SYHC SCHOOL READINESS INITIATIVE
ABSTRACT

PROJECT IDENTIFICATION:
Project Title: SYHC School Readiness Initiative
Project Number: H17MC07864
Project Director: Ed Martinez
Grantee Organization: San Ysidro Health Center
Address: 4004 Beyer Blvd., San Ysidro, CA, 92173
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Home Page: www.syhc.org
Total Amount of Grant Awarded: $246,508

PURPOSE OF PROJECT AND RELATIONSHIP TO SSA TITLE V MATERNAL AND CHILD HEALTH (MCH) PROGRAMS:

Many studies show that there are significant health disparities between Latino children and other ethnic groups, where Latino children are less likely to access healthcare services. Some of the common disparities we see in San Ysidro Health Center (SYHC)’s service area are low socio economic status, Spanish monolingual families, un-insured patients (some do not qualify for a health insurance program); these factors negatively impact young children and their ability to succeed in school. SYHC’s School Readiness Initiative (SRI), founded by Healthy Tomorrows, sought to offer basic health developmental and oral health screenings to children prior to school entry; in an attempt to identify any issues early enough to be successful in treating them.

GOALS AND OBJECTIVES:

The overarching goal of SYHC’s SRI is to help insure children living in SYHC’s catchment area enter school healthy and ready to learn. Specific objectives include:
1) Each year, provide (a) physical health screening, (b) oral health screening, and (c) developmental/behavioral screening to a minimum of 450 children, ages 3-5 years old, and residing in SYHC’s catchment area. 2) Each year, provide pediatric care coordination to 100% of children, ages 3-5 years old, with an “Urgent” referral from any of SYHC’s 4 South Region clinic sites or 2 mobile medical units. It is estimated this caseload will be approximately 100 children per year. 3) Each year, out of the children receiving pediatric care coordination services, ensure a minimum of 60% will adhere to their referral(s) for follow-up care.

METHODOLOGY:
The SRI (1) expands outreach screenings to include developmental screening; (2) enhances access to SYHC’s Pediatric Development Clinic; (3) provides pediatric care coordination services through a 1.0 FTE Pediatric Care Coordinator; (4) establishes “health care homes” for children; and (5) delivers parent education and outreach.

EVALUATION:
SYHC used a process and outcomes evaluation methodology to assess effectiveness of the project in attaining its goal/objectives. Quantitative data was obtained from several data sources including: 1) SYHC Practice Management Database (MegaWest); 2) iNet System (referrals); 3) PCC Database. Primary data collected include patient demographics, referral data, service utilization and health outcomes. Data was extracted from the respective data source, cleaned and analyzed. Performance indicators include (a) number of children 3-5 years old who receive all three screenings;
(b) number of children 3-5 years old with an urgent referral who received pediatric care coordination services; (c) number of children receiving pediatric care coordination services who adhere to their referrals for follow up care.

RESULTS/OUTCOMES:
SYHC's HTPCP provided an opportunity for the development of a program that produced many positive outcomes and lessons learned. Despite some challenges, the SRI attained all the stated goal and objectives. Since the inception of the project, 4,026 children, ages 3-5, received all three school readiness screenings (physical, oral and developmental), resulting in an average of 805 children screened annually, well above the target of 450. The PCC provided 1,112 patients with on-going case management, nearly 125% above the estimated 100 cases per year. Other outcomes include enhanced interdepartmental communication; improved in coordination and integration of developmental and oral health screenings; increased community awareness about the importance of critical screenings prior to school entry; and improvement in parents' ability to navigate the system of care.

PUBLICATIONS/PRODUCTS:
Key products developed by SRI staff include: (1) SRI flyer, developed in collaboration with parents in the community through focus groups, distributed among clinic sites and through mail to families of children (2) Child Health Record, a booklet with important information regarding health screenings, developmental stages, nutrition and emergency numbers. (3) Conference poster, presented at the 2011 American Academy

DISSEMINATION/UTILIZATION OF RESULTS:
HTPC program results and outcomes will be shared among SYHC pediatricians, members of the SRI Advisory Board and other community partners, such as Head Start and South Bay Community Services. Once additional funding is obtained, results and lessons learned from HTPCP will also serve for future reference and planning of expansion of PCC program.

FUTURE PLANS/SUSTAINABILITY:
Although the HTPC grant has ended, SYHC management recognizes the importance and value of the PCC position, and is committed to sustaining the current program via operations funding. Due to the high level of need to expand PCC services to include not only a greater number of kids age 0-5, SYHC will continue to pursue a variety of grant funding opportunities to assist in not only sustaining current PCC services, but also to expand.
## Final Report Narrative

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HTPC- SCHOOL READINESS INITIATIVE
FINAL REPORT NARRATIVE

PROJECT IDENTIFICATION
Project Title: SYHC School Readiness Initiative
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I. PURPOSE OF PROJECT AND RELATIONSHIP TO SSA TITLE V MATERNAL AND CHILD HEALTH (MCH) PROGRAMS

Significant health status disparities exist between Latino children and other race/ethnic groups in SYHC’s service area. Latino children are least likely to have a primary care provider while also experiencing a disproportionate impact of disabling conditions and developmental delays. These disparities, compounded by the low socio economic status, high uninsured rates, and cultural/linguistic barriers experienced by Latino families, negatively impact children’s school readiness. There is significant need for improved access to quality pediatric care, developmental screening and treatment, and care coordination.

SYHC’s Healthy Tomorrows grant supported the health center’s School Readiness Initiative (SRI). The overarching goal of SYHC’s SRI is to help insure children living in the SYESD catchment area enter school healthy and ready to learn. SYHC’s SRI aims to ensure all children residing in the health center’s San Diego County South Region
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catchment area receive the following 3 screenings, and any indicated follow-up/support services, prior to school-entry: Physical exam, Developmental Assessment, Oral Health Screening. The Healthy Tomorrows Partnership for Children (HTPC) federal grant funding directly supported a 1.0 FTE Pediatric Care Coordinator at San Ysidro Health Center. The HTPC Pediatric Care Coordinator (PCC) is responsible for conducting the care coordination / case management activities affiliated with SYHC’s SRI. In this capacity, the PCC works to increase access to care and improve quality health outcomes of high-need children; thus ensuring that these pediatric patients are accessing all necessary and support services to be school-ready.

The project was funded by the Special Projects of Regional and National Significance (SPRANS) demonstration project under Title V of the Social Security Act.

**American Academy of Pediatrics (AAP) – Local Chapter**

SYHC’s HTPC Program remains connected with the local chapter of the AAP by sending periodic updates regarding the health center’s HTPCP to the chapter management. In addition, SYHC’s Developmental/Behavioral Pediatrician, Dr. Beth Trevino, has provided CME lectures for the local AAP chapter and will continue to do so as requested. Further, SYHC’s Pediatricians are active members of the local AAP chapter.
State Title V

During SYHC's HTPCP duration, no specific needs arose to necessitate direct contact with California's State Title V program. However, San Ysidro Health Center, as a prominent provider of maternal and child health services in San Diego County's South and Central Regions, remains up-to-date on Title V programming and services.

II. GOALS AND OBJECTIVES:

SYHC's SRI aims to address the health disparities disproportionately experienced by Latino children by helping them to be healthy and ready-to-learn by school entry. The SRI increases access to both key preventive screenings and follow-up care for the low-income, Latino children living in SYHC's South Region catchment area. This is achieved via the following Goal and Objectives:

Goal: The overarching goal of San Ysidro Health Center (SYHC)'s School Readiness Initiative is to help insure children living in SYHC's catchment area enter school healthy and ready to learn.

This goal is accomplished by achieving the following three (3) Objectives:

1) Each year, provide a) physical health screening, b) oral health screening, and c) developmental/behavioral screening to a minimum of 450 children, ages 3-5 years old, residing in SYHC's catchment area.
2) Each year, provide pediatric care coordination to 100% of at-risk* children, ages 3-5 years old, with an “Urgent” referral from any of SYHC’s 4 South Region clinic sites or 2 mobile medical units (estimated at 100 per year).

3) Each year, out of the children receiving pediatric care coordination services, ensure a minimum of 60% will adhere to their referral(s) for follow-up care.

4) The percentage of patients, 3-5 years old, who receive all three screenings will increase by 5% each year.

* In 2008, a priority ranking system was developed for the PCC program due to the high number of referrals. Eligible children are those who: meet the criteria of “high risk” conditions (i.e. down syndrome, developmental delays, etc.); those who receive services at any of SYHC’s south region clinic sites or 2 mobile medical units.

III. METHODOLOGY:

In order to attain the goal and objectives of the SRI Program, there was a high level of coordination and collaboration with the San Ysidro Elementary School District, the South County Special Education Local Planning Area (SC-SELPA) and various SYHC departments including Dental; Pediatrics; Research and Health Promotion and related programs such as Women, Infant and Children (WIC) program and Healthy Steps mobile health program.

The intervention consisted of the following components: (1) the expansion of developmental screenings within the current menu of physical and oral health screenings for children ages 3-5; (2) referrals to SYHC’s Developmental/Behavioral Pediatrician; (3) pediatric care coordination for children with identified physical, dental or
developmental/behavioral health conditions; (4) access to a pediatric “health care home” for on-going preventive and primary care services; (5) parent outreach and education. Each of these components and the activities and services provided are described below.

Integration of Health Screenings
A priority of SYHC was to integrate developmental screenings to routine Well Child (WC) exams so that every child between the ages of 3-5 is screened. Ongoing trainings are offered to SYHC providers (in addition to CME) by our Behavioral and Developmental specialist, to ensure any delays in development are properly identified and referred to the appropriate service. With respect to school-readiness, this integration specifically involves the PCC to work with Pediatrics, Pediatric Dental, and Developmental Pediatrics to ensure children in this age range receive all 3 of these essential services prior to school-entry. In May of 2009, these departments became co-located at the new Maternal and Child Health Center (MCHC) in order to facilitate access to these services for families, where they can easily find the health and support services they need in a convenient location.

Developmental/Behavioral Pediatrics
Children with suspected developmental conditions/delays are referred to the MCHC Pediatric Development Department where they are examined by the health center’s Developmental/Behavioral Pediatrician, Dr. Beth Trevino, a program supported by another 5-year Healthy Tomorrows grant that started in 2011. The children that Dr.
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Trevino diagnoses with developmental conditions (i.e., speech and language, hearing, fine or gross motor impairment, etc.) are referred to an appropriate treatment site. The PCC tracks parent/child referrals and assist parents as necessary to ensure the family/child accesses services successfully and follows-up with recommended treatment.

Because there is high demand for developmental and behavioral specialty services, SYHC staff has worked to increase access to our Pediatric Development Clinic from outside of the center. SYHC developed a unique referral system for the local school district, where school officials are able to fax referrals directly to the SYHC Referrals Department who in turn enters all the necessary information into the web-based iNet Referral System for appointment scheduling and follow-up by the PCC if the child meets the "at-risk" eligibility criteria.

**Pediatric Care Coordination**

The HTCP grant directly funds one full-time Pediatric Care Coordinator (PCC) to oversee the SRI. The PCC's primary role is to conduct care coordination/case management activities affiliated with the SRI which focuses on children, ages 3-5; however, she also provides services to children older and younger depending on urgency. In this capacity, the PCC works to increase access to care and improve the quality health outcomes of children (ages 0-18) diagnosed with developmental conditions, other serious health conditions, and/or those children who the pediatrician feels may need additional assistance to ensure that these pediatric patients are

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accessing all necessary screenings and support services to be school ready. The PCC assists parents to navigate the health care system by helping them to obtain supportive services to reduce barriers to care such as language, transportation, educational level, etc.

**Establishment of “Health Care Homes”**

Establishing a “health care home” for all pediatric patients is important for continuity of care. In order to ensure that children receive the necessary screening, treatment and support prior to school entry and beyond, SYHC established a protocol to identify and assign all pediatric patients without a regular Primary Care Physician (PCP) to a SYHC provider. Children are identified through the Healthy Steps mobile health program which provides health screenings, education and public benefit assistance at various community events and locations. The PCC also identifies patients along with any siblings that may not have a PCP.

**Outreach, Education & Screenings**

Outreach, education and screenings are currently performed at four satellite clinic sites in the South Region of San Diego (San Ysidro, National City, Chula Vista and Otay) and SYHC’s Healthy Steps mobile medical units. The Healthy Steps program provides health screenings and education to children/families at various community locations on a weekly basis. The SYHC Dental Department also coordinates with the mobile medical units to provide dental screenings. Children with potential developmental issues are referred to Dr. Trevino who conducts additional developmental
screenings/assessments. In addition to the outreach and screening activities provided by the clinic sites and mobile medical units, the PCC also conducts outreach and education with families, community organizations and the school district.

**Advisory Board Activities**

To ensure the SRI's methodologies are community- and family-centered, SYHC followed through with a HRSA recommendation (2009 Site Visit Performance Report) to establish and maintain an Advisory Board. The SRI Advisory Board meets quarterly, engaging in discussion and providing recommendations on activities and policies related to the SRI. Current members of the Community Advisory Board include parents; SYHC staff (PCC and Developmental/Behavioral Pediatrician); and three learning and development staff from the San Ysidro Elementary School District.

Since the grant has ended, SYHC has decided to continue this previously established Advisory Board; to serve the purpose of the Healthy Tomorrow's SYHC Pediatric Development Clinic Grant. Minimal changes to this new board will be made.

**IV. EVALUATION:**

The evaluation plan for the SRI has evolved over the years to ensure that objectives and measures are relevant, appropriate and realistic. During HTPC FY 2008, SYHC hosted the American Academy of Pediatrics for the HTPC Technical Assistance Site Visit (June 3, 2008). Based on recommendations by AAP, SYHC did revise the
Evaluation Plan to include more appropriate measures. In 2009, objectives were slightly changed again based on additional guidance by HRSA during a site visit.

SYHC used a process and outcomes evaluation methodology to assess effectiveness of the project. Quantitative data was obtained from several data sources including: 1) SYHC Practice Management Database (MegaWest); 2) iNet System (referrals); 3) PCC Database. Primary data collected include patient demographics, referral data, service utilization and health outcomes. Data was extracted from the respective data source, cleaned and analyzed on a monthly, bi-monthly and annual basis. Table 1 indicates the objectives, indicators and data sources used to evaluate the project.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Indicators</th>
<th>Data Source</th>
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<tbody>
<tr>
<td>1. Each year, provide a) physical health screening, b) oral health screening, and c) developmental screening to a minimum of 450 children, ages 3-5 years old, residing in SYHC's catchment area.*</td>
<td>Number of children, 3-5 years old, who received all 3 screenings</td>
<td>PCC Database, SYHC Practice Management System (MegaWest)</td>
</tr>
<tr>
<td>2. Each year, provide pediatric care coordination to 100% of eligible children, ages 3-5 years old, with an &quot;Urgent&quot; referral from any of SYHC's 4 South Region clinic sites or 2 mobile medical units.**</td>
<td>Number of eligible children, 3-5 years old, with Urgent Referrals, who received pediatric care coordination services</td>
<td>PCC Database, iNet Referral System</td>
</tr>
<tr>
<td>3. Each year, out of the children receiving pediatric care coordination services, ensure a minimum of 60% will adhere to their referral(s) for follow-up care.***</td>
<td>Number of case managed patients, ages 3-5 years old, who adhered to one or more referral</td>
<td>PCC Healthcare Access Tracking Tool, SYHC Practice Management System (MegaWest), EHR system for Children's Hospital of San Diego</td>
</tr>
</tbody>
</table>

*Revised in FY 2008  
**Revised in FY 2008  
***Revised in FY 2008, 2009  
San Ysidro Health Center, Inc
V. RESULTS/OUTCOMES

Introduction

The following section provides annual and year-to-date (YTD) results for the SYHC School Readiness Initiative for the project period: 3/1/2007 – 2/29/2012. As illustrated below, results demonstrate that the project did achieve its goals and objectives by increasing access to care and improving health outcomes of children ages 3-5 years old through screening, outreach and promotion; and integration of services.

As mentioned previously, the evaluation plan was revised several times due to the unanticipated challenges that limited the program’s ability to meet objectives each year. Site visits from the American Academy of Pediatrics (2008) and HRSA (2009) resulted in recommendations to modify objectives and measures based on these challenges which included 1) staffing of the PCC position; 2) difficulty establishing contact with referred and active case managed patients and families; 3) low health literacy and ability to overcome barriers 4) competing priorities among the parents of PCC patients and 5) high demand of PCC services. Nonetheless project staff overcame obstacles by developing and implementing innovative solutions which are described in further detail on page 17 in the Lessons Learned section.

PCC Caseload

As illustrated in Table 2, the PCC provided care coordination/case management services to a total of 1,359 pediatric patients (0-18 years old) during the project period; however, the PCC was unable to establish a care plan for 247 children resulting in

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1,112 patients who received on-going case management (nearly 125% above the estimated 100 cases per year). Of the 1,112 patients provided with case management, 204 patients, ages 3-5, with "Urgent" referrals received case management services.

| Table 2. PCC Care Coordination/Case Management Caseload |
|---------------------------------|---|---|---|---|---|---|
| Patients (0-18 years)          | Y1| Y2| Y3| Y4| Y5| YTD |
| 159                            | 174| 64| 65| 81| 543 |
| Patients (3-5 years)           | 87| 121| 63| 43| 51| 365 |
| Urgent Patients (3-5 years)    | 0| 2| 19| 62| 121| 204 |
| Unable to Establish Contact     | N/A| N/A| 10| 119| 118| 247 |
| (Inactive)                      |   |   |   |   |   |    |
| TOTAL                           | 246| 297| 156| 289| 371| 1,359 |

Demographics/Insurance Status

In FY 2010, HRSA required the collection of race/ethnicity and insurance status of patients served through the SRI. As shown in Table 3 and 4, the PCC collected information on a total of 506 active patients. Of the 506 served by the PCC, 477 were primarily Latino children and nearly 70% had Medi-Cal and Healthy Families health coverage.

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<thead>
<tr>
<th>Table 3. PCC Patient Demographics</th>
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<tr>
<td>Ethnicity</td>
</tr>
<tr>
<td>CHSCN Infants, Children &amp; Youth</td>
</tr>
<tr>
<td>Served</td>
</tr>
<tr>
<td>Infants (&lt; 1 year)</td>
</tr>
<tr>
<td>Children &amp; Youth 1-25 years</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>

San Ysidro Health Center, Inc.
### Table 4. PCC Patient Insurance by Age

<table>
<thead>
<tr>
<th>CSHCN Infants, Children and Youth Served</th>
<th>(a) Number Served</th>
<th>(b) Total Served</th>
<th>(c) Title XIX %</th>
<th>(d) Title XXI %</th>
<th>(e) Private/Other %</th>
<th>(f) None %</th>
<th>(g) Unknown %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants &lt; 1 year</td>
<td>21</td>
<td>21</td>
<td>53%</td>
<td>14%</td>
<td>0%</td>
<td>33%</td>
<td>0%</td>
</tr>
<tr>
<td>Children/Youth 1 to 25 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12-24 months</td>
<td>30</td>
<td>485</td>
<td>68%</td>
<td>8%</td>
<td>3%</td>
<td>19%</td>
<td>3%</td>
</tr>
<tr>
<td>25 months - 4 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5-9</td>
<td>188</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>10-14</td>
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<td>15-19</td>
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<td>20-24</td>
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<tr>
<td>TOTAL</td>
<td>506</td>
<td>506</td>
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</tr>
</tbody>
</table>

### Goal/Objectives

Despite some unexpected challenges, **the SRI was successful in meeting its goal and project objectives.** Since the inception of the project, **4,026 children, ages 3-5, received all three school readiness screenings (physical, oral and developmental) resulting in an average of 805 children screened annually, well above the target of 450.** Of the children, ages 3-5 years old with an “Urgent Referral”, that the PCC was able to contact, **100% received PCC services. Objective three was met with an annual average of 69% (target was 60%) of children, ages 3-5, who adhered to their referrals.**

**Table 5** provides annual and YTD project results for each objective. Due to the revisions of the evaluation plan (2008 and 2009) and varying data collection processes used by the PCC’s, an accurate comparison of annual data could not be done and thus caution should be taken when interpreting results.
Key Results Include:

**Table 5. Process and Outcome Objectives**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Process</th>
<th>Y1</th>
<th>Y2</th>
<th>Y3</th>
<th>Y4</th>
<th>Y5</th>
<th>YTD/AVG</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Each year, provide a) physical health screening, b) oral health screening, and c) developmental/behavioral screening to a minimum of 450 children, ages 3-5 years old, residing in SYHC’s catchment area.</td>
<td></td>
<td>485</td>
<td>776</td>
<td>663</td>
<td>1,167</td>
<td>935</td>
<td>4,026</td>
</tr>
<tr>
<td>2. Each year, provide pediatric care coordination to 100% of eligible children, ages 3-5 years old, with an “Urgent” referral from any of SYHC’s 4 South Region clinic sites or 2 mobile medical units.</td>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>3. Each year, out of the children receiving pediatric care coordination services, ensure a minimum of 60% will adhere to their referral(s) for follow-up care.</td>
<td></td>
<td>N/A*</td>
<td>N/A*</td>
<td>78%</td>
<td>75%</td>
<td>54%</td>
<td>69%</td>
</tr>
</tbody>
</table>

*This objective was developed in FY 2008 and therefore not tracked prior to then.

**Health Outcomes**

Between March 1st 2007 and February 29 2012, a total of 1,112 pediatric patients received case management services. The primary presenting issue for case managed patients was developmental (32%), followed by oral health (20%) and mental health (19%).

Table 6 lists the referral reasons for *all* pediatric patients. Note that the total number does not equal number of cases as patients can have more than one presenting issue.

Of the 3-5 year old patients served by the PCC program, the most prevalent reasons for receiving care coordination were Developmental issues (53%) and
Oral health issues (23.1%).

<table>
<thead>
<tr>
<th>Table 6. Health Referral Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral Type</td>
</tr>
<tr>
<td>Developmental Issues</td>
</tr>
<tr>
<td>Mental/Behavioral Health</td>
</tr>
<tr>
<td>5-12 years old, Overweight/Obese</td>
</tr>
<tr>
<td>&lt; 5 years old, Overweight/Obese</td>
</tr>
<tr>
<td>Identified as premature birth</td>
</tr>
<tr>
<td>Oral Health</td>
</tr>
<tr>
<td>Ophthalmology/optometry</td>
</tr>
<tr>
<td>Seizure disorders</td>
</tr>
<tr>
<td>Those with multiple (significant) diagnoses</td>
</tr>
<tr>
<td>&quot;Other&quot;</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
</tr>
</tbody>
</table>

In addition to ensuring the receipt of the aforementioned school-readiness screenings and any indicated follow-up, the care coordination also resulted in a variety of other significant, positive healthcare access outcomes for the pediatric patients and families served. **Table 7** illustrates the results of an analysis done by reviewing records of all closed cases.

<table>
<thead>
<tr>
<th>Table 7. Healthcare Access Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome (Child)</td>
</tr>
<tr>
<td>Lost to follow-up prevented</td>
</tr>
<tr>
<td>Families able to navigate/get necessary care (with minimal PCC assistance, once information was provided)</td>
</tr>
<tr>
<td>Missed appointments prevented</td>
</tr>
<tr>
<td>Primary Care Physician appointment adhered to</td>
</tr>
<tr>
<td>Medical complications prevented</td>
</tr>
<tr>
<td>Child Development Clinic appointment adhered to</td>
</tr>
<tr>
<td>Enrolled into health insurance program</td>
</tr>
<tr>
<td>Referred to community agency</td>
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</table>
Other Outcomes

There were several project outcomes that have had a significant impact on the readiness of children, ages 3-5, in the South Region of San Diego. Key outcomes are described below.

System/Service Delivery Changes

In May 2009, SYHC’s Maternal and Child Health Center (MCHC) opened its doors allowing for integration of women and children’s health services. MCHC offers Pediatric Dentistry, Pediatric Care, Developmental Services, OB/GYN, WIC services, and a Family Resource Center in one building. The co-location of these services provided the SRI staff with the opportunity to develop close working relationships with all departments. The integration of child health and development screenings began with education and referrals. SYHC’s past HTPC Project Director (Ms. Keir) helped develop an SYHC Program Directory that had program descriptions and contact information about family programs offered within SYHC including the SRI/PCC services. Presentations were conducted at clinic staff meetings that resulted in increased staff awareness regarding SYHC’s variety of services which allowed for better patient education regarding importance of key screenings, availability of services, eligibility and access information. As a result, SYHC family programs and services are in high demand.

Prior to SRI, SYHC did not have a standardized tool to screen for developmental issues.
However, in 2008 the Parents’ Evaluation of Developmental Status (PEDS) tool was implemented by SYHC pediatric physicians. Through ongoing provider education and training by the Developmental/Behavioral Pediatrician, all SYHC pediatric physicians administer developmental screenings at every Well Child visit. All physicians are updated on changes to developmental services and available community resources.

Since June 2009, SYHC’s PCC and pediatric dental department started collaborating closely, to help identify young patients with high risk for oral health issues. Any young child (0-5 years) identified as high risk for dental problems through our Oral Health Initiative (OHI) assessment, are now referred to the PCC for follow up.

**Collaboration**

SYHC has been able to build and maintain a strong collaborative relationship with the local school district (SYSD) and over 10 community organizations, County agencies and hospitals. In 2009, a referral process was developed that allowed two SYSD schools (Beyer elementary and Willow elementary) to make direct referrals to our Referrals Department. This system has enabled school officials to notify the SYHC and PCC about children who were identified as needing dental, medical or developmental services rather than solely leaving the responsibility to the family to navigate the system of care, a barrier that results in delayed care or inaction.

The SRI Advisory Board has also helped develop stronger partnerships between SYHC staff, pediatricians, SYSD schools and families. Through on-going communication and
collaboration, the Board has been able to accomplish many of its goals including 1) Changes to the SYHC Well Child Exam Form that collects information required by the school district 2) development of a SRI flyer designed to educate families about the importance of the three screenings and to motivate them to have these done before their children’s school entry. The flyer was distributed to schools, SYHC clinic sites and community organizations. In addition, the flyer was also mailed out to the parents of 3-5 year old patients who were missing any one of the three screenings 3) Increased SYHC presence at the schools where the PCC participated in Back-to-School Open Houses and presents information on SYHC services and resources 4) grant partnership opportunities.

Lessons Learned

Over the five year project period, the SRI experienced some setbacks and challenges that resulted in many lessons learned. Key challenges included staffing the PCC position; establishing contact with referred patients; factors impacting family adherence to referral follow-up appointments; and inability to provide PCC services to every child in need. Despite these challenges, however, SYHC was able to overcome most of them and continues to come up with innovative ways to address them. SYHC’s SRI distinguishes itself by leveraging resources, establishing partnerships and integrating necessary child health screenings.
Since its 2007 inception, SYHC’s SRI has yielded many key lessons learned:

1) Clear and user friendly protocols can guide effective collaboration within SYHC, and between SYHC and other Community Based Organizations (CBO).

2) The proactive and innovative bridging of interdisciplinary fields (i.e. healthcare and education) is a creative way of reaching vulnerable children.

3) Establishment of an efficient referral process between SYHC and the local school district allows school staff to refer a child in-need of health services to SYHC – increasing access to care and ensuring timely communication between the clinic and school.

4) Development of clear, culturally-appropriate pediatric case management principles, practices and procedures help to ensure that SYHC’s high-risk/need children are being cared for; increasing their school-readiness and improving their overall life course.

5) Collaboration and coordination among CBOs facilitate necessary exchange of information, sharing of resources and creation of a cooperative safety net.
6) Patient and family centered: Success of the program requires a focus on immediate medical needs and family’s social issues (e.g. housing, food or financial difficulties).

7) Empowerment- Critical to improving access to care and long-term behavior change is empowerment of parents and children through education and assistance in the navigation of the health care system.

8) Continuing education for staff - Ongoing provision of information and trainings regarding customer service, child health, patient navigation and other topics help staff provide patients with quality care in a respectful and effective manner.

In addition to the key lessons outlined above, there were several specific challenges that the PCC program experienced. However, SYHC worked diligently to find creative and sustainable solutions to issues impacting the program. The PCC, Michelle Favela works extremely hard to address and reduce barriers for families. Several key challenges and the solutions developed for each are described below:

*Loss to Follow-Up/Adherence*

One key challenge for the PCC was establishing and maintaining communication with patient families. Many families don’t have a stable home or contact phone number, thus making it difficult for the PCC to follow-up on referrals or case management activities. In order to mitigate this time intensive task, a policy was developed. The PCC attempts to
contact the patient's family three times (phone calls). If no response, the PCC will then send a letter. If the PCC does not receive a response within 2 weeks, the case is closed.

Adherence is another challenge that is common with our patient population. For many, competing priorities, transportation, lack of understanding about the importance of screening children before school entry and other access problems are the main reasons for not following through with referrals or attending appointments. Key to the success of the program has been the development of the theoretical framework described in Table 6 that was developed to guide the delivery of services.

<table>
<thead>
<tr>
<th>Table 6. PCC Principles and Practices</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Define PCC function to parents</td>
<td>It is important to clarify role of the PCC for parents as one of support and assistance not of medical or therapeutic nature.</td>
</tr>
<tr>
<td>Educate and empower parents</td>
<td>Key to long-term behavior change and improved outcomes is parent education and empowerment. A goal of the program is to improve their knowledge and ability to navigate the system of care.</td>
</tr>
<tr>
<td>Patient and family centered</td>
<td>Children are primary focus but it's also important to address the needs of the family unit as they relate to the child's well being.</td>
</tr>
<tr>
<td>Overcome barriers</td>
<td>The PCC works with parents to set goals and develop action plans to reduce barriers to care. Key to overcoming barriers is parent engagement and personal responsibility.</td>
</tr>
<tr>
<td>Communication with medical provider</td>
<td>On-going communication with the medical providers is key to continuity of care.</td>
</tr>
<tr>
<td>Communication through different methods</td>
<td>It is critical to consider literacy levels and learning styles of parents. Multiple methods should be used as appropriate.</td>
</tr>
<tr>
<td>Service Delivery Model &amp; Protocols</td>
<td>Adhering to the service delivery model and protocols will allow for better evaluation.</td>
</tr>
</tbody>
</table>
One barrier having a significant impact on the rate of adherence to referrals for children/families in the PCC program is the lack of a Social Security Number (SSN) for insurance and inability to pay full out of pocket expenses for the healthcare. The PCC has worked diligently with these patients to identify solutions that are appropriate and feasible for the families.

One strategy used to improve adherence to screening guidelines for children ages 3-5, was implemented in 2009. Unfortunately it was found to be ineffective. The PCC did mass mailings three different time periods during 2009-2010 to encourage families to have their children get current with physical, developmental exams and dental screenings. Bilingual letters were sent out to the parents of all SYHC south region patients who were 1-4 years of age and identified to be due for physical and/or dental exam. The mailings consisted of: (1) a personalized letter highlighting the missing assessment and providing information on how services can be accessed at SYHC's multiple sites, and (2) SYHC's SRI flyer, which explains why all 3 screenings are important. A study found that out of 239 tracked calls, only 7.5% were attributed to the mass mailing. Given this low percentage, SRI staff concluded the mass mailing was an inefficient use of staff time and clinic resources, therefore this activity was suspended.

The PCC utilizes several strategies, methods and tools to improve care coordination outcomes and adherence to appointments. Examples of tools developed to encourage adherence with parents include the Child Health Record, the SRI Flyer and the Pending
Action Form. The Child Health Record is a comprehensive booklet aimed at educating parents on the importance of screening their children, following through with appointments and encouraging them to track and document progress. This tool is described in pages 22-24. Copies of the flyer and Child Health Record can be found in Appendix A and B.

**High Service Demand**

Per month, there is an average of 50 incoming dental referrals, and approximately 100 referrals identified through iNet referral system and direct pediatrician referrals. Each month, PCC manages an average of 75 cases (it was determined that a caseload of 60-65 would be the maximum in order to fully address the needs of the patients). Therefore, it is impossible for the PCC to provide case management services to every referred child, despite the high need. When possible and appropriate, the PCC will refer families to SYHC’s Family Resource Center (FRC), to receive information on SYHC and community resources. This helps ensure more families receive the information they need in a timely manner, especially if they don’t qualify for PCC assistance.

In order to ensure that SYHC’s “high-risk/need” pediatric patients receive immediate care, SYHC developed a triage system that ranked priority referrals based on specific high-risk criteria. As mentioned previously, the PCC receives referrals from several sources including (1) Direct dental referrals for high risk patients- screened through Oral Health Initiative assessment; (2) Direct pediatrician referrals from any of SYHC’s south region clinics and 2 mobile medical units; (3) Patients identified through bi-weekly iNet
referral system search, considered to have “high risk” conditions. The referrals from the above sources are collected and triaged, according to age of child and risk-level; children aged 3-5 years are prioritized as they fall in the age range during which school-readiness can be most affected.

Data Collection/Analysis
Due to the challenges with staffing the PCC position data collection methods and tracking tools have varied. Over the last several years, the current PCC, Michelle Favela, has spent a significant time developing a more efficient system. These changes include: (a) simplification of Healthcare Access Tracking Tool; (b) improved reporting form (b) modification of patient database for simpler data entry; (c) development of a Daily Encounter Form to track type of visit and length of visit to help identify time intensive issues that may be addressed through other means (i.e. group education, referrals to other SYHC health education, etc.).

VI. PUBLICATIONS/PRODUCTS:

Publications
Conference Poster. 2011 American Academy of Pediatrics: Future of Pediatrics conference. Poster has general information about HTPCP such as program goal and methodology, information about project area and population, program components (three screenings, parent education, school referrals, and advisory board), lessons learned and program outcomes. Authors: Keir, Katherine; Favela, Michelle.
Products

During HTPCP there were specific forms and tools that were developed and modified throughout the program, to assist with data collection, referral adherence and overall organization of the project:

1. **SRI flyer.** Provides information about importance of the three screenings prior to school entry (dental, physical and developmental screenings), and where to access those services.

2. **Child Health Record** Booklet for SYHC parents key child health information and how to access services. It includes information about routine exams (physical and dental), developmental stages, immunizations, nutrition information, emergency numbers, and other important information.

3. **Healthcare Access Tracking Tool**- an Excel workbook to track positive/negative outcomes, referrals kept and missed, appointments, service type and care coordination activity.

4. **Patient Update Form**- A form placed in a patient chart that updates doctors with current patient information regarding appointments, services and pending actions, prior to them meeting with a patient for appointment.

5. **Pending Action Form**- is intended for patients and their families and lists any pending actions by PCC or parent(s).

6. **Initial Assessment Form**- A PCC form designed to collect important patient demographic, socioeconomic information, family and medical status and history; etc.

7. **Exit Assessment Form**- This form is completed when a case is closed and PCC is able to communicate with family. This one page document includes: (1) patient information; (2) date of exit assessment; (3) reason of closing case; (4) summary of accomplishments; (5) list of goals that were met; (6) list of actions that are still pending; (7) pertinent medical update.

**Product Key Authors:** Katherine Keir and Michelle Favela, Program Coordinator, (619) 205-1969, mifavela@syhc.org.

San Ysidro Health Center, Inc.
VII. DISSEMINATION/UTILIZATION OF RESULTS:
SRI staff will soon begin to share complete program results and outcomes with the community including the SRI Advisory Board and other related coalitions and organizations. In order to sustain program impact and further enhance partnerships; the SRI Advisory Board has transitioned to serve as the board for the new HTPC grant funding SYHC’s Pediatric Development Clinic. In addition, future conference presentation on school readiness will be planned.

VIII. SUSTAINABILITY:
Although the HTPC grant has ended, SYHC management recognizes the importance and value of the PCC position, and is committed to sustain the current program via operations funding. Due to the high level of need to expand PCC services to include a greater number of kids age 0-5, SYHC will continue to pursue a variety of grant funding opportunities to assist in not only sustaining current PCC services, but also to expand.

Through its School Readiness Initiative, SYHC has forged strong partnerships with the local school district, with whom, health center staff is in constant communication regarding current and future collaborative efforts. In addition, strong relationships have also been built with the local Children’s Hospital, San Diego Regional Center, and other organizations serving children and their families. These relationships will be key factors in leveraging future funding for SYHC’s school readiness activities in terms of collaborative proposal development, letters of support, etc.

San Ysidro Health Center, Inc.
Will your child be ready for school?

Help your child succeed in school by getting these 3 screenings!

We have convenient clinic locations to serve you and your family’s health care needs!

Chula Vista Family Clinic
865 3rd Avenue, Suite 133
Chula Vista, CA 91910

National City Family Clinic
1136 D Avenue
National City, CA 91950

Otab Family Health Center
1537 3rd Avenue
Chula Vista, CA 91911

Maternal and Child Health Center
4050 Beyer Blvd.
San Ysidro, CA 92173

South Bay Family Dental
2 Euclid Avenue, Suite A
National City, CA 91950

Mobile Clinic Units
Various Locations

1) Physical Exam:
   • An exam to make sure your child is growing up healthy!
   • Offered at all clinic sites.

2) Developmental Exam:
   • Part of the Physical Exam to make sure your child communicates, behaves, and relates to others according to his or her age.
   • Offered at all clinic sites.

3) Dental Exam:
   • An exam of your child’s mouth to make sure his or her teeth and gums are healthy!
   • Offered at all dental clinic sites.

We accept Medi-Cal, Medicare and most insurance plans. If you do not have medical coverage, you may qualify for health care services at a reduced cost.

Please call us at (619) 662-4100 to make an appointment for any or all of the 3 screening exams.
Our Mission:
To improve the health and well-being of our community's traditionally underserved and culturally diverse people.

San Ysidro Health Center, is a non-profit, 501 (c)3, tax-exempt organization.

First 5 San Diego Partner
MATERNAL AND CHILD HEALTH CENTER (MCHC)
SERVICES DIRECTORY
4050 Beyer Blvd., San Ysidro, CA 92173

Registration, Eligibility, Information and Medical Records............. 1st Floor

Community Classroom..................................... 1st Floor

Laboratory.................................................. 2nd Floor

Pediatrics.................................................. 2nd Floor

Early Child Development................. 2nd Floor

Family Resource Center................. 2nd Floor

Prenatal Care / Women's Health...... 3rd Floor

Pediatric Dentistry......................... 3rd Floor

Women, Infants & Children (WIC).... 3rd Floor
SAN YSIDRO HEALTH CENTER
CLINIC LOCATIONS

Chula Vista Family Clinic
865 3rd Avenue, Suite 133
Chula Vista, CA 91910
Lunes a Viernes 8 AM - 5 PM

Maternal & Child Health Center
4050 Beyor Blvd.
San Ysidro, CA 92173
Lunes a Viernes 8 AM - 5 PM

National City Family Clinic
1136 D Avenue
National City, CA 91950
Lunes a Viernes 8 AM - 5 PM

Otay Family Health Center
1637 3rd Avenue
Chula Vista, CA 91911
Lunes a Viernes 8 AM - 5 PM

Paradise Hills Family Clinic
2400 E. 8th Street, Suite A
National City, CA 91950
Lunes a Viernes 8 AM - 5 PM

San Ysidro Health Center
4004 Beyor Blvd.
San Ysidro, CA 92173
Lunes a Viernes 8 AM - 7:30 PM
Sábado 8:30 AM - 2 PM

SYHC Ocean View Clinic
3177 Ocean View Blvd.
San Diego, CA 92113
Lunes a Viernes 8 AM - 5 PM
Sábado 8 AM - 12 PM

SYHC Euclid Clinic
286 Euclid Avenue, Suite 308
San Diego, CA 92114
Lunes a Viernes 8 AM - 5 PM

South Bay Urgent Care Center
340 4th Avenue, Suite 7
Chula Vista, CA 91910
Lunes a Viernes 10 AM - 8 PM
Sábado 10 AM - 6 PM

San Diego Children's Dental Center
8110 Birmingham Way, Bldg. 28
San Diego, CA 92123
Lunes a Viernes 8 AM - 5 PM

South Bay Family Dental Center
2 Euclid Avenue, Suite A
National City, CA 91950
Lunes a Jueves 7:30 AM - 6:30 PM
Viernes 8 AM - 5 PM

WIC Chula Vista
1655 Broadway, Suite 18
Chula Vista, CA 91911

WIC Imperial Beach
886 Palm Avenue
Imperial Beach, CA 91932

WIC National City
1005 Plaza Blvd., Suite A-B
National City, CA 91950

WIC San Ysidro
4494 Camino Do La Plaza
San Ysidro, CA 92173

For further information or to schedule an appointment at any of our clinic locations, please call us at (619) 652-4100.
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CHALLENGING BEHAVIORS IN CHILDREN

Keep in mind that all behavior is a way of communication and there is typically a reason for problem behaviors. Adults can learn to understand and interpret children's challenging behavior and offer support, not punishment.

Here are some ways that can help reduce challenging behavior:
  a. Respond calmly- without your own anger.
  b. Teach alternate behaviors- appropriate ways of expressing what he/she wants or needs.
  c. Offer choices- opportunities to have more control over his/her environment.
  d. Notice positive behavior- provide praise.
  e. Be consistent- your child will know what to expect (i.e. brush teeth every night before bed).

<table>
<thead>
<tr>
<th>PEDIATRICIAN AND SPECIALISTS</th>
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<tbody>
<tr>
<td>Name</td>
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<tr>
<th>Surgeries and Procedures</th>
<th>Date</th>
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PREPARING FOR AN EMERGENCY

The best way to make your family feel safer is to be prepared before disaster strikes. Have a kit and make a plan!

Your family kit should include:

- Water: one gallon per day.
- Food: at least three days supply.
- Medications: prescription with dosages and over-the-counter medications.
- Radio/flashlight: battery powered.
- First aid kit.
- Personal documents: identification, passport, insurance policies, etc.
- Contact information: of family members and emergency numbers.
- Map: for alternate traveling out of affected area.
- Money: for necessary supplies, as ATM's may be closed.
- Clothing: extra set of warm clothes, and shoes.
- Sanitary supplies: toilet paper, personal hygiene products, etc.
- Tools: wrench, manual can opener, duct tape.

For more information about preparing for an emergency, contact your local American Red Cross at (858) 309-1200 or visit their website at http://www.sdarc.org
WELL-CHILD CARE VISITS

Every one of these visits is important to make sure your child is healthy! (These are the minimum number of visits, more visits may be recommended.)

[Check boxes for visit intervals: 2-4 days, 1-2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4-5 years, 6-8 years, 9-12 years, 13-16 years, 17-20 years]

IMPORTANT INFORMATION

Help prevent child abuse by: knowing who your child spends time with, talking about safety away from home, and explaining difference between “good touch” and “bad touch.” Ask your doctor for more information on how to protect your children.

If you know a child is being abused, report it to Child Welfare Services (CWS) or to the local police (see phone numbers below).

Domestic Violence not only means being hurt physically, it also includes: sexual, emotional, psychological and financial abuse. There is help! Ask your doctor or call the Domestic Violence line, available 24 hours (see phone numbers below).

DENTAL VISITS

Regular dental check-ups keep teeth healthy. Tooth decay is the number one health problem for kids in California.

[Check boxes for visit intervals: FIRST VISIT (By 6 months of age.), 1 YEAR - 21 YEARS (Every 6 months to 1 year. Ask your dentist for a specific recommendation for your child.)]

EMERGENCY TELEPHONE NUMBERS

Emergency: 911
(Medical, Fire, Police)

Poison and Intoxication: 1-800-222-1222

Crisis Line: 1-800-479-3339

Domestic Violence and Sexual Abuse: 1-888-335-4657
(Available 24 hours)

Child Protective Services: 1-800-344-6000
(CPS - Available 24 hours)
NUTRITION INFORMATION

BREASTFEEDING (INFANCY):
- Will keep your baby healthier.
- Will help you return to your normal weight.
- Recommended for the first year.
- In the first month, the baby will need 8-10 feedings per day.
- Burp your baby often during feedings.
- Try different feeding positions to find the one that works best.
- Feedings and stools will be less often as your baby grows.

SOLIDS (INFANCY):
- 4-6 months: Begin solid foods; start with infant rice cereal mixed with breastmilk or formula.
- 5-6 months: Add strained vegetables one at a time.
- 6-7 months: Add strained fruits and juice.
- 7-8 months: Add strained meats.
- Serve solids from a spoon (not bottle).
- Offer 1 new food at a time. Wait at least 3 days before trying another one.
- As more solid foods are eaten, less breast milk or formula is needed.

FEEDING FROM 1 TO 5 YEARS (TODDLER/PRE-SCHOOL):
- 3 meals/day + healthy snacks.
- Serving size = one tablespoon for each year of age.
- Each day:
  - 6+ servings of bread, cereal, rice or pasta.
  - 3+ servings of vegetables
  - 2+ servings of fruit.
  - 3-4 servings of milk, yogurt or cheese.
  - 2-3 servings of meat, poultry, fish, dry beans, and eggs.
- Dilute juice; limit to 1 glass a day.
- Serve meals/snacks at same time each day.
- Let your child decide how much to eat.
- Do not use rewards to get your child to eat.
- Do not use food as a reward or punishment.
- Do not force your child to eat a new food.

FEEDING FROM 5 TO 12 YEARS (SCHOOL AGED/PRE-TEEN):
(In addition to above)
- Healthy breakfast.
- Healthy snacks/seconds.
- Balanced meals.
- No soda.
- Involve child in food shopping and preparation.

RECOMMENDED IMMUNIZATIONS SCHEDULE

Schedule for Persons 0 Through 6 Years of Age

| Vaccine | Age | 0-2 months | 3-12 months | 13 months | 14 months | 15 months | 16 months | 17 months | 18 months | 19 months | 20 months | 21 months | 22 months | 23 months | 24 months | 25 months | 26 months | 27 months |
|---------|-----|------------|-------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
| Hepatitis A | | | | | | | | | | | | | | | | | | |
| Diphtheria, Tetanus, Pertussis | | | | | | | | | | | | | | | | | | |
| Pneumococcal | | | | | | | | | | | | | | | | | | |
| Influenza | | | | | | | | | | | | | | | | | | |
| Measles, Mumps, Rubella | | | | | | | | | | | | | | | | | | |
| Varicella | | | | | | | | | | | | | | | | | | |

Schedule for Persons 7 Through 18 Years of Age

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Age</th>
<th>7-10 years</th>
<th>11-12 years</th>
<th>13-18 years</th>
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</thead>
<tbody>
<tr>
<td>Tetanus, Diphtheria, Pertussis</td>
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<tr>
<td>Human Papillomavirus</td>
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<tr>
<td>Pneumococcal</td>
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<tr>
<td>Influenza</td>
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<tr>
<td>Measles, Mumps, Rubella</td>
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<tr>
<td>Varicella</td>
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The above Recommended Immunizations Schedules were obtained from the Department of Health and Human Services - Centers for Disease Control and Prevention and are approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians. If you would like to obtain a complete copy of the above schedules and descriptions, please visit:

http://www.cdc.gov/vaccines/recs/schedules/default.htm
CHILD DEVELOPMENT STAGES
INFANCY (0 - 12 MONTHS)

SAFETY:
- Car seats.
- Put infant to sleep on back.
- Avoid bottle-propping.
- Cleaning supplies/meds.matches = in locked cabinet.
- Set water heater to < 120 degrees F.
- Don't leave baby alone in tub.
- Check behind the car before backing out.
- Working smoke detectors in home.
- Gate all stairs.
- If gun in home keep unloaded with safety on; store in locked cabinet out of child's reach.
- Apply sunscreen (SPF 15 or greater) when child is outside; re-apply every 2 hours. (use only after 6 months of age - shade is best.)
- Do not expose baby to tobacco smoke.

BEHAVIOR:
- Socializes by watching your face and exchanging looks.
- Uses gestures, sounds, facial expressions and different cries to let you know they are hungry, tired, or bored.
- Explores by looking at, holding and putting their mouths on different objects.

NUTRITION / PHYSICAL ACTIVITY:
- Breastfeeding.
- Do not send baby to bed with bottle.
- Avoid giving hard candy and gum (may cause choking).
- Do not add honey/sugar/salt to baby's food.

DEVELOPMENT:
- Turns to voice; loves when you talk and sing to them.
- Speaks first word with meaning.
- Sits without support.
- Pulls to stand. Will take his first steps soon.
- Waves bye-bye.

CHILD DEVELOPMENT STAGES
ADOLESCENT (15 - 18 YEARS)

SAFETY:
- Always wear a seatbelt when riding in a car.
- Water safety.
- Always use sunscreen with SPF for 15 or higher and reapply every 2 hours.
- You can get sexually transmitted diseases (STDs) by having oral, vaginal, or anal sex with someone who already has a STD. Always use a latex condom if you decide to have sex. It can help prevent pregnancy and STDs like HIV.
- Don't let others pressure you into drinking or doing drugs. Never drink and drive.
- If you have been hit, slapped, kicked, forced to have sex, or physically hurt by anyone, report it. Tell your parents, doctor, school nurse, school counselor, or another adult.

BEHAVIOR:
- Independence.

NUTRITION / PHYSICAL ACTIVITY:
- Decrease fried and fast foods. No soda.
- Increase exercise.

DEVELOPMENT:
- Becoming an adult.
- Needs multiple adult role models.
- Begins to think abstractly.
- Makes specific goals and understands the specific steps to implement them.
- Sexual experimentation; beginning of intimacy and caring for others.

A breastfed baby is as healthy as possible. A mother's milk has just the right amount of fats, sugars, and protein that is needed for a baby to be healthy.
CHILD DEVELOPMENT STAGES
PRE-TEEN (10 - 14 YEARS)

SAFETY:
- Injury prevention – seatbelts, helmet, water safety.
- Talk to your preteen about not using alcohol, drugs, and tobacco.
- No smoking/drinking/substance abuse.
- (9-11 yo) Parents: Talk to your preteen about not giving in to peer pressure.
- Talk to your preteen about relationships with the opposite sex.
- Monitor use of iPod (hearing problems) and video/computer games.
- Monitor for excessive sadness and depression.

BEHAVIOR:
- Responsibility (chores, homework).
- Bullying.
- Friends are more important than family.
- Be careful about media (violence).

NUTRITION / PHYSICAL ACTIVITY:
- Decrease fried and fast foods, no soda.
- Increase exercise.

DEVELOPMENT:
- Puberty.
- Rapid Changes.
- Acne.
- Prefers relationships with friends to family.
- Limits in conceptualization due to concrete thinking.
- Often have vague and unrealistic plans.
- Adjusting to emerging sexual development, sexual curiosity, and body image.
- Self-centered and tests the moral systems of others.
- Consequences must be stated clearly.

MISCELLANEOUS:
- For child: Confidential services are available with your PCP.

CHILD DEVELOPMENT STAGES
TODDLER (1 - 3 YEARS)

SAFETY:
- Child-proof home (begin at 6 months of age).
- Cleaning supplies/meds/matches placed in locked cabinet.
- Set water heater to < 120 degrees F.
- Don't leave baby alone in tub.
- Check behind the car before backing out.
- Working smoke detectors in home.
- Gate all stairs.
- If gun in home keep unloaded with safety one; store in locked cabinet out of child's reach.
- Apply sunscreen (SPF 15 or greater) when child is outside; re-apply every 2 hours.
- Do not expose baby to tobacco smoke.

BEHAVIOR:
- Temper tantrums.
- Discipline with time-out can start right after 1st birthday.

NUTRITION / PHYSICAL ACTIVITY:
- Exercise / Decrease T.V.
- Do not send baby to bed with bottle.
- Avoid giving hard candy (may cause choking).
- Do not add honey/sugar/salt to baby's food.
- No T.V. in bedroom.

DEVELOPMENT:
- Independence and language leaps.
- Shares what he sees by pointing to objects.
- Imitates actions of parents (cooking, cleaning etc.)
- Uses a spoon and fork.
- Scribbles with a crayon.
- Begin potty-training!
- Combines words to speak in phrases and sentences.
- Knows 10 words by 1½ years old.
- Knows over 50 words by 2 years old.
- Walks well, runs, and learns to jump.
- Pedals a tricycle.
CHILD DEVELOPMENT STAGES
PRE-SCHOOL (4 - 5 YEARS)

SAFETY:
- Helmet.
- Safety-proof your home.
- Booster seats.

BEHAVIOR:
- Discipline (consistency, structure, limit-setting); set up a routine for child.
- Child can begin to lie.
- Can now learn concepts like "privacy" and can take more responsibility for personal hygiene and bathing.
- Parents: Teach, explain the differences of "good touch" vs "bad touch".

NUTRITION / PHYSICAL ACTIVITY:
- No soda.
- Exercise.
- Decrease T.V., computer, video games.
- No T.V. in bedroom.

DEVELOPMENT:
- Get ready for school.
- Copies shapes and can draw a person.
- Holds pencil in adult fashion.
- Writes first name.
- Uses correct grammar and pronunciation when speaking.
- Tells jokes and "tall tales".
- Lots of imagination and fantasy play.
- Questions "why" and "what does that mean".
- Takes turns, plays cooperatively.
- Knows colors.
- Counts objects.

MISCELLANEOUS:
- Imagination.
- Night terrors.
- Chores.

CHILD DEVELOPMENT STAGES
SCHOOL-AGE (6 - 9 YEARS)

SAFETY:
- Injury prevention – seatbelts, helmet.
- Know your child’s friends and their families.
- Monitor games and web.
- (9-11 yo) Parents: Talk to your preteen about not giving in to peer pressure.
- (For girls – prepare them for puberty/menstruation to decrease fear).

BEHAVIOR:
- Discipline – Give love, set limits.

NUTRITION / PHYSICAL ACTIVITY:
- Decrease fried and fast foods, no soda; water instead of soda.
- Increase exercise.

DEVELOPMENT:
- Reading, relationships, and playing by the rules.
- Able to sit quietly on command to pay attention in school.
- Knows alphabet letters.
- Recognizes words and learns to read and spell.
- Has "best friends".
- Plays rule-based and competitive games.
- Rides a bicycle.

MISCELLANEOUS:
- No computer in bedroom.

* Booster seat at all times until your child weighs 80 pounds.

Have you tried repeatedly to cut down on drinking, without success?
Do you feel annoyed by criticism about your drinking habits?
Have you had guilty feelings about drinking?
Do you need an "eye opener" drink in the morning?
Do you smoke and/or use illegal drugs?

Alcohol, smoking, and drugs can have a bad effect on your health and your child's health. If you answered "yes" to 1 or more of these questions, please talk to your doctor or your child's doctor - we can help!