bordering community to Illinois means that families move back-and-forth between states. This movement can impact the continuity in delivering services to our clients.

The most common language spoken by our clients is English, followed by Spanish and Vietnamese. The majority of our clients are Caucasian, followed by African American and Asian. Approximately 63.8 percent of our clients have a medical home and 31.5 percent have a dental home.

What is a strength of the SCHED program, including any best practice(s)?

A particular strength of our child health program is the established relationship with partners in the community that enables us to link clients to needed services. Our child health consultants and I-Smile™ coordinator maintain lists of current resources to help meet the needs of our clients. The list includes physicians and dentists who accept new Medicaid clients, specialists who accept Medicaid, and food, clothing and heat assistance resources just to name a few. Not only do we refer to resources in our community, but many agencies refer to our program as well. In addition, our employees have established an excellent relationship with the school nurses. This relationship is important since often times school nurses are aware of the needs of their students and can work with our program staff to meet those needs.

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Spotlight on Scott County Health Department

continued

How has a family benefitted from a service provided by SCHD?

Families are being served on multiple levels through I-Smile™. Oral health education and promotion has given families clear and simple messages about how to assure oral health for their children and how to seek regular dental care. Barriers to dental care for children continue to exist. Once a family has made contact with the I-Smile™ coordinator, the process to overcome those barriers begins. This can be illustrated by the following story of one particular client who was served by our agency. (Real names are not used.)

Eight-year-old Hudson was referred to I-Smile™ by his school nurse who became concerned about the child's complaints of tooth pain and the presence of visible holes and dark spots on his teeth. The nurse called I-Smile™ and asked the I-Smile™ coordinator to call the parent.

The child's mother, Ilene, a seasonal construction worker and single mother is worried about Hudson's teeth, too. The family has no health or dental coverage, and money is tight. She tells the I-Smile™ coordinator that she has applied twice to **hawk-i** and been denied both times. Hudson's condition cannot wait for another application; he needs dental care now.

The I-Smile™ coordinator explained that he may be eligible for a Title V dental voucher. A dental voucher was issued to a local dentist who examined the child, prescribed an antibiotic, and let the I-Smile™ coordinator know that Hudson needed a pediatric dentist.

This gave mom and the I-Smile™ coordinator a little time to plan their next move. The I-Smile™ coordinator encouraged the mom to call **hawk-i** and find out why Hudson has been denied. If needed, the I-Smile™ coordinator can issue a dental voucher to a pediatric dentist.

In the next week, the I-Smile™ coordinator tried to call Ilene several times to no avail. A few weeks later she called. It turns out she has been working overtime and was away from her phone during business hours. She managed to call **hawk-i**, but the representative referred her to DHS. Hudson's mouth was starting to hurt again. A dental voucher was issued to a pediatric dentist and the child was seen right away. Another round of antibiotics was prescribed, and the pediatric dentist faxed over a copy of Hudson's treatment plan. It was enormous! Every tooth in his little mouth needed treatment. The cost was \$4,197. The I-Smile™ coordinator's heart sank. The dental voucher program could not cover it all. The I-Smile™ coordinator needed to figure out why **hawk-i** was denied.

Winter had come, and the seasonal construction work was gone. Ilene was not working, and unfortunately neither was her phone. The school nurse was able to help us get in touch once again. Ilene was overwhelmed by the cost of the treatment and she was ready to give up. Together, the I-Smile™ coordinator and Ilene made conference calls to both DHS and **hawk-i**. It turns out that someone had mistakenly entered the wrong denial code. Instead of being denied for Medicaid, and accepted for **hawk-i**, a code was entered that denied Hudson for both. The mistake was fixed and he was covered!

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There were still more bumps along the road. In the end, Hudson got the dental care he needed, but it required the full spectrum of available services. Without the I-Smile™ coordinator, Hudson's needs would likely still be unmet today.

A little about some of the MCH staff at SCHD ...

JaNan Less, (Community Health Coordinator/Project Director for MCH program): JaNan has served as the project director since October 2009 and is working to expand the services provided through Scott County's child health program. When JaNan isn't working, she enjoys spending time with family and friends, traveling and learning new things.

Brianna Huber, (Child Health Consultant): Brianna serves as a care coordinator for the child health program and has worked for SCHD for two years. Brianna is the lead consultant for community outreach and marketing activities for the *Care for Kids* program. Brianna is currently attending Western Illinois University in pursuit of a Master of Arts degree in Health Sciences with an emphasis in Public Health. In her spare time, Brianna enjoys softball, and working on her properties.

Kari Elmer (Child Health Consultant): Kari is also a child health consultant who serves as a care coordinator and has worked for SCHD for two years. She is an Early ACCESS service coordinator. Kari enjoys spending time with her family, reading and cooking.

Briana Boswell (Dental Hygienist): Briana has been a dental hygienist for nearly 12 years and I-Smile™ coordinator in Scott County since the program's onset, first at Community Health Care, Inc., and later at the SCHD. Briana enjoys biking, hiking and spending time with her husband and three children.

Teri Arnold (Administrative Office Assistant): Teri is the administrative office assistant for the SCHD. She has over 25 years of clerical experience. Teri manages the fiscal components of the department's contracts. Teri enjoys spending time with her grandkids, playing volleyball and tropical winter vacations.

Tiffany Kennedy (Community Health Consultant): Tiffany has been a community health consultant with the SCHD for a little over six years. She currently serves as the CARES Administrator, prepares the Fee for Service validation reports, and monitors the programmatic aspects of the child health grant. In her spare time, Tiffany likes to spend time with friends and family, watch movies, read and travel.

What are the two most effective strategies/best practices that have been used to improve children's oral health?

The first most effective and broad reaching strategies has been the development of the I-Smile™ Workgroup - a group of community partners that meets quarterly to discuss developments in children's oral health in Scott County. The group's collaboration has led to a series of partnerships that have resulted in new and innovative efforts to improve children's oral health in Scott County, including: trainings for medical and dental professionals, establishment of a dental voucher program and referrals network, and most recently the development of a volunteer dental hygiene workforce to assist with school dental screenings.

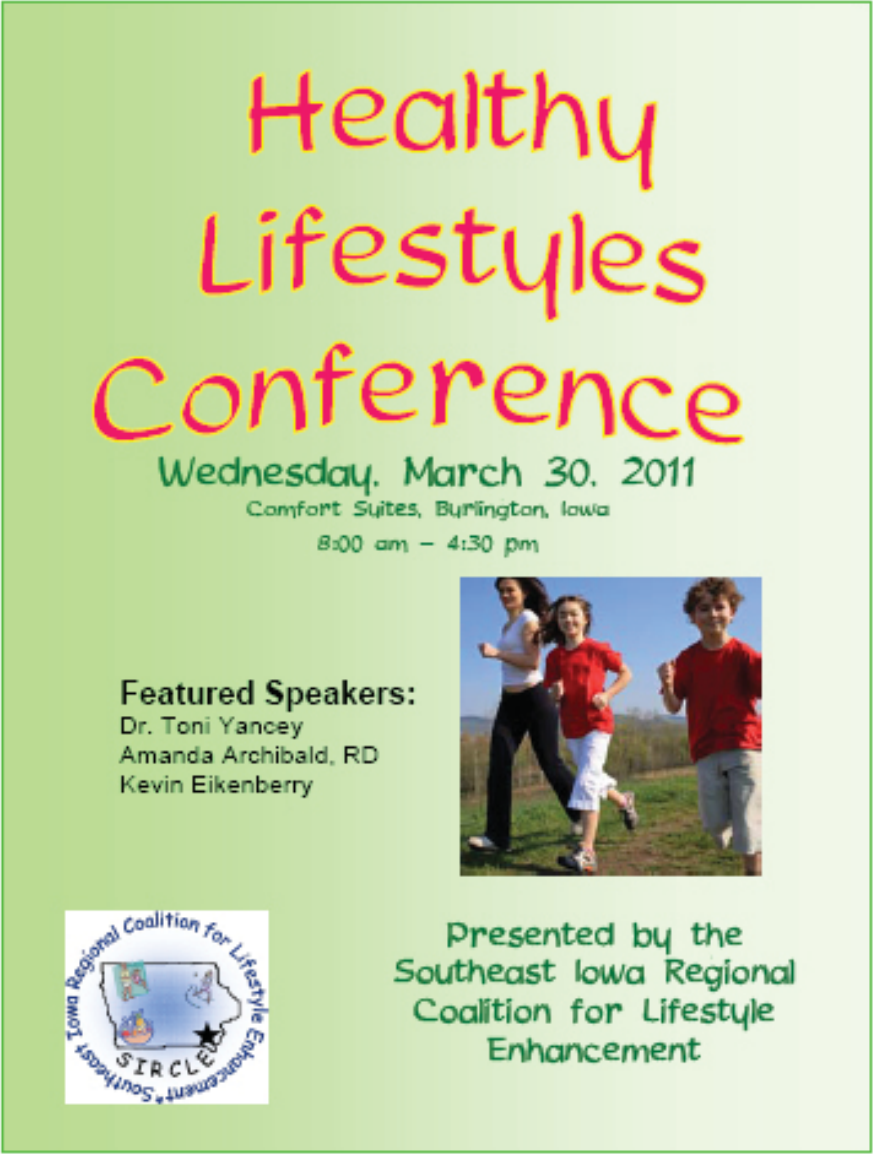
The second most effective strategy was the participation of our I-Smile™ coordinator in local Give Kids A Smile® activities. The I-Smile™ coordinator serves on the Give Kids A Smile® (GKAS) Board with local dentists. This opportunity provided a venue to to meet regularly and build relationships with the local dentists. As the GKAS

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program went through some changes and restructuring, SCHD was able to serve as a resource and support and in doing so, earned the trust of local dentists. GKAS participating dentists are now much more willing to accept I-Smile™ referrals throughout the year.

What is SCHD's greatest success with the I-Smile™ program?

The greatest success of the SCHD I-Smile™ program has been the ability to engage the community stakeholders to become part of the solution for meeting the oral health needs in Scott County. We are finding that dentists and dental hygienists are contacting our I-Smile™ coordinator to find out how they can play an active role in helping to address Scott County's oral health needs. As a county with a large population, it would be impossible to meet the oral health needs of our children without reaching out to other professionals as well. The relationships that have been established with physicians, school nurses, Head Start staff, early childhood workers, WIC clinics, Child Health Specialty Clinics, DHS and more has played a role in addressing our oral health needs. These partnerships provide the infrastructure necessary to build a safety net for assuring that Scott County children have access to a dental home.



The poster features a light green background with a thin green border. At the top, the title 'Healthy Lifestyles Conference' is written in a large, red, rounded font. Below the title, the date 'Wednesday, March 30, 2011' is in a smaller green font, followed by the location 'Comfort Suites, Burlington, Iowa' and the time '8:00 am - 4:30 pm'. On the left side, under the heading 'Featured Speakers:', the names 'Dr. Toni Yancey', 'Amanda Archibald, RD', and 'Kevin Eikenberry' are listed. To the right of the text is a photograph of three people (two women and one child) running in a grassy field. At the bottom left is the logo for the Southeast Iowa Regional Coalition for Lifestyle Enhancement, which includes a map of Iowa and the acronym 'SIRCLE'. At the bottom right, the text 'Presented by the Southeast Iowa Regional Coalition for Lifestyle Enhancement' is written in green.

Healthy Lifestyles Conference

Wednesday, March 30, 2011
Comfort Suites, Burlington, Iowa
8:00 am - 4:30 pm

Featured Speakers:
Dr. Toni Yancey
Amanda Archibald, RD
Kevin Eikenberry

Presented by the
Southeast Iowa Regional
Coalition for Lifestyle
Enhancement

Oral Health Recent Events

Delta Dental of Iowa Foundation Statewide Public Service Campaign Encourages Dental Visit by 1

Children in Iowa don't see their family dentist on average until they are 3 years old,¹ when in fact it's recommended that a child should go to the dentist by age 1 or within six months after the first tooth erupts.²

In honor of National Children's Dental Health Month in February, the Delta Dental of Iowa Foundation is kicking off "Dentist by 1," a statewide public service campaign to educate parents about the benefits of taking their children to the dentist by age 1 and to encourage them to schedule a visit.

As part of the campaign, the Delta Dental of Iowa Foundation is offering a free infant toothbrush* for children up to age 3 who have visited the dentist. Parents can complete a form at www.OralHealthIA.com to receive a toothbrush and be entered into a monthly drawing for a kids' Sonicare® toothbrush.

Delta Dental will also provide educational materials to Iowa hospitals, clinics, pediatricians and OB-GYN offices. The Delta Dental of Iowa Foundation's "Dentist by 1" campaign is supported by the Iowa Academy of Pediatric Dentistry, the Iowa Dental Association, the Iowa Department of Public Health, and University of Iowa College of Dentistry.

Visit www.OralHealthIA.com to view a special section dedicated to the importance of visiting the dentist by age 1 and for more tips on establishing good oral health habits for a lifetime of healthy smiles.

To request posters on the "Dentist by 1" campaign, please contact Cindi Neubauer at 515-261-5590 or send Cindi an e-mail at cneubauer@deltadentalia.com.

¹Delta Dental of Iowa 2010 Claims Data.

²American Academy of Pediatric Dentistry, the American Academy of Pediatrics and the American Dental Association.

* Infant toothbrushes will be given to the first 10,000 people who complete the form on the Delta Dental of Iowa website at www.OralHealthIA.com.



To view a Dentist by 1 poster, go to page 13 of The UPdate.

Administration/Program Management

2011 Childhood Immunization Schedules

The recommended immunization schedules for persons aged 0 through 18 years and the catch-up immunization schedule have been approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). See pages 14-16 of The Update to view the following three schedules released by the Centers for Disease Control and Prevention (CDC):

- Recommended Immunization Schedule for Person Aged 0 through 6 Years
- Recommended Immunization Schedule for Person Aged 7 through 18 Years
- Catch-up Immunization Schedule for Persons Aged 4 Months through 18 Years Who Start Late or Who are More Than 1 Month Behind

Changes in the immunizations schedules for 2011 include:

- Guidance has been added for the hepatitis B vaccine schedule for children who did not receive a birth dose.
- Information on use of 13-valent pneumococcal conjugate vaccine has been added.
- Guidance has been added for administration of 1 or 2 doses of seasonal influenza vaccine based upon the child's history of monovalent 2009 H1N1 vaccination.
- Use of tetanus and diphtheria toxoids, and acellular pertussis (Tdap) vaccine among children aged 7 through 10 years who are incompletely vaccinated against pertussis is addressed, and reference to a specified interval between tetanus and diphtheria toxoids (Td) and Tdap vaccination has been removed.
- Footnotes for the use of human papillomavirus (HPV) vaccine have been condensed.
- A routine 2-dose schedule of quadrivalent meningococcal conjugate vaccine (MCV4) for certain persons at high risk for meningococcal disease, and recommendations for a booster dose of MCV4 have been added.
- Guidance for use of Haemophilus influenzae type b (Hib) vaccine in persons aged 5 years and older in the catch-up schedule has been condensed.

To access the MMWR containing the schedule, go to www.cdc.gov/mmwr/preview/mmwrhtml/mm6005a6.htm.

The National Childhood Vaccine Injury Act requires that health-care providers provide parents or patients with copies of Vaccine Information Statements (VIS) before administering each dose of the vaccines listed in the schedules. Additional information is available from state health departments and from CDC at www.cdc.gov/vaccines/pubs/vis/default.htm.

Detailed recommendations for using vaccines are available from ACIP statements (at www.cdc.gov/vaccines/pubs/acip-list.htm) and the 2009 Red Book. Guidance regarding the Vaccine Adverse Event Reporting System form is available online at www.vaers.hhs.gov or by telephone (800-822-7967).

National Public Health Week April 4-10 “Safety is No Accident”

It only takes a moment for an injury to happen – a fall on a stair, a moment's glance away from the road, a biking or sports-related injury, a medication mix-up. But it also takes just a moment to protect against injuries and make communities safer. The potential for injury is all around us. Each year, nearly 150,000 people die from injuries, and almost 30 million people are injured seriously enough to go to the emergency room.

Injuries are not “accidents”, and we can prevent them from happening. Taking actions such as wearing a seatbelt, properly installing and using child safety seats, wearing a helmet and storing cleaning supplies in locked cabinets are important ways to proactively promote safety and prevent injuries.

For more than a decade, communities around the country have celebrated National Public Health Week each April by highlighting public health achievements and raising awareness of issues important to improving the public's health. Each year, the American Public Health Association (APHA), selects a different issue around which to rally together and focus efforts to protect the nation's health. During NPHW 2011, APHA will continue its broad vision to make America the healthiest nation in one generation by raising awareness of the importance of injury and violence prevention through this year's theme “Safety is No Accident: Live Injury-free.” During National Public Health Week 2011 – April 4 – 10, 2011, we can work to educate Americans that “Safety is No Accident.” Together, we can help Americans live injury-free in all areas of life: at work, at home, at play, in your community and anywhere people are on the move. We all need to do our part to prevent injuries and violence in our communities.

The American Public Health Association's 48-page National Public Health Week toolkit is now available at www.nphw.org/nphw11/pdf/2011NPHW_toolkit.pdf. The 2011 Partner Toolkit aims to help you get involved. In it you will find fact sheets, media outreach materials, suggested community events, legislative information, and resources to use throughout National Public Health Week. Start planning your NPHW event today!

Join us as we work together to create a safer and healthier nation.

Calendar

March 10, 2011

**MCH Advisory Council Meeting, 1-3 p.m., Iowa
Lutheran Hospital, Conference Room 1**

March 28-29, 2011

Maternal Nutrition and Breastfeeding Workshop

***April 5-6, 2011**

**2011 Iowa Governor's Conference on Public Health
Scheman Conference Center, Ames**

June 9, 2011

**MCH Advisory Council Meeting, 1-3 p.m., Iowa
Lutheran Hospital, Conference Room 1**

* Required meeting

FEBRUARY Contract Required Due Dates

15 - Due: Electronic
Expenditure Workbooks

30 - Export WHIS Records to
IDPH



THE UPdate



Bureau of Family Health: 1-800-383-3826

Teen Line: 1-800-443-8336

Healthy Families Line: 1-800-369-2229

FAX: 515-242-6013

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Area code is 515



Introduce your child to the dentist.

Before they can even say "Hello."

Here's a surprising fact: children should visit the dentist by age 1. In fact, before the first baby teeth even erupt, parents can take measures to help protect their little ones from the effects of dental disease.

Childhood dental disease ranks as the most common chronic condition among children – even though cavities are nearly 100% preventable.

Discover the small changes in dental habits – including visiting the dentist – that can have big effects on a child's oral health. Visit www.OralHealthIA.com to learn more.



Delta Dental of Iowa Foundation



Dentist By 1

Cavities are nearly **100% preventable.**

Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States • 2011

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

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B ¹		HepB	HepB				HepB					
Rotavirus ²			RV	RV	RV	RV ²						
Diphtheria, Tetanus, Pertussis ³			DTaP	DTaP	DTaP	DTaP	<i>see footnote³</i>	DTaP				DTaP
<i>Haemophilus influenzae</i> type b ⁴			Hib	Hib	Hib	Hib ⁴	Hib					
Pneumococcal ⁵			PCV	PCV	PCV	PCV	PCV				PPSV	
Inactivated Poliovirus ⁶			IPV	IPV			IPV					IPV
Influenza ⁷							Influenza (Yearly)					
Measles, Mumps, Rubella ⁸							MMR			<i>see footnote⁸</i>		MMR
Varicella ⁹							Varicella			<i>see footnote⁹</i>		Varicella
Hepatitis A ¹⁰							HepA (2 doses)				HepA Series	
Meningococcal ¹¹												MCV4

Range of recommended ages for all children

Range of recommended ages for certain high-risk groups

This schedule includes recommendations in effect as of December 21, 2010. 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. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations: <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967.

1. Hepatitis B vaccine (HepB). (Minimum age: birth)

At birth:

- Administer monovalent HepB to all newborns before hospital discharge.
- If mother is hepatitis B surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if HBsAg-positive, administer HBIG (no later than age 1 week).

Doses following the birth dose:

- The second dose should be administered at age 1 or 2 months. Monovalent HepB should be used for doses administered before age 6 weeks.
- Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg 1 to 2 months after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).
- Administration of 4 doses of HepB to infants is permissible when a combination vaccine containing HepB is administered after the birth dose.
- Infants who did not receive a birth dose should receive 3 doses of HepB on a schedule of 0, 1, and 6 months.
- The final (3rd or 4th) dose in the HepB series should be administered no earlier than age 24 weeks.

2. Rotavirus vaccine (RV). (Minimum age: 6 weeks)

- Administer the first dose at age 6 through 14 weeks (maximum age: 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
- If Rotarix is administered at ages 2 and 4 months, a dose at 6 months is not indicated.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). (Minimum age: 6 weeks)

- The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib). (Minimum age: 6 weeks)

- If PRP-OMP (PedvaxHIB or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
- Hiberix should not be used for doses at ages 2, 4, or 6 months for the primary series but can be used as the final dose in children aged 12 months through 4 years.

5. Pneumococcal vaccine. (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])

- PCV is recommended for all children aged younger than 5 years. Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
- A PCV series begun with 7-valent PCV (PCV7) should be completed with 13-valent PCV (PCV13).
- A single supplemental dose of PCV13 is recommended for all children aged 14 through 59 months who have received an age-appropriate series of PCV7.
- A single supplemental dose of PCV13 is recommended for all children aged 60 through 71 months with underlying medical conditions who have received an age-appropriate series of PCV7.

- The supplemental dose of PCV13 should be administered at least 8 weeks after the previous dose of PCV7. See *MMWR* 2010;59(No. RR-11).

- Administer PPSV at least 8 weeks after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant.

6. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)

- If 4 or more doses are administered prior to age 4 years an additional dose should be administered at age 4 through 6 years.
- The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.

7. Influenza vaccine (seasonal). (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])

- For healthy children aged 2 years and older (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used, except LAIV should not be given to children aged 2 through 4 years who have had wheezing in the past 12 months.
- Administer 2 doses (separated by at least 4 weeks) to children aged 6 months through 8 years who are receiving seasonal influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
- Children aged 6 months through 8 years who received no doses of monovalent 2009 H1N1 vaccine should receive 2 doses of 2010–2011 seasonal influenza vaccine. See *MMWR* 2010;59(No. RR-8):33–34.

8. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)

- The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.

9. Varicella vaccine. (Minimum age: 12 months)

- The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose.
- For children aged 12 months through 12 years the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

10. Hepatitis A vaccine (HepA). (Minimum age: 12 months)

- Administer 2 doses at least 6 months apart.
- HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A is desired.

11. Meningococcal conjugate vaccine, quadrivalent (MCV4). (Minimum age: 2 years)

- Administer 2 doses of MCV4 at least 8 weeks apart to children aged 2 through 10 years with persistent complement component deficiency and anatomic or functional asplenia, and 1 dose every 5 years thereafter.
- Persons with human immunodeficiency virus (HIV) infection who are vaccinated with MCV4 should receive 2 doses at least 8 weeks apart.
- Administer 1 dose of MCV4 to children aged 2 through 10 years who travel to countries with highly endemic or epidemic disease and during outbreaks caused by a vaccine serogroup.
- Administer MCV4 to children at continued risk for meningococcal disease who were previously vaccinated with MCV4 or meningococcal polysaccharide vaccine after 3 years if the first dose was administered at age 2 through 6 years.

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/recs/acip>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).

Recommended Immunization Schedule for Persons Aged 7 Through 18 Years—United States • 2011

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

Vaccine ▼	Age ►	7–10 years	11–12 years	13–18 years	
Tetanus, Diphtheria, Pertussis ¹			Tdap	Tdap	Range of recommended ages for all children
Human Papillomavirus ²	see footnote ²		HPV (3 doses)(females)	HPV series	
Meningococcal ³		MCV4	MCV4	MCV4	
Influenza ⁴			Influenza (Yearly)		Range of recommended ages for catch-up immunization
Pneumococcal ⁵			Pneumococcal		
Hepatitis A ⁶			HepA Series		Range of recommended ages for certain high-risk groups
Hepatitis B ⁷			Hep B Series		
Inactivated Poliovirus ⁸			IPV Series		
Measles, Mumps, Rubella ⁹			MMR Series		
Varicella ¹⁰			Varicella Series		

This schedule includes recommendations in effect as of December 21, 2010. 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. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations: <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967.

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).

(Minimum age: 10 years for Boostrix and 11 years for Adacel)

- Persons aged 11 through 18 years who have not received Tdap should receive a dose followed by Td booster doses every 10 years thereafter.
- Persons aged 7 through 10 years who are not fully immunized against pertussis (including those never vaccinated or with unknown pertussis vaccination status) should receive a single dose of Tdap. Refer to the catch-up schedule if additional doses of tetanus and diphtheria toxoid-containing vaccine are needed.
- Tdap can be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.

2. Human papillomavirus vaccine (HPV). (Minimum age: 9 years)

- Quadrivalent HPV vaccine (HPV4) or bivalent HPV vaccine (HPV2) is recommended for the prevention of cervical precancers and cancers in females.
- HPV4 is recommended for prevention of cervical precancers, cancers, and genital warts in females.
- HPV4 may be administered in a 3-dose series to males aged 9 through 18 years to reduce their likelihood of genital warts.
- Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).

3. Meningococcal conjugate vaccine, quadrivalent (MCV4). (Minimum age: 2 years)

- Administer MCV4 at age 11 through 12 years with a booster dose at age 16 years.
- Administer 1 dose at age 13 through 18 years if not previously vaccinated.
- Persons who received their first dose at age 13 through 15 years should receive a booster dose at age 16 through 18 years.
- Administer 1 dose to previously unvaccinated college freshmen living in a dormitory.
- Administer 2 doses at least 8 weeks apart to children aged 2 through 10 years with persistent complement component deficiency and anatomic or functional asplenia, and 1 dose every 5 years thereafter.
- Persons with HIV infection who are vaccinated with MCV4 should receive 2 doses at least 8 weeks apart.
- Administer 1 dose of MCV4 to children aged 2 through 10 years who travel to countries with highly endemic or epidemic disease and during outbreaks caused by a vaccine serogroup.
- Administer MCV4 to children at continued risk for meningococcal disease who were previously vaccinated with MCV4 or meningococcal polysaccharide vaccine after 3 years (if first dose administered at age 2 through 6 years) or after 5 years (if first dose administered at age 7 years or older).

4. Influenza vaccine (seasonal).

- For healthy nonpregnant persons aged 7 through 18 years (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used.
- Administer 2 doses (separated by at least 4 weeks) to children aged 6 months through 8 years who are receiving seasonal influenza vaccine for the first

time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.

- Children 6 months through 8 years of age who received no doses of monovalent 2009 H1N1 vaccine should receive 2 doses of 2010-2011 seasonal influenza vaccine. See *MMWR* 2010;59(No. RR-8):33–34.

5. Pneumococcal vaccines.

- A single dose of 13-valent pneumococcal conjugate vaccine (PCV13) may be administered to children aged 6 through 18 years who have functional or anatomic asplenia, HIV infection or other immunocompromising condition, cochlear implant or CSF leak. See *MMWR* 2010;59(No. RR-11).
- The dose of PCV13 should be administered at least 8 weeks after the previous dose of PCV7.
- Administer pneumococcal polysaccharide vaccine at least 8 weeks after the last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with functional or anatomic asplenia or an immunocompromising condition.

6. Hepatitis A vaccine (HepA).

- Administer 2 doses at least 6 months apart.
- HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, or who are at increased risk for infection, or for whom immunity against hepatitis A is desired.

7. Hepatitis B vaccine (HepB).

- Administer the 3-dose series to those not previously vaccinated. For those with incomplete vaccination, follow the catch-up schedule.
- A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB is licensed for children aged 11 through 15 years.

8. Inactivated poliovirus vaccine (IPV).

- The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
- 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.

9. Measles, mumps, and rubella vaccine (MMR).

- The minimum interval between the 2 doses of MMR is 4 weeks.

10. Varicella vaccine.

- For persons aged 7 through 18 years without evidence of immunity (see *MMWR* 2007;56[No. RR-4]), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
- For persons aged 7 through 12 years, the recommended minimum interval between doses is 3 months. However, 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.

The table 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

PERSONS AGED 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)		
Rotavirus ²	6 wks	4 weeks	4 weeks ²		
Diphtheria, Tetanus, Pertussis ³	6 wks	4 weeks	4 weeks	6 months	6 months ³
<i>Haemophilus influenzae</i> type b ⁴	6 wks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose) if first dose administered at age 12–14 months No further doses needed if first dose administered at age 15 months or older	4 weeks ⁴ if current age is younger than 12 months 8 weeks (as final dose) ⁴ if current age is 12 months or older and first dose administered at younger than age 12 months and second dose administered at younger than 15 months No further doses needed if previous dose administered at age 15 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months	
Pneumococcal ⁵	6 wks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose for healthy children) if first dose administered at age 12 months or older or current age 24 through 59 months 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 8 weeks (as final dose for healthy children) if current age is 12 months or older 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 months 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 wks	4 weeks	4 weeks	6 months ⁶	
Measles, Mumps, Rubella ⁷	12 mos	4 weeks			
Varicella ⁸	12 mos	3 months			
Hepatitis A ⁹	12 mos	6 months			
PERSONS AGED 7 THROUGH 18 YEARS					
Tetanus, Diphtheria/ Tetanus, Diphtheria, Pertussis ¹⁰	7 yrs ¹⁰	4 weeks	4 weeks if first dose administered at younger than age 12 months 6 months if first dose administered at 12 months or older	6 months if first dose administered at younger than age 12 months	
Human Papillomavirus ¹¹	9 yrs		Routine dosing intervals are recommended (females) ¹¹		
Hepatitis A ⁹	12 mos	6 months			
Hepatitis B ¹	Birth	4 weeks	8 weeks (and at least 16 weeks after first dose)		
Inactivated Poliovirus ⁶	6 wks	4 weeks	4 weeks ⁶	6 months ⁶	
Measles, Mumps, Rubella ⁷	12 mos	4 weeks			
Varicella ⁸	12 mos	3 months if person is younger than age 13 years 4 weeks if person is aged 13 years or older			

1. Hepatitis B vaccine (HepB).

- Administer the 3-dose series to those not previously vaccinated.
- The minimum age for the third dose of HepB is 24 weeks.
- A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB is licensed for children aged 11 through 15 years.

2. Rotavirus vaccine (RV).

- The maximum age for the first dose 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.
- If Rotarix was administered for the first and second doses, a third dose is not indicated.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).

- The fifth dose is not necessary if the fourth dose was administered at age 4 years or older.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib).

- 1 dose of Hib vaccine should be considered for unvaccinated persons aged 5 years or older who have sickle cell disease, leukemia, or HIV infection, or who have had a splenectomy.
- If the first 2 doses were PRP-OMP (PedvaxHIB or Comvax), and administered at age 11 months or younger, the third (and final) dose should be administered at age 12 through 15 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 final dose at age 12 through 15 months.

5. Pneumococcal vaccine.

- Administer 1 dose of 13-valent pneumococcal conjugate vaccine (PCV13) to all healthy children aged 24 through 59 months with any incomplete PCV schedule (PCV7 or PCV13).
- For children aged 24 through 71 months with underlying medical conditions, administer 1 dose of PCV13 if 3 doses of PCV were received previously or administer 2 doses of PCV13 at least 8 weeks apart if fewer than 3 doses of PCV were received previously.
- A single dose of PCV13 is recommended for certain children with underlying medical conditions through 18 years of age. See age-specific schedules for details.
- Administer pneumococcal polysaccharide vaccine (PPSV) to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant, at least 8 weeks after the last dose of PCV. A single revaccination should be administered after 5 years to children with functional or anatomic asplenia or an immunocompromising condition. See *MMWR* 2010;59(No. RR-11).

6. Inactivated poliovirus vaccine (IPV).

- The final dose in the series should be administered on or after the fourth birthday and at least 6 months following 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 following the previous dose.
- In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk for imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).

7. Measles, mumps, and rubella vaccine (MMR).

- Administer the second dose routinely at age 4 through 6 years. The minimum interval between the 2 doses of MMR is 4 weeks.

8. Varicella vaccine.

- Administer the second dose routinely at age 4 through 6 years.
- If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

9. Hepatitis A vaccine (HepA).

- HepA is recommended for children aged older than age 23 months who live in areas where vaccination programs target older children, or who are at increased risk for infection, or for whom immunity against hepatitis A is desired.

10. Tetanus and diphtheria toxoids (Td) and tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).

- Doses of DTaP are counted as part of the Td/Tdap series.
- Tdap should be substituted for a single dose of Td in the catch-up series for children aged 7 through 10 years or as a booster for children aged 11 through 18 years; use Td for other doses.

11. Human papillomavirus vaccine (HPV).

- Administer the series to females at age 13 through 18 years if not previously vaccinated or have not completed the vaccine series.
- Quadrivalent HPV vaccine (HPV4) may be administered in a 3-dose series to males aged 9 through 18 years to reduce their likelihood of genital warts.
- Use recommended routine dosing intervals for series catch-up (i.e., the second and third doses should be administered at 1 to 2 and 6 months after the first dose). The minimum interval between the first and second doses is 4 weeks. The minimum interval between the second and third doses is 12 weeks, and the third dose should be administered at least 24 weeks after the first dose.

Information about reporting reactions after immunization is available online at <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 immunization, is available from the National Center for Immunization and Respiratory Diseases at <http://www.cdc.gov/vaccines> or telephone, 800-CDC-INFO (800-232-4636).