First 5 San Diego

First 5 Commission of San Diego County

Improving the lives of children 0 to 5

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improving the lives of children 0-5

Annual Evaluation Report 2005-2006

HARDER+COMPANY
COMMUNITY RESEARCH

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Founded in 1986, Harder+Company Community Research is a comprehensive social research and planning organization located in San Diego, San Francisco, and Davis, California. The focus of the company's work is in broad-based community development and human services. Its staff conducts needs assessments, program evaluation, planning studies, and trainings for a wide range of clients across the country.

Acknowledgements

The collaborative approach of the evaluation brought together many contractors, families, and stakeholders to participate as partners in the evaluation process. For contractors, this often meant expanding their view of evaluation to focus on the collective impact of the initiative as opposed to solely focusing on specific program outcomes. The willingness of the Commission's contractors to see themselves as part of a larger system working to improve services for young children and their families made this evaluation possible. We hope that they have also benefited from seeing themselves as part of a "learning community." For families and stakeholders, this meant taking time out of their busy days to reflect on the impacts First 5 may have had in their lives and the community. These conversations took place in the form of focus groups, surveys, interviews, and case studies. Without these individuals, understanding the impact of the Commission's work, both in numbers and in personal stories, would not have been possible.

In particular, Harder+Company Community Research would like to thank the following people:

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The ***Cajon Valley Unified School District's School Readiness Program*** is a classroom-based model. Children spend their time in the cheerful "First 5 Classroom" on the campus of Anza Elementary School. As part of the program, children's development is screened periodically using the "Ages and Stages Questionnaire." These regular assessments help parents and teachers identify children's needs for additional services. One mother, whose child was connected with therapy to assist with developmental delays, notes that "it helped me to realize that my son needed help. … They have specialists there that read to him and that put together activities for him. … It's good when they can find out that your child needs more help when he's very young."

Children at the ***Cajon Valley Unified School District's School Readiness Program*** have the opportunity to meet other children their age, which is a new experience for many of the children. Parents, required to volunteer in the classroom, also meet one another and get to know their children's classmates. The friendships that result extend beyond the classroom. As one mother explains, "They go to each others houses. It's beyond First 5 now…they visit each other." Parents recognize how these relationships are important for their children's development. "The program helps the kids to develop with other children. That's what I try to tell parents [who aren't involved in the program], 'Yes, your child is intelligent. He knows his name. He knows his colors. He knows the entire ABCs. But does he know how to interact with other children? No.'"

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Executive Summary

This was a year of profound growth and change within the First 5 Commission of San Diego. The Commission has transitioned from the more disparate approach of funding distinct programs, into developing and funding strategic initiatives that target specific outcomes to improve the lives of children 0 to 5 and their families, and transforming some of the key systems that serve them. The Commission can now readily define its key project areas – access to healthcare, oral health, health and developmental services, obesity prevention, school readiness, special needs, preschool for all, early literacy, the Kit for New Parents and parent development – as well as special efforts such as 2-1-1 and innovative projects. This year has also seen the conclusion of some of the Commission's earliest grants. These programs provided quality services for children and families and demonstrated some important approaches.

In an era of increasing public demands for responsible government and accountability, the Commission has structured its focus and funding upon a solid base:

- The Commission's Strategic Plan targets needs identified from local data and special studies, so that the Commission funds the efforts that will make a difference for children and families while avoiding duplication of services.
- Each of the Commission's funded efforts targets priorities listed in its Strategic Plan as well as specific, measurable outcomes listed in its Evaluation Framework.
- Each Initiative incorporates the strategies of: direct services, community strengthening, provider capacity building and systems change.
- Where possible, contractors are required to use evidence-based or promising practices.[1]
- The evaluation design for each initiative and project specifies process and outcome data that will provide feedback for program improvement, for monitoring contractor performance, and for aggregating results to show impact at a county level and to also contribute to the results of First 5 efforts across the state.

This report contains the synthesis and analysis of the data collected during FY 2005-2006 – the successes as well as the areas for further study and/or needed improvement. The successes are here to celebrate and the challenges have been included, to both fully inform the public and to contribute to the knowledge of the best methods and innovations for improving the lives of young children and their families. This chapter is organized by the four Issue Areas of the Commission's Strategic Plan:

[1] Evidence-based or promising practices are required when there is sufficient research and study in the area or field that supports the desired outcomes, e.g.. parent education. Proven practices are required for efforts which do not lend themselves to research (health insurance enrollment). A hybrid approach is used for projects that are highly innovative, especially those which focus on systems change (the creation of health and developmental system of care, the Preschool for All Demonstration Project).

- Children's Health
- Children's Learning and Social-Emotional Health
- Parent and Family Development and Resources
- Systems Improvement and Community Change.

Children's Health

In the result area of Children's Health, the Commission targets the following goals:

- *Children are born and stay healthy.*
- *Children have access to preventative and comprehensive healthcare services.*
- *Families have the knowledge, skills, and resources they need to promote their children's optimal health.*

In FY 2005-2006, the following initiatives and projects specifically focused on children's health:

- Healthcare Access (HCA)
- Oral Health Initiative (OHI)
- Health and Development Services (HDS)
- School Readiness Initiative (SR)
- Partnership for Smoke-Free Families
- Capital projects

In addition, the Commission funded other programs that supported children's health including: 2-1-1 San Diego, a resource and referral service; outreach and media campaigns promoting early childhood health issues; and the Kit for New Parents.

Key Results of Children's Health

The Commission funded health projects that focused on: health insurance enrollment and retention; appropriate use of healthcare resources; screenings, assessments and treatment; parent knowledge and skills to promote their child's health; smoking cessation; and provider collaboration. The following is a brief summary of some of the key results achieved in the Issue Area of Children's Health:

Health and Development Services (HDS)

- In the first months of this project 1970 first time mothers received newborn home visits where they were educated on the values of breastfeeding and connected with lactation support programs. When needed, they also received support in establishing a medical home. (Outcome data will be available in future reports.)
- Contractors and subcontractors conducted hundreds of developmental, behavioral, and language screenings, assessments, and treatments. Outcomes of these services will be reported next year.

Healthcare Access Project (HCA)

- During FY 2005-2006, contractors extended outreach to 144,312 families. A total of 11,541 children and 4185 pregnant women were confirmed to be enrolled in a health insurance plan. Outreach and confirmed enrollments numbers increased over last fiscal year and exceeded the outcomes of similar projects.[2]
- As part of the follow-up process, contractors provided education and support to families to establish a medical home (98.2% average[3]), to take their child to a well-child visit (97.9% average), and visit the dentist (62.1%). In all cases, the HCA outcomes exceeded county comparison data. Additionally, only 12% of these families took their child to an emergency room, (half the countywide average), suggesting families are not utilizing the ER for non-emergency services.
- Due to follow-up effort, 94.8% of families were still enrolled in health insurance at 18 months.

Non-Initiative Programs and System Change

- ***2-1-1 San Diego:*** The resource and referral hotline provided approximately 41,250 parents of children 0 to 5 information on community health resources.
- ***Kit for New Parents:*** Approximately 26,000 kits were distributed, containing valuable information about children's health, basic child care, safety knowledge, and accessing resources.
- ***Media Campaigns:*** Each week, the Immunization Media Campaign reached an estimated 335,000 households and the Health and Oral Health Media Campaign reached 196,000 Latino households through television interstitials. In addition the campaigns blanketed the community with health messages through bus tails, direct mailings, phone banks, and at community events.
- ***Partnership for Smoke-Free Families (PSF):*** PSF screened 5797 pregnant women for tobacco use and exposure and almost 200 smokers were linked with a cessation resource. Some 500 "spontaneous quitters" were sent a sequenced mail-based intervention consisting of five mailings – an evidence-based, effective strategy for smoking cessation.
- ***Provider Collaboration (HCA, OHI, and HDS):*** The Commission instituted a new systems model, funding a county-wide or regional system of care coordinated by a lead contractor who coordinates a network of subcontractors. This leads to increased collaboration as providers to work together and better understand one another's services.

Oral Health Initiative (OHI)

- During the fiscal year, OHI providers screened 24,560 children ages 0-5 and provided routine treatments for 8842 children ages 0-5. Care coordination, a critical component of ensuring children identified with issues receive appropriate services, was provided to 4285 children.

[2] Some Oral Health and School Readiness programs also provided health insurance enrollment services.
[3] All percentages in this bullet represent an average of the 6-month and 12-month follow-up survey results.

- Capital projects were funded to build clinics and dental operatories, provide needed medical equipment, and improve access to health services.
- Providers educated 10,601 parents on the long-term impacts of good oral health on a child's school readiness. Additionally, they educated 2111 pregnant women about the effect of good oral health on their unborn child.

School Readiness Initiative (SR)

- 435 children were screened for their developmental progress in fall and spring, and referred for services when delays were identified. 7475 children received health screenings (mostly vision and hearing).

Children's Learning and Social-Emotional Health

In the second Issue Area, Children's Learning and Social-Emotional Health, the Commission targets the following goals:

- *Children have access to quality services that promote their early learning.*
- *Children are socially and emotionally healthy.*
- *Children are cognitively developing appropriately.*
- *Families have the knowledge and skills they need to support their children's learning and social-emotional health.*

In FY 2005-2006, the following initiatives and projects had learning and social-emotional health components:

- School Readiness Initiative (SR)
- Comprehensive Approaches to Raising Educational Standards (CARES)
- Intergenerational Initiative (IG)
- Preschool for All Master Plan (PFA)
- Health and Development Services (HDS)

In addition, the Commission funded other programs that supported this issue area, including: 2-1-1 San Diego (a resource and referral service) and the Kit for New Parents. The Commission also funded a variety of capital projects that supported the construction or renovation of early care and education centers and playground structures.

New Arrivals

The Commission funded a five-year $30 million Preschool for All Demonstration Project as well as Parent Development Initiative in 2005-2006 that will address this Issue Area. Services will begin for both projects in the first part of the coming fiscal year. In 2006-2007, the Commission will launch a Social-Emotional Health Initiative.

Key Results of Children's Learning and Social-Emotional Health

The Commission funded projects addressing children's learning and social-emotional health that focused on: cognitive development; social-emotional development; parent utilization of resources; high provider standards; and parent knowledge and skills to promote their child's learning and social-emotional health. The following is a brief summary of some of the key results achieved in these areas:

Health and Development Services (HDS)

- A large component of this project includes screening, assessing and treating children for developmental, speech and language, and behavioral concerns. For example, 102 behavioral screenings were provided to 70 children in FY 2005-2006, *all* of whom were identified as needing further behavioral assessment.

Intergenerational Initiative (IG)

- The utilization of Senior Mentors allowed teachers to focus on skilled activities, such as lesson planning and working with higher need students. This heightened the standards that teachers were able to bring to their classrooms.
- Senior Mentors assisted in improving the children's: cooperative behaviors, ability to interact with adults, self-confidence language acquisition, early learning skills, and communication skills.
- 80% of parents surveyed indicated that they learned something new about their children's development and 61.5% indicated that they have learned to help their children get ready for kindergarten because of the involvement of the Senior Mentors.

Non-Initiative Programs and System Change

- ***CARES:*** Over 1,762 participants worked toward a degree in the fields of Early Education or Child Development, or a Child Development Permit. Over 90% of survey participants noted that the education received through CARES increased the quality of their programs and helped them work more effectively with children and parents. The CARES program has also helped retain qualified staff in early care and education settings, providing important stability for young children.
- ***Kit for New Parents:*** Approximately 26,000 kits were distributed, containing valuable information for parents about their child's early learning and social-emotional health.

Preschool for All (PFA)

- Increasing the quality of early education settings is a principal goal of the Preschool for All (PFA) Demonstration Project. Planning for PFA occurred during this fiscal year and a key product of that effort is a three-tiered quality system for providers, which includes a comprehensive examination of all aspects of provider programs as well as financial incentives for achieving higher levels of quality. In this fiscal year, the PFA Master Plan was completed and adopted by the Commission, and implementation planning began.

School Readiness Initiative (SR)

- 435 children receiving intensive services through School Readiness programs were assessed for their developmental progress. Data from standardized assessments (the DRDP) show that these children made statistically significant progress in the domains of problem solving, social skills and communication. 97.5% of children demonstrated improvement in communication; 86.7% in gross motor skills; 83.7% in fine motor skills; 97.7% in problem solving; and 92.2% in personal social skills.
- The SR programs provide holistic programs that also address social-emotional development. 224 children were identified and referred for behavioral services. 49.1% of those referred were successfully connected with services.

Parent and Family Development and Resources

In the result area of Parent and Family Development and Resources, the Commission targets the following goals:

- *Parents have the skills, comprehensive support and resources they need to promote their children's optimal development and school readiness.*
- *Communities have adequate service capacity that is effective, coordinated, integrated and sustainable.*
- *Families have access to culturally and linguistically responsive services.*
- *Policymakers and the public understand the importance of children's early years and support efforts to promote school readiness.*
- *The work of the Commission and First 5 funded programs is enhanced by community-driven solutions to issues that affect children and families.*

All current Commission funded initiatives have parent education components that contribute to reaching the goals listed above. Additionally, the Commission funded two other activities that support parent and family development and resources: 2-1-1 San Diego and the Kit for New Parents. The Commission also funded a *First 5 for Parents* project that will begin providing parent development services next fiscal year.

Key Results of Parent and Family Development and Resources

The aspects of the Commission's initiatives and projects addressing Parent and Family Development and Resources focused on developing parents' knowledge of and ability to: promote their child's optimal development and school readiness; employ positive parenting skills; locate needed resources; and appropriately utilize resources. The following provides a is a brief summary of some of the key results achieved in these areas:

Healthcare Access Project (HCA)

- A critical enhancement of this are the follow-up efforts that ensure continued enrollment and provide information and education about appropriate utilization of services for well child checkups and dental visits.

Non-Initiative Programs and System Change

- ***2-1-1:*** As a central clearing house for resources and referrals, 2-1-1 assisted approximately 41,250 caregivers of children ages 0-5 this past fiscal year, in finding needed health and social services. [4]
- ***Kit for New Parents:*** Over 26,000 parents received a Kit in FY 2005-06, which includes a local resource guide to assist families in finding needed resources and support.

Oral Health Initiative (OHI)

- The initiative provided care coordination to 2385 children 0-5 and 897 pregnant women, ensuring that families utilized appropriate services.

School Readiness (SR)

- School Readiness programs provide direct classes or referrals to parent education, early and family literacy programs and kindergarten transition programs.
- SR programs made 2932 family support referrals and 74 referrals to human services agencies. However, it has been difficult to accurately track the rate of successful referrals.

Systems Improvement and Community Change

The Commission's fourth Issue Area strives to create a lasting legacy for young children and their families in San Diego County. The Commission accomplishes this through a variety of avenues, including directly funding activities that will improve the many different systems of care for young children and by infusing a systems change approach to funding.

- *Communities have adequate service capacity that is effective, coordinated, integrated, and sustainable.*
- *Families have access to culturally and linguistically responsive services.*
- *Policymakers and the public understand the importance of children's early years and support efforts to promote school readiness.*
- *The work of the Commission and First 5 funded programs is enhanced by community-driven solutions to issues that affect children and families.*

[4] Estimated number of families based on the percent of callers of children ages 0-5 by the total number of callers in FY 2005-2006.

Key Results of Systems Improvement and Community Change

The aspects of the Commission's initiatives and projects addressing Systems Improvement and Community Change focus on building: service capacity, providers' awareness of other services for young children; coordinated systems of care; sustainable funding; responsive services, public policy supporting the 0-5 population, and community driven solutions. The following provides a brief summary of some of the key findings in these areas:

- Broad scale-initiatives such as Healthcare Access, Health and Developmental Services, and the Oral Health Initiatives seek to support, link, and, as needed, develop a continuum of services so that families do not fall through the cracks. Contractors assist families from the initial contact through the completion of any treatment services. This requires coordinated and integrated service delivery. The hope is that such efforts create provider relationships that are sustained beyond the life of the Commission's funding.
- 58.7% of Commission funded programs indicated that they had a sufficient number of trained staff to provide services to their target populations. Nearly one-third of responding organizations reported that they were not adequately staffed.
- 34.8% of respondents reported having a waiting list during this last fiscal year,[5] suggesting that there is not adequate service capacity to meet the needs of San Diego's young children and their families
- 52.2% of participants regularly solicit client feedback or conduct client satisfaction surveys.
- (95.7%) are currently heavily reliant on First 5 for their programs. According to the funded program survey results:
    - 15.2% of Commission contractors have non-First 5 funding sources that could support the program
    - 32.6% have identified potential non-First 5 funding sources
    - 34.8% have been unsuccessful at identifying alternative funding sources to First 5
    - 28.3% have not yet looked for funding.[6]
- Communication efforts have begun across Commission projects and initiatives but remain underdeveloped. There exists a great potential for connecting First 5 services between HCA, OHI, HDS, SR and PFA. Furthermore, the initiatives could better coordinate with other Commission-sponsored activities such as its media campaigns and with 2-1-1.
- The regional structures endemic of the Commission's systems of care projects (HCA, OHI, HDS, PFA) have the potential to facilitate communication and streamline services among a network of subcontractors – maximizing efforts and avoiding service duplication.

[5] There was slight variation in how the question was asked among the initiatives.

[6] When adding these percentages, they do not equal 100% because some respondent checked multiple answers

- The PFA Master Plan incorporated significant level of community input during its year-long design phase and in the planning of the implementation, with over 100 individuals participating in the effort.
- Interviews with key stakeholders highlighted the Commission's accomplishments:
    - "They have done a tremendous job in regards to parents and literacy."
    - "They have done a good job on grassroots efforts to reach children and families."
    - "The County [funding] is categorical. [First 5] has an opportunity to be creative and innovate."

Other Issues for Study

The area of systems change is central to the Commission's mission but challenging to evaluate. This year's data revealed two areas worth further study:

- The majority of programs (63.3%) stated that they designed or adapted their program to specific ethnical or cultural groups most often by employing bilingual staff or distributing materials in multiple languages. A deeper review will determine if these adaptations are effectively adapting to cultural and linguistic needs.
- A larger majority (95.0%) stated their program was specialized or adapted to meet the needs of children with special needs. Most referred children with special needs to other agencies. A more concerted evaluation could determine if children with special needs are being provided meaningful services.

The FY 2005-2006 marked the final steps in the Commission's shift away from funding individual programs to funding more systems-level efforts. It is important to note that these initiatives provide services in a much larger system of care that can both promote and inhibit their abilities to produce the Commission's desired outcomes. Consider the following:

> ***Interfacing with other State and local programs/processes***: Commission programs that work in tandem with other local and State programs and processes are vulnerable to problems in these systems affect contractors' ability to meet their targets. This is especially true with Healthcare Access contractors where the system is fraught with delays in processing.
>
> ***The importance of Commission partners:*** As the Commission builds more regional systems, the role and performance of the countywide coordinators and regional lead contractors becomes critical to the overall success of the initiative. For example, the American Academy of Pediatrics (AAP) is the "critical glue" for Health and Development Services (HDS), as is the Council of Community Clinics for the Oral Health Initiative.

These contextual issues are woven throughout the initiative's chapters and should be taken into account when assessing the success of the Commission and its contractors in meeting goals and producing outcomes that benefit San Diego's children and families.

Conclusions

Despite any systematic challenges, the initiative approach to funding provides the Commission with the opportunity to: create targeted outcomes that can be tracked, understand the impact of its funding decisions, and address challenges in a more efficient and methodological manner. The initiative approach has also strengthened the quality and rigor of the Commission's evaluation program and enhanced its ability to identify, measure and report on meaningful outcomes.

In addition, by supporting broader initiatives that create collaboratives, the Commission is connecting formerly disconnected services; and by concentrating efforts on a limited number of targeted outcomes, the Commission is more likely to have a deep, meaningful impact and cause lasting effects, than when funding a number of unconnected individual grantees.

The most developed and established initiatives – HCA and OHI – are within Issue Area 1: Children's Health. The newer efforts – PFA, HDS, and First 5 for Parents – will take root during their startup year, and see deeper results within one or two years after initial implementation. Future evaluation reports will reflect a fuller complement of the Commission's portfolio of community investment and contain a deeper outcomes evaluation across all of the issue areas.

General Trends in Initiative Funding

Despite the broad variety of projects funded by the Commission that contribute to school readiness, there are common threads of successes and challenges across the different initiatives.

Successes

- ***Concentrated effects*:** With the shift to initiatives, the Commission's contractors have similar activities and are focusing their efforts on common goals. Consequently, the evaluation is able to assess the concentration of effect to a much more rigorous level.
- ***Increasing partnership:*** The Commission instituted a lead/subcontractor model for a number of projects. This promotes both creation of regional networked services and encourages collaboration among contractors that may not have previously worked together.
- ***Sustainability of the model*:** The Commission's lead/sub model is beginning to create true partnerships among providers and the recognition of the value of partnership. It is hopeful that, even if programs are unable to secure additional funding to support their programs, the collaborative model may encourage them to sustain their partnerships beyond First 5 funding.

Challenges

- ***Outreach*:** Outreach efforts in underserved communities remain a challenge across programs, whether for health insurance enrollment or to locate families needing services.
- ***Start up time*:** As initiatives become more complex and address the creation of systems of care at a deeper level, the start-up activities are more complex and involve the building of partnerships and networks. As such, start-up time is a more significant but critical first step in the effective provision of services.
- ***Identification of need beyond the capacity of services*:** In its effort to promote early identification of health needs and developmental delays in young children, the Commission has funded a number of screening and assessment activities. A concern is that the number of children identified with early intervention needs through such screenings and assessments may exceed the number of providers and the funding to supply such services. For example, as Oral Health projects identify children that need extensive oral care, the local capacity to accept those children may not keep pace – both in terms of funding and the number of available providers with the training and facilities to treat very young children.

Introduction

In 1998, Proposition 10 authorized the use of a tobacco tax to support services for children 0-5 and their families. This unprecedented decision to support early childhood programs created the First 5 Commission of San Diego, and gave this Commission the flexibility to determine its structure, approach, and focus in response to the local community. Now, 8 years later, the Commission has developed has as an organization, a key funder of services, and an agent of change. Part of the Commission's continued development is to reflect on the results of its activities and carefully consider how services could be improved. The Commission's evaluation provides this opportunity. On an annual basis, the Commission receives a comprehensive report of the results of its activities in order to reflect on the past year's successes and challenges. By doing so, the Commission can make informed decisions about modifications and supports to existing funded programs.

The purpose of this report is to document the work accomplished by the First 5 Commission of San Diego County from July 2005 through June 2006 (FY 2005-2006). It is an impact evaluation report, which seeks to address the successes and challenges of the Commission's initiatives and activities. It does not evaluate individual programs. In addition to documenting the overall impact of Commission initiatives and activities, this report also highlights:

- System change
- Emerging needs and trends among San Diego's 0-5 population and their families
- Promising practices

The report synthesizes relevant data collected by contracted programs and by the Harder+Company evaluation team. When appropriate, it includes benchmark data and research to contextualize the results of funded initiatives. By compiling this information in a central location, it is intended to inform the State and Local Commissions and the San Diego County community about First 5's progress. It also provides information to inform First 5's future decision making.

Growing Initiatives, Improving Outcomes: First 5 San Diego's Evaluation Design for 2005-2006

The 2005-2006 evaluation year marks the first year in which the majority of the Commission's funds were devoted to initiatives. San Diego First 5 "initiatives" are defined as a group of programs that seek to generate common outcomes for young children and their families by pursuing similar activities and approaches. For example, the first initiative using this method, Healthcare Access Initiative (HAI), funded a number of programs that outreached to the uninsured, enrolled them in insurance, and encouraged appropriate utilization of health care. Initiatives are generally organized by the six San Diego Health and Human Services (HHSA) regions to ensure services reach all areas of the county. All contractors are tasked with meeting the same objectives and outcomes.

The switch to initiatives was a major step in the Commission's ability to effectively, and appropriately describe contractor progress toward meeting the Commission's goals and objectives of its strategic plan. Prior to this, outcomes could *generally* be described for funded programs because the RFPs were written with broad strokes instead of succinctly articulating the outcomes expected from contractors. As the Commission focused its resources on achieving more concentrated impact, the evaluation also became more defined and the outcomes more meaningful.

The approach to evaluating the Commission's work has been a partnership between the Commission staff, the Commission's contractors, and Harder+Company Community Research. This approach is depicted in Exhibit A. The evaluation begins with the Evaluation Framework (see Appendix C). This framework was developed by Harder+Company and the Commission's Evaluation Leadership Team (ELT) to broadly define objectives and indicators of success. Using this Framework as a road map, the Commission selects from the Framework's indicators when developing new initiatives. These indicators are then refined by Harder+Company and the ELT in the context of the particular subject matter and included in outgoing RFPs. Once contractors are selected, Harder+Company works in collaboration with the contractors to further refine the indicators in the context of the services they provide and develop consensus on common data collection tools and implementation strategies. The initiative evaluations include individual, program, initiative, and system level analysis.[1] As a result of this profoundly collaborative process, the Commission has an understanding of the impact of its initiatives as a whole and contractors develop a "learning community" that can share data, compare findings, and discuss solutions to challenges- ultimately improving outcomes to young children and their families.

Key Components of the First 5 2005-2006 Evaluation Design

Consensus based: Within the evaluation framework, each initiative's funded programs reach agreement on common tools and evaluation approaches.

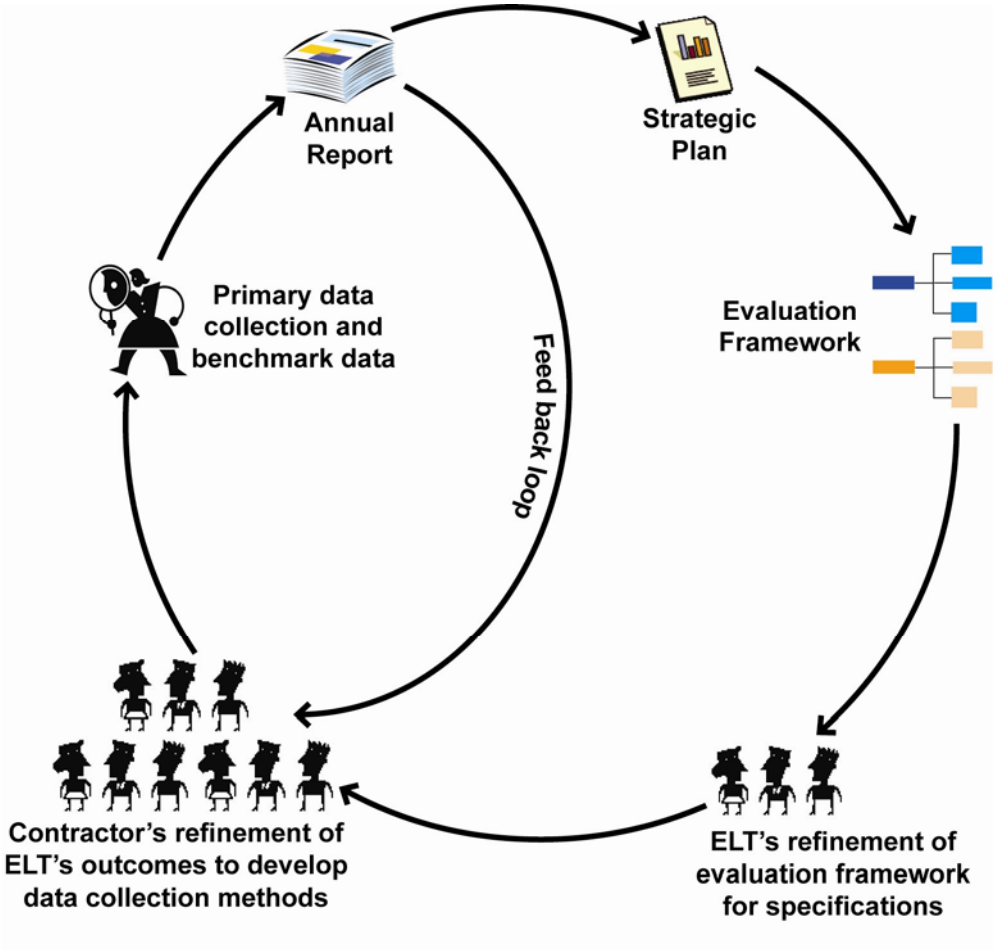
Utilization focused: The evaluation balances rigor of academic research with what is meaningful, feasible and timely for use in planning, policy, and program improvement.

Multi-level: Evaluation information is collected from multiple sources at multiple levels (client, program, initiative, systems, and community).

Mixed methods: The design utilizes an array of quantitative and qualitative methods, ranging from surveys and assessments that quantify behavior change to focus groups and participatory photography that lend context and an opportunity to hear directly from families who receive services funded by First 5.

[1] Program level findings are not presented in Annual Reports. The program level findings are provided to individual contractors in September as part of the Commission's "learning community" approach. At these meetings, initiative contractor meet with their peers to discuss their individual findings in relationship to the Initiative as a whole. These methods frequently provide opportunities to share successes, challenges, and possible solutions to program issues to improve future outcomes.

Exhibit A
Commission Approach to Evaluation



Each initiative has its own unique evaluation design that is tied to the Commission's strategic plan. In keeping with the Commission's approach of describing impact through "numbers and stories", evaluation designs include common quantitative outcomes collected by child assessments, parent surveys, and funded program surveys as well as qualitative methods, such as focus groups, case studies, stakeholder interviews, and participatory photography. Specific details of the designs are included in each initiative's chapter and in Appendix B.

How to Read This Report

The purpose of this report is to provide the Commission with an understanding of its broad impact. It does not attempt to highlight the complete and individual results of particular contractors, nor does it present an exhaustive analysis of all the data collected by contractors and the Harder+Company evaluation team. The evaluation team selected and presented findings that are most useful to the Commission and that best describe First 5 San Diego's impact on children and families.

Organization of the Report

- The report is organized by 9 chapters. Chapter 1 provides a meta analysis of the Commission's impact by its four strategic plan Issue Areas. Chapters 2-6 are initiative-specific results. Chapter 7 overviews findings from non-initiative contractors from their program evaluations submitted to Harder+Company. (Harder+Company was not involved in this level of evaluation). Chapter 8 provides an overview of current trends in the San Diego 0-5 population, and the last Chapter offers recommendations based on all of these findings.
- The "big picture" of each initiative's results are contained in each chapter's cover page, which outlines the Initiative's major findings. The details of these findings are in the text following the cover page.
- The artwork from the participatory photography project appears between chapters. This project involved parents who participated in selected First 5 School Readiness programs who were given cameras and asked to document the impact of First 5 in their lives. Details about this method are in Appendix B.
- Story-based impacts, such as quotations and case studies are incorporated throughout the text and in text boxes.
- For technical information about the report, the analyses, or the findings, please contact the Jennifer James, the evaluation's project director at Harder+Company Community Research, 619-398-1980.

A Note about Statistical Methodology

- The "n" that appears in tables, graphs, and the text indicates the number of people responding to this question. For example (n=124) means 124 people answered the question.
- Missing data, where people left a question blank, was not included in the analysis. Although missing data can sometimes be a meaningful statistic, readers are often confused by actual percent (which includes missing data) and valid percent (which omits missing data). This report only presents valid percents, or the number of people that gave an answer divided by the number of people that answered the question.

- Many findings are noted as being "statistically significant." This means that the groups being compared (most often the comparison is between Time 1 and Time 2 groups) are truly different from one another and that the difference is not by chance alone. Statistically significant findings are identified in the exhibits with an * and the p value is located below the table.
- The Harder+Company Evaluation Team used the most rigorous statistical tests the data would allow. When selecting the test, the evaluation team accounted for the quality of the data as well as the readability of the findings for a larger audience. Typically, Chi-Square tests were conducted, as appropriate.
- Each Commission initiative has an assigned lead from the Harder+Company evaluation team. These individuals are also the analysts responsible for developing the analysis plan and presentation method that would be easily understood by multiple audiences. Because each initiative is unique in terms of the questions asked, the number of surveys returned, and the implementation methodologies, the analysis performed for one initiative may differ from another.

Via an outreach/ resource center approach, the ***Chula Vista Elementary School District's School Readiness Program*** offers families home visits, parent education classes, and intensive intervention for children with behavioral issues. Many of the families who partake of these services have faced challenging and emotional situations at home. More than one parent-photographer described experiencing family violence as a child. In some cases these experiences impacted women when they had their own children. Some mothers were struggling with abusive relationships when they found the program. They credit the program with enhancing their feelings of empowerment and equipping them with the skills they needed to make the choices that were best for their children's emotional health. They are quick to note the impact that their own growth has had on their children's development, "When your attitude changes, so does theirs."

Learning how to interact with other children is an essential school readiness skills. Children participating in the ***Chula Vista Elementary School District's School Readiness Program*** have enhanced their social skills as a result of their parents' acquisition of new parenting skills and the availability of resources to support their child's optimal social-emotional development. Once shy children have begun to come out of their shells; "he's breaking down barriers," remarks one mother. The children's newfound confidence and improved behavior will be an asset in the kindergarten classroom - to the children themselves, to their classmates, and to their teachers.

Chapter 1
Healthcare Access Project

Key Results

Increased Health Insurance Enrollment: 92.6% of families surveyed reported their children were still insured 12 months after initial enrollment, a 4.0% increase from last fiscal year.

Improved Linkage to Medical Home: At 12 months after enrollment, nearly all families (98.4%) surveyed were able to name their child's clinic or doctor, a proxy indicator for a medical home.

Increased utilization of Healthcare: At 12 months after enrollment, 98.1% of families surveyed indicated their child had visited the doctor or health care provider and 64.5% of children two years and older had visited the dentist.

Low percentage of emergency room utilization: Only 11.9% of families surveyed reported seeking medical care for their child at an emergency room, a decrease of 4.9% from the previous fiscal year.

Identification of emerging differences in health plans: Medi-Cal clients are more likely than Healthy Families clients to name their child's doctor and to have taken their child to the doctor, and less likely to have taken their child to the emergency room. However, Healthy Families clients are more likely than Medi-Cal clients to have taken their child 2 years and older for a visit to the dentist.

Summing It Up

Children and Families Reached

- 144,312 families were reached through outreach services representing a 71.3% increase from last fiscal year.
- 16,624 children 0-5 were assisted with the insurance application process, an increase of 29.4% from last fiscal year.
- Exceeding the annual target of 3205 for the second consecutive year, HAI enrolled 4185 pregnant women, an increase of 9.1% from last fiscal year.

Children Assisted and Enrolled

- 44.0% of assisted applications became confirmed enrollments in FY 2005-06, a gap which narrowed compared to last year's 60.4%.

Healthcare Access Project Design

First 5 Commission of San Diego County

Central	East	North Central	North Coastal	North Inland	South
SAY San Diego	Neighborhood Health Care	SAY San Diego	Vista Community Clinic	North County Health Services	Home Start
• Crawford Community Connection • Family Health Centers of San Diego • Horn of Africa • O'Farrell Family Support Services • SDYCS • San Diego Family Care	• Family Health Centers of San Diego • Home Start, Inc. • La Maestra Family Clinic • Mountain Health & Community Services • SDYCS	• Bayside Community Center • Center for Community Solutions • Linda Vista Health Care Center • North Clairemont Healthy Start	• The Council of Community Clinics • North County Health Services	• Fallbrook Family Health Center • Neighborhood Healthcare • Palomar Pomerado Home Health	• Beacon FRC • Kimball FRC • Lincoln Acres FRC • Nestor FRC • New Directions FRC • Project Samahan • Rayo de Esperanza FRC • Reachout to Families FRC • San Diego County Public Health Center • United FRC

Goal 1

Increase and sustain enrollment of eligible children 0-5 and pregnant women in existing health plans (Medi-Cal, Healthy Families and AIM).

*1.2

Goal 2

Link enrollees to a medical home.

Goal 3

Support appropriate utilization of services ensuring that children and pregnant women receive preventative health services and families get the help they need to navigate the healthcare system.

*1.1, 1.2

* Refers to Desired Results listed in the Strategic Plan and the Evaluation Framework (Appendix C).

Introduction

Access to healthcare is a critical step to ensuring that children are healthy and entering school ready to learn. Research demonstrates that families without health insurance are more likely to either delay care for their children or access care through hospital emergency departments.[1] An estimated 8.7% of San Diego's children 0-5 are without insurance[2]— consistent with the national statistics but slightly lower than California (8.7% reported in 2000 and 4.3% reported in 2003, respectively).[3,4] To address this need, the First 5 Commission of San Diego County funded a Healthcare Access Project (HCA) to not only enroll families into care, but to provide retention and education services to ensure that families learn to utilize appropriate healthcare services.

In FY 2005-06, the Healthcare Access Project (HCA) completed its second year of direct services and outreach activities to increase insurance enrollment, retention, and appropriate utilization of health services in San Diego County. Launched in February 2004 in response to the high number of uninsured children 0-5 in the county, the Commission awarded two-year contracts to six programs. These programs focus on children eligible for Health Families or Medi-Cal for Children (Medi-Cal), and pregnant women eligible for Medi-Cal or AIM (Access for Infants and Mothers program). Funding is distributed proportionally by the estimated number of uninsured children in each of the six County Health and Human Services Agency (HHSA) regions: North Coastal, North Inland, North Central, Central, East, and South. Due to the success of the project during FY 2004-05, the six HCA programs were awarded 18-month contract extensions in effect through June 2007.[5] The total funds appropriated for HCA is $11,249,600 with $3,494,065 spent in FY 2005-06.

This chapter provides findings from the 2005-2006 HCA evaluation as well as a comparison of the Healthcare Access Project's outcomes for fiscal years 2004-05 and 2005-06. The findings come from various data sources including family surveys of those enrolled and accessing services at 6, 12, and 18 month points, as well as monthly contractor reports, which included provider capacity building, support, and infrastructure activities. Additionally, two case studies were conducted with parents whose children are enrolled in Healthy Families and Medi-Cal and these families' HCA Insurance Retention Specialists. Finally, interviews were conducted with members of the health community who served as expert observers and provided insight on the project's contribution to systems improvement and community change.

[1] Hadley, J. "Insurance, Medical Care Use, and Birth, Child, and Maternal Health Outcomes." Sicker and Poorer: The Consequences of Being Uninsured. Menlo Park, CA: Kaiser Commission on Medicaid and the Uninsured, 2002.
[2] First 5 San Diego. San Diego Family Survey. San Diego, CA: Author, 2005.
[3] Centers for Disease Control and Prevention. National Survey of Early Childhood Health (n=2,068). 2000. Accessed August 30 2006. <http://www.cdc.gov/nchs/about/slaits/nsech.htm>
[4] University of California, Los Angeles. California Health Interview Survey (n=8,526. 2003. Accessed August 30, 2006. <www.chis.ucla.edu>
[5] The initial 2-year contracts ended January 2006. The 18-month contract extensions bring the project program year in line with the Commission's fiscal year.

Key Elements of this Project

The primary goal of the Healthcare Access Project (HCA) is to increase and sustain health insurance enrollment for eligible children 0-5 and pregnant women in Healthy Families, Medi-Cal, and AIM. This addresses "Issue Area 1: Children's Health" outlined in the Commission's 2004-2009 Strategic Plan and specifically, Desired Result 1.1: that *children are born and stay healthy*. The project accomplishes this with the following elements:

Extensive Outreach

Key experts from the County Health and Human Services Agency (HHSA) state that HCA is excelling at enrollment and retention services. Yet, there are still gaps to fill with outreach. Interviewees recommend that the Project focus on outreach activities that tie "funding to more empirical research as to where there is a need. Realign the scope of what contractors are doing to a more broad outreach and enrollment [approach]." First 5 San Diego HCA efforts were based upon data supplied by the County at project inception. The San Diego County's Access Care for Children Team (ACT) has been in the process of developing data that will identify the hard to reach "eligible, but uninsured" population with the use of GIS mapping. This type of empirical data would be essential to the advancement of healthcare access countywide. Continued collaboration with existing San Diego County efforts such as ACT will strengthen healthcare access activities and prevent duplication of services.

- Contractors work in collaboration with a large network of subcontractors and community partners to maximize resources.
- Program staff assists families with health insurance enrollment and helps families navigate the healthcare system.
- Program staff provides support to families to ensure utilization of available healthcare services.
- Program staff assists families with coverage maintenance throughout the year, should they encounter difficulties such as financial hardships and annual renewal tasks.
- Contractors meet regularly to discuss challenges and emerging best practices, allowing for program improvement.

Summing it up: Number of Children Reached

The Healthcare Access Project strives to reach out and enroll the remaining 8.7% of uninsured children who are eligible for insurance, but not yet insured. The Commission's HCA Project not only enrolls families and children in Healthy Families, Medi-Cal, and AIM, but also assists them in retaining coverage and positively affecting appropriate health care utilization. This follow-up component makes the Commission's project unique among other County enrollment activities. The outcomes of these follow-up activities are presented in the section "Making a Difference.".

This fiscal year, the project reached more children and families in the county than the previous year. As Exhibit 1.1 shows, 144,312 people were contacted through outreach services, an increase of 71.3% from last year. Of these, parents of 16,624 children received assistance with the application process, representing an increase of 29.4% from last fiscal year. Furthermore, the

project has surpassed its annual enrollment target for pregnant women for last two years (3,826 in FY 2004-05 and 4185 in FY 2005-06 vs. the annual target of 3205). This year the number of pregnant women enrolled increased by 9.1% over last fiscal year.

Exhibit 1.1
Number of People Reached by the Healthcare Access Project

Enrollment Activity	FY 04-05	FY 05-06	% Change*	2 FY Total (FY 04-06)
Families who received outreach services	84,266	144,312	+71.3%	228,578
Children 0-5 assisted	12,843	16,624	+29.4%	29,467
Children 0-5 confirmed enrolled	8008	11,541	+44.1%	19,549
Pregnant women enrolled	3836	4185	+9.1%	8021

* Indicates percent of increase or decrease from the previous year.

Enrollment Process

As mentioned above, the HCA Project outreach is the beginning of a broader intervention of support for families. The primary focus of CAAs is to assist families with the application process for Medi-Cal, Healthy Families, and AIM. This process can be an overwhelming undertaking for families due to the many details required for the application and complex verification processes. The level of detail required of applicants often results in incomplete applications, which translates into long wait times for results, re-application requests, and even enrollment denial.

Part of the first goal of the project is to "sustain health insurance enrollment for eligible children 0 to 5 and pregnant women in Healthy Families, Medi-Cal, and AIM." One key expert describes insurance enrollment as a "convoluted process. The application process still takes too much time… [it's] too complicated." When clients submit paperwork, the State's review process is lengthy, leaving families unaware of the status of their application. Larger systems issues, such as processing delays, customer service issues, and changing eligibility requirements, continue to be a challenge. (See the 2004-2005 Evaluation Report for details.) CAAs keep current on assisting families to overcome these hurdles by attending trainings from insurance provider representatives, communicating with regional health services representatives, and holding collaborative meetings with each other and local community partners.

Children Assisted and Enrolled by Month

To understand the number of families served by this project, it is important to make a distinction between the terms "assisted" and "confirmed" enrollment. CAAs make every effort to ensure that families are eligible before providing application assistance (i.e. assisted). Application assistance entails multiple visits with families to help complete forms. Documentation is almost always incomplete. Follow-up appointments with clients and telephone calls to insurance providers continue until notification of approval (or denial) is received. Once enrollment has been confirmed (i.e. confirmed) CAAs schedule follow-up appointments. These appointments ensure that families know their healthcare provider and proper usage of the insurance card.

Exhibit 1.2
Children Assisted and Enrolled by Month

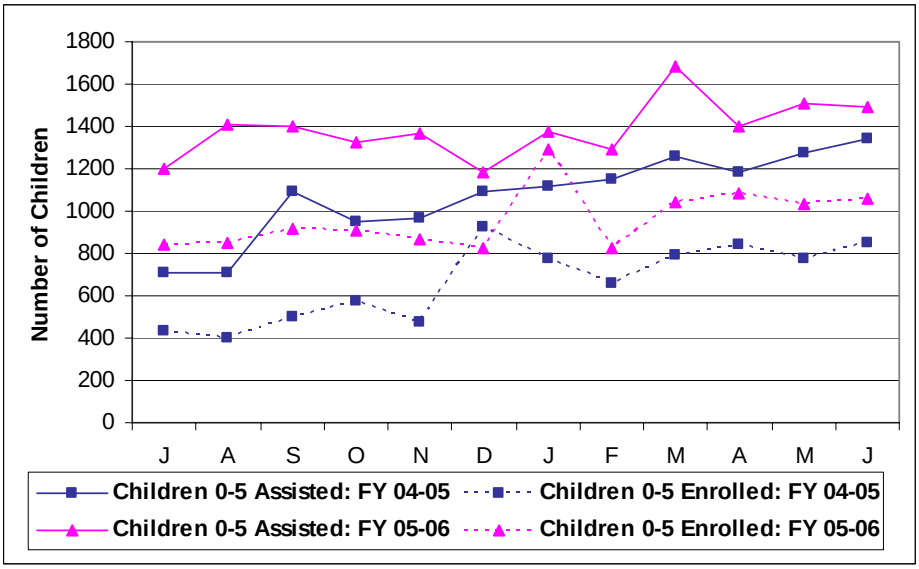


Exhibit 1.2 shows the monthly number of assisted and enrolled children 0-5 for each fiscal year of the project. The general pattern exhibits an upward trend of application assistance and confirmed enrollment from FY 2004-05 to FY 2005-06. Indeed, the gap between application assistance and confirmed enrollments has narrowed over the course of the project, suggesting an improvement in the services provided by HCA contractors. In FY 2004-05, 62.4% of assisted applications were confirmed as enrolled. This proportion increased to 69.4% in FY 2005-06, narrowing the gap between assisted applications and confirmed enrollments. A closer look at the dynamics of assisted and confirmed enrolled helps to clarify this improvement.

Assisted

The FY 2005-06 data shows more monthly variation in the number of *assisted* applications than the previous fiscal year. Some of this fluctuation could be due to the shortage and turnover of HCA program staff. For example, the increase in assisted applications in March 2006 may be the result of additional program staff during this period. There has also been concern that immigration reform publicity might contribute to the challenge of enrolling the children of parents without secure immigration status. The anticipation of the May 2006 Senate passage of the Comprehensive Immigration Reform Act may have added to the decline in assisted applications in April 2006. However, this decline is more likely a return to a normal level of assisted applications from the spike in March. Although FY 2005-06 exhibited more fluctuation in the number of assisted applications from month to month, it does not appear that the Act has had much impact to date.

Confirmed enrolled

For *confirmed* enrollment by month, the data for both fiscal years exhibits similar patterns. There are increases in the months of December and January, which may be due to a rise in the number of children who become ill during the cold and flu season. Illness may lead some parents to seek care for their child at a health center where the provider enrolls them in a health insurance program. (See the following case study, “Navigating the Maze”.) This reaffirms the need to continue health prevention education for parents and the insurance enrollment efforts of the Healthcare Access Project. Considering the gap between assisted and confirmed enrollment has decreased this fiscal year, CAAs attempts to increase enrollment confirmation has proven successful.

Case Study #1
Navigating the Maze

When Juanita had her first child Isabel, she was employed full-time and had health insurance that covered her and her self-employed husband. After she and her husband carefully considered the costs of commuting for work, child care, and the difference between their incomes, Juanita quit her job and became a stay-at-home mom. Consequently, she was taken off of her employer's health insurance plan, and offered Cal-COBRA,[6, 7] which to her surprise was too expensive. "Once I stayed home…that's when things got difficult," and for a while, she did not have any health coverage.

Enrollment

"It makes life a lot easier to know that [my children] have coverage. To be honest with you it's a relief to know that if anything happens to any one of them I can just go to the doctor and not have to worry about fighting the bills."
– Juanita, First 5 Parent

When Juanita's daughter Isabel got sick, she went to a North County Health Services Clinic (NCHS), a contractor with the First 5 San Diego Healthcare Access Project. When the staff at NCHS found out that she did not have health insurance, they referred her to Norma, a Certified Application Assistant (CAA). Norma helped her fill out the forms and submit the necessary information to enroll in Healthy Families health insurance. Juanita and her family qualified for the Healthy Families program and enrolled with Kaiser, where her primary physician from her previous insurance was located. This allowed her to maintain her child's medical home, which put her more at ease.

Retention

"From now on…if we ever have another child I'm going straight to the clinic and ask them to help me."
– Juanita, First 5 Parent

The importance of the Norma, the CAA, to the health of Juanita and her family was reaffirmed when Juanita became pregnant with her second child. First, Juanita attempted to negotiate the complicated insurance enrollment process by herself. Feeling that she had a better sense of health insurance options, Juanita applied to the Access for Infants and Mothers Program (AIM) for prenatal coverage without assistance. The application process was more complicated than anticipated and between August and November, Juanita submitted the application seven times before she was enrolled, resulting in a significant delay in prenatal care. After that experience, Juanita turned to Norma for help when her second daughter was born six weeks prematurely in March: "They got her

[6] Cal-COBRA (Consolidated Omnibus Budget Reconciliation Act) is a California law that has similar provisions to federal COBRA in which group health insurance is extended in the presence of a qualifying event such as termination of employment or reduction of hours to part-time status, for a duration of 36 months. The law allows for similar premium prices to the employer group plan, but the cost of the entire premium is the responsibility of the individual enrolled in COBRA. California Department of Insurance. "What is COBRA and Cal-Cobra?" Consumers: Health Insurance. Sacramento, CA: Author, 2005.

[7] allHealth Insurance Services. Cal-COBRA. 1998-2001. Accessed 8 August 2006. <http://www.healthinsurancefinders.com/cr_cal_cobra.html>

covered by the end of April, less than a month [after she was born] and she was already covered by Healthy Families, no problem." Norma further assisted Juanita's family in ensuring that her second child, initially placed with another provider, was placed in the same program as her older daughter. Juanita was very pleased with Norma's assistance with establishing a medical home, "She's always had the same pediatrician; her sister had the same pediatrician, so they know our history well."

Utilization

When asked about how things would be different if she did not have health insurance, Juanita responded, "I really think that I'd probably be one of those parents, unfortunately, that even though I know they need it … (my children would) probably be behind on their shots and probably behind on their health." Norma also noted that Juanita's life has been enriched by the services she received. Not only has she received health insurance support from NCHS, but she views NCHS as a system of support. Norma comments, "[Juanita] always calls now that she knows we are here." Indeed, besides providing insurance enrollment assistance, Norma views her role as that of educator, counselor, and social worker. Norma and her staff have been there to touch Juanita's life, from insuring her family to providing resources to find a quality childcare program. Juanita is currently expecting her third child. And when her baby is born, Norma will continue to provide her family with information on accessing the same quality health services as she has in the past.

"We're not just outreach workers, you know…we establish a relationship with a client. We have their file folder. We are calling them. They know us."
– Norma, First 5 Provider

Empowerment

"It was a humbling experience to realize, 'hey you're in the same boat as a lot of people, you just don't realize it.'"
– Juanita, First 5 Parent

Juanita's involvement with NCHS has also encouraged her to give back to the community. She now volunteers at NCHS as a promotora (health promoter) for diabetes. The decision to go from a career woman to stay-at-home mom has had an impact on Juanita and her family in many different ways, but perhaps one of the strongest is her renewed sense of community.

Making a Difference: Healthcare Access in Action

Once enrollment is confirmed by families, follow-up appointments are scheduled to ensure families understand their benefits, service access instruction, and to provide education about maintaining check-up appointments, the importance of immunizations, and medical visit expectations.

To gauge the effectiveness of the program, follow-up surveys are administered by either Retention Specialists or by CAAs. These surveys ask about length of enrollment, enrollment status, linkage to a medical home, service utilization, and the reason for lapse in coverage if a family has disenrolled. Such information provides measures of utilization and insight into the challenges families face in maintaining their insurance coverage. The following table presents findings of key health care utilization and retention outcomes for the past two fiscal years. Included in the table are results and county comparisons (if available) by type of follow-up survey. The data represent 8,569 surveys; 2,834 surveys[8] in FY 2004-05 and 5,735 surveys in FY 2005-06. The remainder of this section provides details about the survey's findings.

The Who's Who in HCA

While there is overlap in tasks, there are three distinct roles in the process of reaching the uninsured and subsequent enrollment, retention and service utilization:

Certified Application Assistants (CAA): The CAA receives formal training through the county, with certification upon completion. Their primary function is to assist clients with the enrollment process, typically involving multiple visits. Families often need help completing forms and compiling all the necessary documentation. CAAs also facilitate outreach activities.

Retention Specialists: The primary role of the retention specialist is to conduct and process the follow-up surveys that record the status of insurance enrollment and track project outcomes on service utilization. They often attend trainings and become CAAs.

Outreach Specialists: The outreach specialist coordinates with the CAA to conduct community outreach activities to find eligible, uninsured families in the County. Outreach activities consist of distributing flyers, presenting at schools and community centers, exhibiting at health fairs, and participating in referral networks. They also assist CAAs in various capacities.

Provider's Perspective

Being a CAA: "I help families with paperwork they can't understand, and if they didn't have me to assist them, they probably wouldn't have health insurance."

Most rewarding aspect of job: "I help the families, not only with their applications for health insurance, but showing them different resources in the community. For example, if I see that a family is in need I know where to direct them. If they need hardship money, maybe they need to apply for welfare. I also can assist them with that…If we don't have programs here at the health center, I can find a resource in the community for them, or a homeless shelter."

Suggestions for improvement: "I need more time with patients, that's one of my goals. I need more time with them." The CAA also had these suggestions for the insurance programs: "[With Healthy Families clients], I think the time length of getting enrolled, from receiving an application to getting enrolled… It takes about 3 weeks, and ideally it would be 2 weeks…[for Medi-Cal] maybe just better customer service."

– First 5 CAA

[8] The number of surveys for 2004-05 is more than the number included in the analysis for last year's annual report (n=2363). Additional surveys were received after the data submission end date and were entered and analyzed for this year's analysis.

Exhibit 1.3 Making a Difference: Health Care Access Project Outcomes			
Survey Results*	**FY 04-05**	**FY 05-06**	**Difference****
Outcome Area 1: Enrollment status			
6-month follow-up	94.8%	95.2%	+0.4%
12-month follow-up	88.6%	92.6%	+4.0%
18-month follow-up	--	94.8%	--
County comparison	N/A	N/A	
Outcome Area 2: Linkage to a medical home (proxy indicator; name their child's clinic or doctor)			
6-month follow-up	98.2%	98.0%	-0.2%
12-month follow-up	99.0%	98.4%	-0.6%
18-month follow-up	--	99.6%	--
County comparison	97.2%	97.2%	
Outcome Area 3: Utilization of health care (taken child to doctor or health care provider by follow-up period)			
6-month follow-up	96.3%	96.4%	+0.1%
12-month follow-up	97.8%	98.1%	+0.3%
18-month follow-up	--	99.3%	--
County comparison	63.2%	63.2%	
Outcome Area 4: Utilization of dental care (taken child to dentist by follow-up period)			
6-month follow-up	59.4%	57.6%	-1.8%
12-month follow-up	66.2%	64.5%	-1.7%
18-month follow-up	--	64.4%	--
County comparison	42.6%	42.6%	
Outcome Area 5: Emergency room utilization (taken child to ER by follow-up period)			
6-month follow-up	10.2%	12.8%	+2.6%
12-month follow-up	16.8%	11.9%	-4.9%
18-month follow-up	--	11.4%	--
County comparison	24.6%	24.6%	

* *6-month follow-up:* A total of 5004 surveys were received, representing a response rate of approximately 70.0% in FY 2005-06 (vs. 68.2% in FY 2004-05).
12-month follow-up: 2855 surveys were received, representing a response rate of approximately 68.9% in FY 2005-06 (vs. 70.6% in FY 2004-05).
18-month follow-up: 710 surveys were received, representing a response rate of approximately 67.9% in FY 2005-06 (there was no 18 month survey data in FY 2004-05).
County comparison: All comparison data includes the most recent data. With the exception of data for emergency room utilization, which is from the 2001 California Health interview Survey, all data originates from the 2003 California Health interview Survey. Comparisons are: % of currently insured children, ages 0-5 in San Diego County with a usual place to go when sick or in need of health advice; % of currently insured children, ages 0-5 in San Diego County had seen a doctor a year ago or less; % of children two or older in San Diego County had a dental visit in the past 1-6 months; % of currently insured children, ages 0-5 in San Diego County had visited an emergency room in the past 6 months.
** Indicates increase or decrease from the previous year.
NOTE: Non-responses include people who could not be reached, have moved, as well as disconnected or wrong telephone numbers. Contractors attempted to contact each family 3 times before considering them non-respondents

Maintaining coverage

While providing the uninsured with enrollment services is a key component of HCA, maintaining coverage is equally important. Once enrolled, the follow-up and personal connection of the CAAs and Retention Specialist to the families is a unique feature of the HCA Project, resulting in the high rates of success compared to other insurance enrollment efforts.

HCA contractors exhibited increases in the enrollment status of clients from FY 2004-05 to FY 2005-06. At 6 months, there was a slight increase of 0.4% from last fiscal year. A larger increase is found at the 12 month follow-up comparison, with an increase of 4.0% in the number of clients who maintained insurance for their children. The high retention rate for the past two years is in part attributed to the CAAs and Retention Specialists' follow-up efforts. The follow-up calls provide an opportunity to check in with families, assess additional health needs, and re-enroll families in the State's health plans as needed.

"We try to stress to them if there is any letter they receive in the mail, if there's anything, to give us a call. At least read it to us over the phone. Because sometimes what they tend to do is they get something in the mail and they think 'oh, I know how to fill it out' and they send it back and it's wrong and they get disenrolled."

– First 5 CAA

The positive results of the CAAs work extend beyond merely assisting clients with the application and calling to verify their continued enrollment. CAAs build relationships and develop trust, assisting families with everything from acquiring basic necessities to scheduling doctor's appointments. They ensure that parents understand the importance of keeping all their paperwork, carrying provider verification with them, showing their insurance card at the pharmacy, and keeping their scheduled appointments. One key expert noted that language capabilities and trust are important for reaching and enrolling uninsured immigrant families and their children. These types of culturally competent services build trust and relationships and strengthen families' ability to maintain a medical home and appropriately utilize health care.

Maintaining Linkage to Medical Home

The second goal of the Healthcare Access Project is to link families enrolled in health insurance to medical homes. A medical home is not just having a doctor that you go to regularly, but rather "primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective."[9] Having an ongoing relationship with a health provider has shown to improve health outcomes for children and increase the likelihood of utilizing health services for prevention as well as illness. Survey findings indicate that, through the continued support of the CAAs, families continue to see a primary doctor. If the parent could name their child's clinic or doctor, then it was assumed that a medical home was established.[10] From FY 2004-2005 to FY 2005-06, there was a slight decrease in the percentage of clients who could name their child's clinic or doctor at the 6 and 12 month follow-up (98.2% to 98.0% and 99.0% to 98.4%, respectively). However, both fiscal year percentages are higher than the county comparison of 97.2%.

[9] American Academy of Pediatrics. "The Medical Home [policy statement]." Pediatrics 110 (2002): 184-86.
[10] The survey question, "Can you name this child's clinic or doctor?" was used as a proxy indicator for the establishment of a medical home.

Appropriate Utilization of Services

The third goal of the Healthcare Access Project is to support the appropriate utilization of services by parents to ensure their children are receiving needed preventative health services. One local key expert interviewed recognized that, "there needs to be education for families on how to access and also on how to use and retain coverage. We need to stay connected with them, follow-up. The education piece, that is important." With this type of support, parents learn how to navigate the healthcare system and become advocates for their child's health. This addresses the Commission's goals that children will have access to preventative and comprehensive healthcare services and that families will have the knowledge skills and resources they need to promote their children's optimal health. (See Desired Result 1.2 and 1.3 in Appendix C: Evaluation Framework). There are three utilization outcomes tracked through survey data: utilization of healthcare (visits to the doctor), dental care (visits to the dentist) and emergency room visits. (Also see the text box on Healthy Families and Medi-Cal Outcomes entitled "Are All Plans Considered Equal?" on page 14).

"I would say what works well within, like the way we're doing things, I would say the follow-up after the family is enrolled. Calling them with letting them know if they need help. Before this project I was just enrolling them but I wasn't following-up. By calling them, asking them if they have scheduled the first appointment. They say they don't know how to do it. Then, I will do a three way call with the doctor's office to help them make an appointment."

– First 5 CAA

Visits to the doctor

To determine whether parents were utilizing health care regularly, they were asked at each survey interval if they had taken their child to the doctor or clinic since they enrolled in health insurance. At the 6 and 12 month intervals, there was a slight increase in the percentage of respondents who indicated they had taken their child to the doctor or clinic from last fiscal year (96.4% and 98.1% respectively).

Visits to the dentist

For children 2 years and older, parents were asked if they had taken their child to the dentist since they enrolled in health insurance through HCA.[11] The findings for this fiscal year show a slight decrease at the 6 and 12 month survey intervals:

- At 6 month follow-up, the percentage of children who visited the dentist decreased by 1.8% from last fiscal (59.4% to 57.6%).
- Similarly at 12 months, the number of children who visited the dentist decreased by 1.7% from last fiscal year to (66.2% to 64.5%).

Despite the decrease in dental care utilization, FY 2005-06 findings are still higher than the overall county figures. Local benchmark data states that children visiting the dentist in the last

[11] It is recommended that a child's first visit to the dentist be at one year old according to the American Academy of Pediatric Dentistry. "Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Children." Clinical Guidelines. Chicago, IL: Author, 2003.

six month ranges from 42.6%[12] to 52.8%[13]. This comparison highlights the success of the Healthcare Access Project and the intense follow-up performed by CAAs and Retention Specialists. It is not clear to what extent families enrolled through HCA are also utilizing the services of the Commission's Oral Health Initiative. (See Chapter 2 for details on the Oral Health Initiative). Currently, connections between the two projects are being established to create a more coordinated system.

Visits to the Emergency Room

Inappropriate use of the emergency room for non-emergency needs has financial consequences for the family, congests a system already under stress, and is costly to the healthcare system. Recognizing this, CAAs provide health education to enrolled families to discourage them from using emergency rooms unless absolutely necessary and encourage them to establish and utilize a medical home. CAAs explain the types of situations that warrant an emergency room visit and provide instruction on the 24-hour hotline listed on their insurance cards. To capture the pattern of emergency room visits, clients were asked if they had visited the emergency room since they enrolled in health insurance. At the 6 month survey interval, the percentage of emergency room visits increased by 2.6% from last fiscal year. However, at 12 months, the number of children who had visited the emergency room since insurance enrollment decreased by 4.9% from last year. Since these figures include appropriate use of emergency services, it is assumed that the rates of children who visited an emergency room for a non-emergency are lower.

Hardship Fund

Each contractor has established a Hardship or "Wraparound" Fund to assist families with maintaining their insurance coverage in moments of urgent need. Policies for use and administration of funds are set by each agency. Many families in need are provided with items such as baby supplies and grocery store gift cards. The Hardship Fund alleviates some of the financial burden of paying monthly premiums by assisting families with basic necessities.

[12] University of California, Los Angeles. California Health Interview Survey. 2003. Accessed 17 July 2006. <www.chis.ucla.edu>
[13] First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.

Are all Health Plans Considered Equal? Medi-Cal vs. Healthy Families

Appropriate Utilization of Healthcare

Regardless of the education and number of follow-up interviews provided by the CAA's and Retention Specialist, the differences in health plans appear to have significant impact on the appropriate utilization of healthcare:

- Medi-Cal clients are more likely to be able to name their child's primary care provider than Healthy Families clients ($p < .05$).
- Medi-Cal clients are more likely to have taken their child to their primary care physician since insurance enrollment than Healthy Families clients ($p < .01$). This is most likely the result of the higher co-pays required by Healthy Families.
- Medi-Cal clients are less likely to have taken their child to the emergency room since insurance enrollment than Healthy Families clients ($p < .05$).
- For both fiscal years, Healthy Families clients are more likely to have taken their child 2 years or older for a dental visit than Medi-Cal clients ($p < .01$).

An Interesting Shift

A closer look at the type of insurance in which clients enrolled over the last two fiscal years reveals an interesting shift:

- This fiscal year, enrollment in Healthy Families decreased by 3.2%
- This fiscal year, enrollment in Medi-Cal increased by 3.8%

One explanation for the increase in Medi-Cal enrollment may be that the number of families earning less than $10,000 also increased by 0.7% in San Diego County from 2003 to 2004.* Therefore more families were eligible for Medi-Cal. Three factors possibly contribute to the shift in enrollment for the last fiscal year:

- Increased Healthy Families premiums and co-pays
- Increased Medi-Cal income limits
- Increased percentage of the poorest families.

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* U.S. Census Bureau. American Community Survey 2004. 2004. Accessed 2 August 2006. <www.census.gov>

Case Study #2
Lending a Helping Hand

Maritza has 6 children, ages 10, 9, 7, 5, 4, and 1. She grew up in Oaxaca, Mexico, and moved to the United States 10 years ago, at age 22. Two years ago, while pregnant with her last child, her husband left her. Since then, she has been learning to cope as a single mother and manage things that her husband used to take care of, such as making sure her children have medical insurance. It was not easy, as Maritza is not familiar with the American medical system, does not speak English, nor does she read well. When her husband left, the children lost their health insurance, and Maritza was unclear why. However, thanks to the Certified Application Assistants (CAAs) from North County Health Services (NCHS), she succeeded in enrolling the children in Medi-Cal and maintaining medical insurance for her children.

"[The CAA] helps me, as I don't know how to read very well and all that. She's the one who helps me to send in the papers."
– Maritza, First 5 parent

In her words: "Before my husband would get Medi-Cal, then I don't know what happened. I think they cancelled it, then we applied again for it. I think it was temporary, then we applied again. When we got to the [NCHS] clinic I asked where I could apply, and they sent me to the CAA." Adriana is the CAA who has worked with Maritza over the past two years and provided health and social support during this difficult process.

Utilization

With Medi-Cal insurance, Maritza brings her children regularly to the NCHS pediatrics clinic for vaccinations, check-ups, and dental visits. Maritza shared that she has no money to pay for her children's visits, and without the assistance of the CAA's, her children would not receive preventive medical care:

> *When I have Medi-Cal I feel good because I know that I can bring them and I won't have to pay and they will be seen. When I don't have it I'm worried, knowing that there is no money and if they get sick and I have to bring them in, and if they don't have Medi-Cal, then I have to pay.*

Adriana, the CAA who works closely with Maritza, clarifies how important the Healthcare Access Project is in helping families like Maritza's "navigate the system." Maritza is not familiar with any other local resources for her children, and turns to Adriana for help with issues not limited to health insurance. When Maritza's husband left, for example, it was Adriana who assisted her with the welfare application (she now receives $980 per month for rent). The CAAs have also helped her with a supply of diapers and gift certificates for supermarkets (from the program's Hardship Fund – See text box on page 13). Maritza is grateful because the CAAs are friendly and they speak her native language, Spanish.

Retention

Coincidentally, at the time of this case study, Maritza was unaware that her six children had just been disenrolled a second time from Medi-Cal. When she arrived for this case study, she commented that she recently had taken the baby for a check-up and "the card didn't work." According to her, the baby was given temporary Medi-Cal for a month and she believed that the other five still had insurance. Adriana took action knowing it was likely that the baby and the siblings had all probably been disenrolled:

> *Today I asked her [about her insurance]…To my understanding I don't think any of her children have Medi-Cal right now and I think she told me she was supposed to go to an interview and she didn't go. So it probably just got cancelled a couple of days ago, or maybe at the beginning of this month, so that's why I've scheduled her to come in this week… if one of her kids doesn't have it, then none of them have it. She probably doesn't know [that they've all been disenrolled] because she only brought Jessica (the baby) to the doctor.*

Adriana explained that sometimes Medi-Cal eligibility workers call clients in for interviews, either for annual renewals or simply to talk to the client face-to-face. When interviews are missed, Medi-Cal is often cancelled. Disenrollments like this one are common, where a family loses coverage without understanding the reason. Adriana encourages her clients to keep in touch and to contact her if they have any questions or doubts. Adriana also stressed that her role as a CAA is be proactive in contacting clients. CAAs conduct regular follow-ups with families they enrolled to ensure that enrollment continues.

"We try to stress to them if they receive any letter in the mail if there's anything to give us a call. At least read it to us over the phone. Because sometimes they tend to get something in the mail and think "Oh I know how to fill it out." They send it back and it's wrong and they get disenrolled."

– Adriana, First 5 Provider

Empowerment

When asked if she had observed any changes in Maritza since she was enrolled in Medi-Cal, the CAA replied that Maritza has grown a lot and is beginning to take charge of her life:

> *When she first came in she didn't know anything: how to pay a bill, etc. She probably just knew how to get here and that's it. She probably didn't even know how to take a bus or anything. We've noticed changes in her... She's becoming more independent and stronger, saying no to people. I think she's grown as a person and as a woman. She has finally opened her eyes, at least a little bit…I think she's doing everything on her own, she's the head of household.*

While Maritza may slowly be learning to become an advocate for her children, she is still struggling with the basic challenges of everyday life, such as paying the bills and buying diapers for the baby. Adriana's role through HCA ensures that Maritza will have the support and encouragement to care for her children and navigate the complex system of health care.

Why Families Are No Longer Enrolled

In FY 2005-2006, 5.8% of families (n=334) indicated they were no longer enrolled when the 6 and 12 month follow-up surveys were conducted, approximately one percentage point lower than last fiscal year's results (6.7%, n=190). The most common reasons for losing insurance remain consistent across the years: being disenrolled, no longer eligible, and waiting due to administrative delays. This reaffirms the critical role that CAAs play in following-up with families to ensure continued coverage.

Also notable this year is the 3.3% increase in the number of families who are no longer enrolled at 6 months due to obtaining insurance through an employer. Unfortunately, there is no comparison data for the 12 month survey interval from FY 2004-05. However, when comparing this response category in FY 2005-06 by follow-up survey interval, the findings are similar in that 9.2% of families at 6 months and 10.1% of families at 12 months were no longer enrolled due to obtaining insurance through an employer.

Exhibit 1.4
Reasons Not Enrolled

	FY 04-05	FY 05-06	Difference*
Reasons Not Enrolled at 6-month Follow-up*			
Got Disenrolled/No Longer Eligible	38.7 %	35.9 %	-2.8 %
Other	20.2 %	19.0 %	-1.2 %
Still Waiting/Administrative Delays	10.1 %	13.1 %	+3.0 %
Different Insurance Through Job	5.9 %	9.2 %	+3.3 %
Incomplete Paperwork	7.6 %	8.5 %	+0.9%
Missed Payment	7.6 %	4.6 %	-3.0 %
Doesn't Want/Need Medi-Cal	5.9 %	4.6 %	-1.3 %
Moved	4.2 %	4.6 %	+0.4 %
Total Reasons	**100.0 %**	**100.0 %**	**-**
Reasons Not Enrolled at 12-month Follow-up**			
Got Disenrolled/No Longer Eligible	43.8 %	34.3 %	-9.5 %
Other	21.9 %	17.2 %	-4.7 %
Different Insurance Through Job	0.0 %	10.1 %	+10.1 %
Doesn't Want /Need Medi-Cal	6.3 %	7.7 %	+1.4 %
Paperwork Too Difficult	0.0 %	7.1%	+7.1 %
Didn't Know Had to Renew	9.4 %	6.5 %	-2.9 %
Still Waiting/Administrative Delays	12.5 %	6.5 %	-6.0 %
Never Received Renewal Documents	6.3 %	5.3 %	-1.0 %
Moved	0.0 %	5.3 %	+5.3 %
Total Reasons	**100.0 %**	**100.0 %**	**-**

* Indicates increase or decrease from previous year.
** 6-month follow-up: FY 04-05 n=119, FY 05-06 n=153
*** 12-month follow-up: FY 04-05 n=32, FY 05-06 n=169

Challenges

Although the Healthcare Access Project has exhibited exemplary outcomes and improved enrollment numbers from one fiscal year to the next, there are still challenges to be addressed in the coming year:

Time delays: Similar to last year, the internal processes of Medi-Cal continue to delay the enrollment of families in health insurance. Reasons for such delays include database updates and lost applications, resulting in longer wait times for coverage. One agency reports the wait for confirmed enrollment from Medi-Cal taking more that the allowable 45 days.

Transportation: The summer heat has also had negative repercussions on assistance and enrollment. Many clients find it difficult to travel in high temperatures because they do not have transportation, and utilizing public transportation with children becomes burdensome and expensive.

Adequate staffing: Challenges faced by contractors included staff turn-over and balancing simultaneous activities such as outreach, application assistance, and retention. Staff shortages and leaves of absence have made it challenging to handle unpredictable workloads and have affected clients as well. When clients are transferred to new CAAs, some have found it difficult to deal with different personalities and communication styles, and the special CAA/client relationship can be lost.

Working with the system: There are many systemic challenges that can not be addressed by HCA contractors alone. Systemic issues include administrative delays at the State and County level, as well as flaws in the disenrollment policies of health plans. While First 5 San Diego staff and representatives from San Diego's County Health and Human Services Agency have met to strategize around these issues, one key expert noted that more could be done: "We need to sit down and do something, an alignment together. It is more than just signing them up [for health insurance]. It is education and [then] using it. Major players in the County and First 5 could do better coordinating [activities]." First 5 San Diego staff will continue to collaborate with Health and Human Services Agency representatives to improve healthcare access and its processes.

Lessons Learned

Communication and collaboration: Communication and collaboration with project peers and other local community based programs continues to be a cornerstone of this project. The contractors are motivated to improve their services and as a result, some agencies within and across regions meet regularly to share best practices as well as issues, concerns, and problems, and present them in a collaborative effort to find solutions. Communication with other service providers, such as schools or women's centers, has also increased the number of referrals to and from the project.

Cross-training and streamlining: This fiscal year, Retention Specialists were trained in the duties of CAAs. This increased program capacity and resources for application enrollment as it allowed them to step into the role of CAA when needed. Additionally, CAAs are now

responsible for their own retention activities, instead of referring families to another individual. Clients report satisfaction with the consistency and continuity of working with the same person at every stage of the process; it establishes rapport and builds strong relationships and trust, which could be a factor in this year's increased retention and utilization of services.

Continuous Training: CAAs received more training on enrollment processes, which may have contributed to the increased number of children enrolled. Trainings to coordinate efforts of service delivery were provided by project coordinators in partnership with the Council for Community Clinics. This has created new opportunities to partner and strengthen relationships at the local, regional and county levels.

Connecting across First 5: Some HCA contractors and CAAs have started working with the providers of the Oral Health Initiative (OHI). It is anticipated that more of these types of linkages will occur during the next fiscal year.

Promising Practice: The Checklist

Providing services to families in need is a priority, but client satisfaction with services is equally important. Program and service delivery improvements are needed to ensure that clients leave informed and with all their questions answered. One HCA agency developed a client checklist designed to ensure that clients receive and understand all the necessary information during their enrollment appointment. Clients are asked to initial by each item explained by the CAA if they completely understand it, and confirm that all their questions have been answered. This new system empowers clients to ask questions of the program staff, thus gaining the skills and knowledge to advocate for their families. The CAAs use it as a tool to convey all necessary information to clients.

Recommendations

The Commission might consider the following recommendations as the Healthcare Access Project continues to progress:

1. Utilize the Hardship Fund for Transportation. Some families were unable to make appointments due to transportation issues. Consider utilizing the Hardship Funds for this support.

2. Continue to Provide Ongoing Training. One challenge has been the retention of the CAA and retention specialists themselves. Whether this is due to temporary loosing staff for sick or maternity leave or a staff person's permanent departure from the agency, continuous training should be pursued.

3. Collaborate with other First 5 Projects: The Healthcare Access Project contractors have started to work with other First 5 projects such as the Oral Health Initiative. It is strongly urged that this collaborative process continue to create a larger system of coordinated services.

4. Collaborate with the County's Access to Care for Children Team (ACT): Access to Care for Children Team (ACT) is a County program that identifies the location of potentially underserved areas in the community. ACT's Opportunity Analysis, which identifies potential underserved areas by census tracts, is beginning to analyze data collected through GIS mapping. This analysis could enable County agencies to pinpoint pockets of potentially uninsured families in specific neighborhood blocks. HCA and ACT should continue working together toward their goal.

5. Problem solve with the County: This year, contractors started dialogues with the County Health and Human Services Agency to work together on insurance enrollment and retention procedures. This kind of partnership is strongly encouraged to continue addressing administrative delays and other systemic barriers.

A Final Word on Healthcare Access Project

For the past two years, the Healthcare Access Project has been successfully providing outreach and support services that increase health insurance enrollment, retention and appropriate healthcare utilization for children 0-5 and pregnant women in San Diego County. The steady improvement of the project's outcomes indicates that the project continues to enhance its service activities and provide a valuable service for the families. However, the project also continues to struggle with system-level challenges, such as processing delays of Medi-Cal and Healthy Families applications, and local challenges, such as outreaching to families most in need. By continuous cross-county dialogue about these challenges both within First 5 and with other County agencies, it is anticipated that the results of this project will continue to be positive.

Chapter 2
Oral Health Initiative

Key Results

Previously undetected oral health concerns were identified: Oral health screenings revealed concerns in more than a quarter of children and almost half of pregnant women.

Patients entered the oral healthcare system for the first time or after a delay in care: Nearly two-thirds of children and more than three-quarters of pregnant women examined had either never received a dental exam before or had not received an exam within the past year.

The proportion of patients with untreated dental decay decreased following routine treatment: Roughly half of patients had dental decay initially but only 2.4% of children 0-5 and 1.5% of pregnant women had dental decay after routine treatment.

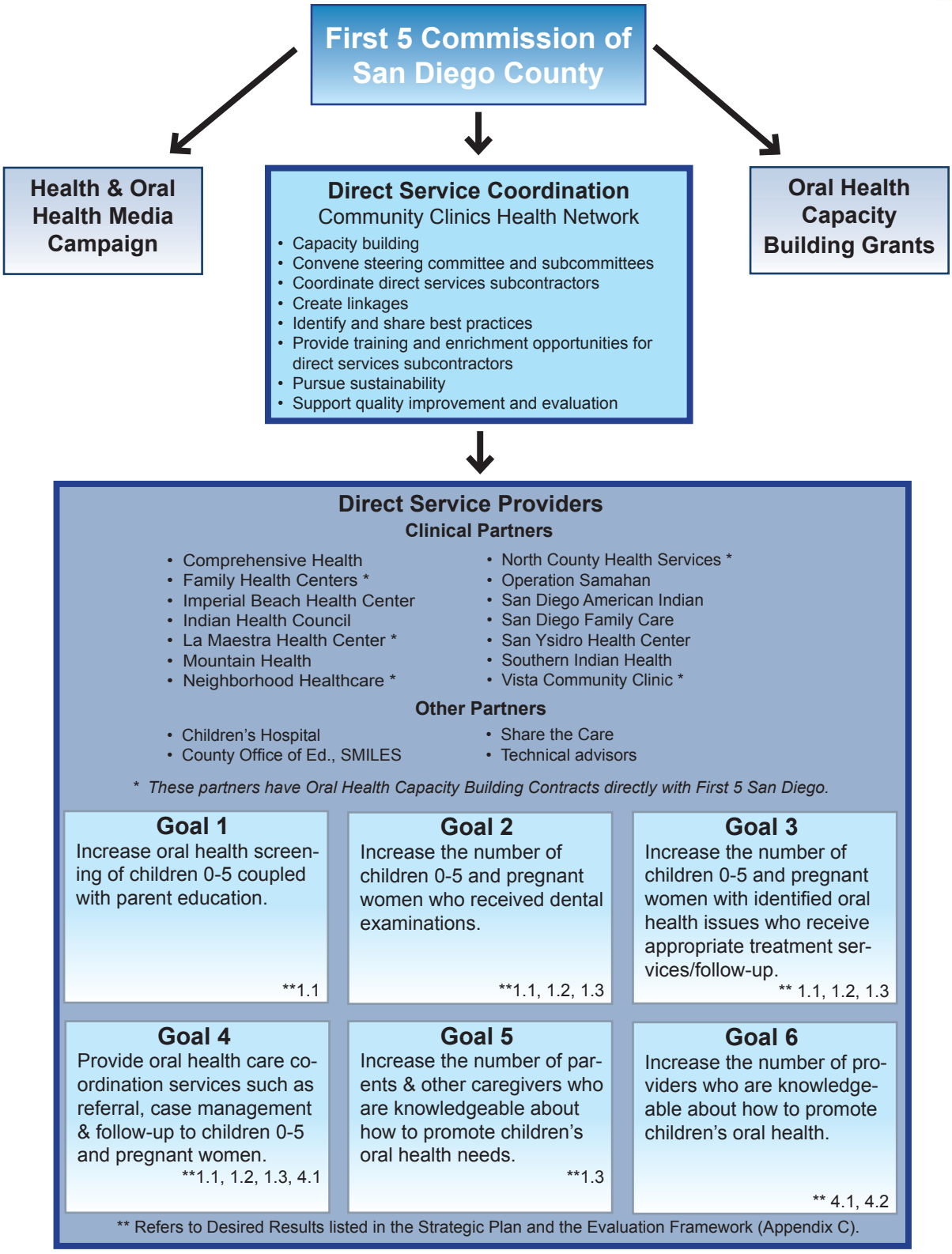
Care coordination services connected patients to needed services: While the complexities of the service system complicated patients' ability to access care, overall, most care coordination referrals resulted in receipt of services.

Service capacity increased: 12 new operatories were built, or are in the process of being built. Additionally, survey results suggest most dentists who were trained through the Initiative are likely to increase the number of children 0-5 in their practice.

Summing It Up

- 24,560 children 0-5 and 1125 pregnant women participated in oral health screenings
- 12,242 children 0-5 and 649 pregnant women received dental exams
- 8842 children 0-5 and 343 pregnant women obtained routine dental treatment, and 637 children 0-5 obtained specialty dental treatment
- 4285 children 0-5 and 897 pregnant women participated in care coordination
- Over 13,000 parents, caregivers, and pregnant women received oral health education
- More than 170 dental and healthcare providers were trained about oral health issues
- In addition, dental infrastructure was built and media messages reached the community

Oral Health Initiative Design



Introduction

Tooth decay is an epidemic in young children. According to the U.S. Surgeon General, tooth decay is "the single most common chronic childhood disease – five times more common than asthma."[1] Tooth decay affects more than a quarter of children ages 2-5 in the United States.[2] Similarly in California, a recent survey revealed that more than a quarter of kindergarteners (27.9%) had untreated dental decay.[3]

While a cavity is sometimes considered an isolated problem, easily repaired with a filling, it is actually evidence of a systemic infection. The bacteria that cause tooth decay in a child constitute a serious disease. Untreated oral health disease may cause pain; affect a child's nutritional status and diet, sleep patterns and appearance; impair psychological status and social interaction; and cause problems with speech and language development.[4, 5, 6] Given the range of problems that can be caused by oral health disease, poor oral health affects children's ability to function in school.[7] The pain of untreated tooth decay can lead children to miss school; treating tooth decay can also lead to absences.[8] Addressing children's oral health needs before they enter school is a step in ensuring they arrive ready to learn.

The Oral Health Initiative (OHI) launched its services in Spring 2005 to address the growing concern of oral health and its connection to the school readiness of the County's children. The Commission approved $4.2 million for OHI to support direct services and capacity building through the spring of 2007. During FY 2005-06 the Commission invested $1,979,628 in these activities.[9] The Commission's latest five year allocation plan includes a commitment to oral health services through FY 2009-10, and an additional $4 million of funding. OHI includes three components: 1) direct services for children and pregnant women; 2) capacity building contracts to build and enhance dental facilities to serve this population; and 3) a media campaign. The intent of OHI is to meet oral health needs on a coordinated, comprehensive, countywide basis, while meeting the needs of unique geographic and culturally diverse communities.

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[1] Satcher, D. Oral Health in America: A Report of the Surgeon General. Washington, DC: U.S. Department of Health and Human Services, 2000.
[2] Centers for Disease Control and Prevention. Oral Health: Preventing Cavities, Gum Disease and Tooth Loss. 2006. Accessed 13 July 2006. < http://www.cdc.gov/nccdphp/publications/aag/oh.htm >
[3] Dental Health Foundation. Mommy, It Hurts to Chew, the California Smile Survey; An Oral Health Assessment of California's Kindergarten and 3rd Grade Children. Oakland, CA: Author, 2006.
[4] Centers for Disease Control and Prevention. Oral Health: Preventing Cavities, Gum Disease and Tooth Loss. 2006. Accessed 13 July 2006. < http://www.cdc.gov/nccdphp/publications/aag/oh.htm >
[5] Satcher, D. Oral Health in America: A Report of the Surgeon General. Washington, DC: U.S. Department of Health and Human Services, 2000.
[6] Centers for Disease Control and Prevention. Preventing Chronic Diseases: Investing Wisely in Health – Preventing Dental Caries. 2005. Accessed 13 July 2006.
<http://www.cdc.gov/nccdphp/publications/factsheets/Prevention/oh.htm>
[7] Satcher, D. Oral Health in America: A Report of the Surgeon General. Washington, DC: U.S. Department of Health and Human Services, 2000.
[8] Ibid.
[9] These figures do not include funds for the health and oral health media campaign, as its focus is not exclusively oral health.

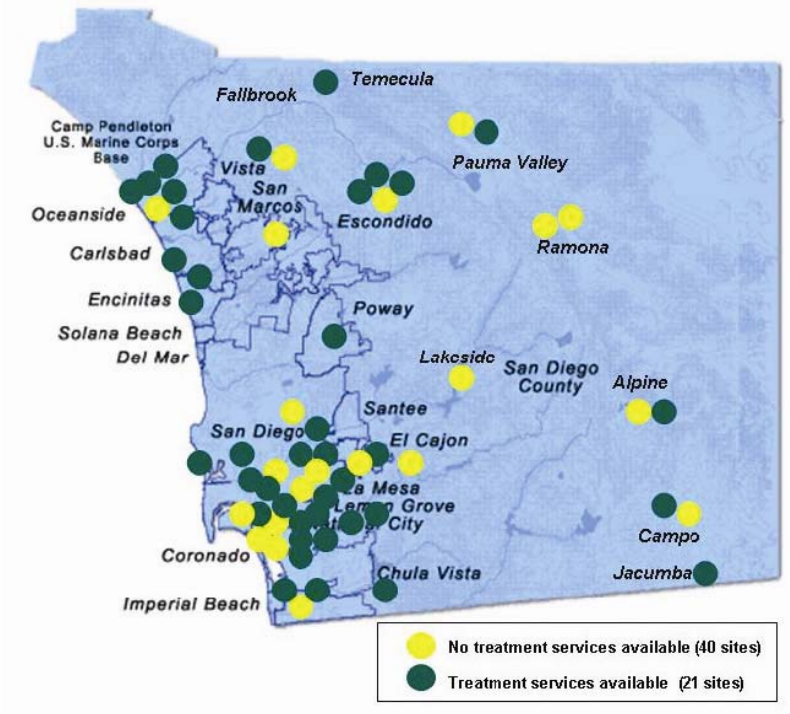
Key Elements of the Oral Health Initiative

The provision of oral health services reflects the Commission's 2004-2009 Strategic Plan, "Issue Area 1: Children's Health," Desired Result 1.1, *children are born and stay healthy*, and Desired Result 1.2 *children have access to preventative and comprehensive healthcare services*. The Oral Health Initiative also address "Issue Area 4: Systems Improvement and Community Change," Desired Result 4.1 *communities have adequate service capacity that is effective, coordinated, integrated and sustainable*, and 4.2 *families have access to culturally and linguistically responsive services*.

As illustrated in the diagram on the cover page of this initiative, the largest component of the Initiative is an oral health direct services project. The Community Clinics Health Network (referred to in this chapter as "the lead agency") oversees the project, which unites more than a dozen subcontracted programs (referred to in this chapter as "OHI programs") across the County. As the map (Exhibit 2.1) illustrates, some programs operate at more than one site, creating an expansive network of care, providing services in six goal areas:[10]

1. Oral health screenings for children 0-5 and pregnant women
2. Dental examinations for children 0-5 and pregnant women
3. Treatment services and follow-up for children 0-5 and pregnant women
4. Care coordination services for children 0-5 and pregnant women
5. Oral health education for parents and caregivers of children 0-5, pregnant women, childcare providers, and staff at community-based organizations
6. Training for prenatal care providers, general dentists and primary care providers

Exhibit 2.1
Service Sites for First 5 San Diego
Oral Health Direct Services Project



[10] Not all OHI programs address all six goals areas. Some focus on one or two goals, while others offer a broader range of services. Programs offer services in line with their capacity (e.g. if they have a dental clinic that can provide treatment services) and their expertise (e.g. specialization in a particular service).

Summing it Up: Individuals Served by OHI

The oral health direct services project touched thousands of children 0-5, pregnant women, and parents of children 0-5 during FY 2005-06, along with hundreds of health and child care providers. The project greatly exceeded its targets in all but three areas: dental exams for pregnant women, routine treatment for pregnant women, and provider training for general dentists. Exhibit 2.2 summarizes the total number of individuals who received direct services during FY 2005-06.[11] Providers excelled at providing oral health services for children 0-5. The 12-Month Targets for screening, exam, treatment, and care coordination of children 0-5 were greatly surpassed. By contrast, providers struggled to meet their 12 targets in a number of goal areas. Screenings, care coordination, and caregiver education exceeded their targets, while dental exams and treatment did not meet their targets.

Exhibit 2.2
Number of Individuals Receiving Direct Services, by 12-Month Targets FY 05-06*

Goal Area	12-Month Target	Actual	% of 12-Month Target
Goal 1: Oral Health Screenings			
Children 0-5	5000	24,560	491.2%
Pregnant Women	1000	1125	112.5%
Goal 2: Dental Exams			
Children 0-5	3500	12,242	349.8%
Pregnant Women	700	649	92.7%
Goal 3: Treatment			
Children 0-5, Routine Treatment	3500	8842	252.6%
Pregnant Women, Routine Treatment	700	343	49.0%
Children 0-5, Specialty Treatment	100	637	637.0%
Goal 4: Care Coordination			
Children 0-5	3000	4285	142.8%
Pregnant Women	600	897	149.5%
Goal 5: Caregiver Education			
Parents of Children 0-5	4500	10,601	235.6%
Pregnant Women	600	2111	351.8%
Childcare Providers and CBO Staff	250	346	138.4%
Goal 6: Provider Training			
Prenatal Providers	30	45	150.0%
General Dentists	100	70	70.0%
Primary Care Providers	40	59	147.5%

*The oral health direct services project began services in April of 2005. These annual targets represent the number of individuals to be served in the twelve months between April 1, 2005 and March 31, 2006; and again between April 1, 2006 and March 31, 2007. There are no explicit targets for the fiscal year. However, as the fiscal year is also a twelve month period, the annual targets have been cited here as "12-Month Targets".

[11] OHI programs collect and report monthly unduplicated counts of the number of individuals served under each goal area. However, client level data collection is not currently in place, as they would place undue burden on the programs. Therefore, the total number of individuals served may include duplicate counts as the same individual may have accessed services in more than one goal area and/or month.

Making a Difference: Oral Health in Action

The six goals of the Initiative's direct services project were further refined and expressed as a series of process measures and outcomes. Each month, OHI programs report these data elements in aggregate. The evaluation centers on understanding how many children 0-5 and pregnant women were reached, received appropriate preventative dental care, and connected to treatment. In addition, the evaluation captures oral health provider education results.[12]

To minimize duplicate data collection, each OHI program tracks their data in the manner most appropriate for their site; programs track pre-defined data elements but the data is housed in different places at each site.[13] All programs then report their aggregated monthly data in a customized, Excel-based tracking tool. In addition, several qualitative methods complement numeric data in the evaluation design: a focus group with Care Coordinators; a case study recounting the experience of one family with three OHI programs; in-person intercept interviews with 14 parents accessing direct services[14]; and telephone interviews with three key experts in maternal and child oral health. In addition, 15 OHI programs and the lead agency responded to a pen-and-paper "OHI program survey" designed to assess the project's functioning and sustainability. The findings of all of these methods are interwoven throughout the chapter.

Goal 1: Oral Health Screenings

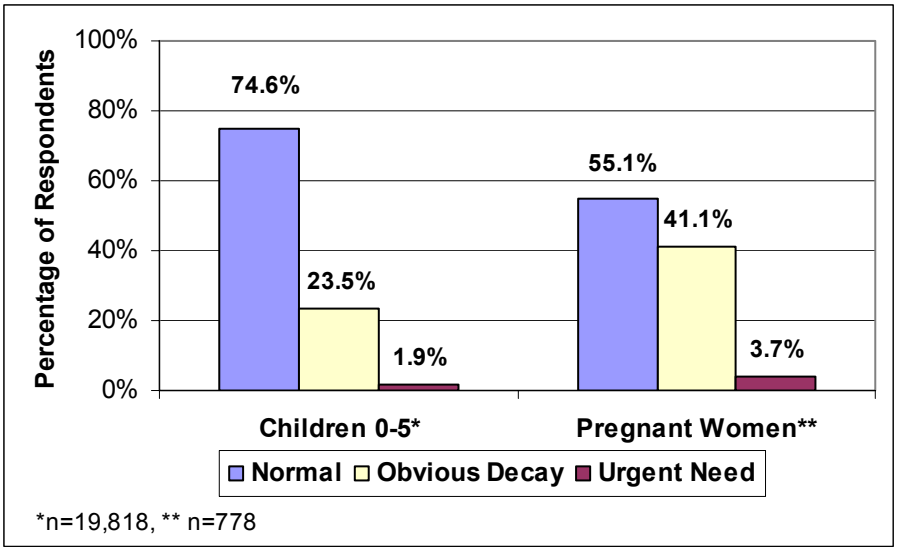
Some OHI programs offered screenings prior to First 5 funding. However, joining the Oral Health Initiative afforded other programs the opportunity to introduce oral health screenings into their practice. This service system enhancement is important, since both the American Academy of Pediatrics and the American Academy of Pediatric Dentistry recommend that every infant should receive an oral health risk assessment from a qualified pediatric health professional by six months of age.[15, 16, 17] Considering these clinical guidelines, it is notable that 31.7% of children screened were under one year of age.[18]

[12] "Providers" refers to prenatal care providers, general dentists, and other primary care providers.
[13] For example, there is a common definition of "dental exam" but programs track exam data via billing software, appointment calendars, manual counts, or a combination of data tracking systems.
[14] Intercept interviews with parents were conducted in lieu of the scheduled focus group. Parents come to dental clinics infrequently, so it is best to speak with parents individually while they wait for their child's appointment, rather than schedule a separate meeting for parents to discuss as a group. For this reason, the number of interviews completed is consistent with the number of participants expected to attend a focus group.
[15] American Academy of Pediatrics. "Oral Health Risk Assessment Timing and Establishment of the Dental Home." Pediatrics 111.5 (2003): 1113-1116.
[16] American Academy of Pediatric Dentistry. "Guideline on Infant Oral Health Care." Clinical Guidelines. Chicago, IL: Author, 2004. 68-71.
[17] "Pediatric health practitioners" include pediatricians, family practitioners, nurse practitioners, and physician assistants; in general, any licensed medical practitioner.
[18] Represents the percent of children 0-5 for whom OHI programs reported age (18,476 of the 24,560 total children 0-5 screened). It is not possible to determine the number of children under age who were less than six months of age at the time of screening since programs report aggregate data.

Detecting previously undetected oral health concerns

Oral health concerns were identified in thousands of children 0-5 and pregnant women through the screenings provided as part of the Oral Health Initiative (Exhibit 2.3). Screenings revealed obvious decay or urgent dental needs in more than a quarter of children 0-5 and almost half of pregnant women screened.[19, 20] These findings suggest a pressing need to connect screening recipients with abnormal results to treatment, a service OHI programs are well-poised to provide given their mandate to coordinate care.

Exhibit 2.3
Results of Oral Health Screenings FY 05-06



Out of the office and into the community

An oral health screening is a simple procedure that requires little equipment. While dental clinics are the preferred choice of setting, providing screenings at medical clinics can reach patients during well-child and prenatal visits. OHI programs also offer screenings in the community, beyond the clinic's doors. For example, subcontractors provided screenings at preschools and childcare centers, WIC offices, health fairs, and community gatherings.

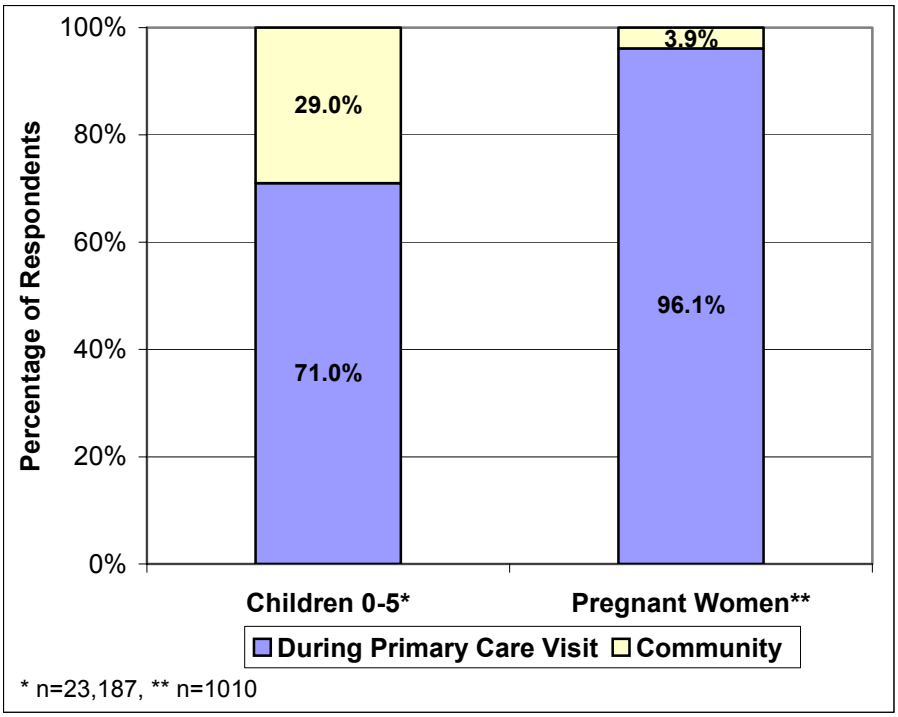
During FY 2005-06, 29.0% of children 0-5, and 3.9% of pregnant women received screenings in community settings (Exhibit 2.4).[21] Seven of the 13 OHI programs that offered screenings provided some screenings in the community. For individuals reached at these non-clinic settings,

[19] No population-based comparison data is available for pregnant women or for children 0-5 at the county-level.
[20] For comparison, in California, slightly more than 20% of kindergarteners screened were found to need early dental care, and approximately 4% needed urgent dental care. Dental Health Foundation. Mommy, It Hurts to Chew, the California Smile Survey; An Oral Health Assessment of California's Kindergarten and 3rd Grade Children. Oakland, CA: Author, 2006. Note that the Dental Health Foundation screenings and the First-5 funded screenings did not use the exact same screening protocol, but both did use similar methods to screen children and both categorized the extent of decay in three roughly analogous categories.
[21] Represents the percent of children 0-5 and pregnant women for whom OHI programs reported a screening location (23,187 of the 24,560 total children 0-5 screened; 1010 of the 1125 total pregnant women screened).

dental problems may have remained undetected if not for the efforts of OHI programs to screen in a variety of settings.

The ability of OHI programs to reach children outside the clinical setting is evidence of how First 5 can extend oral health services to children who may not have access to dental care. Both the Care Coordinators in the focus group and the providers interviewed for the case study expressed how the broad reach of oral health screenings makes this approach one of the project's most valuable components. As one provider noted, "the screenings are great, the sealant clinics are great. Those things are all helpful."

Exhibit 2.4
Settings of Oral Health Screenings



Brusha-Brusha-Brusha: Tooth-brushing and Oral Health Behaviors at Home

Tooth brushing

Young children generally lack the fine-motor skills needed to properly brush their own teeth.* A simple rule is that an adult should brush a child's teeth until the child can write in cursive, a level of dexterity few children have before age six. One Care Coordinator shares how she often sees poor hygiene in children who brush their own teeth, "I ask the parents: 'Who brushes the child's teeth?' and they say 'He (the child) does.' But the kids need help. They have a lot of plaque on the [gum] line [because they can't brush as well as an adult could]." Many of the parents interviewed reported that their children 3-5 brush their own teeth. Of 11 such children, four brushed their teeth (either once or twice) with no help from an adult on the day prior to the interviews; three brushed their teeth twice but had an adult brush them once; and four had their teeth brushed by an adult twice or more than twice. While this anecdotal evidence cannot be inferred to represent the County as a whole, it is valuable in that it offers a glimpse into the oral health practices of a few families.

Fluoride

With few exceptions, children in San Diego County do not have fluoridated tap water, commonly found in many other areas. For that reason many children in the County are advised to take supplemental fluoride, ** Roughly half parents of children 3-5 interviewed (6 of 11 parents) reported that the toothpaste their child used the day prior to the interview contained fluoride (all 11 children used toothpaste at least once). Most brands contain fluoride, though non-fluoridated toothpaste is available. The other five parents were unsure if the toothpaste contained fluoride, which may suggest parents are unaware of fluoride's importance. Additionally, only three of the 13 children over six months of age take supplemental fluoride (e.g. prescription vitamins with fluoride). Infants and young children need "optimal exposure" versus over-exposure to fluoride, which can be dangerous during tooth development. Therefore, providers must advise parents about fluoride supplementation based on the unique needs of each child, ***, **** It may be that children who do not take supplemental fluoride have been advised not to, or they may need it but are not getting it.

Baby-bottle syndrome

Dental and medical providers alike report that "baby-bottle syndrome" (rampant tooth decay in infants and very young children) is widespread among OHI programs' patients. However, only one of 14 parents interviewed reported that her child takes a bottle or sippy cup to bed. Parents may have under-reported these behaviors if they know the practice is discouraged by doctors and dentists. Regardless, the effects of taking a bottle or sippy cup to bed could be detrimental to any child.

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* American Academy of Pediatric Dentistry. Quick Tips for Busy Parents: Brush Up on Tooth-brushing. Accessed 30 July 2006. <http://www.aapd.org/hottopics/news.asp?NEWS_ID=433 >

** Many providers believe that the county needs to fluoridate its water supply. However, others point out that decay would be significant even if San Diego had fluoridated water. Providers report seeing the most decay among children newly emigrated from Mexico. These children would not customarily drink from faucets since bottled water is generally preferred in Mexico. As one provider explains, "They might cook with it…but the group that's most vulnerable is also the least likely to use the city water system."

*** Hale K.J. and K. Heller. "Fluorides: Getting the benefits, avoiding the risks." Contemporary Pediatrics. 17.2 (2000): 121.

**** American Academy of Pediatric Dentistry. "Policy statement on the use of fluoride." Pediatric Dentistry. Chicago, IL: Author. 26 (2004): 28-29.

Goal 2: Dental Exams

Current guidelines from the American Academy of Pediatric Dentistry specify that children should visit a dentist for an exam no later than age one, and routine exams should be repeated every six months.[22] These visits are also the foundation of a child's dental home, making dental exams a particularly important service to have in the community. Similarly, the mother's dental home often becomes her child's dental home, making outreach to pregnant women especially important. Preventative dental care is most important for pregnant women as studies have found an association between gum disease and poor birth outcomes including preterm delivery and the delivery of low birth weight babies.[23, 24]

Additionally, dental exams are often the point of entry where patients are routed to the needed restorative treatment, a task often accomplished with the help of a First 5-funded Care Coordinator.

Stopping the Spread of Decay: Fluoride Varnish and Sealants

While many of the services provided by OHI programs focus on prevention rather than treatment of oral health disease, there are a few notable treatment procedures. The application of fluoride varnishes and dental sealants are effective both clinically and in terms of cost. An interviewed key expert explains:

> *Fluoride varnish… [is] an opportunity to reduce the number of kids with decay....A little fluoride kit is only about two dollars and takes about five minutes to apply. The recommendation is for children under six, which is your First 5 population. Medi-Cal would pay for up to three applications per year.**

In FY 2005-06, OHI programs reported applying fluoride varnishes to the teeth of 5,956 children 0-5 during oral health screenings and dental exams. In addition, 619 children 0-5 received sealants during oral health screenings and dental exams. These figures should be considered the *minimum* number of children who received these treatments, as programs do not report a definite number of children who *do not* receive them. Therefore, the actual number of children who received fluoride varnishing and sealants may be higher than reported.

While these numbers represent a small proportion of the total number of children screened and examined, they are noteworthy since fluoride varnishing and sealants are potent defenses against the spread of decay.

* It is notable that Medi-Cal would pay for fluoride varnish because this represents an opportunity to leverage First 5 funding. First 5 supports the staff that administers the fluoride varnish treatment, then Medi-Cal reimburses the provider for the service. Unless providers have the capacity to deliver services, Medi-Cal reimbursement is irrelevant.

[22] American Academy of Pediatric Dentistry. "Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Children." Clinical Guidelines. Chicago, IL: Author, 2003. 84-86

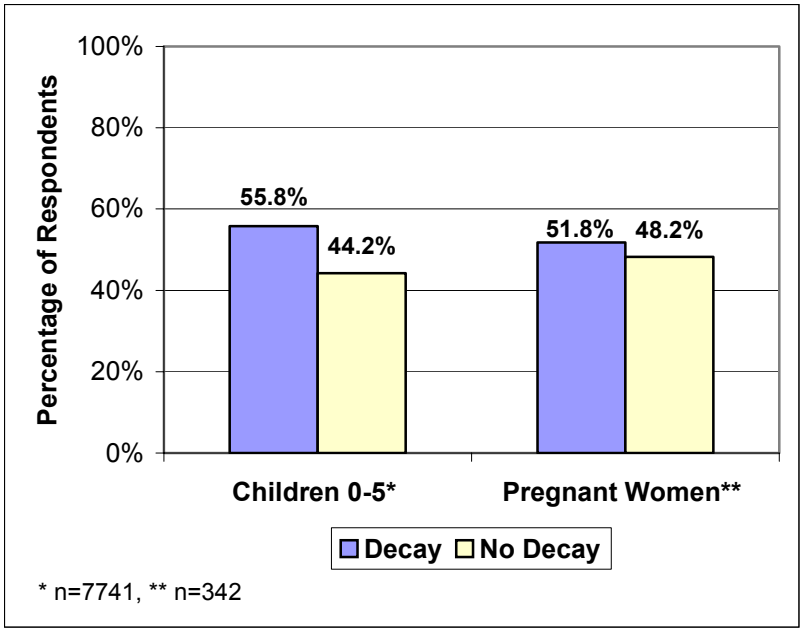
[23] Garfield, M. L., B. J. Clooey-Gilbert, D. M. Malvitz and R. Romaguera. "Oral health during pregnancy: An analysis of information collected by the Pregnancy Risk Assessment Monitoring System." Journal of the American Dental Association. 132.7 (2001): 1009-1016.

[24] Offenbacher, S., V. Katz, G. Fertik, et al. "Periodontal infection as a possible risk factor for preterm low birth weight." Journal of Periodontol. 67.10 (1996): 1103-13.

Detecting previously undetected oral health concerns

More than half of children 0-5 and pregnant women examined had dental decay (Exhibit 2.5).[25] Identifying the need for restorative treatment is the first step in repairing a mouth damaged by decay. However, it can be difficult to complete a patient's treatment plan, as found in the case study, "Open Wide."

Exhibit 2.5
Results of Dental Exams FY 05-06



Bringing patients into the oral healthcare system for the first time or after a delay

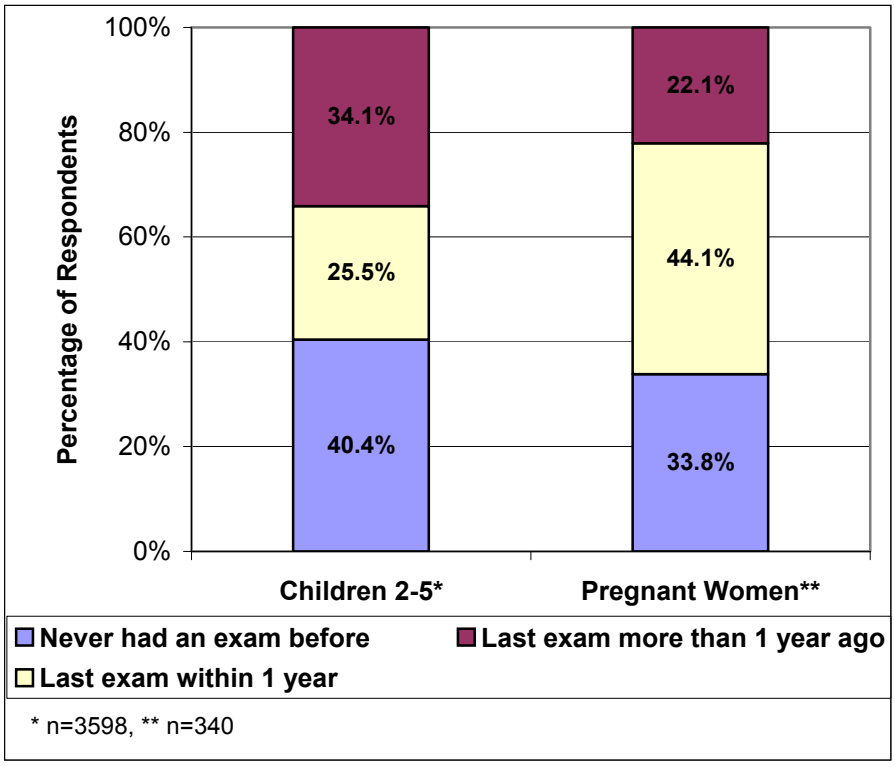
While clinical guidelines for pediatric care recommend children have a dental exam every six months, Healthy People 2010 sets the more modest goal of annual dental visits, aiming for fifty-six percent of children[26] and adults to have visited the dentist within the past year.[27] To simplify data collection, OHI programs reported the length of time since patients' last dental exams in three categories: never visited the dentist; last visited the dentist *more than one year ago*; and last visited the dentist *within the past year*.[28]

[25] Represents the percent of children 0-5 and pregnant women for which OHI programs reported exam results (7,741 of the 12,242 total children 0-5 examined; 342 of the 649 total pregnant women examined).
[26] Objective 21-10 includes children over age two.
[27] Office of Disease Prevention and Health Promotion. "With Understanding and Improving Health and Objectives for Improving Health." Healthy People 2010: Volume II. Washington, DC: U.S. Department of Health and Human Services, 2000. Accessed 13 July 2006. <www.healthypeople.gov>
[28] Both the American Academy of Pediatric Dentistry and the American Academy of Pediatrics recommend children begin annual dental exams by their first birthday. Therefore, by age two, a child should have had an exam within the past year. OHI programs do not report last dental exam data for children under age two.

OHI programs report 40.4% of examined children 2-5 had never received a dental exam and another 25.5% received their last dental exam more than a year ago. Over one-third (33.8%) of pregnant women had never received a dental exam and 44.1% received their last exam more than a year ago (Exhibit 2.6).

These findings contrast sharply with figures for the county and state for both children 0-5 and pregnant women. In San Diego County, 60.5% of children ages 2-5 had visited the dentist within the past year, according to the 2005 First 5 Family Survey.[29] Statewide, 69.9% of kindergartners had been to the dentist within the past year; 12.9% had been to the dentist before but it was more than a year ago, and 17.2% of kindergarteners screened had never been to a dentist.[30] It is estimated that between 67.0% and 84.3% of pregnant women in California (ages 18-44) have received dental care in the past year.[31] The differences between OHI patients and their peers indicate success of the direct services project's in bringing dental services to children who need them, and who may not receive this necessary care in the absence of such a Commission-funded effort.

Exhibit 2.6
Lapse of Time since Last Dental Exam



[29] First 5 San Diego. San Diego Family Survey. San Diego, CA: Author, 2005.
[30] Dental Health Foundation. Mommy, It Hurts to Chew, the California Smile Survey; An Oral Health Assessment of California's Kindergarten and 3rd Grade Children. Oakland, CA: Author, 2006.
[31] Timothé P., P.I. Eke and S.M. Presson. "Dental care use among pregnant women in the United States reported in 1999 and 2002." Preventing Chronic Disease. 2.1 (2005).<http://www.cdc.gov/pcd/issues/2005/jan/04_0069.htm>

Oral Health Capacity Building Contracts

In 2005, the Commission awarded six Oral Health Capacity Building Contracts.* As one key expert stated, building dental infrastructure allows First 5 to leave a legacy in the county when Proposition 10 tax monies decrease with declining smoking rates. All contracts included funding for dental equipment: a total of twelve new and/or improved dental operatories to serve children 0-5 and pregnant women. Five were also funded to hire additional dental staff; two were to provide parent and caregiver oral health education; and one received funding to train providers.**

Results: it was built, did they come?

With these improvements, the contractors expected to increase the number of screenings, exams, and treatment services delivered to children 0-5 and pregnant women. Each clinic set its own targets based on the number of individuals served the year prior to receiving funding.*** Contractors reported varying degrees of success:

- Three of the six contractors reported increases in the number of screenings, exams and/or treatment services delivered to children 0-5 and/or pregnant women
- Two contractors experienced decreases
- One has yet to open the new facilities due to delayed building permits and inspections.

Five of the six awardees are also part of the oral health direct services project. For these clinics, overlapping funding has the potential to create a well-equipped, wrap-around system of care.

Challenges

The clinics noted several challenges during the course of FY 2005-06:

- All six clinics faced logistical challenges in implementing their capital improvements such as delayed equipment orders, building permits, and inspections.
- Additionally, all five of the clinics that completed their building projects encountered difficulties recruiting, referring, and delivering oral health services to pregnant women.
- Two of the five clinics that completed their building projects had difficulties recruiting and retaining quality oral health providers, and did not have the staff available to utilize their new equipment to capacity.
- Five clinics had pediatric dentists and dental assistants on staff at some point during FY 2005-06. Even so, these were often part-time positions; two of these clinics were only able to serve their target population two to four days per month.
- A need for additional Spanish language educational materials and information regarding oral health services for pregnant women was also cited by two of the five clinics that completed their building projects.

Many of these challenges are echoed in the experience of the larger oral health direct services project. These difficulties are endemic to the system of care in San Diego County at this time, and offer the Commission the opportunity to address these pressing needs in its future work.

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* The six clinics are: Community Health Systems, Inc., Family Health Centers of San Diego, La Maestra Community Health Center, Neighborhood Healthcare, North County Health Services, and Vista Community Clinic.
** Providers include pediatric dentists, registered dental assistants and hygienists, outreach workers and administrative staff. Training was to train outreach workers, medical and dental staff on anticipatory guidance and oral health screenings, exams, and treatment.
*** For example, one clinic intended to examine 9480 children 0-5 and pregnant women the year following the completion of the capacity building activities, compared to 3522 children 0-5 and pregnant women the year prior. The clinics' self-made targets increased by a range of 20-300%.

Goal 3: Treatment

The treatment of dental caries is vitally important to prevent further proliferation of the disease within the patient's own mouth. Treatment also reduces the likelihood of the patient passing bacteria to others; for example, from mother to baby. The Oral Health Initiative provides two different levels of treatment as part of the direct services it funds:

…Parents ask, "Why to worry about the baby teeth? They are going to lose them, they're not too important".
– First 5-funded Care Coordinator

- Routine treatment for children 0-5 and pregnant women
- Specialty treatment and tertiary care services for children 0-5

Routine treatment for children 0-5 and pregnant women

Routine treatment includes fillings, crowns, root canals, and extractions. Generally these restorative procedures are performed with local anesthetic and/or nitrous oxide ("laughing gas"). Since routine treatment services are not performed under sedation or general anesthesia, they require patients to be cooperative, which can be a challenge for very young children.

"Now that we started [providing First 5-funded oral health services], we see more children. Now [our dentist] is doing [fluoride] varnishes, prophy treatments (teeth cleanings) right away, it doesn't matter. If he sees a child with severe decay he starts right away… [he] pulls out the decay and puts in temporary fillings. …Before we didn't have the treatment."
– First 5-funded Care Coordinator

The extent of the problem: number of procedures vs. number of children served

For every 100* children 0-5 who underwent routine treatment…

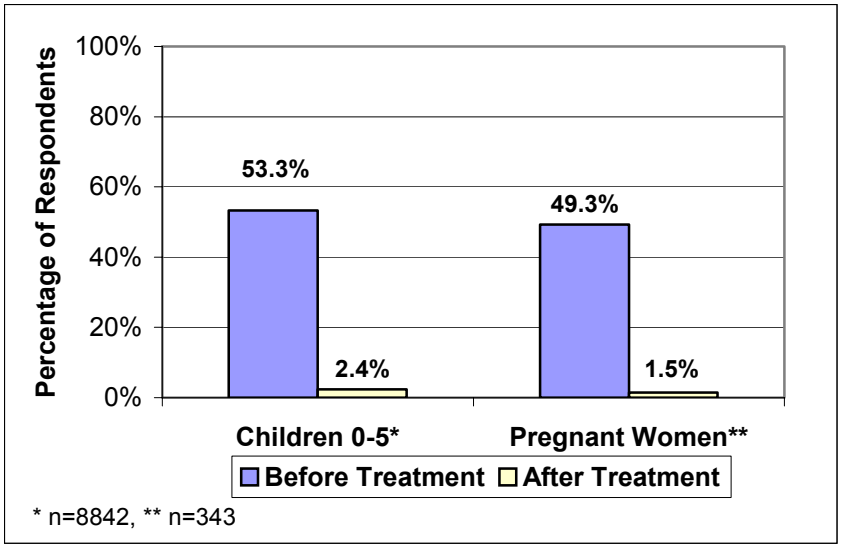
- Fifty-five teeth were filled
- Six teeth were crowned
- Five pulpotomies (baby tooth root canals) were performed
- Four teeth were extracted

* FY 2005-06; the number of procedures per 100 children is rounded to the nearest whole number.

The OHI programs that offer routine treatment detailed the restorative procedures they performed. Restorative procedures are not tracked at the client-level, so the number of procedures reported is a duplicate count (as the same patient may have received several services). However, it is possible to calculate a ratio of treatment services delivered in relation to the number of children treated; an unduplicated count (see textbox). Members of the oral health direct services project's Steering Committee characterized this data as evidence of "moderate" prevalence of dental decay.

Reduced proportion of children 0-5 and pregnant women with untreated dental decay

Exhibit 2.7
Untreated Dental Decay: Before and After Routine Treatment



As expected, the number of children 0-5 with untreated dental decay decreased following receipt of routine treatment services. As Exhibit 2.7 illustrates, the percent of children 0-5 with untreated dental decay decreased from 53.3% before treatment to 2.4% afterwards.[32] A similar decrease is noted for pregnant women; 49.3% of pregnant women had untreated decay before treatment and 1.5% had untreated decay after treatment. In the focus group, Care Coordinators noted that most pregnant women they see need treatment to address problems with their gums.

It is not known if the patients who had decay following treatment were referred to another source of care to complete treatment. This may have been the case, particularly for children who could have been routed through care coordination to the project's specialty treatment services. Alternately, these patients might not have completed their treatment plans due to lack of compliance (e.g. missing appointments), moving, or another reason.

Specialty treatment for children 0-5

Children are not able to complete treatment under "routine" circumstances for many reasons ranging from the inability to sit still in the chair, to needing dental work prior to organ transplant surgery. These children are candidates for specialty treatment and tertiary care services. Generally this level of dental work is performed by a pediatric dental specialist. Specialty treatment and tertiary care services are most often completed while the patient is under sedation or general anesthesia, either in an adequately-equipped dental office setting or in a hospital operating room.

When originally conceived, the oral health direct services project set aside $150,000 per year to pay for specialty treatment for children with no other source of payment. At the project's start, potential programs were identified to provide these services. However, a number of unforeseen events came into play, preventing the establishment of the treatment pool during FY 2005-06:

[32] The initial rate of dental decay does not equal 100% because some OHI programs code prophylaxis (teeth cleaning) as a treatment service.

- First, some OHI programs inaccurately assumed that their treatment services funded through other Commission funds would continue and did not include treatment in their OHI subcontract.[33] Consequently, when non-OHI program funded ended, these programs shifted their focus from augmenting services as originally planned to maintaining existing operations (e.g., maintaining existing dental clinic services to meet patients' basic needs instead of expanding specialty care services).
- Second, there was limited capacity among OHI programs to provide specialty/tertiary care. These advanced treatment services require specially trained dental staff, more elaborate equipment than is found in most dental offices (e.g. for general anesthesia), and the site must carry sufficient liability insurance.
- Second, providers who had sufficient capacity had long waitlists.

Despite these barriers, the project explored alternatives to allow provision of specialty/tertiary treatment. Alternatives include building a relationship with a private dentist offering this level of treatment and the possibility of providing a "traveling team" of specialty providers to treat children at different locations across the county. Another specialty/tertiary treatment accomplishment in FY 2005-06 is the establishment of a reimbursement/billing process and eligibility criteria; these determine which children in need of specialty/tertiary treatment would be covered by the treatment pool once a specialty/tertiary treatment service provider(s) is identified. While the specialty/tertiary treatment pool was not yet in place at the end of FY 2005-06, this spring the first child began the process as a pilot case. In the project's remaining tenure, it is anticipated that more children will receive specialty/tertiary treatment through the treatment pool as it is more firmly established.

One OHI program provides specialty/tertiary services in the absence of an official treatment service provider.[34] The children this program served did not have their care paid through the treatment pool, but they received specialty services and are thus counted under this objective. In FY 2005-06, of the 637 children 0-5 who received specialty treatment services from this program, slightly more than two-thirds (67.1%) had special needs as defined by First 5 California.[35] This is evidence of how the project has contributed to systems improvement and community change as outlined in the Commission's 2004-2009 Strategic Plan, "Issue Area 4," Desired Result 4.2, *families have access to culturally and linguistically responsive services, and that services include children with special needs in their general programs*.

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[33] Commission Health and Developmental Assessment and Treatment programs (RFGA #20055).

[34] This OHI program's contract began three months later than those of most other OHI programs. This program was originally contracted to provide routine treatment services to children 0-5, however, during evaluation implementation, it was determined that this program should report its data under the "specialty treatment" heading due to differences between the services it provides compared to those of other programs. In addition to the children treated by this program, an unknown number of children were referred for specialty treatment services outside of the OHI system of care (e.g. to private pediatric specialists not funded by First 5).

[35] First 5 California's definition of special needs is "Children who are 1) protected by the Americans with Disabilities Act, 2) at-risk of a developmental disability as defined by the Early Intervention Services Act, or 3) who do not have a specific diagnosis but whose behavior, development, and/or health affect their family's ability to find and maintain services; includes developmental delays, serious emotional disturbances, learning disabilities, speech impairments, hearing impairments, visual impairments, orthopedic impairments, and other health impairments lasting six months or more." SRI International. Definition of Disability for the Evaluation of the Special Needs Project. Menlo Park, CA: Author, 2004.

A last word on treatment services: playing the waiting game

While children 0-5 are generally more able to access treatment than pregnant women, the high numbers of children treated masks the struggle many face to access treatment quickly. According to Care Coordinators, it can take a very long time for a child to complete treatment. Below are some of the reasons they cited:

- "If [the decay] is severe we refer [the child] out because we don't have a specialist."
- "We only do sedations on Fridays."
- "We refer to Children's Hospital, but the wait there is at least two months."
- "We have half hour appointments. Let's say a child has ten cavities, that will take five appointments at least but some parents don't want to bring their child in every week; little kids get traumatized."
- "We have a three month long wait list. A lot of patients take two or three years [to complete treatment]."

Lack of adequate dental staff (pediatric dentists, dental assistants, dental hygienists, and dental receptionists) is an underlying theme in these observations. In the OHI program survey, the majority of respondents (12 of 15) indicated that their OHI program had sufficient and trained staff to provide services to their target population during FY 2005-06. However, observations from the Care Coordinators, the programs' quarterly progress reports to the lead agency, and the case study all point to long waits which are at least partially due to lack of staff. In addition, four OHI program survey respondents (of the 11 who answered the question) reported that their OHI program has patients scheduled for appointments more than three months away because they could not fit them in any sooner. It is of interest that four more respondents left this question blank when they opted to answer most other questions, which could suggest that they also have long waitlists but did not wish to disclose.

As the project moves forward, collaboration with all available dental resources in the County is needed to maximize patients' access to timely treatment services. These may include developing further linkages with private dental practices and professional organizations such as the San Diego County Dental Health Coalition.

Case Study # 3
Open Wide:
Exploring the cracks children fall through when seeking dental care

Jesus had another appointment at Children's Hospital's Mid-City dental clinic (Children's) last week. The pediatric dental specialist filled some of his teeth. These were not the same teeth that were crowned a few months ago. Nor were they the teeth that had root canals a few months before the crowns.

Jesus' story is similar to those of many young children in San Diego County. While there is no estimate available for the county, approximately one quarter of kindergarteners need early or urgent dental care to address decay in California.[36] Decay is even more prevalent among children who, like Jesus, are of Latino origin and/or of modest income.[37] Providers interviewed for this case study report that decay is rampant among their young patients. They cite causes ranging from cultural norms (such as putting babies to bed with a bottle: "that's a good half of the problem right there"), inadequate dental hygiene (brushing teeth, etc.), and not seeing a dentist for prevention and/or early treatment. Underlying these reasons, providers acknowledge that many of the families they see have "a lot other things to worry about [like] food and shelter;" and many do not have insurance. Parents often discount the importance of baby teeth since children lose them regardless of dental care, further compounding the issue.

Before the start of the Oral Health Initiative

In April 2004, two years prior to his most recent appointment at Children's, Jesus went to the dental clinic at La Maestra Health Center (La Maestra) in Mid-City for a dental exam. (La Maestra and Children's both operate First 5-funded OHI programs.) An exam and X-rays revealed he had poor oral hygiene and gingivitis. Seven teeth needed fillings; and three teeth had deep cavities so close to the nerve, pulpotomies (baby tooth root canals) were needed, followed by stainless steel crowns to cover them. La Maestra prepared a treatment plan, cleaned Jesus' teeth, and applied fluoride. With help from a bilingual dental assistant, the dentist gave Jesus' mother, Maria, information about brushing, flossing, and eating habits.

Jesus returned to La Maestra in May 2004 and twice in June 2004 for several fillings and one pulpotomy. However, the work required to treat such extensive decay exceeded the little boy's patience. The staff tried repeatedly to perform a second pulpotomy but Jesus was not cooperative so La Maestra referred him to Children's Hospital. The receptionist at La Maestra connected Maria to Children's; easily located in the same building. Jesus' medical home, San Diego Family Care, is also on-site (and also operates a First 5-funded OHI program). Maria appreciates the

[36] Dental Health Foundation. Mommy, It Hurts to Chew, the California Smile Survey; An Oral Health Assessment of California's Kindergarten and 3rd Grade Children. Oakland, CA: Author, 2006.

[37] Ibid. Statewide in 2006, 32.9% of Latino children had untreated decay compared to 19.8% of White children, and 29.2% of children of other ethnic backgrounds. One-third (33.1%) of kindergarteners eligible for free or reduced-price lunch programs had untreated decay compared to 21.6% of their peers who were not eligible for these programs.

convenience of the Mid-City complex; it is only a few blocks from the family's home. If it were farther Maria explains, she would have trouble getting her son to Children's Hospital's campus across town because the family does not have a car.

Up to this point, Jesus' was progressing towards completing his treatment plan. He had several factors in his favor. In addition to the clinics' proximity, Jesus had Medi-Cal to cover the cost of his dental care. Still, a year's time elapsed before his next appointment at Children's. The staff at Children's asserts that it took a while for Maria to bring him back, though there is no indication in his chart of any missed appointments and Maria has no recollection of postponing treatment. Indeed, the absence of care coordination before the start of First 5-funded oral health services may have been a contributing factor.

After the start of the Oral Health Initiative

Around the time Jesus re-entered care in 2005, the Oral Health Initiative launched its direct services component (April 2005). When Jesus returned to Children's for his well child annual exam in March 2005, his treatment plan resumed, though he was not seen until August. There are many challenges contributing to this delay, most of which center on the availability of appointments. "Depending on the schedule loads, and with sedation, the dentists are backed up quite a bit....There are only a few spots for sedation appointments; the times are limited, unlike nitrous appointments." Also, Children's Mid-City clinic can only see patients like Jesus on Fridays. Maria suggests that, "it would be better if they worked during the week [instead of just on Fridays] because then it wouldn't take so long to get an appointment." Due to this wait time, Jesus returned for additional appointments in January and May 2006. Children's Hospital is one of the only OHI programs that do not have a First 5-funded Care Coordinator, another factor that may have delayed Jesus' treatment completion. Despite these challenges, two an a half years after his dental problems were first identified, Jesus has completed treatment.

In some ways, Jesus' story is a "best-case" scenario; he has a Medi-Cal and a medical and dental home. For children without these resources, the path to completing treatment can be even more cumbersome. Providers explain how they might handle such a case, "the quickest way would be to do a physical [through] CHDP [the Child Health and Disability Prevention program], which allows medical and dental care for a limited amount of time while they apply for insurance. Then simultaneously … [our OHI Care Coordinator would] help [the child get a] dental appointment."[38] The second adds, "[Our non-OHI insurance enrollment specialist] always helps the [child] get Medi-Cal or Healthy Families, and even if they don't qualify, she helps them apply for something else." If the only coverage a child has is through CHDP, which does pay for some treatment services, children need to complete as much of their treatment as possible, as soon as possible. A third provider explains, "for those temporary [CHDP] patients…they try to schedule all of the dental appointments within the month. For example, if a patient needs ten treatments, they will do one per day for ten days. They try to get as much done as possible within the time allotted." Even with the improvements OHI has made to San Diego County's system of oral healthcare; accessing care can still be difficult for some children.

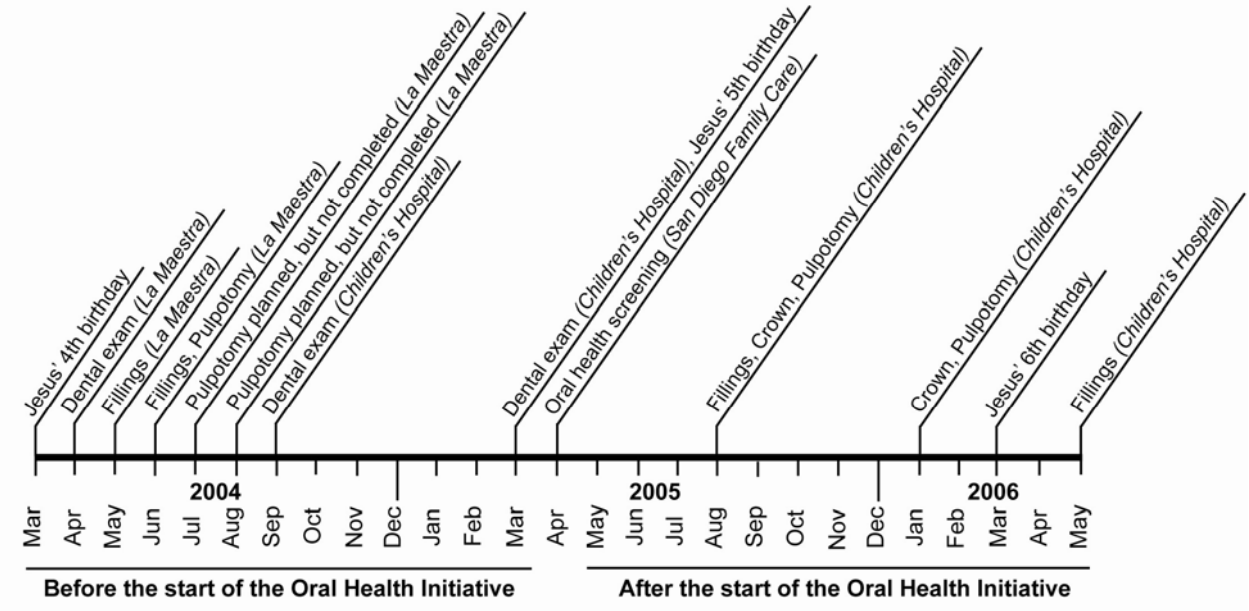
[38] See "How Health Insurance Affects Care Coordination" for details about the CHDP Program.

Changing habits: benefits of oral health education

Hopefully, now that Jesus has had the treatment he needed and Maria has learned about oral health, his family will be able to keep his teeth (and his baby sister's) healthy with preventative care at home and through regular dental exams. Providers cited a lack of oral health education as one of the county's most pressing gaps in dental services for young children. The benefits of oral health education are underscored by Maria and Jesus' experience. After talking with Jesus' dentists, Maria now helps Jesus brush his teeth. She also brushes her two-year-old daughter's teeth and reports that she wiped her daughter's gums each day before her teeth arrived. Jesus' little sister used to take a bottle of milk to bed, but the dentists told Maria not to put her to bed with anything but water. Maria also gives her children fluoride supplements.

Still, Maria says that the family has not bought any dental floss yet, and that there is no particular reason why they have not done so. Additionally, even after her son's extensive treatment, Maria says that she still does not "understand why [Jesus' teeth have decay] because he hardly ever eats any candy and he brushes his teeth twice a day." Despite the many positive changes the family has made, there is still room for improvement. Jesus' story exemplifies how there is an ongoing need for more education across the County about the spread of caries and the importance of completing treatment plans, and for increased dental service capacity to treat Jesus' peers.

Exhibit 2.8
Timeline of Jesus' Experience Seeking Dental Care



Goal 4: Care Coordination

Many OHI programs did not offer dental care coordination services prior to receiving First 5 funding for oral health services. This is particularly true for clinics that do not have dental facilities. Therefore, the addition of care coordination services in FY 2005-06 was an important step to ensuring that communities have adequate service capacity that is effective, coordinated, integrated and sustainable.[39]

As a new component in an already complicated system, care coordination took various forms at different clinics during FY 2005-06. The oral health direct services project did not prescribe a model of care coordination, but rather each partner designed an approach to meet its needs and capabilities. Most OHI programs were funded for one half-time Care Coordinator. At some clinics, care coordination was a very light-touch service: at many clinics, care coordination consisted of internal referrals to the dental clinic from the clinic's medical counterpart (e.g. pediatric staff walked the child over and a screening was completed). Others coordinated care only if a medical provider screened the child and noticed abnormalities, or if a dental exam indicated that a child needed specialty treatment. In these instances, the Care Coordinator generally gave the family a dental referral and helped them make appointments. Some would also schedule children's appointments in the dental clinic and/or call families for follow-up. The variety of care coordination implementation makes evaluating its impact somewhat difficult, as patients in care coordination did not receive the same services.

Facilitating Access to Needed Oral Health Care

Exhibit 2.9 presents the minimum referral completion rates for children 0-5 and pregnant women who participated in First 5-funded care coordination services. These are minimum rates because it is not possible to track all referrals through to completion. For example, there is a confirmed completion rate of 71.3% for children 0-5 referred for a dental exam. That is, OHI programs verified that 71.3% of children referred for an exam obtained one. It is not known if the other 28.7% of children referred to a dental exam received that service.

Exhibit 2.9
Care Coordination Referral Results, by Type of Referral

Type of Referral	Number Referred	Successfully Connected	Confirmed Completion
Children 0-5			
Exams	3350	82.5%	71.3%
Routine Treatment: Internal *	1872	98.4%	66.7%
Routine Treatment: External **	588	87.9%	27.0%
Specialty Treatment	582	35.6%	15.3%
Pregnant Women			
Exams	671	85.0%	58.4%
Routine Treatment: Internal*	613	64.6%	49.4%
Routine Treatment: External**	17	70.6%	70.6%

* Referrals to the dental clinic within the same clinic.
**Referrals to dental providers outside of the referring clinic.

[39] First 5 San Diego. First 5 San Diego Commission 2004-2009 Strategic Plan. San Diego, CA: Author, 2004.

These unconfirmed children may have: made an appointment for an exam in the future; missed an appointment; had the exam but could not be contacted due to incorrect or outdated contact information. Therefore the referral completion rate for children 0-5 referred for a dental exam is at least 71.3%.

The data suggest that accessing dental exams and routine treatment within the referring clinic (internal) was easiest for children 0-5. These results may also reflect that it was easiest for Care Coordinators to verify these services compared to others. The drop between the number of children who connected to any type of treatment (i.e. who made an appointment) and the number of children who completed treatment may be additional evidence of long waiting lists.

For pregnant women, the number of patients that were connected and confirmed completed routine treatment emphasizes the difference in insurance coverage available for children versus adults. While 98.4% of children 0-5 referred internally for routine treatment made an appointment, only 64.6% of pregnant women did so. Connecting pregnant women to care was often very difficult for two reasons: few women who enter care coordination have health insurance, and those women who do generally have Medi-Cal or Emergency Medi-Cal and are often not able to access treatment services. Due to these plans' limited coverage, they would have to pay for many services despite having Medi-Cal. Some clinics are able to route certain pregnant women to care through programs that serve Native American or homeless women. The majority of women, however, do not qualify for these programs. Most clinics offer services on sliding fee scales and/or payment plans, but have found that the vast majority of women opt to forgo treatment rather than pay for it out of pocket. Some clinics have responded with pregnancy "promotions" such as offering a specially priced bundle of dental services (cleanings and X-rays) for sixty dollars or "throwing in" some dental services when a woman pays for her prenatal care through the same clinic. OHI programs also state that many women are afraid to undergo treatment while pregnant.

Care Coordination as an improvement to the oral healthcare system

As previously stated, many clinics added care coordination as a result of First 5-funding. Care Coordinators from these clinics observed the change in their clinics' functioning as a result:

- Some clinics report seeing more children 0-5 overall. Others report seeing more very young children: "Now we see them much younger…newborn babies, one-, two-year-olds…. [Before First 5-funding for oral health services] they were older."
- There is more personal interaction between clinics and parents: "[Before First 5-funding for oral health services] parents would get an 800 number. Now I contact them myself."
- Pregnant women get more education at some clinics as a result of First 5-funding for oral health services.
- Some clinics more actively solicit pregnant women as patients: "We seek them out in the community"; "We go and find them. If they come through the door, we are so excited!"
- Care Coordinators estimate that 60-90% of patients receiving coordination are referred from their clinic's medical departments (i.e. from pediatrics or obstetrics); representing a significant step towards bridging clinics' medical and dental departments. This indicates an important improvement because at many clinics these branches have been somewhat disconnected, which has hindered providers' ability to treat the whole child.

Despite this progress, other aspects of clinics' functioning have not changed. Notably, the length of time for a child to complete treatment at some clinics is similar to before First 5-funded oral health services began.

"Overall in the county it's difficult to find and difficult to get a quick appointment with a pediatric dentist, a dentist who can really take care of children less than five who are going to scream, run away, or bite."

– First 5-funded OHI service provider

How Health Insurance Affects Care Coordination

Care Coordinators note that most of the children they work with do not have dental insurance, or Child Health and Disability Prevention program (CHDP) coverage.* Intercept interview findings support this finding: thirteen of the fourteen parents surveyed indicated that their child had medical insurance, but three parents reported that their child did not have dental insurance and one was not sure if their child had dental insurance.

Care Coordinators (or other staff) assist families to apply for any insurance programs for which their child may qualify. Additionally, some clinics offer sliding fee services; for example a complete dental exam costs about thirty dollars on the sliding fee scale at one clinic. Still, many Care Coordinators reported difficulties navigating the CHDP system, which covers care during a brief window of time (ranging from one to two months). Common problems encountered by clinics included not knowing how to bill for a service and missing the "window." The Care Coordinators expressed desire for additional training from CHDP. The project's lead agency has arranged to offer that training as part of monthly Care Coordinator meetings.

Medi-Cal recently updated its billing codes, allowing for easier treatment billing for pregnant women. However, Care Coordinators frequently cited lack of coverage for pregnant women as a major barrier and ongoing need that prevents connecting women to needed care, even with the Medi-Cal changes.

* The Child Health and Disability Prevention (CHDP) program prevents and identifies health problems through periodic, no-cost well-child health exams to children who qualify to grow up healthy. The CHDP Gateway links eligible children to ongoing healthcare coverage. CHDP exams are available at certain ages and include a dental assessment. Additionally, in San Diego County, the Department of Health and Human Services administers the Child Health Disability Prevention Treatment and Reimbursement (CHDP-TR) program. CHDP-TR will pay for diagnosis and treatment of certain medical and dental conditions found during the CHDP well-child screening exam. (Source: County of San Diego Health and Human Services Agency, Provider Information CHDP. 2005. Accessed 27 July 2006. <http://www2.sdcounty.ca.gov/hhsa/ServiceDetails.asp?ServiceID=797>; County of San Diego Health and Human Services Agency, Provider Information CHDP-TR. 2005. Accessed 27 July 2006. <http://www2.sdcounty.ca.gov/hhsa/ServiceDetails.asp?ServiceID=803>)

Goal 5: Caregiver Education

As with many health behaviors that promote children's well-being, caregivers support and shape a child's oral healthcare practices. In the case of very young children, parents and caregivers are completely responsible for their children's oral health care, including cleaning gums and later brushing teeth, providing healthy meals and snacks, modeling sound oral behaviors, and taking the child to the dentist. Therefore, it is essential that parents and caregivers have the knowledge, skills and resources they need to promote their children's optimal oral health.[40] Furthermore, Care Coordinators noted that pregnant women need education about decay-causing bacteria transmission to babies from mothers and strategies to prevent it.

"We tackle [pregnant women] and say: 'Sit with me five or ten minutes'. We give them brochures and information and let them know the dental door is open…every single pregnant women…gets information."

– First 5-funded Care Coordinator

OHI programs employed many different approaches to deliver oral health education to 10,601 parents of children 0-5, 2111 pregnant women and 346 childcare providers and CBO staff. Below are some examples:

- Dental information, oral hygiene instruction, toothbrushes, paste and floss were delivered to children, parents and teachers at preschools.
- Dental Assistants educated pregnant women on oral hygiene, infant oral care and bacteria transmission during prenatal visits.
- Oral health educators distributed and reinforced educational pamphlets to pregnant women, parents and children as well as to dental assistants, dentists.
- Dentists, dental assistants, and medical assistants provided oral health education to pregnant women and parents through videos and educational pamphlets.
- Oral health presentations were delivered to pregnant women and parents through health fairs, prenatal classes and at the Mexican Consulate.
- A pedodontist educated parents on nutrition, baby bottle tooth decay, brushing and flossing through hands-on demonstrations, literature and "goodie bags" containing toothbrushes, toothpaste, floss, and oral health literature.

Changes in the clinics

OHI programs reported an increase in both the types of educational materials available and the frequency of educational encounters with parents of children 0-5 and pregnant women following the start of First 5-funded oral health services. As two Care Coordinators explained: "We have more educational materials now [that our clinic receives First 5-funding for oral health services], so when they go for their well-child [visit], we have more goodie bags"; "Before [receiving this funding], we didn't give that much education to pregnant ladies. Now it's mandatory."

[40] First 5 San Diego. First 5 San Diego Commission 2004-2009 Strategic Plan. San Diego, CA: Author, 2004.

Changes in the participants

Due to the many ways OHI subcontractors administered their educational activities, no participant-level outcomes data was tracked for this goal area. While the programs' educational messages were likely similar, they were not prescribed by either First 5 San Diego or by the lead agency. For example, it is nearly impossible to measure what individuals across the county have learned when they did not receive the same information through a common curriculum or message. Anecdotally, however, some caregivers did report learning about oral health issues and how to promote their child's oral health.

Health and Oral Health Media Campaign

As part of First 5's the three-pronged approach to oral health, KPBS developed and aired an interstitial related to prenatal oral health. To measure its effect on viewers, KPBS showed the spot to 107 parents and caregivers at the "First 5 for Kids! Expo" in October 2005 and then interviewed them about their impressions of the message and its impact.*

Getting the word out

Nearly a quarter of respondents (24.3%) were aware of the spot before the interview, suggesting First 5's televised oral health message has reached its target audience, but that there is still room for improvement.

Learning about prenatal oral health

More than two-thirds of those interviewed (67.3%) reported they learned something new from the spot. Similarly, more than three-quarters of respondents (77.6%) said the spot reminded them of, or reinforced, something they already knew.

Taking action

Approximately half of those surveyed (51.4%, n=55) plan to take or already took action based on seeing the spot. Of those 55 respondents, 71.6% planned to make a change to reduce the spread of cavity causing bacteria by not sharing food and/or utensils. Another 32.7% of respondents who planned to change their behavior cited intentions to visit a dentist regularly and/or while pregnant.

These survey results suggest a benefit to implementing a comprehensive approach to oral health services including a public education media component that adds value to the oral health service system in San Diego County. See Chapter 6 for more about the KPBS media campaigns, including the results of phone banks that referred television viewers to dental services for children 0-5 and pregnant women.

*Additional oral health messages were developed and distributed to the public (e.g. ads on the back of busses); however, viewers' responses to these messages were not measured as part of KPBS' survey effort.

Goal 6: Provider Training

Provider training is an essential component of a comprehensive approach to improving children's oral health. Though it is important to train dentists and dental professionals in topics related to pediatric oral health, provider training must extend beyond the dental community to have its greatest impact. As the American Academy of Pediatric Dentistry's Guideline on Infant Oral Health Care states:

> *Since physicians, nurses, and other health care professionals are far more likely to see new mothers and infants than are dentists, it is essential that they be aware of the [negative effects that infectious oral health disease can have on children's health] and associated risk factors of early childhood caries; and [that they] make appropriate decisions regarding timely and effective intervention.*[41]

In all, 45 prenatal providers, 70 general dentists and 59 primary care providers participated in First 5-funded provider training about maternal and child oral health during FY 2005-06.

Dentists report increased capacity to treat young children

The majority of the dentists (67 of 70) that attended a First-5 funded event in February 2006 were trained. As part of that event, attendees completed a retrospective-post-training participant survey.[42] As illustrated in Exhibit 2.10, dentists reported increased knowledge and behavioral intentions that support increasing access to oral healthcare for children 0-5. Of note:

- Nearly all respondents (97.1%) indicated that, as a result of the provider training, they were likely to increase the number of children 0-5 in their practice.[43]

- Of the seven dentists who did not treat children 0-5 at the time of the training, six reported that it is likely they will increase the number of children 0-5 in their practice as a result of the provider training.

[41] American Academy of Pediatric Dentistry. "Guideline on Infant Oral Health Care." Clinical Guidelines. Chicago, IL: Author, 2004. 68-71.
[42] Participants only completed a survey following the training. There was no initial survey or pre-test to compare post-training survey results. This approach was employed due to the limited time available to complete a survey during the training.
[43] Includes respondents that marked either "very likely" (47.1% of respondents, n=37), "likely" (41.2% of respondents, n=28), or "somewhat likely" (8.8% of respondents, n=6).

Exhibit 2.10 Provider Training: Dentists' Outcomes		
Survey Results*	**Strongly or Somewhat Agree**	**Strongly or Somewhat Disagree**
Outcome 1: Knowledge Gains Following Training		
I learned new information and/or skills	100.0%	0.0%
I am more knowledgeable about when to treat and when/where to refer children 0 to 5 years of age	100.0%	0.0%
I am more knowledgeable about providing anticipatory guidance	98.6%	1.4%
I am more knowledgeable about managing behavior of very young children	97.1%	2.9%
The course enhanced my understanding of cultural competency	97.1%	2.9%
I have a better understanding of the different types of sedation **	95.6%	4.3%
Outcome 2: Behavioral Intentions Following Training		
I will apply the clinical skills learned through this course	98.5%	1.5%
After taking this course, I am more likely to screen children beginning at age one	92.6%	7.4%
After taking this course, I am more likely to treat children beginning at age one	89.5%	10.5%

* Total surveys returned = 70

** Sum of "agree" and "disagree" percents do not equal 100.0% due to rounding.

Results of the OHI Program Survey

OHI programs adapted services to meet the needs of specific ethnic or cultural groups and children with special needs

A majority of respondents received training through the Care Coordinators' monthly meetings about adapting services to meet the needs of specific ethnic or cultural groups and/or children with disabilities and their families.*, ** This evidences how the project design works to create and promote a learning community of providers. Furthermore, most clinics that received training reported adapting services as a result.*** For example, following the training, one clinic identified referral sources for children with special needs requiring immediate care.

OHI programs face challenges securing funding from sources other than First 5

With less than a year remaining in the two-year funding for the project, most OHI programs are not positioned to sustain services without First 5 funding. Three of 14 respondents have access to non-First 5 funding to support their programs and two reported obtaining new, non-First 5 monies from the County.**** However, 12 clinics do not have funding to sustain services: three clinics have identified but not secured non-First 5 funding sources; three have been unsuccessful in their attempts to identify an alternate funding source; and six have not yet searched for alternate funding.

* Nine of 13 OHI programs received training about designing or adapting services to meet the needs of specific ethnic or cultural groups. Nine of 12 programs received training about how to specialize or adapt services to meet the needs of children with disabilities and their families.

** Three of the nine OHI programs received training about adapting services for ethnic and cultural groups, and seven of nine reported receiving training about adapting services for children with special needs.

*** Five of the nine OHI programs trained about meeting the needs of specific ethnic or cultural groups, and six of the nine trained about adapting services to meet the needs of children with special needs, made such changes.

**** One OHI program has secured $9000 and another $32,000.

Challenges

Although the Oral Health Initiative has surpassed many of its targets and improved the oral health for many children 0-5 and pregnant women, there remain a number of challenges that could be improved upon. The main challenges include:

Services to Pregnant Women: In nearly every goal area, providers struggled to meet their annual targets for services to pregnant women. As discussed above, this may be due to the difficulties pregnant women face with healthcare coverage or affording care.

Adequate Dental Staffing and Infrastructure: Evaluation data shows that children and pregnant women may be connected to needed services, but the completion of these services is delayed due to the lack of trained pediatric staff and/or appropriate equipment for procedures, particularly for specialty treatment.

Gaps in service delivery: Care coordination is a critical enhancement to this Initiative that ensures children screened in one program are successfully transferred to the needed exams and treatments in other programs (or within the same clinic). However, confirming patients are connected to care is not occurring at sufficient levels across the initiative. This finding is accompanied by the fact that there are not adequate pediatric dental services in the county for the 0-5 population.

Educational message: Currently, providers engage in a variety of oral health educational activities for caregivers. These range from providing a toothbrush and basic information to more intensive educational encounters. This approach has made it difficult to understand the effectiveness of the initiative's educational activities.

Duplication of efforts with First 5 California: It appears that some OHI activities may duplicate some no-cost services that are available through the State First 5's "First Smiles" program. This includes provider education.

"The serious issue of oral health cannot be resolved in two years."

– First 5-funded OHI service provider

Recommendations

In the future, the Commission may wish to consider the following recommendations:

1. Implement consistent screening procedures: The use of a common risk assessment tool for oral health screenings (such as is available from First 5 California's First Smiles project) would ensure that screening participants receive the same standard of care across the county. Should this be implemented, it would require a consensus building process to generate investment from the many different screening partners.

2. Expand the use of fluoride varnish: Fluoride varnish is a quick, low-cost way to effectively prevent and/or slow the spread of dental decay. Additional provider training may be necessary to encourage broader use of fluoride varnish. It would also be helpful to solicit feedback from subcontractors to identify and address other barriers to its use.

3. Establish the treatment pool for children 0-5 and consider one for pregnant women: Currently, the lead agency is focused on this establishing a vitally important treatment pool for children. Additionally, since many pregnant women are under- or uninsured, and unable to pay for treatment, the creation of a treatment pool for pregnant women could increase their access to care.

4. Solicit subcontractors' feedback to develop strategies to improve care coordination process and ability to track results: Many OHI programs struggle with the care coordination aspect of the project. Monthly Care Coordinator meetings will continue to be an important learning community to discuss and troubleshoot challenges. The Commission and/or lead agency may also wish to consider funding Care Coordinators' time in relation to the number of patients a program serves. Many of the bigger subcontractors have difficulty keeping up with large caseloads (currently, halftime Care Coordinators are charged with 188 to 270 patients).

5. Adopt a common method of providing oral health education and anticipatory guidance to patients, parents, and caregivers in the community: Currently there is no "official" First 5 San Diego-approved oral health message. Subsequently, consumers receive information that is potentially inconsistent in delivery and/or content. One option is to explore the educational materials developed by First 5 California's "First Smiles" program, which are available free of charge to the Commission.[44] Furthermore, some interviewed for the case study expressed how low-income, Latino parents, and particular recent arrivals to the United States, could benefit from additional outreach and/or dental education.

6. Continue to train providers: Increasing the number of providers who have the capacity to serve children 0-5 could help ease the long waiting lists many families encounter.

7. Collaborate with First 5 California to reduce duplication of services: First 5 California's interest in oral health presents an opportunity for First 5 San Diego to leverage its resources by

[44] If First 5 San Diego were to use the State's materials, the local evaluation still would not track pre-post outcomes for participants, as educational encounters are generally too brief to warrant that effort. However, the validity of the messages would be pre-established and process evaluation could reveal how consistently the materials were used.

collaborating with the State. As First 5 San Diego continues to assess its activities and look for ways to reduce duplication, it may wish to offer oral health-related provider training through First 5 California's First Smiles project, which are free to interested counties. Both a key expert and the OHI project's Steering Committee mentioned this current overlap in efforts.

8. Link OHI services with other First 5-funded Initiatives: Consumers of services through one Commission-funded initiative are potential consumers of services through other First 5 initiatives. One intersection is to refer OHI participants to the Healthcare Access Initiative for insurance enrollment assistance (and conversely, for Healthcare Access Initiative to refer clients to OHI programs for dental services). However, all Commission-funded activities present opportunities for OHI to widen its reach.

A Final Word on the Oral Health Initiative

In conclusion, the direct services branch of the Oral Health Initiative achieved several milestones of success during FY 2005-06. They not only exceeded 12 out of 15 of their 12-month targets to provide crucial oral health services to thousands across the county, they also improved the health outcomes of children and pregnant women. These included identification of oral health concerns through screenings and examined early, an important step to halt the spread of decay among children 0-5 and pregnant women, as well as decreasing the proportion of children 0-5 and pregnant women with untreated dental decay. Additionally, care coordination services were added to many clinics, strengthening the county's oral health service system, and ensuring that children and pregnant women were connected to and completed needed care. Finally, the direct services project provided crucial education and information to both parents and providers. The project's service providers are well positioned to begin their second fiscal year of service on behalf of the Commission and it is anticipated that they will continue to improve and enhance the dental services to the 0-5 population.

Chapter 3
Health and Development Services Project

Key Results

Commenced screenings: Early developmental, behavioral, and speech and language screenings are being provided throughout the county.

Developed a System of Care: Collaboration between the countywide coordinator, regional leads, and subcontractors has resulted in successful initiation of a system of care.

Created partner linkages: Partners within the project have increased their knowledge about various service providers both within and across regions, and have begun to create a referral network with these partners.

Implemented essential countywide coordination: Regional leads report that countywide coordination through AAP has been beneficial in assisting them in troubleshooting challenges.

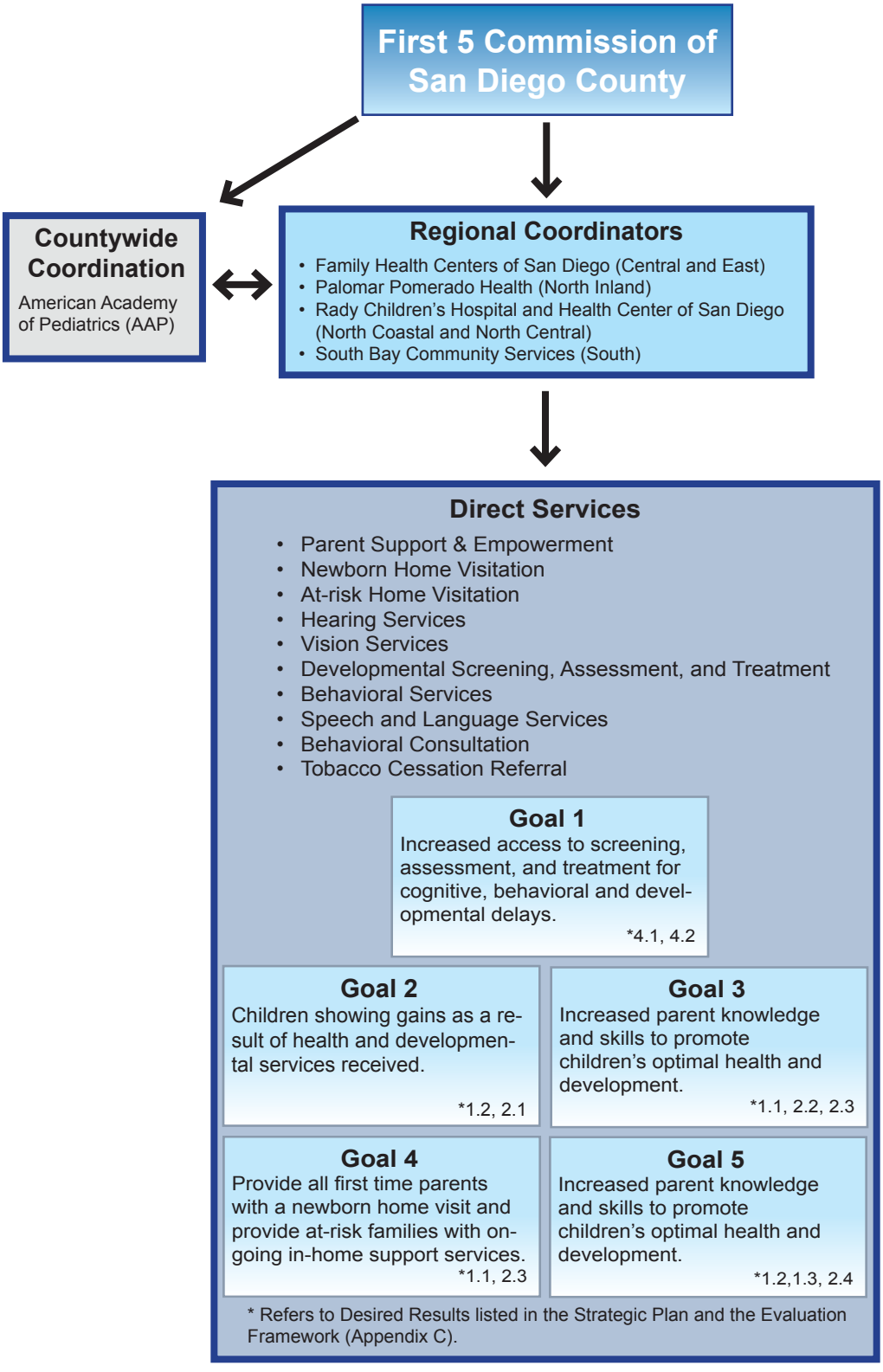
Summing It Up

In the first six months of the project, Health and Developmental Services providers saw roughly 13,775 children 0-5* and provided:

- Over 1,970 home visits to newborns
- Over 1,542 home visits to at-risk families
- Over 8,959 screenings
- Over 1,654 assessments
- Over 4,063 treatment units

* Total number served may be a duplicate count as children may have accessed services in more than one funded category.

Health and Development Services Project Diagram



Introduction

In May 2006, the First 5 Commission of San Diego County allocated $51.6 million over 5 years to create the Health and Developmental Services Project. This project promotes children's optimal development and learning by improving access to professionals who provide early detection and treatment of health problems or delays in a child's ability to learn. Parents establish the foundation for their child's potential during the first five years of their life and directly impact the course of their child's physical and social-emotional health, as well as cognitive development; all of which play a key role in school readiness.[1] According to the American Academy of Pediatrics, 16% of children have developmental disabilities; only 20-30% of which are detected prior to the child's entrance in school.[2] HDS was created to address this need for early evaluation and treatment.

Health and Developmental Services Project Contractors

- ***Countywide Coordination:*** American Academy of Pediatrics
- ***North Central and North Coastal Region:*** Rady Children's Hospital and Health Center of San Diego
- ***Central and East Region:*** Family Health Centers of San Diego
- ***North Inland Region:*** Palomar Pomerado Health
- ***South Region:*** South Bay Community Services

Key Elements of the Health and Development Services Project

The Health and Developmental Services Project (HDS) creates stronger, more comprehensive systems of services for children's physical, developmental and behavioral health needs that incorporate and build upon existing networks, resources and services. HDS seeks to create and strengthen connections between existing programs, expand existing services, fund new programs that fill service gaps, increase provider capacity to delivery high quality services, and leverage funding. The key goals of HDS are:

- To support early education
- To promote early identification and treatment of special health, developmental and behavioral needs in children
- To empower parents to acquire the knowledge and skills necessary to improve their children's health and development

In order to achieve these goals, the Commission awarded contracts to providers in each of the six Health and Human Services Agency (HHSA) regions, and a single contract to the American Academy of Pediatrics (AAP) to oversee and coordinate the successful countywide implementation of the Health and Developmental Services Project.

Each regional coordinator is responsible for developing and coordinating their region's system of care, subcontracting with an average of ten agencies to create a Regional Services Network. This includes connecting with other services and initiatives (both First 5 and non-First 5) in an effort to streamline services.

[1] First 5 San Diego. First 5 San Diego 2004-2005 Annual Evaluation Report. San Diego, CA: Author, 2005.
[2] First 5 Commission of San Diego County Proposed Health & Development Initiative. Key Informant Meetings. San Diego, CA: 2005.

Each Regional Services Network provides the following health and developmental services to children 0-5 and their families directly, or in collaboration with subcontractors:

- Regional coordination of health and developmental services
- Parent support and empowerment
- Newborn medical home visits for all first time parents that include screening and referrals for developmental or behavioral issues, vision and hearing, and ancillary services such as insurance enrollment or smoking cessation
- Ongoing home visiting for families "at risk"
- Screening, assessment and treatment for hearing, vision, developmental, behavioral, and speech and language services
- Health and behavioral consultation services for licensed and license-exempt early care and education providers
- Tobacco cessation referral

As countywide coordinator, the role of AAP is to identify screening protocols and clinical pathways, develop referral guidelines, coordinate data collection and evaluation, organize uniform and standardized outcomes reporting, share best practices, and design quality improvement resources and support. AAP will coordinate trainings for health and child care providers, develop and utilize an advisory committee, create linkages with community based organizations and local, state and national projects, as well as promote fiscal leveraging.

Summing It Up: Individuals Served by HDS

This section provides service numbers for the first six months of HDS (January 1 through June 30, 2006). The first half of this period included a "start-up" phase where providers were not required to begin services. Therefore service counts for many providers are low compared to targets set for families to be served and services to be provided. Given that service data is only available for this initial period, full analysis of these numbers is not included in this report. Future HDS evaluation efforts will fully examine these low service counts and document progress towards goals.

Exhibit 3.1
Total Children Served by Service Category*

Service Category	Total Children Served
At-risk Home Visitation	1111
Behavioral Consultation	67
Behavioral Services**	234
Developmental Screening	1892
Developmental Assessment/Treatment**	1022
Hearing**	2155
Newborn Home Visitation	1970
Speech and Language Services**	397
Vision**	4927
Total Children Served	**13,775**

*Total number of children served may include duplicate counts as the same child may have accessed services in more than one category.
**Number of children served within this service category may include duplicates count as the same child may have accessed more than one service (screening, assessment, and/or treatment) within this category.

In the first six months of the project (January through June 2006), HDS providers served approximately 13,775 children 0-5.[3] Services varied by provider and included hearing and vision services; home visits for newborns and at-risk families; and developmental, behavioral, and speech and language services. In addition, parent support and empowerment and behavioral consultation providers served approximately 1010 parents. Exhibit 3.1 displays the number of children served by service category.

Parent Support and Empowerment

A total of 1384 parent education and empowerment sessions, classes and workshops were provided to 839 parents during FY 2005-06. In addition, 842 children were indirectly served as result of parent support and empowerment services. As with all HDS service categories, referrals to additional services are a key component of Parent Support and Empowerment. Twenty-four parents were referred to additional services within the HDS network; 882 parents were referred to outside services.[4]

Newborn Home Visitation

Newborn home visitation subcontractors provided 1970 initial and 463 follow-up visits to first-time mothers. During these visits, 83.2% of mothers reported that they were currently breastfeeding. Of the families served, 618 were referred for at-risk home visitation services for more in-depth counseling, information and service referrals. Approximately 324 children were referred to HDS funded services and 211 children were referred to services outside the HDS network. Some households (3.5%) included someone who smokes, and were and referred to Partnership for Smoke-Free Families, a key HDS partner. (See textbox at right).

Key System Supports:
Partnership for Smoke-Free Families

The Partnership for Smoke-Free Families (PSF) is contracted by First 5 to collaborate with HDS service providers to integrate smoking cessation materials and linkages to counseling for first time parents with newborns receiving a First 5 funded Newborn Medical Home Visit*. Beginning in January 2006, PSF began working with the HDS Regional Service Networks to incorporate tobacco screening, advice, and referral into the initial newborn home visit. Currently, PSF materials are distributed at newborn home visits in the North Inland and South regions. At these visits, mothers receive smoking cessation information and complete a referral card which is sent to PSF for follow-up if the parent requests resources to help them quit smoking. As of July 31, 2006, 259 PSF *Quit Link for Home Visitor* tobacco screening forms were submitted to PSF (77% of new mothers who received an initial home visit). Of the 259 new mothers screened, four smokers were identified, all of which indicated that they were ready to get help to quit. The California Smoker's Helpline will contact these new mothers for smoking cessation counseling recruitment. PSF will continue to work with the Newborn Home Visitation providers in all six regions to incorporate smoking cessation materials and counseling linkages into the home visits.

* The Commission first authorized PSF funding in February 2000. It was incorporated into HDS in January 2006. For a full description of PSF evaluation results, please see Chapter 7.

[3] All process numbers in this section originate from contractors' quarterly reports to the Commission. Totals may include duplicate counts as the same child/family may have accessed services in more than one service category.
[4] Providers in this service category received a smaller amount of HDS funds compared to other categories. Therefore, Parent Support and Empowerment counts are lower than those of other categories.

At-Risk Home Visitation

A total of 1542 home-visits were provided to 1111 families identified as at-risk and needing additional follow-up and support services. During these visits, 29.3% of mothers reported that they were currently breastfeeding. Home visitors also provided 141 developmental screenings and identified 19 children as needing an additional developmental assessment. Twenty children were referred to HDS services and 344 to services outside the HDS network.

Developmental Screenings

Approximately 1902 developmental screenings were provided to 1892 children during the first six months of HDS. Of these, 1154 children were identified as needing further assessment. Providers referred 963 children to HDS services and three children to services outside the HDS network.

Developmental Assessment and Treatment

Developmental assessments were provided to 557 children. Of these, 438 children were referred to HDS providers for treatment and 230 were referred outside the HDS network. Note that these numbers are not mutually exclusive, as providers may have referred children to an outside provider, such as California Early Start, in addition to an HDS funded provider. Treatment was provided to 465 children, resulting in 1807 treatment units during this period.

Assisting the Child Welfare System: Developmental Screening & Enhancement Program (DSEP)

DSEP, one HDS developmental services subcontractor, provides developmental screenings for children countywide who enter the child welfare system and placed in foster or relative care, or Polinsky Children's Center. Depending on the children's developmental and behavioral needs, DSEP refers them for further evaluation and related services. The result supports increased permanency in the foster home and assists children in school readiness. Between January and June 2006, DSEP screened 528 foster children, most of which were in the Central, East and South regions. Nearly 90% of children screened were in priority zip codes, and over half needed further assessment.

Behavioral Services

A total of 102 behavioral screenings were provided to 70 children during this reporting period, all of whom were identified as needing further behavioral assessment. Eleven children were referred within HDS for additional services, while five were referred outside the network. Fifty-four children were provided behavioral assessments, for a total of 139 assessments. Of these, 15 children were referred to other HDS services, and 8 were referred outside HDS for further assessment or treatment. Treatment was provided to 110 children, for a total of 785 behavioral treatment service units.

Speech and Language Services

During this start up phase, 48 children received a speech and language screening. Of those, 37 needed further assessment (84%). Twenty-five of the children were referred to additional services within HDS, while five were referred outside the network.

Similarly, 48 children were assessed for speech and language delays during this period, and over half of the children were sent to additional services in HDS for treatment and/or follow-up (n=26; 54%), or to providers outside of HDS (n=28; 58%). The number of speech and language treatment units provided during this period far exceeded the screening and assessment numbers; a total of 1278 units of service were provided to 301 children.

Vision Services

Vision screenings were conducted with 4089 children, and 1273 (31%) were identified as needing further vision assessment. Over 200 children were provided referrals to other services within HDS (n=264), and to services outside HDS (n=269). Vision assessments were done with 632 children, and 132 of these children were referred for further treatment within the HDS system; 193 children received vision treatment.

Hearing Services

Hearing screenings were conducted for 2136 children, with 699 of these children were identified as needing further assessment. A total of 46 children were referred for additional HDS services and 376 children were referred to services outside the HDS network. Hearing assessments were conducted for 19 children, all of which were referred to providers outside of HDS for hearing treatment.

Behavioral Consultation

A total of 373 face-to-face and phone consultations were provided – 169 to families and 204 to providers. In addition, 283 workshops were provided for families and child care providers to learn techniques and skills to address behavioral issues. As a result of these workshops, 1339 parents, 988 providers, and 443 children were served. Behavioral assessments were conducted for 69 children; 44 children were referred to HDS-funded services for treatment and eight children were referred to treatment services outside the HDS network.

Capturing the Impact: Overview of the HDS Evaluation Plan

HDS began its first stage of program implementation and evaluation planning in January 2006. Throughout the project, the Commission will measure its impact on parents and children, and the overall outcomes of services provided. The outcome evaluation for HDS was launched in July 2006 to assess the impact of services on children 0-5 and their families. Subcontracting agencies are responsible for collecting data that tracks indicators defined in the contract, and provide outcome information on a semi-annual basis to First 5 San Diego. It is expected that preliminary outcomes data for the indicators listed in Exhibit 3.2 will be available in February 2007.[5]

[5] See Further Notes about the Methdology (Appendix B) for more information related to the outcomes to be tracked throughout the evaluation.

Exhibit 3.2 Health and Developmental Services Outcome Measures (to be measured in FY 06-07)
Commission Strategic Plan Issue Areas 1 and 2: Children's Health and Children's Learning and Social-Emotional Health
% of children being breastfed at 6 weeks and at 6 months
% of children identified as needing assessment who receive assessment
% of children identified as needing treatment who receive treatment/follow-up
% of children receiving treatment who demonstrate health/cognitive/behavioral/developmental gains related to the funded services they receive
% of children utilizing appropriate health care resources (both preventative and urgent) and cognitive/social-emotional care resources to benefit their children 0-5
% of families who demonstrate increased knowledge about how to promote their child's health and development
% of families who demonstrate improved skills to promote their child's health and development

In addition, the emerging systems of care in each region will be evaluated for systems integration, improvement, and community change as a result of the project. During the first six months, the evaluation team focused on developing the client (i.e., parents and children) and system levels evaluation. Baseline findings from the systems-level evaluation are provided below.

Making a Difference: HDS in Action – Preliminary System Level Findings

The HDS systems-level evaluation is based on the Substance Abuse and Mental Health Services Administration's (SAMHSA) design for evaluating systems of care.[6] This approach examines the implementation and development of the HDS systems of care and is designed to provide feedback for continuous improvement of the quality of each regional network. The systems-level evaluation model consists of the Infrastructure Domain and Service Delivery Domain components that describe what must be done to achieve desired goals (see Exhibit 3.3).

Exhibit 3.3
System-level Evaluation: HDS Service Components

Infrastructure Domain	Service Delivery Domain
• Leadership and Partnership • Management and Operations • Evaluation and Quality Improvement	• Service Provision • Provider Capacity Building to Deliver Quality Services • Parent Education, Support and Empowerment • Linkages to Ancillary Supports

For each component, the evaluation examines a variety of performance indicators according to each of the following eight Core Principles, or fundamental assumptions of HDS:

1. Comprehensive.
2. Coordinated & Integrated
3. Early Intervening
4. Family Focused
5. Responsive to Cultural, Linguistic, and Special Needs
6. Readily Accessible
7. Accountable
8. Sustainable

[6] U. S. Department of Health and Human Services - Substance Abuse and Mental Health Services Administration. 2000 Annual Report to Congress on the Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program. Accessed 24 July 2006. <http://www.mentalhealth.samhsa.gov/publications/allpubs/CB-E200/arc05toc.asp>

In the first six months of the project, interviews were conducted with the Countywide Coordinator and staff from each Regional Service Network to assess progress towards achieving goals in each of these areas. The results from these interviews, including direct quotes from Regional Service Network staff and countywide coordinators are provided below. Future systems-level evaluation activities will include reviews of program records, such as: attendance logs, meeting agendas, agency protocols and guidelines; interviews with program staff (management, frontline); interviews with stakeholders; and additional surveys as appropriate.

New Structure, New Roles

Each regional coordinator has prior experience working with many of their subcontracting agencies, either directly or as part of existing referral networks. However, the structure of HDS is new and changes the ways in which service providers collaborate. This paradigm shift places more discretion as well as more responsibility on the lead agency. Both the lead agencies and the subcontractors are adjusting to the new fiscal structure; where lead agencies, and not First 5, monitor contracts with agencies in their Regional Service Networks. The regional coordinators are becoming more comfortable with their role of providing leadership, oversight, and contract management to the agencies in each Regional Service Network:

> *There have been improvements in communication and increased awareness of who does what. There's been a paradigm shift in [our region] in terms of realizing that service delivery is changing for this project. Rather than the old way, it's a system. It's starting to sink in and that's a success.*

Similarly, the subcontracting agencies are adjusting to contacting the regional coordinator, rather than First 5, when they have a question or a concern. This planning and coordination period has been challenging for some subcontracting agencies, especially those that serve more than one region, as the amount of time and resources needed to ensure coordination is substantial.

The initial phase of the project has seen a "dramatic amount of changes in a very short period of time," with regard to service delivery and coordination. The first six months of HDS has been vital to the regional coordinators as they get to know each of their subcontractors and work to understand how they are structured, provide services, and reinforce their role as the lead agency in each Regional Service Network: "We are getting to know the services better. Not just us as regional leads, but the subcontractors too. There were some agencies that knew each other, but some didn't."

Nuances of Regional Service Networks

Each Regional Service Network is composed of a wide variety of service providers, each with their own organizational culture, history, and "different strains on their hands." Recognizing this diversity, the design of HDS allowed some freedom in how each regional coordinator constructed their Regional Service Network. For example, one regional coordinator views their network as being made up of independent organizations that are connected through referrals for services. However, another regional coordinator's objective is to make their regional network a "one-stop-shop," where services are aligned seamlessly.

Additionally, the health and developmental service networks in each region are at different stages in their development. In some regions, the subcontracted agencies were already providing services prior to the HDS contract and had the capacity to begin providing HDS-funded services immediately. Meanwhile in other regions, the subcontracted agencies needed a "start-up" phase to coordinate service delivery. Each region also had many unique challenges or goals specific to their geographic area or target population. While these differences may lead to challenges in the development of each Regional Service Network, some regional coordinators stated that they benefit from this individuality, allowing tailored services to meet the needs in their region.

Successful Collaboration

Despite the differences within each Regional Service Network and among service providers, HDS-funded agencies are committed to working together to improve provision of health and developmental services. Regional coordinators and AAP agree that the biggest success in this early stage of the project has been the collaboration, both within and across Regional Service Networks. The countywide and regional coordinators have been working closely to establish countywide policies and approaches, as well as share resources. For example, a countywide calendar of HDS-related trainings has been established for regional coordinators to send staff from their regions to appropriate trainings occurring elsewhere in the county. In addition, a standard form has been designed for referring families from one region to another for automatic recognition.

There has been increased cooperation among regional coordinators and their subcontractors, as well as among the coordinators themselves: "The comfort level for a lot of regional leads has been raised so now if there is an issue, they don't mind getting on the phone and calling somebody directly…There's a real relationship that wasn't there before." Most agencies stated they are eager to learn from each other: "The most exciting part of the project is working with [other regional coordinators] and creating these new relationships. It's great to learn from these others about similar challenges, etc." Regional coordinators also noted that developing these Regional Service Networks has been a tremendous amount of work. Some feel it has not yet paid off in terms of collaboration and learning: "We have been so busy trying to set up our own systems that I hope we move to a point in which we can have more of an open exchange and learn from each other."

Collaboration has strengthened the relationships between regional coordinators and their subcontractors: "[HDS] has taken [collaboration] to a whole new level. We're laying a good foundation right now that will continue to grow." Most regions included their subcontractors during the development phases of the project, encouraging further relationship building, a critical step in enhancing a referral system. This process has changed the dynamic between service providers. As one regional coordinator reported, funded subcontractors could have been competitive, but instead are working together and learning from each other. One collaboration improvement suggestion is to build a centralized referral system for all of HDS.

Creating Space for Collaboration

In order to bring regional coordinators, subcontracting agencies, and local child health and development experts together to increase the dialogue about HDS and strengthen service delivery, the following meetings are convened regularly:

Regional Service Network Meetings

RSN meetings are convened by AAP monthly for the regional coordinators to discuss challenges and successes and learn from each other. In addition, AAP regularly meets with the regional coordinators individually to address specific challenges and questions.

Subcontractor Meetings

Each regional coordinator convenes regular meetings that bring together all of the subcontracted service providers in their region to discuss referrals, challenges, evaluation, etc.

Evaluation Workgroup

Consisting of evaluation staff from each regional coordinator, AAP, First 5 Commission staff, and Harder+Company staff, this group meets monthly to address the implementation of the HDS Evaluation Plan to ensure quality data collection and its use for program improvement.

HDS Advisory Committee

The committee is convened by AAP to provide feedback on the service delivery models, quality improvement issues, and barriers to service delivery. The committee is made up of local child development experts nominated by the regional coordinators; membership will rotate to ensure a variety of input.

Importance of Countywide Coordination

The regional coordinators commented that they benefit from the leadership of AAP. Many agencies noted that they actively seek the guidance and consensus building role of AAP when designing and implementing policies: "AAP shares the benefit of being knowledgeable about all the regions. Besides their individual expertise, they have the expertise of others." This is a particularly positive finding given that one of the goals of the project is to build a universal approach where possible. The regional coordinators also discussed many roles that AAP should play as countywide coordinator. Several coordinators expressed the desire for AAP to be a clearinghouse of information about subcontractors, HDS service delivery, promising practices, etc. It was suggested that AAP use their reputation to be the face of the project and take the lead in getting support from outside collaborators such as birthing hospitals and military facilities: "[AAP] has the credibility to speak to the public and the pediatricians."

Initial Challenges

As with all new projects, there are initial hurdles to overcome as the regions build their service networks.

Subcontractor participation: One such challenge has been ensuring all subcontractors are included during regional or countywide planning efforts. This has been an issue of time and comfort level. For many providers, time is one their most valuable commodities and meetings to plan better services are often secondary to actually providing services. This relationship building is critical, though, to the success of HDS: "It's hard to build a partnership if not everyone is in the room and it's hard to build ownership of the decisions that are made, or to try and get the buy-in from agencies." Additionally, HDS is requiring agencies to move outside their comfort zones to provide services in an enhanced, though different way.

***Developing referrals*:** Regional coordinators are also working hard to link existing services – such as pediatricians and public health nurses – that can serve as referral sources for families upon identification of a physical, developmental, or behavioral issue. Building these connections requires constant effort to ensure that connections remain, even if there is a change in personnel.

***Perceptions of duplication*:** Some of the leads still find that collaborating with some agencies is difficult, as some community agencies outside the Regional Service Networks perceive that HDS will cause service duplication. Both AAP and the regional coordinators have been working to build community partnerships by articulating the ways HDS improves and expands services, rather than simply replacing existing resources. However, it was noted that, in order to build trust and linkages with outside agencies, there needs to be a coordinated message from HDS-funded agencies: "One challenge has been maintaining coordination from people within the system to people outside the system." Communication between regional coordinators and their subcontractors to construct a clear message about HDS services is needed to ensure outside agencies receive consistent information.

***Outreach to specific cultural and ethnic populations*:**
The Regional Service Networks are faced the challenge of reaching diverse communities in need. For example, one regional coordinator reports that they currently have capacity to serve the Vietnamese population, but there are still language and cultural barriers to reaching clients from other Asian backgrounds in the region: "We have a little bit of [a budget for translation] but if we really want to get in there and understand that community and target services there, I don't think we are as well equipped as we need to be." Furthermore, it is expected that the current immigration debate will lead families to stop accessing services due to the fear that their immigration status will be reported to authorities.

"[Some agencies] are very content to stay within that realm and so a barrier to reaching and serving the target population is making sure that people go beyond the familiar in what they have done in the past and target families in a different way."

– First 5 Provider

Space for services: Identifying community space for service delivery is also a challenge. Regions want to have a community-based model, but have trouble identifying agencies in the target communities with adequate space for treatment. However, the Regional Service Networks are using creative methods to bring services to the community, such as mobile services.

Need for marketing: All of the agencies interviewed agree that there is a need for distributing information to the community about the importance of developmental screenings for young children and to make providers, as well as parents, aware of the services provided by the HDS Regional Service Networks.

There is a desire for the project to be "branded" as something service providers and families will recognize as a source of health and development services. One recommendation is to compile information from various agencies into an all-inclusive brochure. This brochure could be branded to be recognizable by the larger community. Efforts are currently underway to connect to birthing hospitals and other medical providers to inform them about HDS and encourage them to refer children into the Regional Service Networks.

Recommendations

The system-level baseline interviews of the Health and Developmental Services Project indicate that collaborative efforts in each region are successfully building networks of care that promote early identification and treatment of physical, developmental, and behavioral issues for children 0-5. The following recommendations are based on the preliminary process numbers and findings from baseline systems-change interviews as First 5 staff, AAP, regional coordinators, and subcontractors work together to enhance the Regional Service Networks:

1. Continue Collaboration: The regional coordinators and AAP agreed that the first six months of HDS have allowed all funded agencies to work together in new ways, improving direct communication, protocols for referrals, and opportunities to share resources. This dedication to collaboration should continue to grow as the project continues, expanding on existing knowledge about each agency and continuing to gather information where necessary to improve communication.

2. Strengthen Relationships: The role for coordinating and subcontracting agencies is new for many and has required a transition period. Most subcontractors are adjusting to contracting with fellow service providers rather than directly with First 5, and are respectful of the fiscal oversight and management role of the regional coordinators. Subcontractors and regional coordinators should continue to work together in this fashion, respecting the HDS structure and recognizing the authority of each regional coordinator, including following region-specific guidelines and strategies imposed by the lead agencies.

3. Support Regional Coordinators in Their New Role: The regional coordinators are dedicated to ensuring the success of their individual networks. This is a new role for many of the regional coordinators, even though the HDS model. Many had prior collaborative relationships with their subcontractors that did not involve a fiscal or oversight component. The Regional Service Network and other collaborative meetings are useful opportunities for the regional coordinators to learn from each other to solidify their role and strengthen their relationship with their subcontractors. In addition, trainings or technical assistance available from the Commission would be beneficial to strengthen the lead-sub relationship.

4. Get the Word Out: All agencies agreed that the key to maximizing HDS is ensuring that families, child care workers, pediatricians, and other providers are aware of the services available and are able to connect children to services. AAP is working on ways to communicate the goals of the project to community partners to illustrate that HDS creates new resources for children, rather than merely replace existing ones. Furthermore, the Commission should use their media campaigns to communicate the importance of HDS.[7]

5. Maximize Outreach Efforts: Similar to networking with community partners, it is important to reach out to parents in each region to ensure they are aware of and able to access services. Preliminary process data indicate that, while many families are receiving services, most agencies are not yet meeting the service delivery targets. While low numbers are anticipated in a startup

[7] For more information on KPBS and the media campaigns, see Chapter 6.

phase, the agencies can target and maximize outreach efforts through collaborative planning, sharing successes, and improving referral networks to ensure families are provided all of the services they need.

6. Use Data for System Improvement Efforts: Initial evaluation activities show that HDS has implemented all aspects of the health and developmental services and is beginning to report initial process data. As the outcome evaluation is implemented, it is important to look at results closely in order to make improvements to referral networks and service delivery, as well as ensure that the target population in each region is reached effectively.

A Final Word on the First 5 San Diego Health and Developmental Services Project

Throughout the HDS project startup phase during FY 2005-06, contractors and staff have worked diligently to create a system of care for children to receive early health and developmental services. Collaboration between the countywide coordinator, regional coordinators and subcontractors has been successful, as all parties have increased their knowledge about the various service providers and have started to create referral networks. After the initial six months, over 13,000 service units have been provided to children – from early screenings, home visits, behavioral services, speech and language and other related services through the HDS Project. As the project moves forward, it is expected that many more children and families will be served. The benefits of those services will be documented to show how the project impacts children's optimal health and development, key components of school readiness.

Chapter 4
Intergenerational Initiative

Key Findings

Improved learning environments: 89.4% of teachers surveyed indicated that the Seniors' participation in the program increased the teachers' capacity to create a positive learning environment.

Enhanced children's school readiness skills: 99.2% of teachers surveyed stated that the Seniors contributed to children's language, communication, and early learning skills. Surveyed parents also noticed an increase in their child's language or communication skills due to the Seniors (85.7% of parents surveyed).

Increased children's social-emotional health: 97.7% of teachers surveyed indicated that Seniors contributed to the children's ability to get along with their peers. In addition, 77.8% of parents noted that their children showed attachment to the Seniors *(a significant increase from the previous fiscal year)*.

Increased parents' knowledge of child development: 79.2% of parents responded positively when asked if they had learned something new about their child's development based on their interaction with the Seniors.

Summing it Up

- 3629 new children ages 0-5 received services provided by Seniors during FY 2005-06:
  - Most of the children served were between ages 3-5 (79.2%).
  - Over half of the program participants were Latino (57.7%) and nearly half (46.7%) indicated that Spanish was their primary language.
- Seniors contributed over 28,000 volunteer hours during FY 2005-06 in a variety of activities that support school readiness.

Intergenerational Initiative Diagram

First 5 Commission of San Diego County

Service Delivery Models

- **Childcare/Daycare:** Senior Mentors assist program staff in class curricula and/or work with children.
- **Community Centers/Clinics/Waiting Rooms:** Senior Mentors engage children in activities (e.g., reading, drawing).
- **Home Visitation:** Senior Mentors assist children and families with needs in the home.
- **Support Groups:** Senior Mentors provide support and information for relative caretakers and their children.

Collaborative Partner

County of San Diego, Aging and Independence Services (AIS)

Capacity Building/Direct Services Providers

- Bayside Community Center
- Casa de Amparo
- Grossmont Cuyamaca Community College District
- Jewish Family Service
- Neighborhood House Association
- South Bay Community Services
- St. Clare's Home, Little Angels Learning Center
- YMCA Childcare Resource Service (CRS)
- YMCA Youth and Family Services- Kinship Support Services

Goal 1

Increased number of children showing gains as a result of school readiness activities using an intergenerational approach.

* 2.2, 2.3

Goal 2

Increased parent knowledge and skills to promote children's optimal development and school readiness.

* 2.4, 3.1

Goal 3

Increased capacity of early childhood education providers to support school readiness.

*4.1

* Refers to Desired Results listed in the Strategic Plan and the Evaluation Framework (Appendix C).

Introduction

The First 5 San Diego Intergenerational Initiative (IG) is a three-year, $4 million project that began in February of 2004. This Initiative consists of nine contractors who incorporate the volunteer work of "Senior Mentors" to expand existing programs that serve children 0-5 and their families.[1] $1.2 million was allocated during FY 2005-06.

The 65 and over age group is the fastest growing age demographic in the United States.[2] In San Diego County, the total population is expected to increase by 37% between 2000 and 2030, while the 65 and over age group is expected to increase by 136% during that same time period.[3] This older adult population is not only increasing rapidly, but is also the most educated, wealthy, healthy, and active to date.[4] Most seniors also have spare time and a lifetime of experience to share with their community, and recent research shows they are eager to participate in volunteer and/or paid work that has meaning and allows them to make a positive contribution to the community.[5]

Senior Mentor Criteria

Participating seniors are required to meet the following criteria prior to being selected as a Senior Mentor:

- Be at least 55 years of age
- Complete a standardized application
- Pass a background check
- Complete a 12-hour orientation
- Commit to 60 or 80 hours over a one or two month period to receive a stipend for expenses, e.g. transportation

Key Elements of the First 5 San Diego Intergenerational Initiative

The primary goals of the IG Initiative are to tap the senior resources in San Diego County to expand the capacity of organizations that enhance children's readiness for school and also to gauge the effectiveness of using intergenerational strategies for programs working with young children.[6] As a result of the Initiative, intergenerational approaches are a part of the fabric of First 5 San Diego and are now regularly incorporated in the Commission's requests for proposals. The key elements of the Initiative are:

Supporting Diverse Services: The IG Initiative supports nine very different programs. Senior Mentors provide supportive services in some programs and direct services to children and families in others. The range of settings and services include:

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[1] Throughout this chapter, "Senior Mentors" refers to the older adults who volunteer as part of IG, while the use of the word "seniors" refers to senior citizens or older adults in general.
[2] Hobbs, B. Frank and Damon, L. Bonnie. "65+ in the United States." Current Population Reports, Special Studies. Washington, DC: U.S. Bureau of the Census, 1996. 23-190.
[3] SANDAG. 2030 Regional Growth Forecast. San Diego, CA: Author, 2004
[4] Hobbs, B. Frank and Damon, L. Bonnie. "65+ in the United States." Current Population Reports, Special Studies. Washington, DC: U.S. Bureau of the Census, 1996. 23-190.
[5] Peter D. Hart Research Associates. The New Face of Retirement: An Ongoing Survey of American Attitudes on Aging. Washington, DC: Author, 2002.
[6] Throughout this chapter, "school readiness" refers to the social, emotional, physical and cognitive skills necessary to be able and ready to learn successfully. First 5 San Diego. First 5 San Diego Commission 2004-2009 Strategic Plan. San Diego, CA: Author, 2004.

- **Daycare/childcare; preschools:** Supporting childcare workers and teachers in the classroom, aiding in daily tasks with children or assisting with the curricula.
- **Community-based organizations; waiting rooms, clinics:** Engaging and reading with children in busy community clinics and other waiting rooms. These are "light touch" services that reach a large number of children.
- **Home visiting:** Visiting families to help them learn and practice appropriate parenting skills through modeling and interaction.
- **Support groups:** Assisting parents and adult relative caregivers by providing support groups that encourage peer interaction to overcome challenges and support parenting knowledge and skills.

Supporting Diverse Providers: The IG programs also serve diverse populations at their sites, including a variety of children and families in daycare and Head Start centers, community health clinics, and homeless and domestic violence shelters. The Senior Mentors receive trainings specific to serving their work setting, as well as serving children from different cultural backgrounds and those with special needs.

Inter-Agency Collaboration: The Commission initiated a relationship between the IG contractors and the County of San Diego's Aging and Independence Services (AIS). The role of AIS is to provide technical assistance to the IG contractors and First 5 San Diego Commission staff. An AIS staff member also participates in monthly IG Initiative meetings to collaborate on outreach strategies and troubleshoot programmatic challenges.

Building Bonds: In some of the programs, children develop special bonds with individual Senior Mentors, often referring to them as "Grandma" or "Grandpa." One program involves seniors as mentors to parents and grandparents who have become caregivers of young children.

The IG Initiative was not developed with a design that targeted specific services. Its focus is capacity building, so it was positioned in the First 5 San Diego Strategic Plan under "Issue Area 4: Systems Improvement and Community Change" as a direct service strategy.[7]

Summing it Up: Individuals Served by the Intergenerational Initiative

Since the inception of IG, there has been a steady increase in the number of Senior Mentor volunteer hours (See Exhibit 4.1). Although the number of new, unduplicated children served decreased in FY 2005-06, the total number of children served increased (including new children and children receiving ongoing services).

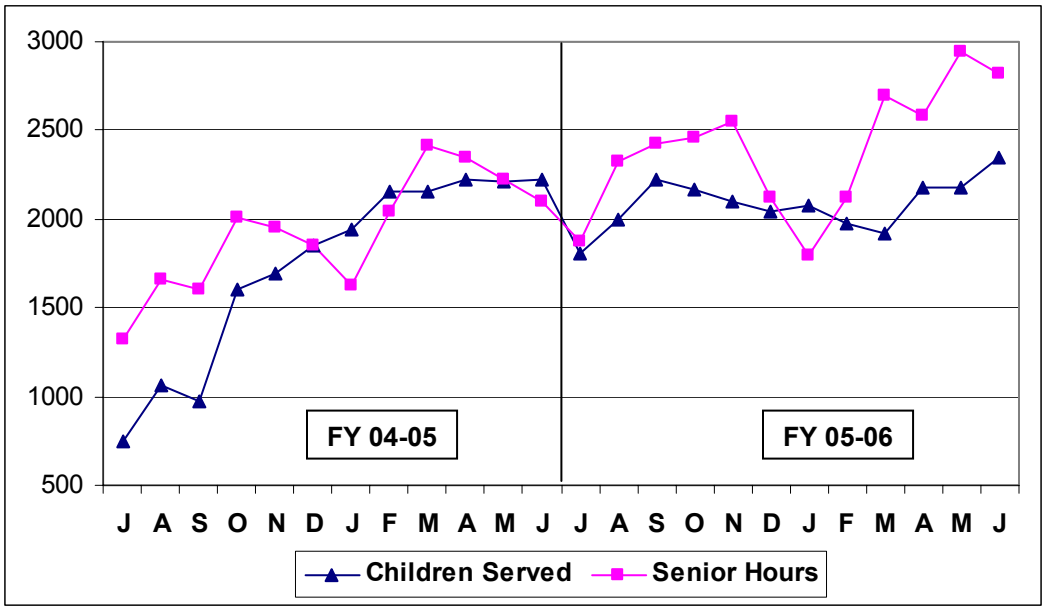
[7] First 5 San Diego. First 5 San Diego Commission 2004-2009 Strategic Plan. San Diego, CA: 2004.

Exhibit 4.1 Number of People Reached by the Intergenerational Initiative				
	FY 04-05	**FY 05-06**	**% Change***	**Total (FY 04-06)**
Children 0-5 (Unduplicated) **	4765	3629	-23.8%	8394
Average Number of Children (per month) **	1737	2082	+19.9%	1910
Senior Mentor Hours***	23,165	28,722	+24.0%	51,887
Average Number of Senior Mentors (per month)***	97	113	+16.5%	105

* Indicates percent of increase or decrease from the previous year.
** Note that many of these are served by "light touch" projects such as Senior Mentors reading in waiting rooms.
*** Some programs received expansion funds to increase the number of Senior Mentors in FY 05-06.

As seen in Exhibit 4.2, both fiscal years had an increase in the number of total Senior Mentor hours, with expected declines during winter months (likely due to holidays, vacations, and illness). The number of children served increased over both years, however, numbers remained fairly stable over FY 2005-06, implying that programs are likely operating at child slot capacity.

Exhibit 4.2
Children Served and Senior Mentor Hours
FY 04-05 and FY 05-06



Case Study # 4
More than Provider Capacity

The Project Generation A to Z (PGAZ) program at Neighborhood House Association places Senior Mentors in Head Start centers as part of the First 5 San Diego Intergenerational Initiative. The primary purpose of the PGAZ program is for Senior Mentors to assist Head Start teachers in the classrooms as "teacher aides," however participants describe other benefits as well.

"I find great satisfaction in teaching them. They are like sponges. They absorb almost everything."
– Grace, First 5 Senior Mentor

"The effects are very obvious on the children. They all want to work with Ms. Grace – sometimes they even cry when they don't get to."
– Mila ,Head Start Teacher

Grace has been volunteering as a Senior Mentor through PGAZ since the IG Initiative began in 2004. She has volunteered exclusively at the Zamorrano Head Start in southeastern San Diego, where she started reading to children. As a retired elementary school librarian and educator, she soon advanced onto more rigorous activities, including teaching reading, writing, and math skills one-on-one or in small groups. She focuses on children who are struggling, and reinforcing skills with children already demonstrating mastery. She is responsible for creating her own learning activities and homework, as well as thoroughly tracking her work with each child on their progress.

Sophia is one child that works with Grace regularly. Sophia is five years old and on track to enter kindergarten in Fall 2006. Sophia's mother Carla states, "I wanted her to go here because I wanted her in a place where she wasn't just being babysat, but where she would learn things and where her social skills could improve." Carla notes that Sophia enjoys her time with Grace tremendously. When Sophia returns home from her day at Head Start, she often mentions that she worked with Grace that day. While it is difficult to separate the effects of Grace's work and the general Head Start experience, Carla reflects that Sophia used to be very shy and afraid to speak up. Now she is outgoing, eager to try new academic activities, and interacts more with adults. Grace and Mila (Sophia's Head Start teacher) both agree with Carla's observations, noting that Sophia is more engaged in the learning process, as well as more vocal and participatory since she started working with Grace. Carla is certain that some of Sophia's improvement in social skills and school readiness is a result of her interactions with Grace:

> *Ms. Grace is a helpful addition to the classroom. The classrooms are large and mixed and when she comes, she will try to focus on the needs of the individual children. She works with them one-on-one. I know she practices things with Sophia that she needs to work on. She is really preparing the children more. I know the teachers do this all day too, but she gives the special attention that teachers aren't able to give in the larger group.*

As Carla mentioned, another major benefit of the Intergenerational Initiative is the value that Senior Mentors provide to the teacher and classroom setting. Both Grace and Mila express that the PGAZ program is extremely beneficial to the teachers. Teachers are often limited in resources, restricting them from doing everything they would like or need to do in the classroom.

The Senior Mentors help to fill those gaps. They provide relief so that the teachers can do other necessary tasks, such as work on curriculum. Grace states:

> *Sometimes if the teacher wants to work on a specific project and one or two children are acting out, I'll take them aside and do something with them so that the teacher can focus the project with the children who want to participate. I'm a relief to her. They need it desperately. They don't have the money to hire more staff.*

Mila shares a similar sentiment:

> *Ms. Grace is helping me a lot with my job as a teacher. Before I would have to find time to work with smaller groups of children and it was very difficult. Most of the time we would have like 10 children to a group, but now she can work with them individually or in small groups. She makes our jobs much easier. It's very helpful that she writes down everything that she is doing with the children, and how the children are progressing - like what areas they need to work on and so forth. We share those observations and use them to track the children's progress. We have a lot of children that need extra help and they really need that one-on-one time.*

But what is it about Senior Mentors that makes their work valuable? Head Start staff mention that there is something extra special about the Senior Mentors. Senior Mentors have wisdom and patience through life experiences, and they have a genuine affinity for these children. Grace describes her relationship with the children not only as a teacher, but also as a Grandma:

"Seniors are very patient and calm with the children, and I think that must come with age!"
– Mila,Head Start Teacher

> *A lot of the children look upon us as Grandmas. We are older people and they trust us in a different way. They tell us what is bothering them more quickly than they tell the teacher. A lot of them are missing grandparents and parents in their lives. They need that extra adult interaction and attention.*

And Grace was quick to recognize how much this volunteer work has had an impact on her own life: the work gives her purpose and inspiration to awaken and enjoy everyday. She reports:

> *I would probably be shopping and spending time with friends if I didn't do this work, but there is a reason I am here. The children are so important and they provide me so much love. If I've been out for a week or so, the children come running up to me and yell my name and give me hugs. The love they give to me is much more than I think I give to them…but then again there is a reciprocation of love through my teaching them.*

"If I can turn one child onto reading or looking at a book or learning something, then I've accomplished a great deal."

– Grace, First 5 Senior Mentor

Making a Difference: Intergenerational in Action

Traditionally, many intergenerational programs focus on the benefits to seniors. However, First 5 San Diego made a marked departure from this approach by creating programs whose primary focus is to utilize the skills, experiences, and abilities of Senior Mentors to assist service providers serving young children and their families.

The evaluation of the Intergenerational Initiative focuses on three main outcomes:

1. ***To increase the capacity of early childhood education providers to support school readiness.***
2. ***To increase the number of children showing gains as a result of school readiness activities using an intergenerational approach.***
3. ***To increase parent knowledge and skills to promote children's optimal development and school readiness.***

The diversity of the programs funded makes it challenging to evaluate the IG Initiative. The key methodology used is reporting by providers (principally teachers) and parents. Two survey instruments were distributed in both FY 2004-05 and FY 2005-06.[8] Because the programs are so different, not all programs utilized both surveys.

Provider Survey (provider and child outcomes)

Seven of the nine IG contractors measured common outcomes through a provider survey.[9] The survey was given to frontline workers who had firsthand experience working with the Senior Mentors. Most individuals surveyed were teachers, teacher's aides, childcare, and daycare workers. In some cases, case managers, therapists, child development specialists and site supervisors were included as appropriate. Since approximately three quarters of respondents (74.8%) were teachers or teachers' aides, all respondents are hereafter referred to as "teachers." A total of 137 surveys were distributed and 132 were returned (96.4% response rate).

Parent Survey (parent and child outcomes)

Seven of the nine IG contractors measured common outcomes through a parent survey during FY 2005-06.[10] Parent eligibility for survey participation was based on two criteria: the parent's familiarity with the Senior Mentors' work and involvement in the program long enough to assess impact. It should also be noted that some agencies omitted certain questions when inapplicable. Of 217 parent surveys distributed, 81 were returned (37.3% response rate).[11, 12]

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[8] For more specific information on last year's survey results, see the 2004-05 Annual Evaluation Report. For more information on the development of the parent and provider Surveys, see Appendix B.
[9] Compared to 5 of 9 in FY 2004-05.
[10] Compared to 6 of 9 in FY 2004-05.
[11] While the overall response rate for parent surveys in FY 2005-06 was low, it should be noted that there were 34 more surveys completed in FY 2005-06 than in FY 2004-05. Contractors were ambitious in their attempts to increase the number returned from FY 2004-05 and requested and distributed more parent surveys in FY 2005-06, which may have contributed to the relatively low response rate.
[12] While 3629 children were served, many of these children were served through light touch services, e.g., waiting room reading programs, and parent surveys were not distributed at these programs.

In addition to the surveys, a case study and focus group were conducted to gather parent, senior, and provider stories on the impact of IG. (See "More than Provider Capacity" on page 70 and "Senior Mentors Provide Invaluable Support to Relative Caregivers" on page 79.)[13]

"One 'wow' moment for me was when a 2 year old girl turned the pages of a book I brought to the classroom. This is a normal activity for normal kids, but she has cerebral palsy and her little hands are fists most of the time."

– First 5 Senior Mentor

Teacher Outcomes

The provider survey was created to assess the effect of the Senior Mentors on the capacity of service providers (in this case, mostly teachers). This directly links to the First 5 San Diego 2004-2009 Strategic Plan, "Issue Area 4," Desired Result 4.1: *Communities have adequate service capacity that is effective, coordinated, integrated, and sustainable*; and specifically part A of that Desired Result: *Increased service capacity to serve the target community.*

The presence of a Senior Mentor in the classroom is an opportunity for the teacher to devote more time to enhancing the program. The evaluation focused on four teacher outcomes that result from the support of Senior Mentors:

- Enhanced positive learning environment
- Increased language and learning activities
- Increased capacity to provide special attention to children
- Increased communication with parents.

All of the teacher outcomes for both FY 2005-06 and FY 2004-05 are found in Exhibit 4.3. Overall, the results remain very high (84% to 94% in most categories), with only small variations between the two fiscal years. There are three notable declining scores:

- There was an 11% decrease in the number of teachers who reported they were able to devote more time to lesson planning.
- There was a 16.8% decrease in the number of teachers who stated that Senior Mentors provided them more time to work with children on transitioning to kindergarten. This is a statistically significant drop (at $p<.05$). It is unknown exactly why this outcome decreased, however, the "unknown" response rate for this survey item was 25% (compared to 15% in FY 2004-05). That is, more teachers stated that they were unable to determine whether Senior Mentors enabled them to work more with the children to prepare them for kindergarten.
- Over three-quarters (76.5%) of teachers were able to spend more time with parents, which was nearly an 8% drop from FY 2004-05 (84.4%).

[13] A focus group was held with participants of YMCA KSSP in both FY 2004-05 and FY 2005-06 because the program model is unique to the project and neither survey is applicable to their program.

Exhibit 4.3 Intergenerational Initiative Teacher Outcomes			
Survey Results*	**FY 04-05****	**FY 05-06*****	**Difference********
Outcome 1: Enhanced positive learning environment			
Increased capacity to create a positive learning environment	91.7%	89.4%	-2.3%
Outcome 2: Increased language and learning activities			
More time for lesson planning	82.3%	71.2%	-11.1%
More language and learning activities	91.5%	89.4%	-2.1%
Outcome 3: Increased attention to children			
Increased attention to new children	93.6%	93.9%	+0.3%
More time to children with special needs	85.4%	84.1%	-1.3%
Increased capacity for preparing children for kindergarten	84.2%	67.4%	-16.8%*****
Outcome 4: Increased communication with parents			
More time for communicating with parents	84.4%	76.5%	-7.9%

* Survey responses were on a scale of one to four, with one being "negatively" and four being "a great deal." Positive responses include the "somewhat" and "a great deal" response categories.
** FY 2004-05: *Teacher surveys* : total n = 97.
*** FY 2005-06: *Teacher surveys*: total n = 132.
**** Indicates increase or decrease from previous year.
***** Statistically significant at $p < .05$

It is not clear why these scores declined when the number of Senior Mentors in the programs and number of volunteer hours actually increased. The funded program survey found that 43% of the IG programs responding reported challenges with having sufficient paid staff to provide services. It may be that Senior Mentors helped to ease some of the gaps due to staffing challenges, but that teachers were overall less able to spend time on increasing language and learning activities and on activities that prepare children for kindergarten.

Although most findings related to teacher outcomes slightly decreased this year, it is important to note that a large majority of the respondents stated benefits to having Senior Mentors in the classrooms (an average positive response rate of 81.7%). These outcomes show that IG continues to support the First 5 San Diego goal to increase provider capacity building and improve school readiness outcomes for children.

"I don't know where I would be without the dedicated, patient and nurturing presence of the volunteers. They are wonderful."
– First 5 IG Teacher

Child Outcomes

The second goal of the Intergenerational Initiative is to "increase the number of children showing gains as a result of school readiness activities using an intergenerational approach." This goal is linked to the First 5 San Diego Strategic Plan "Issue Area 2," Desired Result 2.2: *Children are*

socially and emotionally healthy, and 2.3: *Children are cognitively developing appropriately.* Research shows a relationship between participation in intergenerational programs and improved academic outcomes for young children, especially in literacy and numerical concepts.[14] It can also contribute to improved behavior and socialization skills of children.[15]

In many of the IG programs, Senior Mentors support program staff by conducting home visits, providing assistance in the classroom, assisting with developmental assessments, promoting literacy through reading programs, and working with children with special needs (including children traumatized by domestic violence). In both the provider and parent survey, respondents were asked how Senior Mentors contributed to the following child outcomes:

- Increased early learning skills
- Increased positive attitude toward learning
- Increased social-emotional skills
- Increased adult-child interaction

Child outcomes for both FY 2005-06 and FY 2004-05 can be seen in Exhibit 4.4. The key child outcome findings as reported in the parent and teacher surveys, are as follows:

- Nearly all teachers reported that Senior Mentors contributed to children's language and communication skills and to children's early learning skills, such as doing puzzles and showing interest in books.
- 85.7% of responding parents noticed an increase in their child's language or communication skills, which is a 12.6% (yet statistically insignificant) increase over last year. It is unknown why this increase occurred, however it may be that parents surveyed this year were more aware of the impact of Senior Mentors on their children's skills.
- The teachers' responses in the areas of positive attitude toward learning (as demonstrated by listening, following directions, and making transitions) and social emotional domains remained high.
- The parents' responses in social-emotional domains were slightly lower, with a 5.5% drop in the improvements parents noted in their child's social-emotional skills (e.g. giving affection, interacting with others, showing self-confidence).
- Bonding with the Senior Mentors is an important benefit to assess, as the relationship between the generations is a key component of intergenerational programming. The proxy measures for this relationship include: 1) children mentioned Senior Mentors by name when they are absent (75%) and 2) teachers said the children look forward to days when Senior Mentors are present (86.4%). While these percentages are slightly lower than last year, parental response to their children showing attachment to Senior Mentors increased significantly (55.8% in FY 2004-05 to 77.8% in FY 2005-06).

[14] Waddock, S.A., and M. Freedman. "Reducing the generation gap and strengthening schools." Generations 22.4 (1998-99): 54-57.
[15] Ibid.

Exhibit 4.4 Intergenerational Initiative Child Outcomes			
Survey Results*	**FY 04-05****	**FY 05-06*****	**Difference********
Outcome 1: Increased early learning skills			
Increased language and communication skills (Teacher)	100.0%	99.2%	-0.8%
Increased early learning skills	100.0%	99.2%	-0.8%
Increased language or communication skills (Parent)	73.1%	85.7%	+12.6%
Outcome 2: Increased positive attitude toward learning			
Increased development of a positive attitude toward learning	96.9%	97.7%	+0.8%
Outcome 3: Increased social-emotional skills			
Increased children's ability to get along with their peers	96.9%	97.7%	+0.8%
Increased children's ability to interact with adults	96.9%	98.5%	+1.6%
Increased social-emotional skills (Parent)	76.9%	71.4%	-5.5%
Increased general behavior skills (Parent)	84.6%	83.7%	-0.9%
Outcome 4: Increased adult-child interaction			
Mentioned the Senior Mentors by name when not present	84.4%	75.0%	-9.4%
Look forward to the day the Senior Mentors work	90.5%	86.4%	-4.1%
Showed signs of attachment toward the Senior Mentors	55.8%	77.8%	+22.0%*****

*Teacher Survey responses were on a scale of one to four, with one being "negatively" and four being "a great deal." Positive responses include the "somewhat" and "a great deal" response categories. Parent Survey responses were in yes/no format.
**FY 2004-05: *Teacher surveys*: total n = 97. *Parent surveys:* total n = 47.
***FY 2005-06: *Teacher surveys*: total n = 132. *Parent surveys:* total n = 81.
**** Indicates increase or decrease from the previous year.
*****Statistically significant at $p < .05$

Program staff members note that Senior Mentors help children learn to trust, develop emotionally, and ease separation anxiety from parents. For example, Casa de Amparo utilizes Senior Mentors to work with children who have been abused or neglected, with the goal of helping children rebuild trust through meaningful adult-child interaction. In sum, respondents of both surveys reported positive contributions of the Senior Mentors towards the learning and wellbeing of children during FY 2005-06.

"Because of their special circumstances, as children of actual or potential abuse and/or neglect, I experience the satisfaction in helping provide the children with a safe and secure place that adds structure and consistency to their day. I have seen their progress in expressing their feelings in words and using their words rather than hitting to settle disputes."

- First 5 Senior Mentor

Parent Outcomes

An additional goal of the Intergenerational Initiative is to "increase parent knowledge and skills to promote children's optimal development and school readiness." This goal aligns with the First 5 Strategic Plan under both "Issue Area 2: Children's learning and social-emotional health," Desired Result 2.4: *Families have the knowledge and skills they need to support their children's learning and social-emotional health*; and "Issue Area 3: Parent and family development and resources," Desired Result 3.1: *Families have the skills, comprehensive support, and resources they need to promote their children's optimal development and school readiness.*

To assess this goal, the parent survey included questions about the following outcomes:

- Increased parent knowledge of child's development
- Increased parent awareness of school readiness
- Increased early learning activities with their child

The involvement of parents in the IG programs vary, thus the amount of contact that Senior Mentors have with parents is dependent upon the program model. For example, programs that utilize a home visiting model, such as Jewish Family Service, include Senior Mentors that work with parents, as well as children. In other programs, such as South Bay Community Services, Senior Mentors facilitate "Mommy and Me" and parenting classes.
All of the parent outcomes for both FY 2005-06 and FY 2004-05 can be seen in Exhibit 4.5.

Exhibit 4.5
Intergenerational Initiative Parent Outcomes

Survey Results*	FY 04-05**	FY 05-06***	Difference****
Outcome 1: Increased knowledge of child's development			
Learned something new about their child's development	80.0%	79.2%	-0.8%
Outcome 2: Increased awareness of school readiness			
Learned something they can do to help their child prepare for kindergarten	61.5%	70.8%	+9.3%
Outcome 3: Increased early learning activities			
Increased activities/opportunities for child to play	84.6%	83.7%	-0.9%
Increased reading with child	64.3%	64.2%	-0.1%

* Parent Survey responses were yes/no format.
** FY 2004-05: *Parent surveys:* total n = 47.
*** FY 2005-06: *Parent surveys:* total n = 81.
**** Indicates increase or decrease from the previous year.

The parent reported results from 2005-06 remained high for all areas, as well as very similar to findings from 2004-05. The exception is the 9.3% increase in the number of parents reporting learning something to help their child prepare for kindergarten. This is higher, but not statistically significant. When asked to provide an example, 87.5% focused on cognitive

activities, such as helping their child read, recognize letters, numbers, shapes and colors. The remainder described helping their child develop the social skills and confidence.

As the results above illustrate, Senior Mentors have continued to make an impact in the lives of the families with whom they have had direct contact. In particular, Senior Mentors reinforce the importance of parent involvement in children's daily activities and teach parents new ways they can play a role in their child's school readiness.

"I've learned that if I dedicate more time to educating her by reading books, then I am preparing her for better educational development."

– First 5 IG Parent

Results of the Intergenerational Initiative Funded Program Survey

The IG Funded Program Survey was designed to assess the Initiative's functioning and sustainability. Seven of the nine IG contractors (63%) completed the survey. Notable results are presented below:

Staffing program challenges: 57.1% of IG programs had sufficient and trained paid employees to provide services.

Sufficient capacity: 57.1% of IG programs had a waiting list for children during the fiscal year, which could be a result of either staffing shortage or a high need for these services.

Culturally reflective and inclusive: 85.7% reported being designed to meet the needs of specific ethnic groups. Examples included employing bicultural/bilingual staff and distributing program materials in multiple languages. 100% have specialized services or protocols to meet the needs of children with special needs. Examples included having staff trainings on special needs topics, staffing paid employees or volunteers who work specifically with those children, and creating protocols for referrals to specific agencies for special needs.

Difficulties leveraging non-First 5 funds: 28.6% obtained additional grants or revenue in FY 2005-06 for their First 5 funded programs. Three others (42.9%) have identified potential funding, while two have not (28.6%).

Focus Group # 1
Senior Mentors Provide Invaluable Support to Relative Caregivers

When invitations for a focus group were distributed to caregivers raising a relative child in their home, nineteen people arrived to share their stories of support while participating in the YMCA Kinship Support Services Program (YMCA KSSP). Together, they represented 14 families caring for 36 children. Most of the children are grandchildren, nieces or nephews placed in the care of relatives due to issues of drug abuse, domestic violence, neglect, or abandonment. Some participants, however, became relative caregivers under tragic circumstances. In one such instance, a grandmother began caring for her three grandchildren after their mother died in a car accident. These caregivers receive support from YMCA KSSP Senior Mentors in a variety of ways: weekly support group meetings (alternating in English and Spanish); playgroup sessions for children 0-5; case management, information and referral services; and assistance with guardianship through consultations, telephone calls and home visits.

Participants of the program described heart-wrenching circumstances of loss, grief, and frustration; all shared stories of coping with the unexpected responsibilities of being parents once again. When asked how the children were faring, the majority of families claimed the children were doing fine. There were only two exceptions: one grandparent noted that her grandchild was having trouble making friends at school, and another had a granddaughter who needed vision and dental care. This generally positive report is an interesting contrast to a focus group conducted with the same agency last year, wherein many participants shared concerns about the children's physical or emotional development. A possible explanation for the difference could be that several families have received support from the Senior Mentors since the program began two years ago and the sustained involvement helped them overcome challenges. One participant stated that when she began attending meetings three years ago, she had many difficulties with her grandchildren. Those children are now over age six and are doing well in school, thanks to the Senior Mentors. She continues to attend meetings as her younger grandchildren still benefit from the program.

"I have seen her with her grandchildren. She is their mother. Just as I am the mother of my grandchildren."
– First 5 Grandparent

"I am 81 years old. I have diabetes and high blood pressure… Sometimes my pressure is as high as 300 and I should be in the hospital."
– First 5 Grandmother caring for four grandchildren

Continued program participation is spurred by relative caregivers need for emotional support even when the children may be doing well. One participant shared, "It is one thing for the children to be well, and another for us to be well. My wife and I have been caring for the children for three years, and we haven't worked a single day. I don't know how we've managed…but we've been helped here. As they say where the tree provides shade, that's where we go, and that's why we come here."

Listening and sharing helps lift the veil of depression that can overshadow the caretakers as well, as the caregiver who lost her daughter in a car accident described:

> *I was very depressed, and since coming here I feel very well. The group is good for me. I lost four relatives in the accident…frankly I cried almost daily and I didn't pay attention to [my daughter's surviving] children. A friend told me to*

come here…and I came and the program has been good for me. I'm half-blind and I need surgery, but I still come.

Some participants shared that Senior Mentors who help run the program are appreciated for their age and experiential similarities. Being the same age group may foster trust and friendships between Senior Mentors and caregivers. Some Senior Mentors are even relative caregivers themselves, bringing their similar experiences and knowledge to the program. These similarities quickly create a level of comfort and rapport between Senior Mentors and caregivers.

The support groups run by the Senior Mentors also allow the grandparents to continue learning valuable lessons about caring for children. In the words of one grandparent: "I've become up-to-date. I learn something new about childcare every time I come. I had forgotten all this." Another grandparent expressed how the lessons have changed her behavior:

"The children need help, but we the adults need more help in understanding them."
– *First 5 Grandparent*

I learned a great deal. I was different with my own children than I am now… now I put aside housework to sit for a while and play with the children before bedtime. I put aside housework to take them out for a walk. Before, it was impossible, but now I've learned to give the children productive time.

Similar to last year, participants stated that the most important thing they learned in the sessions was how to care for the children, discipline them, and pay attention to them. In particular, grandparents learned about children's developmental processes, appropriate nutrition, communication with children and adaptation to their age level. Overall, the learning process was difficult, and more than one grandparent expressed that they have "had to start from scratch." Ironically, one caregiver expressed regret for not having learned these lessons a long time ago: "If I'd known about a program like this when I was young, our children wouldn't be in jail, or into drugs, and we would have given them the attention we are giving [our grandchildren] today."

One striking difference from last year's focus group was concern over the program's future. YMCA KSSP ended the lease on its former facility and the support groups now take place at a local school, which caregivers consider smaller and less comfortable. The playgroup sessions occur in a classroom occupied simultaneously by a kindergarten group. Due to the lack of space and funding, the participants feel they cannot recruit more people. Despite these concerns, the grandparents remain determined to work toward the children's future by raising them as if they were their own and supporting the program that has supported them. They are taking ownership of the program through community outreach efforts to increase support group participation, in the hope of a bigger and more comfortable space becoming available. They are grateful to the program and ready to help in any way they can.

"We are getting trained to help our children, and the children are overcoming the traumas they have experienced…I'm very grateful, and I would like to do something, if there is anything I can do, I will do it with pleasure."

– *First 5 Grandparent*

Challenges and Limitations of the Intergenerational Initiative

The IG Initiative has shown that Senior Mentors can build capacity in First 5 programs. As a result, the Commission is now incorporating intergenerational strategies, where appropriate, into the solicitations for its new initiatives. This most recently occurred in the development of the First 5 for Parents Project. Staff is now looking at how to design intergenerational strategies into the upcoming Social-Emotional Initiative. This is a testament to the success of the IG Initiative and the Commission's commitment to broadening the use of intergenerational strategies as an integral part of its programs. An assessment of the first two years of the IG Initiative reveals some of its challenges and limitations, some of which may provide lessons about designing and implementing intergenerational programs in the future:

Challenges on the Recruitment and Retention of Senior Mentors

At times, it has been a challenge for programs to reach their targets for Senior Mentors. Encouragingly, the number of Senior Mentors volunteer hours has increased from year one to year two by 24%; and the number of Senior Mentor volunteers increased by 16.5% (See Exhibit 4.2.). Overall, four elements have contributed to difficulties in recruiting and retaining the Senior Mentors:

1. Inconsistent schedules: The senior population often faces life situations that interfere with consistently volunteering. These situations may include health problems, transportation challenges, seasonal absences, or life events that take priority over volunteer work. As a result, there is a higher level of volunteer turnover within this age group.

2. Background checks: In some instances, the background check process (required to work with young children) has taken so long that the seniors moved onto other volunteer opportunities or lost interest. Many seniors' fingerprints are worn down (due to age) and are therefore not visible and/or readable. In addition, there are often systemic delays in processing background checks beyond the control of programs.

3. Hourly requirement: Initially, the IG Initiative required volunteers to commit to working a minimum of 15 hours per week, for a total of 60 hours per month. This requirement was too intensive for some seniors and made recruitment very challenging. Consequently, contractors offered the option to either fulfill the monthly requirement or complete the hours over two months, and this flexibility attracted more seniors.

4. Bilingual volunteers: There is great need for bilingual Senior Mentors, particularly Spanish speakers, in the communities served by IG programs. The recruitment of bilingual seniors has been challenging throughout this Initiative. There is a need to increase volunteerism among older Latinos to work with community-based organizations. To address this need, IG contractors have shared helpful strategies for recruiting Spanish-speaking Senior Mentors and targeting volunteer incentives to this population.

Challenges of Structure and Design of the Initiative

5. Difficulty in measuring effectiveness: The original IG Initiative design was very broad and outcomes were not well defined. As a result, a wide variety of programs were funded, sharing only the commonalities of incorporating senior volunteers and serving the target population of the Commission. The inconsistencies among programs exist in terms of the training, utilization and skill level of Senior Mentors at the different sites; and the variety of program goals and service models limits the evaluation to parent and provider response surveys. The tremendous variation in programs precluded measuring actual child or family outcomes and thus makes it difficult to understand the effectiveness of IG strategies on improving school readiness.

6. Formation of intergenerational bonds: The case study and focus group in this report demonstrate the strong potential for intergenerational strategies to contribute to building attachments critical to young children and to mentoring parents and caregivers in need and under duress. This can occur when seniors interact closely with children and caregivers. This was not, however, the model for all IG programs. In some, seniors performed administrative work and others performed "light touch" direct services. While these activities are clearly expanding capacity in these organizations, they do not build intergenerational bonds.

"I had a little boy ask me if I was old… I proceeded to ask him what he thought old meant, and he responded with, "Old is white hair and you can't run fast with me outside." I smiled and took the little boy's hand and led him outside to challenge him to a game of Red Light, Green Light."

- First 5 Senior Mentor

7. Stipends: One of the few standardized elements of the IG Initiative is the level and requirements for stipend payments. During the design of the Initiative, the stipend system was established as a method to cover the costs of volunteering, recognize the worth of seniors' contributions, and retain volunteers. However, no contractors using IG strategies for other Commission efforts have opted to replicate this model – including some of the agencies funded under the IG Initiative. Thus, in some organizations with multiple First 5 contracts, the IG Senior Mentors are receiving stipends, and other volunteers receive smaller stipends, or none at all.

8. Partial view of the Initiative: In examining the results of the individual funded programs in light of the literature on intergenerational efforts, the Commission has the opportunity to learn some valuable lessons about the optimal types of IG program designs for its target population. Literature suggests that seniors are most interested in participating in projects that: are personally rewarding; identify and utilize their interests, skills and experience; give them a voice in selecting their activities; and allow them to be a part of the organization and be consulted in planning and other such activities.[16] There was a missed opportunity for AIS or another funder of senior programs to collaborate with the Commission on the evaluation component of this project. Such opportunities would have provided a 360 degree view of the Intergenerational Initiative, including its effect on programs, children, caregivers, and on the seniors, as well.

[16] Kaplan, M., L. Duerr, W. Whitesell, L. Merchant, D. Davis, and E. Larkin. Developing an Intergenerational Program in Your Early Childhood Care and Education Center. University Park, PA: Pennsylvania State University, College of Agricultural Sciences, Intergenerational Programs and Aging, 2003.

Recommendations for the Future

As the Intergenerational Initiative prepares to end its final year of operation, it is important to review the initiative in light of relevant literature and make recommendations for any future IG projects and for other projects in this field:[17]

Recommendations on the Recruitment and Retention of Senior Mentors

1. Allow programs to handle their own recruitment: In the first year of the Initiative, recruitment of Senior Mentors and application screening was handled as a centralized process. This proved to be unnecessarily inefficient and costly. In the second year, centralized promotion funds were given directly to the IG contractors, which streamlined the process and allowed providers to utilize their knowledge of the community. Contractor collaboration, expanded venues for advertising and recruitment, and community partnerships will help improve recruitment and retention.

2. Streamline fingerprinting/background checks: It is important to establish strong partnerships with agencies that provide the fingerprinting and background checks and share tips such as using special creams to enhance the ridges on seniors fingers so their prints will register by electronic systems.

3. Support senior networking and peer support opportunities: Due to geographical distances, differing schedules and transportation challenges, it is generally impractical for Senior Mentors in IG programs to network on an on-going basis. However, periodic trainings and the annual Senior Mentor recognition event provide some opportunity for peer support and should continue. Contractors should also seek opportunities to create partnerships among staff and Senior Mentors. This provides the Senior Mentors with the opportunity to learn from others, feel part of the team and to establish friendships.

4. Increase bilingual senior volunteers: To address the need for bilingual Senior Mentors, IG contractors have shared helpful strategies for recruiting Spanish-speaking Senior Mentors. Nevertheless, recruitment of bilingual seniors has remained challenging and needs more study.

Recommendations on the Structure and Design of the Initiative

5. Difficulty in measuring effectiveness: The Intergenerational Initiative was designed prior to the Commission's transition to outcomes funding, wherein the design of all initiatives ties directly to the Strategic Plan and maps directly to the Evaluation Framework. In addition, all outcomes are specified in the Commission's solicitation for proposals (e.g., RFP, RFGA) so that proposals are created and are selected based on their ability to meet specific objectives. Following this strategy in the future will prevent the development of initiatives that require "retrofitted evaluations" and that elude more targeted outcome measurement.

[17] Kuehne, V.S. "The State of Our Art: Intergenerational program research and evaluation." Journal of Intergenerational Relationships 1.1. (2003): 145-161.

6. Formation of intergenerational bonds: There is a special role IG approaches can play in building critical attachments for young children, which may also be the most rewarding role for seniors. There is also potential for contact with Senior Mentors to help parents and caregivers build increased confidence in their roles and reduce stress and isolation (especially in the home visitation and support group models).[18] Thus, IG strategies can play a role in future Commission programs focusing on social-emotional issues with young children and their parents and caregivers.

7. Stipends: Evaluating the stipend structure used in the IG Initiative could inform future projects. This could include examining its effect on recruitment and retention, as well as any unintended consequences with volunteers who are not receiving stipends.

8. Partner on evaluation for a full view of IG efforts: By partnering with a funder of projects for seniors, the Commission and those committed to supporting intergenerational approaches can get a fuller view of the use of IG efforts funded by the Commission. This could include evaluating:

- How utilizing the unique skills and interests of the Senior Mentors affects program outcomes
- Whether local IG efforts replicate outcomes of other programs that have documented benefits to seniors such as improved health, mental health, and cognitive functioning[19]
- Whether older adults who participate in such a program with young children may be more likely to be advocates for early childhood issues[20]

A Final Word on the Intergenerational Initiative

The Intergenerational Initiative has successfully expanded the capacity in organizations serving young children. In two years, Senior Mentors have provided nearly 52,000 volunteer hours serving 8400 children. In addition, parent and teacher responses strongly support that Senior Mentors enhance services for children, increase parent awareness of and participation in early learning activities, and increase provider capacity in the program setting.

"When people ask how I feel about aging and volunteering, I tell them that being a professional grandparent is something that not everyone can do, and I am proud to be one person that can do it."

- First 5 Senior Mentor

[18] Power, M. and A. Maluccio. "Intergenerational approaches to helping families at risk." Generations 22.4 (1998/99): 37-42.
[19] Fried, L. P., M. C. Carlson, M. Freedman, K. D. Frick, T. A. Glass, J. Hill, S. McGill, G. W. Rebok, T. Seeman, J. Tielsch, B. A. Wasik, and S. Zeger. "A social model for health promotion for an aging population: Initial evidence on the Experience Corps model." Journal of Urban Health 81.1 (2004): 64-78.
[20] Henkin, N.Z., A. Taylor, D.M. Butts, & J. Peterson. "Powerful Allies: Mobilizing Older Adults to Build Strong Communities." Elders as Resources: Intergenerational Strategies Series. Philadelphia, PA: Temple University, 2005.

Chapter 5
School Readiness Initiative

Key Results

Children improved in each of the five developmental domains: Approximately one-third of children participating in School Readiness Initiative program activities showed improvement in all five domains (Communication, Gross Motor, Fine Motor, Personal-social, and Problem-solving). Consistent improvement was found in Gross Motor, Fine Motor, and Problem-solving skills for the last two fiscal years.

School Readiness programs connect parents to resources: Parents emphasized the many ways School Readiness Programs have connected their children to needed health and behavioral health services.

School Readiness programs provide opportunities for parent involvement: Through classroom volunteering, parents became more involved with their child's education, the school environment, and other parents.

School Readiness programs improve schools' capacity: Program staff participated in meetings between Early Childcare Education (ECE) providers and elementary school staff to plan and review protocols that provide smooth transitioning for children entering kindergarten.

Summing It Up

The School Readiness Initiative served 75,372 children 0-5 and their families,* and provided trainings and support to 2,970 staff/service providers during FY 2005-06. Overall, there was a 66.8% increase in the number of children, families, and program staff served from FY 2004-2005:

- 18,020 children 0-5, including 1755 special needs children 0-5; and 9165 parents and caregivers received early care and education services.
- 9020 children ages 0-5, including 766 special needs children 0-5; and 21,079 parents/caregivers received Parenting/ Family Support Services. Of the 6139 parent/family support service referrals that were made, 51.4% were successfully completed (n=3154).
- 3274 children 0-5 received screenings/ assessments. Among the 2024 children who received referrals, 13.3% were confirmed to have successfully accessed services (n=269).
- 1130 staff/providers attended articulation and Kindergarten transition activities.
- 1840 staff/providers attended staff development trainings and other administrative activities.

* The majority of these service contacts were for "light touch" services. The outcomes data in this report represent children who were served intensely.

School Readiness Initiative Diagram

First 5 California

First 5 Commission of San Diego County

Capacity Building/Direct Services

Early Care & Education (ECE) Classrooms	Parent & Child Centers
• Cajon Valley • Escondido Union • National • San Diego Unified • San Ysidro • Vista Unified	• Cajon Valley • Escondido Union • Oceanside Unified • Chula Vista Elementary

Special Needs Project

Chula Vista Elementary

Purpose

To expand and improve its school readiness services for young children with special needs.

5 Essential Elements	Result Areas
• Early Care Education (ECE)	1. Improved child development
• Parenting/ Family Support	2. Improved family functioning
• Health and Social Services	3. Improved child health
• Schools' Capacity • Infrastructure, Administration and Evaluation	4. Improved systems of care

Goal 1
Children 0-5 are making developmental progress toward School Readiness.
* 2.2, 2.3

Goal 2
Children in home environments supportive of optimal cognitive development.
* 1.3, 2.1, 2.4, 3.1

Goal 3
Children receive early and comprehensive screenings and intervention for developmental delays or other special needs.
* 1.1, 2.1

Goal 4
Schools and system are ready for children.
* 2.1, 2.3, 4.1, 4.2, 4.3, 4.4

Goal 1
Identify children with special needs at their earliest point of need.
* 1.1, 2.2, 2.3

Goal 2
Enhance health and development through coordinated service provisions.
* 2.3, 4.1

Goal 3
Support families in navigating systems to better advocate supportive learning environments for children.
* 2.4, 3.1

* Refers to Desired Results listed in the Strategic Plan and the Evaluation Framework (Appendix C).

Chapter Introduction

Each year, 500,000 young Californians enter Kindergarten.[1] However, not all of these children arrive with the necessary skills that make them ready to learn. As a result, some children perform at a significantly lower level than other children their age, and this low performance may continue throughout their school career. The concentration of children whose widely divergent reading and numeracy scores at the third grade is testament to the need for developing a comprehensive approach that works with the child, parents, and the school to help children enter Kindergarten ready to learn.

The School Readiness Initiative was launched in 2002, funding programs in eight local school districts with low Academic Performance Index (API) scores. The Commission has dedicated $8,604,351 to the initiative since its inception, including $2,424,776 in FY 2005-2006. (Funds are matched by the State First 5 Commission.) The School Readiness model is based on the National Education Goals Panel's "Five Essential and Coordinated Essential Elements:"[2, 3, 4]:

- Early Care and Education
- Parenting/Family Support
- Health and Human Services
- School Capacity and Infrastructure
- Administration and Evaluation.

School Readiness contractors strive to improve the transition from early care environments to elementary schools by fostering children's physical, social, emotional, and cognitive development. The Initiative supports families in preparing children for entering school through parent inclusion, education, and support services. It also encourages integration between early care providers and school systems through joint trainings and articulation planning meetings.

An adjunct component of the overall School Readiness Initiative is the Special Needs Demonstration Project (SNP). The Chula Vista Elementary School District was one of the ten sites selected by First 5 California to implement the Demonstration Project. The intent of this pilot project is to enhance School Readiness services in a specific geographic area by identifying children with special needs and providing coordinated services to these children and their families. This School Readiness chapter highlights the results of both the School Readiness Initiative (SR) and the Special Needs Demonstration Project (SNP).

[1] http://www.ccfc.ca.gov/PDF/SR5.pdf
[2] Early Connections: Technology in Early Childhood Development. Five Areas of Child Development. 2005. Accessed 17 August 2006. http://www.netc.org/earlyconnections/index1.html
[3] The goals listed in the diagram and referenced here are specific to the new School Readiness Evaluation Redesign in effect for FY 2006-07. However, these goals also align with the SR evaluation plan for FY 2005-06.
[4] First 5 San Diego's School Readiness Initiative aligns its goals and objectives with both those of the State Commission and the First 5 San Diego Strategic Plan. (See diagram on this chapter's cover page).

Key Elements of the School Readiness Initiative

The School Readiness (SR) is a multifaceted initiative that touches upon each of the four Issue Areas in the First 5 San Diego Strategic Plan. Initially funded in 2002 as a partnership between First 5 California and the First 5 Commission of San Diego, School Readiness is the longest running of the Commission's initiatives and projects. Throughout its four years, the School Readiness has evolved from a series of discrete programs in school districts that broadly addressed the same objectives, to a more focused effort in which programs are pursing common outcomes. The project consists of the following key elements:

School Readiness Initiative Demographics

- The overwhelming majority of children accessing services were 3-5 years old (79.5%). Only 13.8% were less than 3 years old; the remainder is unknown. *
- The majority of children involved in School Readiness programs were of Latino origin (56.4%). Multi-racial children comprised 7.3% of participants, 4.0% were of Asian/Pacific Islander origin, 6.8% were White, 7.5% were African American/Black. The remaining 17.9% were of other or unknown origin.*
- Most children accessing services spoke Spanish as their primary language (49.9%). 30.1% spoke English and 20.0% spoke a language other than Spanish or English.*
- Overall, there was a 66.8% increase in the number of service contacts for children, families, and program staff from the previous fiscal year.**

* Downloaded from the Proposition 10 Evaluation Database System (PEDS) on September 26, 2006 to include the most recent PEDS data for FY 2005-06.

** Based on Commission quarterly reports.

- The programs vary in their design: four are classroom-based located on elementary school sites; three are parent-child centers located in neighborhoods; and one is an outreach/resource center that provides community outreach and on-site services at eight locations in the school district.
- Each program includes services to support child school readiness outcomes; promote parental involvement; enhance schools' preparedness for children; and improve the articulation between early care providers and the schools.
- The School Readiness Initiative utilizes a "whole child" approach, based upon the National Education Goals Panel (NEGP)'s "Five Essential and Coordinated Elements" of School Readiness.
- Contractors meet regularly to discuss challenges and share successes enabling them to improve their programs.
- During FY 2005-06, the School Readiness contractors made modifications to their programming and reporting requirements in preparation for the new State Evaluation Framework and application for new State funding.

Summing It Up: Number of Children and Families Reached

In FY 2005-06, the School Readiness programs provided 75,372 service contacts to children 0-5 and their families, and provided trainings and support contacts to 2970 staff/service providers; a 66.8% increase from the previous fiscal year. [5, 6]

What follows is a comparison of year-to-year changes by the Initiative's Five Essential and Coordinated Elements, as well as findings and quotes gathered directly from parents in School Readiness programs who participated in a participatory photography project called *Hear My Voice* (see text box below for details) and two key expert interviews with a kindergarten teacher and a elementary school principal.

How Did They Do That?

The School Readiness Initiative showed a dramatic increase in numbers served from FY 2004-05 to FY 2005-06. This increase is due to three primary reasons:

- Improved reporting practices at some sites
- Full implementation of all School Readiness project components
- Implementation of the Special Needs Demonstration Project in Chula Vista.

Hear My Voice: The First 5 San Diego Participatory Photography Project

The photographs in this report were all taken by San Diego County parents who participated in *Hear My Voice*: The First 5 San Diego Participatory Photography Project. *Hear My Voice* blends photography with more traditional evaluation methods to create a parent-driven means of expressing the benefits that families have experienced from First 5-funded programs. The pictures and quotes found throughout this report have been exhibited on 4' x 8' banners at the State First 5 Conference, First 5 Commission meetings, program sites and on public exhibition.

This year, *Hear My Voice* presented a glimpse into the lives of fifteen families who participated in three different First 5 San Diego School Readiness programs.* Parent-photographers worked with the evaluation team and a local photographer to learn how to use a camera to tell their stories and document significant changes in their lives. They received cameras, film, and the assignment of expressing how the School Readiness program has made a difference in their lives through photographs. Later, through interviews and reflecting on the photos, parents told their stories in a unique and compelling way.

* See Appendix B for details.

[5] All process numbers in this section originate from School Readiness sites' quarterly reports to the Commission. In many instances children and families were counted for each service contact. Therefore, the numbers reported are duplicated service contacts.

[6] The majority of these service contacts were for "light touch" services. The outcomes data in this report represent children who were served intensely.

Early Care and Education

Early Care and Education (ECE) services include preschool classes, learning centers for child and parent interaction, and Kindergarten Transition programs. These services address First 5 San Diego's Strategic Plan "Issue Area 2: Children's Learning and Social-Emotional Health." Specifically, they address the Desired Result to *provide children access to quality services that promote their early learning and fill a gap in ECE services.*[7] According to parents participating in *Hear My Voice (*see *Hear My Voice* text box*)*, SR programs provide opportunities for children who may slip through the cracks: their parents' income does not qualify them for State Preschool or Head Start and yet they cannot afford private preschool. Parents were thankful for this opportunity: "I highly recommend it. It's a good program if you can't afford preschool. … [My son has] grown drastically [since he started coming to the First 5 School Readiness Program]."

Exhibit 5.1 displays a notable increase (99.3%) in the service counts of children and parents served through the ECE programs from the last fiscal year. In particular, the service counts of children served were nearly twice that of the previous fiscal year. There was a 273.1% increase in the number of children participating in preschool classes and early learning, but a 42.4% decrease in Kindergarten Preparation programs.[8] Children participating in classes or learning centers attended multiple times per week over the span of the year, while Kindergarten Preparation programs are short (usually two weeks), intensive school readiness experiences for children who did not attend preschool. This suggests that more children are accessing traditional preschool classes or attending early learning centers in preparation for kindergarten.

Exhibit 5.1
Total Served through Early Care and Education

Type of Program	Children 0-5			Special Needs Children 0-5			Parents/Caregivers		
	FY 04-05	FY 05-06	% Change	FY 04-05	FY 05-06	% Change	FY 04-05	FY 05-06	% Change
Kindergarten Preparation*	1067	615	-42.4%	7	38	442.9%	591	265	-55.2%
Toddler and Preschool Classes**	2005	7481	273.1%	397	879	121.4%	380	803	111.3%
Early Learning Centers***	5968	9924	66.3%	450	838	86.2%	4670	8097	73.4%
Total Early Care and Education	**9040**	**18,020**	**99.3%**	**854**	**1755**	**105.5%**	**5641**	**9165**	**62.5%**

* Includes KinderCamp and Kindergarten PreStart, which are short, summer programs primarily provided to children who have had little or no preschool experience.
** Includes District Preschool and other programs, which are longer (frequently semester long programs).
*** Includes play groups and Parents and Children Together (PACT) program

[7] See Appendix C for more information related to Desired Results.
[8] The efforts of one school district fully implementing its program at all school sites could partially explain the 273.1% increase in the number of children participating in Toddler/Preschool classes.

There were also noteworthy results for special needs children served through the School Readiness Initiative.[9] There were significant increases in the number of service contacts with special needs children who attended Kindergarten Preparation (442.9%), Preschool Classes (121.4%), and Early Learning Centers (86.2%). This represents an overall increase of 105.5% from last fiscal year. These findings may reflect the progress of School Readiness programs to identify and serve the special needs population. Given that an estimated 8% of children 0-5 are estimated to have special needs,[10] the initiative as a whole exceeded the benchmark in reaching and/or identifying these children. (For FY 2005-06 the benchmark at 8% calculates to be 1442, and the actual number of children with special needs served was 1775). However, it should be noted that this progress could be attributed to the addition of SNP at one site as well as improvements to existing SR services.[11]

Parents and caregivers served by ECE programs show similar patterns as the findings for children 0-5. Overall, there was an increase (62.5%) in the number of service contacts from last year. There is also a 73.4% increase in service counts of parents who participated in early learning centers, suggesting that the parent-child centers are reaching their target population.

Parent and Family Support Services

Parents have a direct impact on the developmental progress of their child.[12, 13, 14] The Parent and Family Support Service element of the School Readiness Initiative addresses the needs of parents, including literacy and parenting education. These programs address all four Issue Areas of the Commission's Strategic Plan.[15]

Parent and Family Support Services were delivered in multiple formats. Some children and parents were served together in parenting education, family literacy, or Kindergarten transition programs. Other parents attended adult or parenting education classes while their children participated in instructional childcare. More intense, individual services were also provided to parents, such as case management, home visiting or parent-teacher conferences. Exhibit 5.2 summarizes the level of family support services provided by SR programs.

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[9] Special needs children are defined as children with "disabilities and other special needs who are protected by the American with Disabilities Act (ADA); or have or at risk for a chronic condition whether physical, developmental, health, behavioral/mental health, and related services and/or supports of a type or amount beyond that required generally." SRI International. Definition of Disability for the Evaluation of the Special Needs Project. Menlo Park, CA: Author, 2004.

[10] http://mchb.hrsa.gov/chscn/index.htm

[11] The Special Needs Project (SNP) reports process numbers to the State First 5 Commission, which should isolate the Special Needs Project numbers served from the larger School Readiness Initiative. However, some of the clients identified through the SNP may also receive School Readiness services, which may account for the large increase in children with special needs in FY 2005-06.

[12] U.S. Department of Education. No Child Left Behind: What Parents Need to Know. Accessed 15 December 2005. <http://www.ed.gov/nclb/overview/intro/parents/nclb_pg5.html>

[13] U.S. Department of Education, Office of Planning, Budget, and Evaluation; Office of Educational Research and Improvement (ED). Preparing Young Children for Success: Guideposts for Achieving Our First National Goal. An America 2000 Education Strategy. Washington, DC: Author, 1991.

[14] First 5 San Diego. Parent Center. Accessed 15 December 2005. <http://www.ccfc.ca.gov/sandiego/parent.html>

[15] First 5 San Diego. First 5 San Diego Commission 2004-2009 Strategic Plan. San Diego, CA: 2004.

Exhibit 5.2 Total Served through Parent and Family Support Services									
Type of Program	**Children 0-5**			**Special Needs Children 0-5**			**Parents/Caregivers**		
	FY 04-05	**FY 05-06**	**% Change**	**FY 04-05**	**FY 05-06**	**% Change**	**FY 04-05**	**FY 05-06**	**% Change**
Parenting Education*	1308	1664	27.2%	1	119	11800.0%	4805	6056	26.0%
Early/Family Literacy Programs**	552	1781	222.6%	71	153	115.5%	1239	2582	108.4%
Kindergarten Transition Process	212	398	87.7%	0	29	*****	149	418	180.5%
Family Support***	2718	4873	79.3%	158	433	174.1%	6312	11,722	85.7%
Human Services****	622	304	-51.1%	0	32	*****	624	301	-51.8%
Total Family Support and Services	**5412**	**9020**	**66.7%**	**230**	**766**	**233.0%**	**13,129**	**21,079**	**60.6%**

* Includes Parents As Teachers (PAT), Welcome Baby Kits and other health classes
** Includes Community-based English Tutoring (CBET) and English as a Second Language (ESL) classes.
*** Includes outreach for notification of services, Parent Intervention Programs (PIP), and consultations with parents
****Includes support and services for basic needs, child care, nutrition
*****Percent change cannot be calculated when baseline is zero.

There was a dramatic 200.0% increase in the number of children participating in Early Family Literacy programs and an increase of more than 100.0% in parent/caregiver participation. However, there was over a 50% decrease in human services contacts provided directly by the SR programs for both children 0-5 and their parents/caregivers. The decrease in the provision of human services parallels an increase in referrals that SR programs made to health and social service agencies from FY 2004-05 to FY 2005-06. This is especially true of healthcare and behavioral referrals, which increased markedly in this fiscal year. (See Exhibit 5.3 discussion for further analysis). Further investigation of this matter is needed and will be pursued in FY 2006-07.

School Readiness program staff made program improvements and changes within the Parent and Family Support and Services element that may have contributed to increases in service contacts from last fiscal year. According to the Funded Program Survey, there has been an increase in the number of classes including handling behavior issues and language development (English Language Learners). These program improvements address the type of support that families need to prepare children for school.

"We are seeing some benefit with the ELL [English Language Learners] populations. They are getting exposure to [the] English language at a younger age. They are able to keep up with the pace. They need to immerse themselves sooner [in the language]."

– First 5 Key Expert

The findings for children with special needs are also of note. The numbers of children with special needs who were provided with Parent and Family Support increased dramatically from FY 2004-05 to FY 2005-06. In FY 2004-05, 4.2% of families receiving supports services had a child with special needs; in FY 2005-06, it rose to 8.5% -- indicating that SR programs are doing an excellent job in identifying and serving these families. [16]

Parents who participated in home visitation programs and other skill-building courses such as workshops, improved their parenting skills. As one parent participating in *Hear My Voice* noted, "I can't explain how much we've learned [at the School Readiness Program]. I'm at a loss for words." Parents receiving home visiting services noted how much they had learned about child development and about developmentally appropriate games and activities. Others noted improved family functioning and child behavior following participation in parenting and family support services: "He knows there's a schedule and rules. … He's learning to be responsible and to follow a schedule."

Health and Human Services

The School Readiness Initiative has a "whole child" approach to preparing children for kindergarten, addressing cognitive, physical, and social-emotional development. Consequently, in addition to its early learning focus, SR programs provide health and human services such as health plan enrollment; health education; provision and/or referral to basic healthcare; mental health counseling; and services for children with disabilities and other special needs. This element addresses the Issue Area of Children's Health, specifically, *that children are born and stay healthy and children have access to preventative and comprehensive healthcare services*.[17]

In San Diego County as a whole, parents are in need of information and referrals for services such as health insurance enrollment, support for dealing with the stressors of childrearing, and locating a quality child care provider.[18] To fill this need, the SR programs provide screenings, assessments and referrals. However, the success rate of the programs' referral process (i.e., if parents successfully access the services were referred) is unknown as most SR programs do not provide case management services.

Exhibit 5.3 compares the number of screenings/assessments, referrals, and successfully completed referrals. The key results are as follows:

- There was a 143.7% increase in the number of screenings and referrals, with healthcare and developmental screenings/assessments exhibited the most dramatic increases.
- 13.3% of all referrals were documented as successful, a 2.7% decrease from last fiscal year.
- The most successful referrals were related to behavioral services.

[16] http://mchb.hrsa.gov/chscn/index.htm
[17] First 5 San Diego. First 5 San Diego Commission 2004-2009 Strategic Plan. San Diego, CA: 2004.
[18] First 5 San Diego. San Diego Family Survey. San Diego, CA: 2005.

In part, the success of the behavioral referrals can be explained by the contributions of a School Readiness funded behavioral specialist in six programs, representing an in-referral, or a referral that was made to services among funded SR program partners. (Out-referrals, or those made to agencies that are not formally funded by the Initiative, are typically harder to track, and require additional relationship building between the School Readiness programs and the outside agencies.) The successful behavioral referrals may also be due to ECE teachers, who have close, regular contact with children and are more likely to identify, report, and see positive effects in the children who typically act out.

Parents who participated in *Hear My Voice* noted how SR staff identified developmental issues and connected their children to needed health and behavioral health services. Parents also saw changes in the attitudes and behaviors of their children as a result of participating in School Readiness programs. One father recounted how his son changed after a dentist spoke to his preschool class: "He takes [brushing his teeth] very seriously now. He'll finish eating breakfast and go brush his teeth. Then we'll be leaving for school and he'll say, 'Wait! I need to brush my teeth!'…When they bring the dentists and nurses [into the classroom]; that's really helpful. The kids pick up good habits."

"The speech therapist suggested [my son] get his hearing checked because he had a hard time saying his 'Ls'. They did a vision check at that same time and found out that he was almost blind. Now he has glasses."

– First 5 Parent

Exhibit 5.3 Total Children and Parents/Caregivers Served through Health & Human Services									
Type of Service	**FY 04-05**				**FY 05-06**				**% Change in Successful Referrals**
	Screenings/ Assessments	**Total Referrals**	**Successful Referrals**	**% Successful**	**Screenings/ Assessments**	**Total Referrals**	**Successful Referrals**	**% Successful**	
Healthcare	4196	568	113	19.9%	7475	753	79	10.5%	-9.4%
Prenatal	16	38	2	5.3%	11	20	0	0.0%	-5.3%
Health Insurance	65	433	43	9.9%	872	523	23	4.4%	-5.5%
Behavioral	270	67	29	43.3%	405	224	110	49.1%	5.8%
Developmental	794	503	61	12.1%	4349	168	14	8.3%	-3.8%
Human Services*	30	82	13	15.9%	40	160	6	3.8%	-12.1%
Total Health and Human Services	**5446**	**1771**	**283**	**16.0%**	**13,274**	**2024**	**269**	**13.3%**	-2.7%

*Includes dental, hearing, vision, and general medical services

Schools' Capacity

Schools' Capacity is an important element of the Initiative that addresses the planning and communication between school administrators, kindergarten teachers, preschool teachers, ECE providers, school readiness program staff, and parents. This element aligns with First 5 San Diego's Strategic Plan "Issue Area 4: Systems Improvement and Community Change" which targets *providing communities with services that are effective, coordinated, integrated and sustainable*.[19]

Perhaps one of the most critical school capacity elements enhanced by the School Readiness Initiative is that of communication between the ECE programs and elementary schools. This communication is critical to ensuring that early childhood programs support the development of skills for school readiness and also encourages schools to prepare for the transition needs of those children entering kindergarten. As one elementary school principal states, "A good dialogue between the [elementary school teachers, administrative staff, and ECE] staff…collaboration and dialogue are [essential]. The challenge is time…when [dialogue] can take place. [You need to] look for opportunities before and after school or at lunch to build consistency to have regular opportunities for that to happen."

For some SR programs, this dialogue is growing. This year, 1,130 staff/providers attended articulation and Kindergarten transition activities, an increase of 46.2% from last fiscal year. Similarly, preschool teachers, ECE staff, kindergarten teachers, school administrators, and school readiness program staff participate in joint meetings, planning, and reviews to provide wrap-around curriculum development and preparation for children. A kindergarten teacher from one of the School Readiness program districts noted:

> *[The school district and the School Readiness program] try to meet once a year to talk about different programs, needs, expectations how they can help each other…We are all being consistent, a progression of goals that they are going to be asking the child to proceed through. We aren't asking different things. It is a continuum.*

Infrastructure, Administration, and Evaluation

The Infrastructure, Administration, and Evaluation element addresses program coordination at the School Readiness program site, district, and county levels, and includes staff training and development, program evaluation for program improvement, and fiscal accountability.

Infrastructure: Program Infrastructure includes components such as access to teaching materials, staffing, and adequate program space. First 5 funding has brought expanded curriculum and additional staffing to programs. However, some SR programs face challenges finding adequate program space. For example, one parent-child center attempted to obtain additional space at an adjacent building, but was not awarded a grant for which they applied. Another parent-child center has lost their current lease and is looking for larger facilities. To address this challenge, programs shared space and supplies with partnering organizations. Other programs have waiting lists, indicating that program capacity does not meet the needs of families.

[19] First 5 San Diego. First 5 San Diego Commission 2004-2009 Strategic Plan. San Diego, CA: 2004.

Administration: This fiscal year, 1840 staff/providers attended staff development trainings and other administrative activities, an increase of 126.6% from last fiscal year. Program staff received trainings throughout the fiscal year on various topics including innovative curriculum, home visiting, managing challenging classroom behavior, and effective teaching strategies. Six School districts provided mentors and behavioral specialists to assist preschool teachers; and one-on-one teaching consultations were given to teachers requesting further assistance.

In many cases, the programs sought ways to include parents in the administration and planning activities. For example, Parent Advisory Committees continue to provide parent and community input and leadership in three of the School Readiness programs. Committee members assist program and district staff in planning, assessing, and evaluating the program at each site. Other programs discussed parent survey results at quarterly meetings or invited parents to activities and event planning retreats to gain the parents' perspective.

State First 5 Activities

Fiscal year 2005-06 brought a flurry of activities around two State First 5 Commission endeavors. First, the State released its State Evaluation Redesign in late winter 2006. The Redesign required that outcomes reporting become more stringent and streamlined. Consequently, the local School Readiness contractors selected common outcomes and discussed measurement tools that could best track progress toward achieving these common outcomes. The group focused on the need to find a comprehensive tool that would address all Five Essential and Coordinated Elements, but would not be costly or time intensive, and could be administered in both the classroom and for services that are not classroom-based. The local group agreed on the DRDP and the ASQ. Second, four of the eight School Readiness programs worked on their State funding reapplication process. The Cycle 2 Funding Application process was a collaboration between San Diego First 5 staff and the contractors, resulting in the successful refunding of all four School Readiness programs.

Evaluation: SR program staff successfully addressed two of last year's recommendations from last year's evaluation. First, the SR Program Coordinators and Commission staff selected two sets of common, standardized child outcomes tools. This makes it possible to begin to report collective, tangible results. In conjunction with the evaluation team, the School Readiness program coordinators also developed a standardized, retrospective parent survey that will be implemented and analyzed during FY 2006-07.

Second, seven of the eight School Readiness programs collected and submitted usable individual, matched case data child outcomes data using common instruments. Some programs were able to provide data on a high percentage of those children who were intensively served, while other programs used this as a test year to develop an evaluation structure. Overall, both the selection of common tools and full participation by these programs to administer and submit outcomes data allows for more accurate assessment of the impact of the Project.

Making a Difference: School Readiness in Action

The goal of the SR Initiative is to increase the school readiness of children in low API performance schools through various approaches: from direct services and interaction with children, to supporting their families, to improving the connection between early care environments and school systems. Ultimately, all these activities should coalesce to result in improved outcomes for children.

However, there are few tools that can comprehensively assess the development of children in a cost-effective, non-invasive manner. Based on feedback from State First 5 and local and national experts, two tools were selected that could address the five identified domains: the Desired Results Developmental Profile (DRDP) and the Ages and Stages Questionnaire (ASQ). [20] Classroom based programs utilized the DRDP, a teacher observational assessment already mandated for State Preschools. Parent-child centers, where center staff may not regularly and directly observe the child, were asked to use the ASQ, an instrument that can be self-administered by parents. (See Appendix B for details.)

This fiscal year, seven of eight School Readiness programs submitted useable child outcome data. All data and findings reported come from "matched cases" at two points in time (fall and spring).[21] When possible, comparisons are made with last fiscal year's outcomes. There are two primary limitations to these data. First, the findings are from two different tools, one completed by parents and the other by teachers. While these tools measure the same behaviors and skills, the DRDP uses scales and the ASQ uses cut-off scores. Consequently, results cannot be discussed by common domains *across* instruments, but rather must be presented by individual instrument. Second, while the ASQ is an empirically tested instrument, it is designed as a screener, not as an evaluation tool to be analyzed by statistical comparison at two points in time. However, it is a widely-used instrument available to determine a child's developmental level at age-appropriate intervals, and is appropriate for use at parent-child centers. These benefits, in addition to the absence of other feasible tools recommended by the State First 5 Commission or consulted experts, made the ASQ the identified tool for parent-child centers.[22] With these limitations in mind, the results are suggestive but not conclusive of child outcomes. The School Readiness program coordinators and Commission staff continue to refine their approach to assessing child development outcomes.

In addition to these two direct child assessments, a Funded Program Survey was conducted to understand the project's impact on the individual School Readiness programs and their organizations. Furthermore, the participatory photography project, *Hear My Voice* and two key expert interviews with a kindergarten teacher and a principal complement the School Readiness outcomes evaluation design. The findings of these methods are interwoven throughout the remainder of this chapter to document child outcomes.

[20] The DRDP and ASQ are not for diagnoses or Kindergarten screenings. The DRDP is an assessments used to monitor a child's developmental progress, while the ASQ is a screener used to identify developmental concerns.
[21] Last fiscal year, DRDP scores were aggregate.
[22] Local experts include Dr. Todd Sosna, of California Institute for Mental Health and Dr. Gary Resnick of WESTAT. Both experts noted the limitations of the ASQ, but could not suggest a cost-effective, non-invasive alternative and subsequently stated that the ASQ could be utilized with expressed limitations.

Classroom-Based Programs: Desired Results Developmental Profile (DRDP)

The DRDP data come from five School Readiness programs and represent matched Fall and Spring (n=435) scores.[23] Exhibit 5.4 shows a comparison by the last two fiscal years of the overall change in mean score for each developmental area from Fall to Spring.[24] Key findings from this analysis (statistically significant at p<.001) include:

- Children showed improvement in each development area in Spring.
- FY 2005-06 results show more improvement from Fall to Spring in each area than in the last fiscal year.
- Nearly all students were fully mastered in Spring in each developmental area.
- The greatest improvement is found in communication skills.[25]

Developmental improvement was found across all domains of the DRDP with greater improvement from Fall to Spring in communication, problem-solving and fine motor skills, similar to the last fiscal year. These findings may suggest that classroom based School Readiness programs address these areas most effectively.

Exhibit 5.4
DRDP Mean Scores

	FY 04-05*			FY 05-06**		
Developmental Area	**Fall**	**Spring**	**Change**	**Fall**	**Spring**	**Change**
Communication	2.99	3.39	+0.40	2.51	3.40	+0.89
Gross Motor	3.48	3.68	+0.20	3.11	3.69	+0.58
Fine Motor	3.23	3.65	+0.42	2.83	3.58	+0.75
Problem-Solving	3.08	3.47	+0.39	2.61	3.47	+0.86
Personal-Social	3.30	3.56	+0.26	2.90	3.56	+0.66

* FY 04-05 sample size n=279; all change in developmental areas were statistically significant (p<.001)
** FY 05-06 sample size n=435; all change in developmental areas were statistically significant (p<.001)

Difference in Developmental Score in Spring

Further examination of DRDP data found some noteworthy results. When analyzing the change in scores from Fall to Spring, nearly all children showed improvement. Exhibit 5.5 shows the number and percentage of children whose scores increased, decreased, or did not change from Fall to Spring. A very high percentage of children showed improvement in their score from Fall to Spring in each domain. There is no comparison data, as last year's data were not matched cases.

"The program helps…the kids to develop with other children and that's what I try to tell parents, 'yes your child is intelligent, he knows his name, he knows his colors, he knows the entire ABCs, but does he know how to interact with other children?' No."
– First 5 Parent

[23] This represents 52.7% of the children who could be assessed. DRDPs were collected from children who were "intensively served" by a school readiness classroom-based program.
[24] A limitation of this finding is last fiscal year's data was not matched cases, but rather aggregated, summary data.
[25] An increase in mean of 0.87 from Fall to Spring.

Exhibit 5.5 Change in DRDP Development Scores from Fall to Spring, FY 05-06*						
Developmental Area	Decreased		No Change		Increased	
	Number	%	Number	%	Number	%
Communication	4	1.0%	7	1.6%	424	97.5%
Gross Motor	2	0.5%	56	12.9%	377	86.7%
Fine Motor	3	0.7%	68	15.6%	364	83.7%
Problem-Solving	3	0.7%	7	1.6%	425	97.7%
Personal-Social	6	1.4%	28	6.4%	401	92.2%

* Percentages for each developmental area do not equal 100% due to rounding

The majority of children who showed no change from Fall to Spring were assessed as "fully emerged" in the Fall; that is, they achieved mastery of the age appropriate skill. The data on children showing no change from Fall to Spring by domain include:

- All 7 children fully emerged in communications skills
- 44 of 56 children (78.6%) fully emerged in gross motor skills
- 46 of 68 children (67.6%) fully emerged in fine motor skills
- 6 of 7 children fully emerged in problem-solving skills
- 23 of 28 (82.1%) fully emerged in personal-social skills

In sum, the high number of children who were already "fully emerged" in the different categories in Fall would present itself in the data as a "no change," which could be viewed as a negative finding, when in fact it is a neutral finding.

Overall, the findings from this year's DRDP assessments are promising. While these findings suggest that children progressed on the scale to mastery during the year, the mean scores by domains may suggest that the School Readiness programs had a positive effect on the developmental progress of the participating children.

Center-Based Programs: Ages and Stages Questionnaire (ASQ)

Data for the ASQ come from two SR parent-child learning centers. Data exist for 48 intensely served children with two measurements during this fiscal year.[26, 27] The results suggest evidence of developmental progress at the second assessment. While the instrument used in the Fall is different than that used in Spring (since the ASQ is an age-based instrument that may modify the wording of some questions to be developmentally appropriate), the result at each point in time indicates whether the child is developing appropriately for their age by the same domains.[28]

[26] One of the three sites scheduled for ASQ collection did not submit data.
[27] At present, it is not possible to estimate the appropriate sample size because the programs do not track the total number of children who are "intensively served." This will be addressed in next year's evaluation.
[28] See Appendix B for details on the ASQ.

Exhibit 5.6 shows the overall change in mean score from Fall to Spring. Because of the small sample size, results are not statistically significant:

- The greatest improvement for the past two years has been in fine motor skills with an increase (3.1) in FY 05-06 and (6.1) for FY 04-05.
- Most students were above the cutoff point[29] in each developmental area in Fall.
- Children showed developmental gains in all domains in Spring, except personal-social skills where there is a slight decrease in score (-0.8 points); there was an increase in this domain (1.2 points) in FY 04-05.
- There was improvement in gross motor skills (1.6 points) whereas the previous year there was no change.
- There was a slight decrease in communication score (-0.7), though last year there was an important increase (4.3).

These findings suggest that the parent-child learning centers address fine motor skills at an optimal level, which may be due to their encouragement of hands-on activities between parents and children. This is further noteworthy because fine motor skills that are usually slower to develop.

Exhibit 5.6
ASQ Mean Scores

Developmental Area	FY 04-05			FY 05-06		
	Time 1	Time 2	Change	Time 1	Time 2	Change
Communication	48.0	52.3	4.3	53.3	52.6	-0.7
Gross Motor	54.0	53.6	-0.4	55.3	56.9	1.6
Fine Motor	45.8	51.9	6.1	50.0	53.1	3.1
Problem-Solving	49.7	49.3	-0.4	51.7	53.4	1.7
Personal-Social	50.0	51.2	1.2	52.9	52.1	-0.8

Difference in Development Score in Spring

Exhibit 5.7 displays the number and percentage of children whose individual scores increased, decreased, or did not change from Fall to Spring for the past two years. For this fiscal year, only one child's score that did not change was below the cutoff point. Overall, about one-third of children showed improvement in all five domains. Although the proportion of children who showed improvement was higher in FY 2004-05, the sample size limits further comparison.[30]

[29] Children scoring below the cutoff point are referred for further developmental assessments and perhaps treatment.
[30] Due to the small sample size, any further analysis would not be reliable as a shift of one case in either direction would dramatically change the percentages.

Exhibit 5.7 Change in ASQ Development Scores from Fall to Spring												
Developmental Area	FY 04-05*						FY 05-06**					
	Decreased		No Change		Increased		Decreased		No Change		Increased	
	n	%	n	%	n	%	n	%	n	%	n	%
Communication	4	20.0%	8	40.0%	4	40.0%	16	33.3%	17	35.4%	15	31.3%
Gross Motor	5	25.0%	10	50.0%	5	25.0%	10	20.8%	24	50.0%	14	29.2%
Fine Motor	6	30.0%	3	15.0%	11	55.0%	12	25.0%	17	35.4%	19	39.6%
Problem-Solving	6	30.0%	5	25.0%	9	45.0%	11	22.9%	19	39.6%	18	37.5%
Personal-Social	5	25.0%	7	35.0%	8	40.0%	17	35.4%	14	29.2%	17	35.4%

* FY 04-05 sample size n=20
** FY 05-06 sample size n=48

Part of the challenge of using the ASQ as a measurement tool in parent-child learning centers is the child and rater (the parent) are developing simultaneously. As parents learn more about appropriate development by participating in the program, they may (and in fact are likely) to change as raters of their children. However, children showed improvement in all five developmental domains during both fiscal years. Similarly, more children showed improvement in fine motor, problem-solving and personal-social skills. Despite the limitations of the ASQ, these outcomes suggest the developmental progress of children who participate in School Readiness programs.

Parents' School Readiness Outcomes

Parents are the first and best teachers and models for their children.[31, 32, 33] The School Readiness Initiative includes a Parent and Family Support element to improve parenting skills, literacy, and access to needed services. The key outcomes measured in this area are the number of parent referrals and percentage of successful referrals.

School Readiness programs refer parents to services that will improve family functioning, indicating improved access to services. Exhibit 5.8 shows the increase in the total number of Family Support and Services referrals from last fiscal year (health and human services referrals are detailed on page 93). Specifically, the number of referrals to parenting education, kindergarten transition, family support, and human services increased from last fiscal year, while family literacy services remained constant.

"At this place they start getting use to working together with other children. So when the time comes for him to go to school, he'll already be accustomed being with other children."

– First 5 Parent

[31] U.S. Department of Education, Office of Planning, Budget, and Evaluation; Office of Educational Research and Improvement (ED). Preparing Young Children for Success: Guideposts for Achieving Our First National Goal. An America 2000 Education Strategy. Washington, DC: Author, 1991.
[32] First 5 San Diego. Parent Center. Accessed 15 December 2005. <http://www.ccfc.ca.gov/sandiego/parent.html>
[33] U.S. Department of Education. No Child Left Behind: What Parents Need to Know. Accessed 15 December 2005. <http://www.ed.gov/nclb/overview/intro/parents/nclb_pg5.html>

Exhibit 5.8 Total Referred through Family Support & Services							
Type of Program	**FY 04-05**			**FY 05-06**			**% Change in Successful Referrals**
	Total Referrals	**Successful Referrals**	**% Successful**	**Total Referrals**	**Successful Referrals**	**% Successful**	
Parenting Education*	323	71	22.0%	816	95	11.6%	-10.3%
Early/Family Literacy Programs**	74	47	63.5%	74	38	51.4%	-12.2%
Kindergarten Transition Process	12	12	100.0%	15	15	100.0%	0.0%
Family Support***	1711	1006	58.8%	4928	2932	59.5%	0.7%
Social Services****	297	27	9.1%	306	74	24.2%	15.1%
Total Family Support and Services	**2417**	**1163**	**48.1%**	**6139**	**3154**	**51.4%**	**3.3%**

* Includes Parents As Teachers (PAT), Welcome Baby Kits and other health classes
** Includes Community-based English Tutoring (CBET) and English as a Second Language (ESL) classes.
*** Includes outreach for notification of services, Parent Intervention Programs (PIP), and consultations with parents
**** Includes support and services for basic needs, child care, nutrition

Notably, there was an overall increase of 3.3% in the proportion of successful referrals compared to last fiscal year, but a decline in the areas of parent education (10.3%) and early/family literacy programs (12.2%). Similar to last fiscal year, family support referrals, which include outreach for notification of services, are the referrals most often made and successfully completed (59.5%). Many referrals are made to outside agencies and are difficult to track. This was particularly true of the health referrals and referrals to social services. This also suggests that the School Readiness programs could enhance their referral mechanism by providing improved follow-up with parents seeking services and strengthening relationships with providers outside of the school district.

"There's ups and downs in life and you've got to deal with it and he's learned to do that at [the First 5 School Readiness Program]. Like the song about the washer. He hates that song! But I tell him he's got to do it with the class anyway. [I tell him,] 'When the teacher tells you to do something, you've got to respect that."

– First 5 Parent

"He knows there's a schedule and rules. … He's learning to be responsible and to follow a schedule."

***–** First 5 Parent*

Another parent outcome is community involvement through volunteering.[34] The School Readiness Initiative is working to increase community involvement by providing volunteering opportunities for parents to network. One father who participated in *Hear My Voice* cited benefits he noticed as a parent volunteer, including how volunteerism creates a community of parents and how parents' involvement in the schools helps children learn to respect adults other than their own parents. "Parent [volunteers] get involved with the kids that aren't their kids. … [The] First 5 [School Readiness program] brings in the community. … I like the way we [parents] come together for the kids. They [the kids] have learned to trust us [the parent volunteers] and to respect us." Corroborating this belief, a key expert who was interviewed stated, "The key to get the parents connected with their child's education…is the mandatory hours that the parents have to volunteer [their time]." Clearly, parent involvement with their child's education is key to school readiness.

Enhancing Services for Children with Special Needs: Results from the Special Needs Project

In 2005, the Chula Vista Elementary School District (CVESD) received a First 5 California grant to implement a Special Needs Demonstration Project (SNP). The project was one of ten SNP funded across the State and takes place in three CVESD school catchments areas. The project is designed to meet the following State and local goals:

1. ***Screening and Assessment:*** Identify children with special needs at the earliest point.
2. ***Access to Services:*** Enhance children's health and development through coordinated, integrated, and cultural competent service provision
3. ***Community Participation/Inclusion:*** Support families in navigating systems and help parents and caregivers to become advocates and develop nurturing relationship and supportive learning environments for their children

The program augments the existing CVESD School Readiness Initiative project by enhancing, not duplicating, existing services. The annual goal of the project is to provide health and developmental screenings for 500 children 0-5 living in the CVESD catchment area and provide case management for the estimated 75 children who will be identified with special needs through the screening process.

Key Partners

***San Ysidro Health Center*:** Outreach and screenings, referrals and linkages, and enrolling in health plans

***County Office of Education Hope Infant Support Program*:** Inclusive preschool, and parent support and education

Kids Included Together: Provider training to understand inclusive practices in services children with special needs.

***Exceptional Family Resource Center*:** Assists families with children identified with special needs in navigating the system, case management, coordination of services, and staff training

[34] First 5 San Diego. Promoting Your Child's Development and School Readiness. Accessed 21 August 2006. <http://www.first5sandiego.org/pdfs/PromotingChildDevSR1.pdf>

Screening and Assessment

The SNP increases the school readiness of children by early identification of special needs or possible risk factors through screening and referrals. By linking children to needed services, or provided services and supports, these children will be more ready to succeed in kindergarten**.** Since the project began screening in September 2005, the SNP has provided 258 screenings (142 developmental screenings and 116 parent health screenings, both from the same family), short of the original goal of screening 500 children.[35] In addition, 73 children have been screened who live near, yet outside of the SNP catchment area.

SNP and CVESD staffs are working to identify any barriers that may influence outreach activities to meeting the screening target goals. The SNP partners are actively seeking additional outreach opportunities, improving coordination among partner agencies and adjusting staffing to a add another full-time screener who will focus on identifying any harder to reach children and families in the catchment area.

A look at the number of children screened and then recommended for assessment suggests that there may also be challenges to identifying children who are referred on for assessments. While the number of children screened and identified by CVESD as having "no concerns, risk factors" is higher than the State First 5 average (52% and 19%, respectively), only 3% of children screened locally are being referred for further assessment (18% statewide vs. 3% locally). There are three potential reasons for these relatively low assessment rates.

Exhibit 5.9*
State and Local Comparison of Child Screening Results

Results of Screening	Average of all State First 5 SNP projects	CVESD SNP Figures
No concerns, no risk factors	58%	40%
No concerns, risk factors	19%	52%
Recommended for assessment	18%	3%
Don't know	5%	5%

* Data summarized from a Chula Vista Elementary School District PowerPoint presentation to the Board of Education, June 20, 2006.

1. The results are based on results from the Ages and Stages Questionnaire (ASQ), and the parents' self-administration of the survey. Parents may have over-rated their child's development and behavior. Staff training and parent education will be directed in FY 2006-07 to improve the use of the tool.
2. To date, the majority of the screenings have been done in early education settings (Headstart and State Preschool centers) where children with special needs may have already been identified through "Child Find" procedures.
3. When a child has been preliminarily identified through screening as having some "risk factors," the SNP multi-disciplinary Child Study Team analyzes all available child data and will then refer children for full assessment when there is a strong likelihood they will qualify for IEP services. Additional screening in specific areas such as speech/language or cognitive skills may be done if further information is required to determine the need for a full assessment.

[35] Data pulled from the PEDS database, representing FY 2005-2006 data from an August 14, 2006 data run.

The combination of new staffing, new approaches to outreach, and new protocols for referrals may already be having an effect because the rates of identification during July and August 2006 are higher than previous months.

Access to Services

The SNP project brings together a broad coalition of partners to support and enhance services for young children with special needs and their families. This includes the Center for Social Emotional Foundations for Early Learning Partnership; parent education classes focused on challenging behavior, and language development; and inclusion classes for preschoolers (including music and movement classes and a "Mommie and Me" component).

While referrals for various services are routinely made by the SNP staff and screeners, this area could still be improved upon. For example, data indicate that only eight health referrals were documented for the 116 children screened via a "Parent Health Screener."[36] However, 42 of the parents screened indicated that they did not have a regular doctor or health care provider for their children, and 72 of those 116 parents indicated that either they or the screener had "at least one health concern" about their child, and finally, the "Parent Health Screener" indicated that 43 children were identified as having "serious health concerns."

In total, the data show that a "Service Coordination" component was provided to only 35 children. The low referral numbers recorded in the data system suggests the need to improve Special Needs referral process and the follow-up case management of these referrals (i.e., whether the parent actually accessed services) and the tracking of referrals.

Community Participation/Inclusion

The Initiative's partners provide services to assist families in navigating the system of care for their children with special needs as well as becoming advocates for their children. For example, Exceptional Family Resource Center provides one-on-one assistance to families and provides empowerment training to parents; the Hope Infant Support Program offers parent support groups, education, and home-based services; and the Kids Included Together program which provides inclusion training for approximately 20 family and center-based childcare providers in both Spanish and English that supports families and promotes effective communication and relationship building between providers and families. In addition, the SNP partners developed Music and Movement class geared toward inclusion of toddlers aged 1½ - 3.

[36] Data pulled from the PEDS database, representing FY 2005-2006 data from an August 14, 2006 data run.

Key Areas for Improvement in the next Fiscal Year:

- Increase the number of children screened by SNP by employing improved outreach strategies and strengthening the referral network to enable CVESD to reach the targets.
- Ensure SNP staff work with parents in the catchments area to improve the accuracy of the ASQ as a screening tool.
- Review of the current screening and assessment protocols and processes to identify why so few children are being identified and subsequently referred for services.
- Improve Case Management and tracking of children and families who are referred for services.

The SNP project is still in its initial phases. The State Commission is offering support and learning opportunities for all SNP demonstration sites to build upon the collective lessons gained that will enhance services for all sites involved.

Challenges

The following challenges relate to the whole School Readiness Initiative:

***1. Fixed First 5 funding with increasing costs and service demand*:** All School Readiness programs completed their third or fourth year of operation. The reapplication process for State First 5 funding is capped at the same amount of funding for four additional years. Contractors are expected to identify program efficiencies and hopefully identify additional funding streams. School districts are making efforts to blend funding streams, which is challenging. In two cases, additional funding has come from other First 5 efforts – Preschool For All (PFA) and Special Needs Demonstration Project (SNP). Over reliance on First 5 funding remains a concern.

2. Low rate of successful referrals for health and human services: The low documented rate of successful referrals (13.3%) may be both do to a lack of case management – which is not a traditional role for schools – and to lack of a strong system for tracking referrals.

3. Understanding Impact: The parent-child centers reach a broad number of families in underserved communities. Sometimes these families are the working poor, who make too much to qualify for State Preschool or HeadStart, yet cannot afford an early education program for their child. These are voluntary centers, so some families come regularly and others just drop in on occasion. It is difficult to understand the impact of "light touch" programs, especially when the population is transient. It is not clear how this model can be adapted to better assess the outcomes of these programs.

Recommendations

The following recommendations relate to the whole School Readiness Initiative:

***1. Enhance case management*:** Given the low documented percentage of successful referrals, the mechanism to assist families receiving needed services outside of school districts should be strengthened. Incorporating a case management approach, in which families referred for services are offered continued assistance by the initiative's staff until they are able to access the needed services, is a critical component of many of the Commission's other initiatives that have demonstrated improved results for families. Case management is not a traditional school role and some sites may need to establish new practices and develop stronger "tracking systems" to ensure children and families receive the services they need.

2. Improve reporting of child outcomes: This was the pilot year for each program to capture child outcomes using one of two standard tools. It was a challenge for some sites, and not all of them captured data on a scale sufficient to the size of their programs. The goal is for all sites to learn from the experience of FY 2005-06 and fulfill all State and local Commission evaluation requirements, especially in the area of child outcomes. Increasing the number of children assessed and replicating the protocol used in FY 2005-06 should allow the Commission to begin annual comparisons, allowing for a deeper examination of lessons learned.

3. *Improve tracking of parent outcomes:* The School Readiness programs could improve its measurement of parent outcomes. During FY 2006-07, the School Readiness programs will implement a parent survey to better assess improvement in parenting knowledge and skills. The parent survey is a brief, retrospective tool. It is expected that all School Readiness programs will provide parent outcomes data for analysis and inclusion in the next fiscal year report.

***4. Common reporting formats for outcome data*:** While more outcome data was received this year from all programs, developing a consistent reporting format is strongly recommended. With various formats, analyzing the data to yield useful comparisons is challenging. It is anticipated that all program assessments will be entered into the Commission's forthcoming data system. However, an alternative is needed in the interim.

A Final Word on the School Readiness Initiative

The School Readiness Initiative continues to have a positive impact on improving the readiness of children for school. Indeed, children exhibited improved outcomes in all of the five developmental domains. Parents who participated in the *Hear my Voice* project expressed appreciation for access to preschool activities for their children and noted improvement in their child's behavior and their own parenting skills. In some communities, there is a waiting list for these programs, which is, at its heart, a testament to the Initiative's success.

Chapter 6
Non-initiative Programs

Funded Programs

Community Strengthening and Awareness

- San Diego State University Foundation - KPBS First 5 for Kids!
  - Infant Immunization Media Campaign
  - Health and Oral Health Media Campaign

Direct Services

- UCSD Regional Perinatal System, Welcome Baby Program: Kit for New Parents

Provider Capacity Building and Support

- YMCA Childcare Resource Service: San Diego CARES
- Children's Hospital and Health Center: Partnership for Smoke-Free Families

Systems Change

- Capital and Equipment Grants
- Innovative Grants
- 2-1-1 San Diego- Information and Referral Service

Introduction

While the First 5 Commission of San Diego has been strategic in focusing efforts and funding on large initiatives, there are also a number of additional contractors that have been funded by First 5 to work towards specific goals in the Commission's Strategic Plan.

During FY 2005-06, this included continued support of projects that build infrastructure, support the professional development of early childhood educators, and promote the integration of programs and services that serve children 0-5 and their families. This chapter summarizes the contributions of First 5 grantees, contractors, and various Commission activities to systems change and community awareness on a broader level.

Community Strengthening and Awareness

SDSU Foundation/KPBS: First 5 for Kids!

First 5 for Kids[1] is a marketing and media partnership between KPBS and KGTV (10News) funded by the Commission that provides educational information to parents through interstitials, a website, newscasts, radio messages and programs, community events, a variety of print materials and workshops.[2] In FY 2005-06, KPBS undertook two media campaigns: Infant Immunization and Health and Oral Health.

Infant Immunization Media Campaign

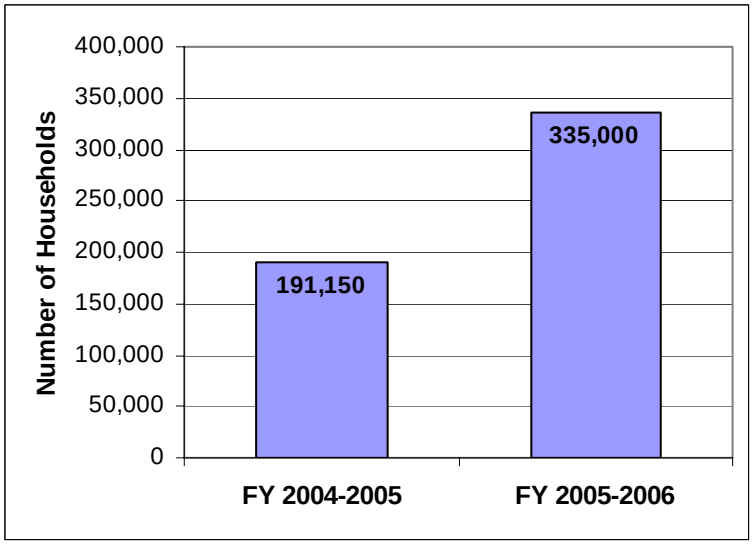
The Commission awarded KPBS the Infant Immunization media contract called First 5 for Kids Infant Immunization in August 2004. The goals of this campaign are to educate families about the importance of immunizations, as well as increase infant immunization rates for children under two years old.[3, 4] The campaign focuses on the Latino, African-American, and the Asian/Pacific Islander communities in San Diego County.

Reaching families

Eight different television interstitials were aired on KPBS and 10News, ranging in topics from appropriate ages for vaccinations, to how to keep immunization records safe. KPBS reached an estimated 85,000 households per week during KPBS' child programming, and 10News averaged approximately 250,000 households per week. The number of households reached per week in FY 2005-06 increased compared to FY 2004-05 (see Exhibit 6.1). This is a seventy-five percent (75.3%) increase compared to last years 191,150 estimated weekly households. These increases were likely due to more run times by both KPBS and 10News during FY 2005-06, since FY 2004-05 was a start up year.

[1] First 5 for Kids was formerly known as "Project Q Kids: Raising Quality Children".
[2] All process and service delivery numbers originate from fact sheets and report summaries provided to Harder+Company by KPBS.
[3] KPBS' Health and Oral Health Campaign is a similar community awareness effort and can be seen following this section.
[4] Additional funding was awarded to KPBS by Sound Partners for Community Health in support of the immunization campaign.

Exhibit 6.1
Households Reached Per Week



Four other primary methods were used to transmit immunization awareness

***Radio**:* The Immunization Campaign used radio announcements on two Spanish speaking and one English speaking station. KLNV, KLQV, and KPBS worked together in disseminating the message to the community through weekly radio broadcasts. KLNV and KLQV reached an average of 85,000 Spanish-speaking women per week, while KPBS FM reached an average of 233,600 San Diegans (both men and women) per week.

***Internet**:* Another form of media used to raise understanding about the importance of immunizations was on the KPBS website. Their 'Kids and Family' webpage, a link from the main KPBS homepage, provides information on healthy eating, immunizations, events in the county and other valuable tips. Between July and December 2005, the 'Kids and Family' website had 92,140 hits.[5]

Direct Mail: In FY 2005-06, KPBS also produced a direct mail piece about childhood immunizations targeting two specific populations: African American and Asian households. To understand its effectiveness, the mailing included a self-addressed and stamped postcard requesting families to return it stating their child's immunizations were up-to-date. The post card required families to have a pediatrician or other

San Diego County Reaches Healthy People 2010 Goal for Preschool-Aged Child Immunizations

Results from Random Digit Dial Immunization Surveys conducted by San Diego Health and Human Services Agency found that San Diego County has met the Healthy People 2010 goal of 80% of **preschool** children receiving all of the recommended vaccines. These include:

- 4 doses of DTaP (diphtheria, tetanus, pertussis)
- 3 doses of polio
- 1 dose of MMR (mumps, measles, rubella)
- 3 doses of hepatitis B
- 1 dose of varicella (chickenpox)

Survey results have hovered slightly above the 80% benchmark since 2002, with 2005 indicating a fully immunized rate of 83%.*

Other studies in the past have noted slightly lower immunization rates (approximately 78%) for San Diego County's kindergarteners.**

* San Diego County Immunization Initiative. Data and Statistics RDD – Random Digit Dialing Immunization Survey. 2005. Accessed 20 July 2006. <http://www.immunization-sd.org/eng/rdd-stats.html>

**Centers for Disease Control and Prevention. National Immunization Study. 2003-2004. Accessed 20 July 2006. <http://www.cdc.gov/nip/coverage/default.htm#NIS>

[5] Website hit counts were no longer available after December 2005.

qualified medical provider sign the card confirming the vaccination status. Parents were then sent a voucher as incentive for returning the card to KPBS. Since mailing two sets of 40,000 postcards during the second program year, 700 participants have responded to being up-to-date with their child's immunizations.

Community Events: KPBS held workshops, such as *Sesame Street goes to the Doctor*, designed to help young children become more comfortable with doctor visits, informing parents and childcare providers about common illnesses, and providing education on the use of antibiotics. Approximately 145 parents and providers attended such workshops. KPBS also provided information to the community through public events. Between July 2005 and March 2006, over 143,000 parents and children were reached. Children's 10Mobile was able to reach the public by distributing immunization resources to more than 6,200 people at community events, more than 700 people through visits to community clinics, and even providing vaccinations to more than 40 children under two years old at the community clinics.

In the previous fiscal year, additional outcomes related to the awareness and effectiveness of the Infant Immunization Campaign were measured through a variety of surveys, intercept interviews, and focus groups.[6] KPBS conducted a similar outcomes evaluation in FY 2005-06 as well; however results were unavailable at the time of this publication.

In summary, KPBS and KGTV have employed various methods of outreach to communicate the importance of immunizations. Parents are now more informed about the importance of immunizations and keeping their children current on vaccinations due to extensive campaign efforts.

Health and Oral Health Media and Outreach Campaign

The Health and Oral Health Campaign began in May 2005 and was promoted through five interstitials, numerous news segments, a website, phone banks, community events, and bus tails which provide information to caregivers on health and oral health topics. Issues covered in these activities ranged from prenatal oral health, which taught pregnant women to see the dentist and practice good oral hygiene, to teaching children health habits such as children's proper nutrition and physical activity. The campaign focused on the Latino, African American, and the Asian/Pacific Islander communities in San Diego County.

Outreach Campaign

First 5 for Kids' Health and Oral Health Campaign reached approximately 196,000 households in the Latino community a week, via television interstitials during FY 2005-06.

Reaching families

To encourage good health and oral health, three television stations worked together to increase community knowledge with five health and oral health segments (examples include "Prenatal Oral Health", "Food Choices" and "Healthy Habits are Learned/Typical Day"). KBNT Univision (a Spanish language station) reached an estimated average of 196,000 households per

[6] For more information on these results, see First 5 San Diego. First 5 San Diego 2004-2005 Annual Evaluation Report. San Diego, CA: Author, 2005.

week and another 12,000 though *Despierta,* a San Diego morning show. KGTV 10News and KPBS collectively reached an estimated average of 285,000 households per week.

Additional Methods

These additional methods were employed to inform and educate the general community about health and oral health concerns included:

Bus Tails and Connection to 2-1-1: One technique used by KPBS to promote children's health and oral health messages, was in the use of bus tails, which on average are seen by 3,000,000 people a month.[7] Buses operated by San Diego Metropolitan Transit System were utilized for this outreach strategy. These bus tails contained brief and directive information about the importance of health insurance enrollment, as well as early dental care. The bus tails also directed the community to call 2-1-1 for more information, a new free dialing code with 24-hour access to information about community, health and disaster services in San Diego.[8] According to 2-1-1, calls have increased since the initiation of the bus tails.[9]

Community events: KPBS and the Children's 10Mobile sponsored over 40 community events organized throughout the county, reaching over 150,000 parents and caregivers. In addition to community events, 25 workshops were presented in San Diego County informing approximately 500 adults. The information gained by parents who participated in these workshops will in turn assist 2,750 children. One specific workshop, *Caillou Can Dental Workshop,* teaches parents and children about good dental health.

Phone banks: Another component of KPBS' outreach included the use of phone banks. The purpose of the phone banks was to inform the community about the importance of health and dental insurance, early dental care; and also to include a resource the community could call for immediate information and referral access. In September 2005 and June 2006, KPBS sponsored the phone banks (two each month, one English and one Spanish speaking), lasting approximately two hours each. The bilingual operators connected callers to a free dental check-up for their child, set up appointments for medical insurance eligibility, and/or referred callers to 2-1-1 if they requested information about other useful resources. KPBS had a goal of receiving 400 phone calls and making 100 appointments for people signing up for health insurance. The campaign surpassed its goal with 402 received calls and over 200 appointments scheduled.

The penetration of the health and oral health interstitials began to be tested at community events hosted by KPBS in Fall 2005. Parents were surveyed on the usefulness and effectiveness of one segment, specifically "Prenatal Oral Health." For more information on the findings regarding the "Prenatal Oral Health" message, see Chapter 2. As the Health and Oral Health Campaign

[7] San Diego Metropolitan Transit System and Panorama Outdoor, whom KPBS subcontracted to create the bus tail advertising.
[8] For more information about 2-1-1 San Diego, see page 128.
[9] The rise in calls to 2-1-1 occurred in winter of 2006, which could be explained by the media campaign. However, this period is also typically a time when 2-1-1 received increased call volume for shelter and other basic needs during.

continues in its second program year, more methods of determining effectiveness of the campaign will be implemented by KPBS.

KPBS and KGTV utilized a collection of techniques to create awareness about these health and oral health topics. However, it is difficult to ascertain the benefit of these activities, or which activities are more effective than others, because there has been little to no follow-up with those receiving the messages to understand if they acted upon the education they received. Anecdotally, and from the KPBS evaluation, it appears that these efforts have educated the public on maintaining a child's healthy life style and oral hygiene based on the sheer number of persons exposed to the message. In the future, it is anticipated that these campaigns will not only continue to reach children and their families, but the effects of this intervention will be better understood.

Limitations of Current and Past Media Efforts and Recommendations for the Future

Media and outreach campaigns funded by First 5 San Diego have contained a variety of important messages that are far reaching among families with young children in the community. However, these campaigns have also had their share of limitations. First 5 San Diego hired an independent contractor in May 2006 to review and evaluate all of the communications efforts supported by First 5 San Diego since the Commission's inception. Some brief findings are as follows:[10]

- While the agencies contracted to carry out the campaigns have included a variety of process and outcomes measurements as part of their contracts, it is difficult to determine what effect the campaigns have had on the target population as a whole since resources were not allocated for a baseline measurement of attitudes or beliefs, nor for ongoing widespread measurement of awareness or perception of the topics of the campaigns.
- Goals of the campaigns were not clearly defined in the original funding processes, neither by the Commission, nor the contractors.
- In the future, First 5 should create an overarching media and outreach plan, clearly define the goals of the plan, and sufficiently fund the implementation of such a plan, along with more stringent and comprehensive evaluation requirements.

[10] V. Abalos. Communications Audit Report. San Diego, CA: First 5 San Diego, 2006.

Direct Services

UCSD Regional Perinatal System, Welcome Baby Program: Kit for New Parents

The Kit for New Parents is a statewide project of First 5 California. UCSD Regional Perinatal System is contracted by First 5 San Diego to tailor the product to the San Diego County community and work with community partners to make the Kit available to every new mother in the county. To accomplish this, they operate the "Welcome Baby Program" (WBP) that maintains a roster of over 750 distribution partners. These partners include a wide variety of agencies and organizations, including hospitals, physicians' offices, libraries, home visiting programs, child care centers, schools, prenatal clinics, and parenting classes. WBP distributes the Kits to these partners and provides partner training and support to ensure effective dissemination of the Kit, as well as recommended tips for partner follow-up with parents, as appropriate. Since the launch of the Kit for New Parents in January 2002, WBP has distributed over 160,000 Kits in San Diego County. Approximately 26,000 Kits were distributed during FY 2005-06.

The Kit

The Kit is currently available in English and Spanish, and contains resources for parents of children 0-5. The Kit contains six videos on the early years, a series of parenting education brochures, a Parent's Guide, and a small book for parents to read to their children.

In Winter 2006, the Kits will be accessible in a DVD version as well as in the following Asian languages: Korean, Vietnamese, Mandarin and Cantonese.

In July 2004, the Kit was adapted for San Diego County to include a developmental growth chart, guide to local resources, a magnet with emergency numbers and a magnet clip with First 5 information in both Spanish and English. A pilot study was conducted to assess the usefulness of the adapted items before those items were launched as part of the Kit in 2004. Now that the adapted Kit has been in circulation for some time, an evaluation assessing the effects of the Kit on San Diego County parents is being planned. Findings will be available in the upcoming fiscal years.[11]

An evaluation of the San Diego Welcome Baby Program (WBP), completed by an independent evaluator in May 2006, found that the program successfully met its organizational goals and activities. The evaluation consisted of a telephone survey conducted with over 300 Kit distributors.[12] The survey asked how partners viewed their role as distributors of the Kit for New Parents and their opinions of WBP. The survey also showed that WBP training is a critical element to ensuring the Kit is not only distributed, but utilized. Indeed, 68.3% of partners who participated in Kit training through WBP were more likely to follow-up with parents receiving the Kit than those who did not.[13] These findings show WBP's on going efforts to improve the

[11] Evaluation findings specific to the *standard* Kit's impact on parents can be seen in the FY 2003-2004 First 5 San Diego annual evaluation report and the entire report can be accessed on RPS' WBP website: www.regionalperinatalsystem.org

[12] Risley, A.J., L. B. Large, G. Cataldo. Kit for New Parents: San Diego Welcome Baby Program. 2005 Partner Survey Report. San Marcos, CA: Social and Behavioral Research Institute, California State San Marcos, 2006.

[13] Partners report having more family visits per month than distributions of Kits because many visits are follow-up visits for other services; therefore parents who already received the Kits are asked about its usefulness, etc.

distribution and partners' familiarity with Kit content and its benefit to parents and the target population. The following data shows partners' views on WBP performance:

- 78.7% heard from WBP often enough for their needs
- 67.0% noted it "Very Easy" to communicate with WBP
- 72.3% said they were able to order new Kits easily
- 92.9% rated WBP as "Very Helpful" in resolving Kit distribution issues

Providing Diverse Services to Children 0-5

In Fall 2002, the Commission released funding to support children age 0-5 and their families. This funding went to 40 grantees to support the Commission's first strategic plan (RFGA# 20133). Many of these activities were related to parent development activities in the areas of health, social-emotion, and cogitative development. In addition, the Commission funded eight programs to provide Health and Developmental Assessments (RFGA# 20055). The Commission saw the closure of its two original grant cycles in December of 2005. These funded projects focused primarily on health, early literacy and parent development. In this reporting period, these projects provided 873,523 service contacts to children (6% to children with special needs) and 38,044 service contacts to parents. These projects also reached 230,165 people through community events and hosted 886 trainings for families and providers.

Each of these groups of funded programs participated in an extensive evaluation of their services in FY 2003-2004 and FY 2004-2005. Over these two years, the programs demonstrated the following consistent results:

- Parents whose children received developmental screenings and treatment noted their child was making developmental gains and that their child's behavior improved.
- Mothers who received First 5 education regarding breastfeeding exceeded the federal "healthy People 2010" goals for breastfeeding at hospital discharge and up to and beyond 6 months.
- Parents participating in First 5 funded parent education classes:
    - showed statistically significant increases in talking, singing, telling stories, and reading to their children.
    - demonstrated an increase in their confidence as parents.

Below is a listing and description of each of the programs funded under these two RFGAs:

Exhibit 6.2 RFGA 20133 and 20055 Funded Programs	
Grantee/ Program	**Program Description**
Alpha of San Diego, Inc. *Alpha Vision & Health Care Advocacy, AVHA Tots*	Provides a more comprehensive vision screening for pre-schoolers and improves access to health care information offered to parents of preschoolers. Services include free or low-cost vision screening, case management, community outreach and education.
American Lung Association of San Diego and Imperial Counties *San Diego County Childhood Asthma Initiative*	Provides bi-lingual/bi-cultural Asthma Coordinators visit homes of asthmatic children 0-5 to provide parents and caretakers with instruction on devices and medications, create physician-approved Asthma Action Plans, conduct environmental assessments, and make referrals. The Initiative also provides asthma education workshops to parents, childcare providers, and other community organizations.
Bayside Community Center *Giant Steps*	Utilizes the Parents as Teachers model to promote parents understanding that they are their child's first teachers. Additionally, they provide the same case management service components and parent community involvement activities as the Healthy Start program.
Catholic Charities Diocese of San Diego *Parents as Teachers - East County*	Provides home-based parent education using the Parent as Teachers model, as well as developmental assessments and referrals as needed to children ages 0-5 who are from refugee or new immigrant families of Middle Eastern descent.
Centro de Salud de La Comunidad de San Ysidro	Two mobile service clinics are professionally staffed and provide health services and parent education to families with children 0-5 in South Bay neighborhoods.
Child Abuse Prevention Foundation *Developmental Screening and Enhancement Program*	Provides developmental and behavioral screenings for children who enter the child welfare system and are placed in foster or relative care. Children may be referred for further evaluation and related services. The result supports increased permanency in the foster home and assists children to be ready to learn when they enter kindergarten.
Children's Hospital and Health Center *Anderson Center for Dental Care Welcome Baby Teeth*	Provides oral health screenings, preventive treatment and parent education to improve oral health. It also links children to dentists in their communities and offers care coordination for children with urgent care needs.
Children's Hospital and Health Center *Children's Care Connection-C3*	Identifies developmental and behavioral concerns in children 0-6 years or up to Kindergarten entry. The free service to families in North San Diego County provides evaluation and enrichment services to children with mild to moderate developmental delays and/or behavioral problems. It also offers services to parents and families in the following areas of need.
Children's Hospital and Health Center: Partnership for Smoke Free Families *Partnership for Smoke Free Families P10 Program (PSF)*	PSF systematically screens pregnant women and new mothers for tobacco exposure and linking them to targeted interventions. Key elements include: standardized screening system; consistent messages from clinicians across the childbirth continuum; proactive links to interventions; transparent, seamless interventions delivered from outside the clinician's office; collaboration with community partners; and a focus on staff and clinician retention in the program and retraining.
Community Health Group Foundation	Provides parent education on child development, home and safety, and health to families with babies under age one upon their enrollment

Exhibit 6.2 RFGA 20133 and 20055 Funded Programs	
Grantee/ Program	**Program Description**
Parent Education Home Visits for Babies Under Age 1	in the Community Health Group Medi-Cal plan.
Episcopal Community Services *S/E Kids First*	Serves children 0-5 who live in two transitional housing programs for victims of domestic violence. The program offers a variety of services including; developmental assessments, parent coaching, parent education, play therapy, psychotherapy and a weekly parent support group.
Community Health Systems, Inc. Fallbrook Family Health Center Health *Vision Treatment & Outreach Assessment*	Provides health, dental, and vision assessments and treatment to children 18 months to five years of age.
Family Health Centers of San Diego *Project Steps to SEED (Social, Emotional, & Educational Development)*	Provides parenting classes and other parent education opportunities as well as School Readiness classes for children 3-5. They also provide developmental screenings, assessments and intervention programs and activities for children 0-5 and their families at three Family Resource Center sites.
Homey's Youth Foundation *Family Health & Literacy Project*	Provides home-based school readiness, health assessment, education, and literacy activities, combined with school-based parenting classes and adult education courses using the HIPPY (Home Instruction for Preschool Parents) Program.
Info Line of San Diego County/2-1-1 San Diego *2-1-1 San Diego*	Provides a comprehensive, 24/7 information and referral line in San Diego County.
Jewish Family Services of San Diego *Parent Education Program*	Provides parent education for parents of children 0-5, targeting the community-at-large, including underserved populations (e.g. teen parents, immigrants, homeless, ESL) using Systematic Training for Effective Parenting curriculum.
Joy of Sports Foundation *Star Program for Parents of Preschoolers*	Provides Star Power/Star Soccer training program to parents to build self-esteem and concentration skills within their children 3-5.
Lawrence Family Jewish Community Center *Nierman Preschool*	Offers a comprehensive, integrated system to promote early childhood education development. First 5 funds support early identification, assessments and treatment for preschoolers, as well as community-based parent education seminars on age appropriate early childhood development.
Mountain Health & Community Services, Inc. *Rural Children & Families Project*	Provides physical health assessments and treatment for children 0-5; and parent support and education, including prenatal care, in rural east San Diego County.
Multi-Cultural Community and Family Services *Immigrant Families Parent*	Provides a comprehensive, culturally and linguistically appropriate Parent Education Program to immigrant and refugee families with children 0-5 in San Diego County. The culturally sensitive workshops present the most recent studies and findings in child development to

Exhibit 6.2 RFGA 20133 and 20055 Funded Programs	
Grantee/ Program	**Program Description**
Education Program	promote school readiness and healthy children.
National City Public Library *WOW Mobile*	Provides area neighborhoods with a traveling resource of health information, family literacy, parenting and child development, and other educational materials for parents and children.
North County Health Services *Project All Ready*	Provides on-site developmental assessments and treatment services to children in licensed childcare centers with a mobile medical team. The team also provides healthcare assessments that include vision, hearing and dental screenings.
North County Solutions for Change, Inc. *Solutions for Kids*	Provides parent education to families with children 0-5 living at the Solutions Family Center Transitional housing program.
Palomar Pomerado Health *Welcome Home Baby Program*	Nurses, lactation consultants, parent educators and other professionals offer first-time mothers ongoing support and information on available resources so they can meet the needs of their child in the first month of life.
Poway Unified School District *Ready to Learn Project*	Provides 14 unique parent education or parent-child activity workshops that equip parents with knowledge about child development and specific skills and strategies to use at home with their children, beginning at birth through age 5.
San Diego Birthing Project *Parent Education In-Home Visitor Program*	Provides in-home parent education classes to mothers with children 0-2. The program offers support, instruction on infant health and development, and information on community resources.
San Diego Community College District Center for Education and Technology *Child Health and Intergenerational Linkage Development Project*	The program increases school readiness by enriching and broadening the scope of the Center for Education and Technology Parent Education Program offerings through activities for families, and intergenerational support for parents.
Santee School District *Children and Families Ready 4 School*	Provides no cost school readiness and parent support programs such as Parents as Teachers (PAT), Home Instruction for Parents of Preschool Youngsters (HIPPY) and Parent Participation classes.
SAY San Diego, Inc. *Start Smart*	Provides parent information and education through in-home and center-based activities and community outreach. Diverse populations with children from infancy through age 5 participate in free parent-child interactive classes held in more than 15 locations in the city of San Diego. Developmental assessments are also available. Services are provided at school sites and via a network of Family Resource Centers and Healthy Starts sites.
SAY San Diego, Inc. *Healthy Start Military Family Cluster – Our Kids Count!*	The Center provides comprehensive in-home, community, and center-based services designed to meet the unique needs of military families.
San Diego State University	Serves families of individuals with special needs by providing parent

Exhibit 6.2 RFGA 20133 and 20055 Funded Programs	
Grantee/ Program	**Program Description**
Foundation: Exceptional Family Resource Center (EFRC) *Healthy and Ready to Learn*	support groups, education, training, resources and referrals. Services are available to the professional community, including technical assistance, education, and training.
San Diego State University Foundation: Por la Vida *Familias Saludables*	Offers neighborhood-based parenting and children's classes to Spanish speaking families. Focuses on building parent and child confidence, self-esteem, and practical parenting skills.
San Diego State University Foundation: *KPBS First 5 for Kids - Infant Immunization Media Campaign and Health & Oral Health Campaign*	Developed projects focusing on strengthening a parent's ability to help their children become ready-to-learn , increasing children's immunizations (Immunization campaign), and increasing awareness of health and oral health issues for children (Health & Oral Health Campaign), using interstitials, newscasts, radio programs, print materials, and online content.
Shiley Eye Center, Dept. of Ophthalmology, University of California San Diego *Mobile Preschool Eye Care Program*	Provides critical mobile eye care to identify, treat, and prevent vision disorders in low-income children 2-5. Referred from systematic preschool vision screenings, children receive full eye exams in the Eye Mobile at their preschool locations to assure that they have the vision needed to enter school ready to learn. Staff also provides follow-up and bilingual information for parents on the importance of eye/brain development and treatment compliance.
South Bay Union School District *Family Health Early Life Promotion- HELP*	Provides parent education and involvement with the initial/early healthy development of children. The program uses a variety of conduits to channel and direct comprehensive child health development messages to parents and caregivers within designated service areas.
St. Vincent de Paul Villages *Project SAFECHILD*	Provides early identification and intervention services for homeless families and children 0-5 residing at St. Vincent de Paul Village. Early identification and referral services are provided to other homeless shelters through the Project SAFECHILD Mobile Unit. Services include ongoing prenatal care, developmental assessments, onsite interventions, and community referrals.
UC Cooperative Extension *Off to a Good Start*	Provides parent education workshops to parents with children 3-5 residing in Chula Vista, National City and San Ysidro. The workshops are designed to help parents provide activities that guide their children's language acquisition and literacy skills; social, emotional and physical development, and meet their nutritional needs to assure school readiness.
Union of Pan Asian Communities *Families Living in Good Health Together-FLIGHT*	Provides families with multilingual parenting and health education workshops, case management services, referrals and follow-up, interpretation, translation, and transportation. Also provides community events and family-centered activities to develop early literacy skills for Cambodian, Chinese, Hmong, Lao, Filipino, Samoan, and Vietnamese parents.
Vista Community Clinic *Infancia Feliz*	The program offers innovative, culturally competent program designed to address the unique and complex needs of low-income Hispanic children 0-18. The program utilizes a multifaceted intervention of home visitation, health education, and facilitated case management to

Exhibit 6.2 RFGA 20133 and 20055 Funded Programs	
Grantee/ Program	**Program Description**
	increase access to care, improve infant health, and foster the parent-child relationship.
YMCA Childcare Resource Service *Health Consultant & Behavioral Health Specialist*	Provides developmental, health, behavioral and hearing assessments, case management resource and referrals, and parent education to families with children 0-5. Services may include: childcare and home-based behavioral observation, developmental assessments, follow-up plans coordinated with parent and childcare providers, and behavioral health specialist follow-up with families. The program also offers parent education and childcare provider education workshops and classes.
Community Health Systems, Inc. Fallbrook Family Health Center Health, *Vision Treatment & Outreach Assessment*	Provides health, dental, and vision assessments and treatment to children 18 months to five years of age.
Home Start, Inc. *South Region*	Conducts outreach and referrals, provides enrollment application assistance and follow-up retention services for insurance enrollment in collaboration with family resource centers and other community-based organizations in San Diego County's South Region.
North County Health Services *Project All Ready*	Provides on-site developmental assessments and treatment services to children in licensed childcare centers with a mobile medical team. The team also provides healthcare assessments that include vision, hearing and dental screenings.
North County Serenity House *Healthy Access for Children*	Located in a residential drug and alcohol abuse treatment program for women, the program provides full on-site developmental assessments for children 18-60 months and at interim periods, as necessary for every child in the program.
Palomar Family Counseling Service *Childnet Developmental Services*	This program, is designed to give parents of children 18-60 months important and useful information about their child's development by helping to ensure he or she is ready To learn. Program staff help parents give their young children the advantage of early skill development in achieving school readiness.
St. Clare's Home, Inc. *Little Angels Learning Center*	This program provides developmental assessment and treatment services on-site at childcare centers and family daycare homes for children ages 18-60 months. A full-time child therapist is responsible for assessments and treatment, and referrals and training to Little Angels' parents and staff.
Therapeutic Services, Inc. *Building Bridges*	A therapeutic school readiness program provides evidence-based services children 3-5, "bridging" their preschool experience to promote optimal success in kindergarten, and throughout their primary grade school years.

Provider Capacity Building and Support

YMCA Childcare Resource Service, San Diego CARES

San Diego CARES (Compensation and Retention Encourage Stability) is part of a statewide First 5 program administered locally by the YMCA Childcare Resource Service, the child care resource and referral agency for San Diego County. The program works to improve the quality of local childcare by encouraging the professional development of early care and education (ECE) providers. Participating providers receive monetary stipends to complete college units, attend professional development training, and obtain a California Child Development Permit. San Diego CARES ensures retention by requiring ECE providers to continue working at the same child care program while they attend college and earn stipends. Through the Family, Friend and Neighbor program, license exempt caregivers receive stipends, educational toys and books for completing training classes. CARES' yearly internal evaluation studies (a program retention survey) has documented the following results. It is of note that these results are very similar to last year and remain consistently high.

Supporting the Development and Retention of Childcare Providers

In order to ensure quality childcare providers, CARES participants must follow certain requirements for approval (complete ECE college courses, work in same child care program for more then nine months, etc.). CARES ensures retention of qualified staff by requiring participants to continue working at their current childcare program for another 9 months while continuing their education. After these conditions are met, the childcare provider qualifies for a stipend.

- During the first four years of CARES, over 2,570 stipends ($750-$3000) were paid to providers that completed coursework.
- Currently, about 1762 childcare providers participate in CARES.
- Over 2000 participants in CARES have completed 20,578 ECE units.

Improved retention of early care and education

- According to CARES 2004-05 retention survey, the turnover rate was 14.4% for CARES participants compared to those who did not participate (26.5%).[14]
- 84% of participating programs felt San Diego CARES had a positive effect on their program.

Improved quality of early care and education programs

- 93% of survey respondents stated that completing the CARES program increased the quality of their childcare program.
- 93% of childcare providers learned to work more effectively with parents.
- 95% learned new skills for working with children.

Improved professional development and other notable findings

- 95% of participants stated CARES provided motivation to continue their education.
- 99% of respondents recommended continuation of the CARES program.
- 93% reported they would apply for another year of the CARES program.

[14] FY 2004-05 data is presented since the FY 2005-06 evaluation was not complete at the time of this writing.

Children's Hospital and Health Center: Partnership for Smoke-Free Families

Partnership for Smoke-Free Families (PSF) is a nationally recognized,[15] countywide tobacco control program that is funded in part by First 5. PSF systematically screens pregnant women and new parents for tobacco use/exposure and links identified participants to targeted interventions. The program works to create systems level change by training providers (obstetricians, nurse home visitors, and pediatricians) to identify and treat tobacco use among the pregnant women and new parents they see.[16]

The goal of PSF is to train clinicians across the childbirth continuum to implement evidence-based practices for treating tobacco use. As part their First 5 contract, PSF works with obstetricians, home visitors, and pediatricians to screen pregnant women and new parents for tobacco use in order to identify smokers and link them with cessation resources. Several annual program evaluations of PSF have shown decreased smoking behavior in prenatal smokers.[17] Given this evidence of success, outcomes were not measured for FY 2005-06. The success of linkage to the Health and Developmental Services Project will be measured in the coming fiscal year (see Chapter 3).

In FY 2005-06, two new program components were added to the PSF Program. In 2005, The *Quit Link* program for pediatric offices was launched in order to proactively link identified parental smokers with treatment resources. Previously, the proactive link to treatment services was exclusively for PSF's pregnant smokers. In January 2006, in order to coordinate efforts with the Commission's new Health and Developmental Services Project, PSF expanded its provider network to include nurse home visitors. PSF began creating

Who Did the Partnership for Smoke-Free Families Reach?*

- 55 obstetric providers (physicians, midlevel providers, nurses and other allied health professionals) received training at one of 7 formal in-service training sessions.
- 5,000 pregnant women were screened for tobacco use and exposure and almost 200 smokers were linked with a cessation resource. Some 500 spontaneous quitters were sent a sequenced mail based intervention consisting of 5 mailings of education materials focusing on relapse prevention.
- Approximately 1000 families received education materials by mail on second hand smoke exposure.
- Pediatric providers at 13 offices were recruited and trained to participate in Quit Link. They in turn, screened over 845 parents of children 0-5. Screening resulted in the identification of 65 parental smokers.

*Note: Results of screening of new parents, part of the Health and Developmental Services Project, was previously reported in Chapter 3.

[15] PSF received the 2004 American Association of Health Plans-HIAA/Wyeth Hera Silver Award for Improvement in Women's and Children's Health Outcomes; the Special Achievement Award for Innovations in Maternal and Child Health (California Department of Health, 2001) and was selected by the Robert Wood Johnson Foundation Smoke Free Families National Dissemination Office to create a manual outlining the implementation and lessons learned of PSF focusing. This manual, printed in 2004, is currently being distributed nationwide.

[16] The training provides clinicians and office staff with skills and resources to implement the U.S. Public Health Service's Clinical Practice Guideline for Treating Tobacco Use and Dependence, which advocates the 5 "A"s approach of asking patients about tobacco use at each visit, advising smokers to quit, assessing smokers' willingness to quit, assisting smokers to quit, and arranging for follow-up to monitor smoking status and provide support.

[17] First 5 San Diego. First 5 San Diego 2004-2005 Annual Evaluation Report. San Diego, CA: 2005.

protocols and providing training to nurse home visitors to systematically screen new parents for tobacco use at the initial newborn home visit and link these new parents with cessation services. Coordinating First-5 funded projects in this way is consistent with the funding principles outlined in the Commission's Strategic Plan and has enabled many more families to live smoke-free.

Systems Change

Capital and Equipment Grants: Building Critical Infrastructure

In 2003, the Commission approved the Capital Funding Program to provide further support the improvement of early childhood development for children 0-5. Capital Funding supported the build-out or purchasing of critical infrastructure, such as modular classrooms and clinics, as well as medical and playground equipment. Exhibit 6.3 displays the nineteen contracts awarded to organizations to fund capital improvements during FY 2005-06.

Exhibit 6.3
Capital Project and Equipment Grants

Capital Improvements	Funds Used
Cal State University, San Marcos	Construct Child Care Center, playground and parking area for CSUSM campus.
Chula Vista Elementary School District	Purchase a modular classroom and install in Rice Elementary School for services for young children exposed to domestic violence and their families that include: preschool curriculum, intake and assessment, children's group and individual counseling, parent and child play groups and parent education.
Child Abuse Prevention Foundation	Renovate nursery and develop outdoor play area and Tot Lot.
Fallbrook Union Elementary School District	Construct and furnish an Early Childhood Learning Center, which will include two preschool classrooms, one special education preschool classroom, two walk-in-and-play classrooms, a parent education room, a playground and support areas.
Family Health Centers of San Diego	Substantially expand the North Park and Logan Heights Family Health Center sites to enhance services for children 0-5.
2-1-1 San Diego (INFO LINE of San Diego)	Purchase 30 workstations and equipment for the call center.
Mental Health Systems, Inc.	Expand the Child Development Center and Family Recovery Center site.
National School District	Purchase and install four portable preschool classrooms, three playground structures and renovate two existing preschool classrooms in National City.
Neighborhood Healthcare	Purchase and renovate building for prenatal programs and healthcare services.
North County Health Services	Purchase an existing medical building that will become a Maternal and Child Health Center.

Exhibit 6.3 (Continued) Capital Project and Equipment Grants	
Capital Improvements	**Funds Used**
Operation Samahan	Purchase screening and diagnostic equipment for fetal and pediatric diagnosis for the Perinatal and Pediatric Clinic.
San Diego Family Care	Purchase and install medical, facilities and supporting equipment for the new Reproductive Health/Prenatal Care Pavilion at the Linda Vista Health Care Center campus of San Diego Family Care.
San Diego Public Library	Add pre-school areas in four new libraries to promote school readiness and literacy.
Scripps Mercy Hospital	Purchase and implement new equipment to enhance the clinical service delivery infrastructure in the Labor & Delivery Unit, Family Birth Unit, and the Special Care Nursery.
St. Andrew Parish Day School	Complete the renovation and refurbishment of St. Andrew's Parish Day School's preschool playgrounds.
St. Vincent de Paul Villages	Construct a new facility to house St. Vincent de Paul Village's comprehensive therapeutic childcare services.
San Ysidro Health Center	Construct a new facility to meet health and social needs of children 0-5 and their mothers.
San Ysidro School District	Purchase two portable classrooms for preschool and build and furnish a resource room and play structure.
U.S. Department of the Navy, Navy Region Southwest	Construct two new Child Development Centers in the Murphy Canyon and Coronado-Naval Air Station communities.

Innovative Grants: Responding to Emerging Needs and Strategies

In 2003, the Commission approved a dedicated budget for Innovative Grants to address unsolicited grant applications for $75,000 or less. These grants must demonstrate an innovative approach for providing linkages with other community organizations to better serve the unmet needs of children 0-5. Exhibit 6.4 displays the seven Innovative Grants approved during FY 2005-06. Each of these services provided direct services to young children and/or their families.

Exhibit 6.4 Innovative Grants	
Grantee/Program	**Description of Project/Services**
American Lung Association of SD & Imperial Counties *Asthma Tele-Counseling*	Provides asthma education and coordination services for families of children 0-5 with asthma who live in the North and East Counties and rural areas.
Home Start, Inc. *Project Priority: A Parent-Child Relationship Program for Military Families*	Provides Parent-Child Interaction Therapy (PCIT) and parent education/process groups to strengthen families with children ages 18 months to 5 years old and who are affected by the war in the Middle East.
Jewish Family Service of San Diego *Preschool in the Park*	Offers parenting instruction, community-based early learning preparation, medical access and play for children 0-5 and their parents. It also provides weekly theme-based curricula to encourage learning, socialization, fine and gross motor skills, and emotional and intellectual growth.
Joy of Sports Foundation *Healthy Preschoolers Program*	Combats childhood obesity at the preschool level by providing physical activity and nutritional education for children, parents and Head Start staff.
La Cuna, Inc. *Individualized Therapy and Support Project*	Provides a therapist to work with La Cuna's foster children to ensure their social and emotional development is not stifled by their early life experiences. It will also provide ongoing, consistent and intensive therapy to all of its foster parents and children.
Riding Emphasizing Individual Needs & Strengths (REINS) San Diego *Therapeutic Consulting Partnership*	Provide therapeutic riding lessons to children with a variety of disabilities.
Social Advocates for Youth (SAY) San Diego, Inc. *Stepping Up Start Smart*	Replicate the core Start Smart weekly parent/child interactive class model with three additional innovative components: collaborate with local housing managers to hold weekly classes at 4 low income apartment communities; add a second weekly class meeting at each site as a playgroup managed by parents; and introduce a formalized parent pledge engaging the parents' commitment to continue a positive learning environment at home.
SDSU Foundation Exceptional Family Resource Center (EFRC) *Systematic Neonatal Intensive Care Unit Referral Project*	Plan and develop a written protocol/process for referring families of infants receiving care in the 13 countywide hospital NICU for family support services
YMCA of San Diego County *Child Care Nutrition and Physical Activity Certification Program*	Creates a countywide Child Care Nutrition and Physical Activity Certification program to help child care providers create a healthier environment for children 0-5 in their care.
Whittier Institute *Project Dulce*	Provides support to mothers of children 0-5 who are overweight, have gestational diabetes mellitus, and/or at high risk for diabetes/obesity by providing education, support and opportunities to learn and practice beneficial behaviors.

2-1-1 San Diego: Information and Referral Service

2-1-1 is the national dialing code for information about community, health, and disaster services. Initial strategic planning for San Diego County's 2-1-1 information and referral service was supported by First 5 San Diego during the FY 2003-04. During FY 2004-05, First 5 continued to support 2-1-1 in their implementation phase. On June 30, 2005, 2-1-1 San Diego had its official launch, and it is now available 24 hours per day, 7 days per week. The Commission has provided $898,000 in operating expenses to 2-1-1, approximately 50% of the organizations budget.[24, 25]

During FY 2005-06, 2-1-1 assisted approximately 125,000 callers in finding needed health and social services. Thirty-three percent (33%) of these callers were from families with children 0-5. 2-1-1 also increased its infrastructure and enhanced local partnerships to maintain this high-capacity. For the next fiscal year, 2-1-1 San Diego projects serving 125,000-175,000 clients if funding goals are met.

2-1-1 San Diego assisted approximately 125,000 callers in finding needed health and social services during FY 2005-06.

"Great service! I took the survey so that service will expand. It's important to be able to find agencies when I need help. I am very supportive of 2-1-1."

- 2-1-1 caller

To understand the quality of services provided, 2-1-1 conducted a 2006 Client Satisfaction Survey with a sample of 366 individuals who called 2-1-1 for services; almost one-third (33%) of survey respondents were parents of children 0-5.

Additionally, ninety-nine percent (99%) of First 5 eligible parents were satisfied with the 2-1-1 San Diego services and 100% indicated it was helpful and would use the service again.[26]

[24] Timko, Betty. Email to author. 3 August 2006.
[25] 2-1-1 San Diego was awarded other grants, but this is among one of the largest in FY2005-06
[26] 2-1-1 San Diego. "First Five Families." 2005-2006 Evaluation Report. San Diego, CA: 2006.

Chapter 7
Trends in Early Childhood

The First 5 Commission of San Diego County has made strategic investments to improve outcomes for children ages 0-5 and their families in San Diego County. However, the needs of this population are constantly changing in response to shifts in population, service delivery, and public policy. The Commission recognizes the need to keep abreast of the key local early childhood local indicators to understand if it programs are contributing to the well-being of the 0-5 population as well as identify emerging trends.

The Commission's approach is to monitor Community Context Indicators. These indicators were selected by the Evaluation Leadership Team as critical cross-county, population-based data elements, that track whether "big-picture" changes are happening over time for children ages 0-5 and their families in San Diego County. Indicator data is tracked to assess trends for San Diego County's children ages 0-5 and their families. This is the first year in which indicator data is presented to the Commission. Future evaluation reports will include trends changes as appropriate and feasible. It is hoped that, armed with this knowledge, the Commission may see both its contribution to improving the lives of children 0-5 and identify opportunities to contribute to a particular area of emerging concern.

A Note about the Indicator Data

In some cases, particularly for health-related indicators, existing data sources were identified and the most recent data is reported. (Although these existing sources may not update data on an annual or even a biannual basis.)

In cases where there is no preexisting, ongoing data source for the County's 0-5 population, information is gathered via a locally tailored Random Digit Dial Family Survey. The first survey was conducted in 2005 and will be conducted every two to three years to track Commission Community Context indicators. When possible, reliable state and national level data is included for comparison. Note that a comparative indicator may not be precisely aligned in its wording or collection strategy. The citation page offers additional information about the data year and source. Finally, Issue Area 1: Children's Health has the most developed available dataset for comparison. Issue Area 2: Children's Learning and Social-Emotional Health and Issue Area 3: Parent and Family Development and Resources frequently do not have state and national comparison data.

The table on the next page presents the key community context indicators of importance to the Commission (all citations are included on a subsequent page). Key trends are noted by Issue Area, along with Commission funded programs that address these areas:

Issue Area 1: Children's Health

- Only 65% of San Diego's children ages 0-5 have had developmental screenings.[1] [Health and Development Services Project]
- Only 60.5% of San Diego's children ages 2-5 receive regular dental care.[2] While this percentage is higher than the State (56.3%)[3] and exceeds the Health People 2010 objective, it is still lower than is recommended by current clinical guidelines.[4,5] [Oral Health Campaign]
- While 91.3%[6] of San Diego's households with children 0-5 have medical insurance, they are lower than those of the State (95.7%)[7]. Similarly, fewer San Diego households have a regular source of medical care than the State (91.3% compared to 97.9%,)[8] and the percentage of children who are up to date and on time for their immunizations also lag behind the State (78.6% and 79.0%, respectively).[9] [Healthcare Access Project]

Other areas to be aware of:

- San Diego County appears to have a lower rate of teen births and a higher rate of women breastfeeding 6 months after hospital discharge than both California and the Nation.[10].
- San Diego has a higher rate of women who drank alcohol during pregnancy than the Nation, but lower than California. This may be an area in which the Commission could target outreach and media efforts.

Issue Area 2: Children's Learning and Social-Emotional Health

Areas that may be affected by Commission efforts:

- San Diego County parents responding to the Family Survey appear to have better access to resources that promote their child's early learning than both the state and nation.[11] [Parent Development, 2-1-1]

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[1] First 5 San Diego, Family Survey Report, San Diego, CA: Author, 2006.
[2] First 5 San Diego, Family Survey Report, San Diego, CA: Author, 2006.
[3] The Urban Institute. National Survey of America's Families (n=34,332), 2002. Accessed 11 October 2005.
[4] Office of Disease Prevention and Health Promotion. "With Understanding and Improving Health and Objectives for Improving Health." Healthy People 2010: Volume II. Washington, DC: U.S. Department of Health and Human Services, 2000. Accessed 13 July 2006. <www.healthypeople.gov>
[5] Both the American Academy of Pediatric Dentistry and the American Academy of Pediatrics recommend all children begin annual dental exams by their first birthday. Therefore, by age two, all children should have had an exam within the past year.
[6] First 5 San Diego, Family Survey Report, San Diego, CA: Author, 2006.
[7] University of California, Los Angeles. California Health Interview Survey (n=8,526). 2003. Accessed 8 October 2005.
[8] First 5 San Diego, Family Survey Report, San Diego, CA: Author, 2006; University of California, Los Angeles. California Health Interview Survey (n=8,526). 2003. Accessed 8 October 2005.
[9] Ibid.
[10] California Department of Health Services, Center for Health Statistics. Birth Statistical Master Files. 2004.
[11] First 5 San Diego, Family Survey Report, San Diego, CA: Author, 2006; University of California, Los Angeles. California Health Interview Survey (n=8,526). 2003. Accessed 8 October 2005; Centers for Disease Control and

Other areas to be aware of:

- Although there is no comparison data, it is of note that generally half of the parents interviewed for the Family Survey stated that their child did not exhibit age appropriate self-soothing and self-regulating behaviors or the ability to get along with others.[12] (The Commission is preparing to release a project to address children's social-emotional health.)

Issue Area 3: Family and Parent Development and Resources

Areas that may be affected by Commission efforts:

- A high percentage of San Diego County parents reported that they know where to access key healthcare services (98.2%)[13] and a markedly smaller percentage knew where to access childcare (75.3%)[14] and parental support (55.7%)[15] services. [2-1-1, Parent Development]

Other areas:

- San Diego County parents were more likely to report having adequate childcare at 75.3%[16] than parents across both the State (26.0%)[17] and the Nation (60.0%).[18] (However, it is not clear is this is the result of variations in data collection methods.)

Issue Area 4: Systems Improvement and Community Change

Unlike the other Issue Areas, changes in the service systems are not as easily tracked. Below are a number of key areas of observation and data that relate to the work of the Commission to improve systems and initiate community change.

Service coordination and integration*:* The Commission's initiative approach seeks to support, link, and, as needed, develop a continuum of services so families do not "fall through the cracks." Contractors from the HCA, HDS, and OHI initiatives, for example, are expected to accompany families from the initial contact through the completion of any treatment services that they may receive.

Prevention. National Survey of Early Childhood Health (n=2,068). 2000. Accessed 14 October 2005. <http://www.cdc.gov/nchs/about/major/slaits/nsech.htm>

[12] First 5 San Diego, Family Survey Report, San Diego, CA: Author, 2006.

[13] Ibid.

[14] Ibid.

[15] Ibid.

[16] Ibid.

[17] California Child Care Resource & Referral Network. Understanding Child Care Issues in California. 2005. Accessed 14 October 2005. <http://www.rrnetwork.org>.

[18] Cubed, M. "The National Economic Impacts of the Child Care Sector." The National Child Care Association. (2002):6.

***Service capacity**:* 41.3% of funded programs report that they do not have sufficient and trained staff to provide services to their target populations. This may reflect challenges of funding and providing competitive salaries in the nonprofit sector. 34.8% of respondents reported having a waiting list during this last fiscal year.[19] This suggests that the Commission is addressing high need areas and populations.

Awareness of First 5 projects and services: The efforts of 2-1-1 San Diego and the Commission's media projects could be more coordinated and integrated with the activities of the other initiatives. The Commission staff already identified this coordination as an area for growth.

***Sustainability**:* According to the funded program survey, most programs (95.7%) are heavily reliant on First 5 funding for their programs.[20] This could reflect declining funding from other public agencies and the philanthropic sector. It suggests that First 5 could assist contractors with identifying other funding sources.

Cultural and linguistic responsiveness: Over 80 languages are spoken in San Diego County. The majority of programs (63.3%) stated that they designed or adapted their program to specific ethnical or cultural groups, [21] though does not indicate how extensively the variety of languages spoken in this area is covered. This suggests that the Commission could play a role in supporting the development of culturally and linguistically responsive contractor services.

***Responsive to special needs**:* A large majority (95.2%) stated their program was specialized or adapted to meet the needs of children with special needs.[22] However, it is not clear to what extent programs have adapted to meet this need. When asked to describe in what ways program services had been specialized or adapted, approximately one-third indicated that their specialization or adaptation consisted primarily of referral assistance. Approximately one-fifth indicated specialized staff, a change or enhancement in the way services are done, or assessments to determine special need. This suggests that if children with special needs are to be a target population for the Commission, a more concerted effort should be made to ensure that these children are provided meaningful services.

***Becoming a resource to the community**:* First 5 has made strides in educating the San Diego County community about the importance of the 0-5 years. As one key expert stated, "They have done a tremendous job in regards to parents and literacy." Another stated, "They have done a good job on grassroots efforts to reach children and families.". Because of its role and its dedicated funding stream, First 5 can align its activities with other County efforts, with the asset of having more flexible and responsive structures. "They have a lot of flexible money," noted one key expert. "The County [funding] is categorical. [First 5] has an opportunity to be creative and innovate."

[19] From findings of a Funded Program Survey conducted by Harder+Company Community Research. Note that there was slight variation in how the question was asked among the initiatives.
[20] Funded program survey conducted by Harder+Company Community Research in Spring 2006.
[21] Ibid.
[22] Ibid.

Conclusion

Initial trends suggest that the First 5 Commission of San Diego County is contributing to areas of high need and may be positively influencing larger community trends for children 0-5 and their families. Furthermore, a number of the needs identified through Community Context indicators will be addressed by projects the Commission has just funded (e.g., Preschool For All) or is preparing to fund (e.g., Social Emotional Services). However, the needs of this target population will continually grow and change and there may be need to be adjustments in the funding direction of the Commission. It is anticipated that these areas will be addressed in the upcoming revision to the Commission's Strategic Plan.

Community Context Indicators

Issue Area	Desired Results	Community Context Indicators (Indicators included in the 2004-2009 strategic plan are marked with an asterisk)		San Diego	CA	US
IA1: Children's Health	1.1 Children are born and stay healthy	% of very low birth weight births (under 1,500 grams)*		1.2%	1.2%	1.4%
		% of low birth weight births (under 2,500 grams)		6.5%	6.5%	6.7%
		% of live births where mother received first trimester prenatal care*		85.9%	85.8%	85.8%
		% of women who drank alcohol during pregnancy		17.0%	19.0%	10.1%
		% of women who smoked during pregnancy*		8.0%	9.0%	10.4%
		Rates of births to teen girls ages 15-17 (births per 1,000		18.7%	21.3%	22.4%
		% of Kindergarteners who received the recommended		78.6%	79.0%	80.0%
		% of children who breastfed at hospital discharge, at six weeks, and at six months*	6 wk	83.4%	n/a	n/a
			6 mo	48.1%	45.1%	36.3%
		% of parents who self-report their children's health is "very good or excellent"		82.6%	73.8%	85.9%
	1.2 Children have access to preventati ve and comprehensive health care services	% of children who received well-baby and child checkups by age 2*		2.7%	3.0%	3.1%
		% of households with children with medical insurance		91.3%	95.7%	91.3%
		% of children receiving vision screenings	3 yr	52.8%	n/a	n/a
			4 yr	76.6%	n/a	n/a
			5 yr	77.3%	n/a	n/a
		% of children with a regular source of medical care		91.3%	97.9%	97.5%
		% of children receiving regular dental care*		52.8%	56.3%	52.2%
		% of children who have had developmental assessments*		65.0%	n/a	n/a
		% of children with up to date and on time immunizations		78.6%	79.0%	80.0%
	1.3 Families have the knowledge, skills and resources they need to promote their children's optimal health	% of households in which someone smokes		n/a	n/a	27.0%
		Also cross-reference with subset of indicators for Desired Results 1.2 and 3.1 (i.e., insurance, childcare, parent support, etc.)		See above		

Community Context Indicators

Issue Area	Desired Results	Community Context Indicators (Indicators included in the 2004-2009 strategic plan are marked with an asterisk)		San Diego	CA	US
IA2: Children's Learning and Social-Emotional Health	2.1 Children have access to quality services that promote their early learning	% of children who have access to resources that promote their early learning (access to reading and writing materials)		65.1%	52.5%	52.0%
	2.2 Children are socially and emotionally healthy	% of children that exhibit age-appropriate self-soothing and self-regulation behaviors	Temper tantrums	10.8%	n/a	n/a
			Physical when angry	5.8%	n/a	n/a
			Uses words for feelings	47.1%	n/a	n/a
		% of children entering kindergarten ready for school (soc-emo)*		n/a	n/a	n/a
		% of children with high levels of interaction with their parents/other children	Get Along with other children	43.6%	n/a	n/a
			Get along with adults	56.3%	n/a	n/a
	2.3 Children are cognitively developing appropriately	% of children with disabilities and other special needs who participate in early childhood care and education programs*		n/a	10.7%	61.0%
		% of families who report reading, telling stories, singing regularly to their children*	Reading	65.1%	52.5%	52.0%
			Tell Stories	42.2%	n/a	n/a
			Sing Songs	59.4%	n/a	n/a
		# of hours children spend watching television (Weekday TV watching at inappropriate levels, children >3)		56.3%	n/a	n/a
		% of children entering kindergarten ready for school (cog)*		n/a	n/a	39.0%
		% of children identified with disabilities or as high risk who		n/a	58.0%	53.0%
	2.4 Families have the knowledge and skills they need to support their children's learning and social-emotional health	% of parents practicing positive discipline techniques	Discussion strategies	39.5%	n/a	n/a
			Isolation techniques	19.9%	n/a	n/a
			Physical reaction	10.4%	n/a	n/a
		% of parents reporting high level of confidence in their parental roles	Believe they are child's most important teacher	96.9%	n/a	n/a
			Feel they are good caregiver	81.7%	n/a	n/a
IA3: Parent and Family Development and Resources	3.1 Families have the skills, comprehensive support and resources they need to promote their children's optimal development and school readiness	% of parents who know where to access key services (i.e., health care, childcare, parent support)	Get parental support	55.7%	n/a	n/a
			Healthcare	98.2%	n/a	n/a
			Childcare	75.3%	n/a	n/a
		% of parents who report having adequate childcare		75.3%	26.0%	60.0%

Community Context (Level II) Indicators Citations

Issue Area	Desired Results	Community Context Indicators (Indicators included in the 2004-2009 Strategic Plan are marked with an asterisk)		San Diego	CA	US
IA1: Children's Health	1.1 Children are born and stay healthy	% of very low birth weight births (under 1,500 grams)*		California Department of Health Services. Birth Records. 2004.	California Department of Health Services, Center for Health Statistics. Birth Statistical Master Files. 2005.	Centers for Disease Control and Prevention. "Births: Final Data for 2002." National Vital Statistics Reports 52.10 (2003): 65-66.
		% of low birth weight births (under 2,500 grams)		California Department of Health Services. Birth Records. 2004.	California Department of Health Services, Center for Health Statistics. Birth Statistical Master Files. 2005.	California Department of Health Services. Vital Statistics Data Tables. 2004.
		% of live births where mother received first trimester prenatal care*		California Department of Health Services. Birth Records. 2004.	California Department of Health Services. Birth Records. 2005.	Centers for Disease Control and Prevention. National Vital Statistics Reports - Births. 2003.
		% of women who drank alcohol during pregnancy		California Department of Health Services, Maternal, Child and Adolescent Health Branch. Alcohol Use During Pregnancy. Sacramento , CA: Author, 2005.	California Department of Health Services, Maternal, Child and Adolescent Health Branch. Alcohol Use During Pregnancy. Sacramento , CA: Author, 2005.	Centers for Disease Control and Prevention. "Alcohol Consumption Among Women Who are Pregnant or Who Might Become Pregnant - United States, 2002" Morbidity and Mortality Weekly Report. 24 December 2004: 53(50): 1178-81.
		% of women who smoked during pregnancy*		California Department of Health Services, Maternal, Child and Adolescent Health Branch. Smoking During Pregnancy. Sacramento, CA: Author, 2002.	California Department of Health Services, Maternal, Child and Adolescent Health Branch. Smoking During Pregnancy. Sacramento, CA: Author, 2002.	Centers for Disease Control and Prevention. National Vital Statistics Reports - Births. 2003.
		Rates of births to teen girls ages 15-17 (births per 1,000 populations)		California Department of Health Services, Center for Health Statistics. Birth Statistical Master Files. 2004.	California Department of Health Services, Center for Health Statistics. Birth Statistical Master Files. 2003.	Centers for Disease Control and Prevention. National Vital Statistics Report - Births. 2003.
		% of Kindergarteners who received the recommended vaccinations		Centers for Disease Control and Prevention. National Immunization Survey. 2000-2004. Accessed 8 October 2005.	Centers for Disease Control and Prevention. National Immunization Survey. 2000-2004. Accessed 8 October 2005. <www.cdc.gov/nis>	Centers for Disease Control and Prevention. National Immunization Survey. 2000-2004. Accessed 8 October 2005. <www.cdc.gov/nis>
		% of children who breastfed at hospital discharge, at six weeks, and at six months*	6 wk	First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005	n/a	n/a
			6 mo	Centers for Disease Control and Prevention. National Immunization Survey (n=30,824). 2004. Accessed 3 January 2006. <www.cdc.gov/nis>	Centers for Disease Control and Prevention. National Immunization Survey (n=30,824). 2004. Accessed 3 January 2006. <www.cdc.gov/nis>	Centers for Disease Control and Prevention. National Immunization Survey (n=30,824). 2004. Accessed 3 January 2006. <www.cdc.gov/nis>
		% of parents who self-report their children's health is "very good or excellent"		First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	Centers for Disease Control and Prevention. National Health Interview Survey (n=12,249). 2003. accessed 8 October 2005. <www.cdc.gov/nchs/nhis>	University of California, Los Angeles. California Health Interview Survey (n=8,526). 2003. Accessed 8 October 2005. <www.chis.ucla.edu>
	1.2 Children have access to preventative and comprehensive health care services	% of children who received well-baby and child checkups by age 2*		First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	The Urban Institute. National Survey of American's Families (n=34,332). 2002. Accessed 11 October 2005. <www.urban.org>	The Urban Institute. National Survey of American's Families (n=34,332). 2002. Accessed 11 October 2005. <www.urban.org>
		% of households with children with medical insurance coverage		First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	University of California, Los Angeles. California Health Interview Survey (n=8,526). 2003. Accessed 8 October 2005. <www.chis.ucla.edu>	Centers for Disease Control and Prevention. National Survey of Early Childhood Health (n=2,068). 2003. Accessed 14 October 2005. <http://www.cdc.gov/nchs/about/major/slaits/nsech.htm>
		% of children receiving vision screenings	3 yr	First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	n/a	n/a
			4 yr	First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	n/a	n/a
			5 yr	First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	n/a	n/a
		% of children with a regular source of medical care		First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	University of California, Los Angeles. California Health Interview Survey (n=8,526). 2003. Accessed 8 October 2005. <www.chis.ucla.edu>	Centers for Disease Control and Prevention. National Survey of Early Childhood Health (n=12,249). 2003. Accessed 8 October 2005. <http://www.cdc.gov/nchs/nhis>
		% of children receiving regular dental care*		First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	The Urban Institute. National Survey of America's Families (n=34,332). 2002. Accessed 11 October 2005.	The Urban Institute. National Survey of America's Families (n=34,332). 2002. Accessed 11 October 2005.
		% of children who have had developmental assessments*		First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	n/a	n/a
		% of children with up to date and on time immunizations		Centers for Disease Control and Prevention. National Immunization Survey. 2000-2004. Accessed 8 October 2005.	Centers for Disease Control and Prevention. National Immunization Survey. 2000-2004. Accessed 8 October 2005. <www.cdc.gov/nis>	Centers for Disease Control and Prevention. National Immunization Survey. 2000-2004. Accessed 8 October 2005. <www.cdc.gov/nis>
	1.3 Families have the knowledge, skills and resources they need to promote their children's optimal health	% of households in which someone smokes		n/a	n/a	Centers for Disease Control and Prevention. Secondhand Smoke and Children. 2003.
		Also cross-reference with subset of indicators for Desired Results 1.2 and 3.1 (i.e., insurance, childcare, parent support, etc.)		See above		

Issue Area	Desired Results	Community Context Indicators (Indicators included in the 2004-2009 Strategic Plan are marked with an asterisk)		San Diego	CA	US
IA2: Children's Learning and Social-Emotional Health	2.1 Children have access to quality services that promote their early learning	% of children who have access to resources that promote their early learning (access to reading and writing materials)		First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	University of California, Los Angeles. California Health Interview Survey (n=8,526). 2003. Accessed 8 October 2005. <www.chis.ucla.edu>	Centers for Disease Control and Prevention. National Survey of Early Childhood Health (n=2,068). 2000. Accessed 14 October 2005. <http://www.cdc.gov/nchs/about/major/slaits/nsech.htm>
		% of children that exhibit age-appropriate self-soothing and self-regulation behaviors	Temper tantrums	First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	n/a	n/a
			Physical when angry	First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	n/a	n/a
			Uses words for feelings	First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	n/a	n/a
	2.2 Children are socially and emotionally healthy	% of children entering kindergarten ready for school (soc-emo)*		n/a	n/a	n/a
		% of children with high levels of interaction with their parents/other children	Get Along with other children	First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	n/a	n/a
			Get along with adults	First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	n/a	n/a
	2.3 Children are cognitively developing appropriately	% of children with disabilities and other special needs who participate in early childhood care and education programs*		n/a	California Department of Education, Special Education Division. Special Education Enrollment by Age and Disability Statewide Report. 2005. Accessed 11 Aug. 2006 <http://data1.cde.ca.gov/dataquest/SpecEd>	U. S Department of Education, Westat for the Office of Special Education and Rehabilitative Services. Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act. 2003. 11 Aug. 2006 <http://www.ed.gov>
		% of families who report reading, telling stories, singing regularly to their children*	Reading	First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	University of California, Los Angeles. California Health Interview Survey (n=8,526). 2003. Accessed 8 October 2005. <www.chis.ucla.edu>	Centers for Disease Control and Prevention. National Survey of Early Childhood Health (n=2,068). 2000. Accessed 14 October 2005. <http://www.cdc.gov/nchs/about/major/slaits/nsech.htm>
			Tell stories	First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	n/a	n/a
			Sing Songs	First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	n/a	n/a
		# of hours children spend watching television (Weekday TV watching at inappropriate levels, children >3)		First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	n/a	n/a
		% of children entering kindergarten ready for school (cog)*		n/a	n/a	Child Trend Data Bank, Early School Readiness. 1999. 11 Aug. 2006 <http://www.childtrendsdatabank.org/indicators>
		% of children identified with disabilities or as high risk who receive development and/or behavioral services by kindergarten entry		n/a	U. S Department of Education, Westat for the Office of Special Education and Rehabilitative Services. Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act. 2003. 11 Aug. 2006 <http://www.ed.gov>	U. S Department of Education, Westat for the Office of Special Education and Rehabilitative Services. Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act. 2001. 11 Aug. 2006 <http://www.ed.gov>
	2.4 Families have the knowledge and skills they need to support their children's learning and social-emotional health	% of parents practicing positive discipline techniques	Discussion strategies	First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	n/a	n/a
			Isolation techniques	First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	n/a	n/a
			Physical reaction	First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	n/a	n/a
		% of parents reporting high level of confidence in their parental roles	Believe they are child's most important teacher	First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	n/a	n/a
			Feel they are good caregiver	First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	n/a	n/a
IA3: Parent and Family Development and Resources	3.1 Families have the skills, comprehensive support and resources they need to promote their children's optimal development and school readiness	% of parents who know where to access key services (i.e., health care, childcare, parent support)	Get parental support	First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	n/a	n/a
			Healthcare	First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	n/a	n/a
			Childcare	First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	n/a	n/a
		% of parents who report having adequate childcare		First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.	California Child Care Resource & Referral Network, Understanding Child Care Issues in California. 2005. Accessed 14 October 2005. <http://www.rrnetwork.org>	Cubed, M. "The National Economic Impacts of the Child Care Sector." The National Child Care Association. (2002): 6.

Recommendations

The 2005-2006 evaluation synthesized the work of five initiatives and multiple independent contractors to assist the Commission in understanding its progress toward meeting the goals of the Strategic Plan. While each chapter provides initiative-specific recommendations, a meta-analysis of the findings yielded a number of cross-Commission recommendations.

Recommendation #1: Increase the visibility of the First 5 Commission of San Diego

There are still many policymakers, service providers, and community members who are unaware of both the importance of the first five years and First 5 San Diego's role in supporting young children and their families. Increasing this awareness is critical to developing community support for its families, as well as the role of the Commission. This year, the Commission undertook a comprehensive review of its communications plan. Following the plan recommendations will enhance the effectiveness of First 5 communications and outreach efforts.

Recommendation #2: Improve communication and collaboration between Commission funded initiatives and activities

The Commission has excelled at facilitating communication and connections within its projects. However, it is just beginning to facilitate this same communication and connection among its funded activities. This past fiscal year, Program Managers began facilitating meeting this fiscal year to establish more formal connections among the initiatives. The Commission would do well to continue and expand this role and to seek new ways to connect Commission activities.

Recommendation #3: Continue to support and expand ongoing learning through the creation and support of learning communities

Contractors continue to benefit from regular meetings and opportunities to share challenges and successes. Initiative meetings should be more than reporting contractual issues and include a collective learning process. In addition to within-initiative meetings, some contractors have requested cross-initiative meetings, similar to the all-grantee meetings the Commission sponsored in previous years. These all-contractor meetings could support learning communities and increase collaboration as discussed in recommendation #2, above.

Recommendation #4: Provide technical assistance to grantees and contractors to develop sustainability plans

Over the past three years, most grantees and contractors have struggled to identify funding sources beyond First 5 to sustain their programs. Some may have expected continued First 5

funding and consequently, these providers may not have looked for alternate funding sources. Most providers would benefit from Commission assistance in sustainability. The Commission should view facilitating sustainability as one of their roles to support and enhance services for young children and their families. This support could consist of sustainability activities as a standing agenda item for contractor meetings. Such meetings allow for networking between contractors other local and regional foundations, and searching for and forwarding grant opportunities to contractors.

Recommendation #5: Develop the Commission's leadership role as an advocate for children ages 0-5 and their families

The Commission has the unique opportunity to expand its role as a funder and champion important issues of young children. This leadership role could be expanded in two key ways:

***Advocate for First 5 Issues*:** The Commission could advocate for issues of critical importance to young children and their families. For example, the Commission could advocate for programs that would increase the number of pediatric dentists, bilingual speech therapists and behavior specialists who work with the preschool population.

***Advocate for First 5 funded programs*:** Continue to utilize the Commission's unique role in the County to assist projects with system-level challenges that impede their ability to serve families to their fullest extent. Examples of this include working with other county health insurance enrollment services to target and improve outreach efforts.

Recommendation #6: Support Lead/Subcontractor relationship

A number of newer initiatives include a lead/subcontractor relationship to structure the Commission's funded work. In this structure, the Commission only communicates with the lead agency, which is responsible for their subcontractors. It is an effective and efficient structure for regular day-to-day functioning and contractual issues, but has also created some challenges that could be remedied through two key activities. First, some initiative components were not fully implemented because the Commission was not part of the review of subcontractor scopes of work. For example, care coordination in the Oral Health Initiative is a missing component for some subcontractors, which is ultimately an initiative flaw. The Commission should consider reviewing all subcontractor scopes of work to ensure that the initiative's key components are present. Second, lead contractors are now in a new position, required to lead both in developing their respective initiative components and in holding subcontractors responsible for theirs. The Commission should (and in fact is already working on) connecting leads to the County's Contracting and Purchasing Department to conduct a subcontractor management in-service to support their new role.

Recommendation #7: Ensure the cultural and linguistic effectiveness of contractors

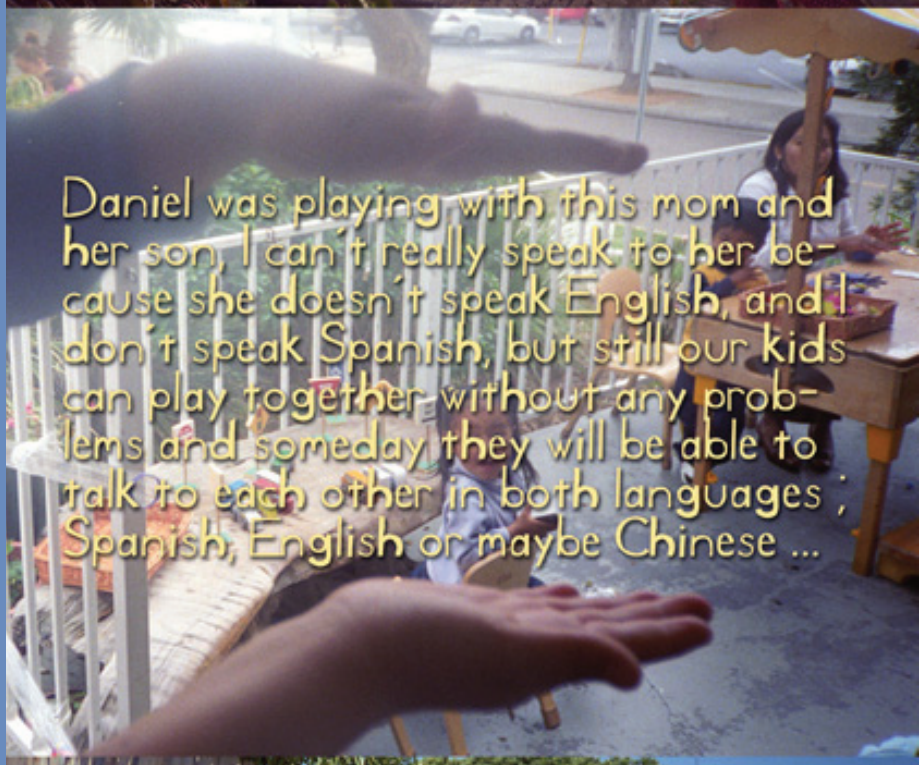
It is the expressed intent of the Commission to be both culturally and linguistically sensitive to the San Diego County community. Although this is embedded in their work and expected of its contractors, there has not been an assessment to ensure that these services are culturally and

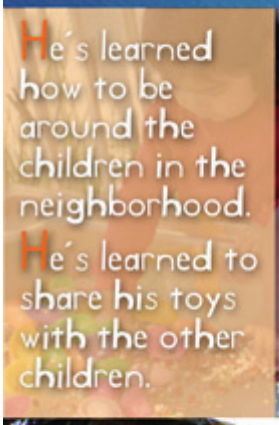
linguistically responsive. The Commission should consider conducting a review of the quality and effectiveness of this aspect of their contractors' services and, as needed, assist contractors to develop needed competencies and skill sets. Such assessment should include the following key themes from which targeted trainings could be developed[1]:

- Evidence that a community assessment was conducted to identify cultural groups and their cultural backgrounds represented in the community.
- Program design and program services that reflect awareness, respect for, and inclusion of cultures as a context for providing program services (e.g., acknowledgment of cultural beliefs and practices, and the use of non-English languages as needed)
- For children who are English language learners, services that support the continuation of the development of the child's primary (home language), and English acquisition.
- Development of partnerships between practitioners and parents.
- Evidence of professional staff development and training on cultural competency and care including cross-cultural communication.

[1] Themes were developed in consultation with Dr. Alfonso Rodriguez, Research Director of Neighborhood House. Dr Rodriguez co-lead a grant for the Department of Health and Human Services for Head Start cultural competency trainings and is a noted expert in the field.

Families of all backgrounds frequent the drop-in early learning center at ***Oceanside School District's School Readiness Program, "LISTOS"***. One mother noted the diversity of the families who she has met at the LISTOS center: "…Black, White, Spanish, Asian, from different countries…all different kids from different countries…moms, dads, and the nanny. Everyone is there."





LISTOS
PARENT-CHILD CENTER
Oceanside Unified School District

For more info
Call: 766-966-1923

First 5 San Diego
First 5 Commission of San Diego County
Improving the lives of children 0 to 5

Located in a cottage just blocks from the Pacific Ocean, the ***Oceanside School District's School Readiness Program, "LISTOS"***, is a drop-in early learning center. The living room is lined with books, art projects and other activities, and an aquarium fills the fireplace. Nearly every item is labeled in English and Spanish, and bilingual directions for parents explain how to engage children at each work station. Many of the center's families moved to San Diego County from rural Mexico. Mothers recall how in Mexico their children - even the very young ones - were free to explore the countryside, and that their homes were more spacious than the apartments and trailers that they now rent in Oceanside. They explain how LISTOS has become a second home; some come every day the center is open. Here, children have room to run and jump and play, and parents do not worry that a neighbor or landlord might complain about the noise.

Appendix A
First 5 San Diego
Grantees and Contractors

Appendix A provides information on each of the programs funded by the First 5 Commission of San Diego County during FY 2005-2006. Each program description includes an overview of the services the program provides and contact information. Programs are listed by initiative/project, in line with the structure of this report.

1. Health Care Access Project (see Chapter 1)
- *Home Start, Inc. – South Region*
- *Neighborhood Healthcare - East Region*
- *North County Health Services - North Inland Region*
- *SAY San Diego, Inc. - Central Region*
- *SAY San Diego, Inc. - North Central Region*
- *Vista Community Clinic – North Coastal Region*

2. Oral Health Initiative (see Chapter 2)
- *Community Clinics Health Network*
- *San Diego State University Foundation: KPBS*
- *Community Health Systems, Inc.*
- *Family Health Centers of San Diego*
- *La Maestra*
- *Neighborhood Healthcare*
- *North County Health Services*
- *Vista Community Clinics*

3. Health and Developmental Services Project (see Chapter 3)
- *Rady Children's Hospital – North Coastal Region*
- *Rady Children's Hospital – North Central Region*
- *Family Health Centers of San Diego – East Region*
- *Family Health Centers of San Diego – Central Region*
- *Palomar Pomerado Health – North Inland Region*
- *South Bay Community Services – South Region*

4. Intergenerational Project (see Chapter 4)
- *Bayside Community Center*
- *Casa de Amparo*
- *Grossmont Cuyamaca Community College District*
- *Jewish Family Service of San Diego*
- *Neighborhood House Association*
- *South Bay Community Services*
- *St. Clare's Home Little Angels Learning Center*
- *YMCA Childcare Resource Service*
- *YMCA Youth & Family Services*

5. School Readiness Initiative (see Chapter 5)

- *Cajon Valley Union School District*
- *Chula Vista Elementary School District*
- *Escondido Union School District*
- *National School District*
- *Oceanside Unified School District*
- *San Diego Unified School District*
- *San Ysidro School District*
- *Vista Unified School District*

6. Non-initiative contractors and activities (see Chapter 6)

- *Community Strengthening and Awareness*
- *Provider Capacity Building and Support*
- *Systems Change*
    - *Capital Campaign*
    - *Innovative Grants*
    - *2-1-1 San Diego*

1. Healthcare Access Project

Home Start, Inc. **South Region** Home Start utilizes a one-door community-based approach to provide bilingual/culturally competent access to healthcare services through Family Resource Center's, school, business partners, County Health and Human Services Agency's, Public Health, hospitals and clinics.	**Contact Name:** Silvia Garcia **Phone:** (619) 422-9208 Ext.5462 **Email Address:** sgarcia@home-start.org **Website Address:** www.home-start.org
Neighborhood Healthcare **East Region** Neighborhood Healthcare provides education, outreach, retention, and healthcare application assistance for children and pregnant women in the East region.	**Contact Name:** DeWan Gibson **Phone:** (619) 517-7993 **Email Address:** DeWang@nhcare.org **Website Address:** www.nhcare.org
North County Health Services **North Inland Region** North County Health Services is the lead in a partnership with Neighborhood Healthcare, Fallbrook Family Health Center and Palomar Pomerado Home Health in a collaborative that increases and sustains insurance enrollment and retention in San Diego County's North Inland region. North County Health Services also links clients to medical homes, and support their service utilization.	**Contact Name:** Michelle Weedon **Phone:** (760) 736-8661 **Email Address:** Michelle.weedon@nchs-health.org **Website Address:** www.nchs-health.org

SAY San Diego, Inc. **Central Region** This program provides healthcare outreach and insurance enrollment and retention activities across the Central region of San Diego County in collaboration with Family Health Centers of San Diego, San Diego Youth and Community Services, San Diego Family Care, Horn of Africa, O'Farrell Family Support Services and the Crawford Community Connection.	**Contact Name:** Lynnae Milo **Phone:** (619) 582-9056 Ext. 234 **Email Address:** lmilo@saysandiego.org **Website Address:** www.saysandiego.org
SAY San Diego, Inc. **North Central Region** This program provides outreach activities to locate families that need health insurance for their children. Certified Application Assistants help identified families enroll in low or no-cost healthcare plans. Program staff then follow the families to ensure they are maintaining insurance coverage and accessing health care services for their children. The program serves the North Central region of San Diego County in collaboration with Linda Vista Health Care Center, Bayside Community Center, North Clairemont Healthy Start and Center for Community Solutions.	**Contact Name:** Sandra Simmer **Phone:** (858) 974-3603 **Email Address:** sandra@saysandiego.org **Website Address:** www.saysandiego.org
Vista Community Clinic **North Coastal Region** Vista Community Clinic provides outreach and support services that increase insurance enrollment and retention in North Coastal San Diego County, in collaboration with North County Health Services and the Council of Community Clinics.	**Contact Name:** Rosie Rodriguez **Phone:** (760) 407-1220 Ext. 126 **Email Address:** rosie@vistacommunityclinic.org **Website Address:** www.vistacommunityclinic.org

2. Oral Health Initiative

Community Clinics Health Network (Direct Services)

Contact Name:
Christy Rosenberg
Phone:
(619) 542-4321
Email Address:
crosenberg@ccc-sd.org
Website Address:
www.ccc-sd.org

The purpose of the Oral Health Initiative (OHI) is to increase the number of children 0-5 in San Diego County who are free from oral health disease. Fourteen community health centers provide oral health prevention, education, care coordination and/or treatment services. The initiative also draws on the capacity and expertise of specialized public and private partners to provide tertiary treatment services, provider education and other system improvement activities. Partners for this project include:

Clinical programs:

- Comprehensive Health
- Family Health Centers
- Imperial Beach Health Center
- Indian Health Council
- La Maestra Health Center
- Mountain Health
- Neighborhood Healthcare
- North County Health Services
- Operation Samahan
- San Diego American Indian
- San Diego Family Care
- San Ysidro Health Center
- Southern Indian Health
- Vista Community Clinic

Other programs:

- Children's Hospital
- County Office of Ed., SMILES
- Share the Care
- Technical advisors

San Diego State University Foundation: KPBS **(Health & Oral Health Campaign)** In partnership, KPBS & KGTV have developed projects focusing on strengthening a parent's ability to help their children become ready-to-learn , increasing children's immunizations (Immunization campaign), and increasing awareness of health and oral health issues for children (Health & Oral Health Campaign), using interstitials, newscasts, radio programs, print materials, and online content.	**Contact Name:** Cathy Lloyd **Phone:** (619) 594-7152 **Email Address:** Clloyd@kpbs.org **Website Address:** www.kpbs.org
Community Health Systems, Inc. **(Oral Health Capacity Building)** Community Health Systems, Inc. has expanded dental capacity for children 0-5 and pregnant women in the Inland North County. These efforts included relocating the Fallbrook Family Health Center (FFHC) dental clinic to a larger site and adding pediatric dental suite dental suite including two operatories.	**Contact Name:** Leticia Bermudez **Phone:** l.bermudez@chsica.org **Email Address:** (760) 731-7778 **Website Address:** http://www.chsihealth.org
Family Health Centers of San Diego **(Oral Health Capacity Building)** Family Health Centers of San Diego, San Diego's largest community health center, is in the process of constructing two pediatric operatories at the Logan Heights Family Health Center (LHFHC) Dental Clinic to exclusively serve ethnically diverse, low-income children from infancy through age five. In addition, the project also includes reconstruction of the dental clinic common areas to accommodate the anticipated increase in patients.	**Contact Name:** Fran Butler-Cohen **Phone:** (619) 515-2301 **Email Address:** franb@fhcsd.org **Website Address:** http://www.fhcsd.org
La Maestra Community Health Centers (LMCHS) **(Oral Health Capacity Building)** La Maestra Community Health Centers provides oral health services for children 0-5 and pregnant women. Through its capacity building project, La Maestra Dental Clinics has increased services to low-income children ages 0-5 and pregnant women through two measures: 1) installation of two pediatric operatories; and 2) the provision of culturally and linguistically sensitive training for all staff directly serving LMDC low-income patients who are either children ages 0-5 or pregnant women.	**Contact Name:** Alejandrina Areizaga **Phone:** (619) 584-1612 **Email Address:** aleareisaga@lamaestra.org **Website Address:** http://www.lamaestra.org
Neighborhood Healthcare **(Oral Health Capacity Building)** Provide oral health services for children ages 0-5 and pregnant women in East and North Inland County through installation of pediatric dental operatory in Lakeside and purchasing of pediatric-focused dental equipment to increase patient capacity in Escondido.	**Contact Name:** Doreen Gagnon **Phone:** (760) 520-8328 **Email Address:** doreeng@nhcare.org **Website Address:** http://www.nhcare.org
North County Health Services (NCHS) **(Oral Health Capacity Building)** NCHS is a federally designated 329/330 Community/Migrant Health Center located in north San Diego County. NCHS has expanded their capacity to provide oral health services for patients 0-5 and pregnant women through its expansion, to build-out/renovate and equip three new dental operatories. In addition to direct care services, patients receive oral health education.	**Contact Name:** Sylvia Aguirre-Aguilar **Phone:** (760) 736-8669 **Email Address:** saguirre-aguilar@nchs-health.org **Website Address:** http://www.nchs-health.org
Vista Community Services **(Oral Health Capacity Building)** The purpose of the proposed project is to expand the capacity of Vista	**Contact Name:** Dorothy Lujan **Phone:**

Community Clinic (VCC) to provide oral health services to low-income, uninsured children, ages 0-5, and pregnant women, in coastal north San Diego County. Two additional dental operatories were added to the Vale Terrace clinic site in Vista. This included the purchase of equipment, instruments, and start up supplies. This proposed expansion has increased capacity to six (6) dental operatories. The funding has provided for deeper penetration and expansion of the preventive oral health component of VCC, which is designed to intervene before children are affected by dental diseases such as baby bottle tooth decay, painful dental caries, and other dental diseases, and to prevent disease progression.	(760) 631-5000 Ext. 1133 **Email Address:** dorothy@vistacommunityclinic.org **Website Address:** http://www.vistacommunityclinic.org

3. Health and Developmental Services Project

Rady Children's Hospital **North Coastal Region** Rady Children's Hospital provides a comprehensive continuum of health, developmental, behavioral, vision, hearing, and speech screening, and treatment services to all newborns of first-time children ages 0-5 living in greatest poverty. Partners for this project include: • Chadwick Center for Children & Families-CHSD • Children's Care Connection (C3)-CHSD • Exceptional Family Resource Center • Home Start • North County Health Services • Palomar Pomerado Hospital-Welcome • Speech & Language Department-CHSD • Vista Community Clinic • YMCA-Childcare Resource Service	**Contact Name:** Vyan Nguyen, MD. **Phone:** (858) 576-1700 Ext. 6577 **Email Address:** vnguyen@chsd.org **Website Address:** www.chsd.org
Rady Children's Hospital **North Central Region** Rady Children's Hospital provides a comprehensive continuum of health, developmental, behavioral, vision, hearing and speech screening, assessment and treatment services to all newborns of first-time mothers and children ages 0-5 living in greatest poverty. Also, children 0-5 entering foster care through PCC or direct placement into homes across San Diego County will have access to developmental and behavioral assessment. Partners for this project include: • Chadwick Center for Children & Families-CHSD • Children's Care Connection (C3)-CHSD • Developmental Screening and Enhancement Program-CAPF & CHSD • Exceptional Family Resource Center • Home Start • Naval Medical Center-San Diego • Palomar Pomerado Hospital- • Welcome Home Baby • SAY San Diego Healthy Start Military Family Cluster • Shiley Eye Mobile-UCSD • Speech & Language Department-CHSD • Union of Pan Asian Communities (UPAC) • YMCA-Childcare Resource Service	**Contact Name:** Jeanne Gordon **Phone:** (858) 966-1700 Ext. 7644 **Email Address:** jngordon@chsd.org **Website Address:** www.chsd.org

Family Health Centers of San Diego **East Region** Provide a comprehensive continuum of health, developmental, behavioral, vision, hearing, speech screening, assessment and treatment services to all newborns of first-time mothers and children ages 0-5 living in greatest poverty. Partners for this project include: • Exceptional Family Resource Center • Welcome Home Baby • Shiley Eye Center • YMCA Childcare Resource Service • Home Start, Inc. • San Diego Center for Children • KIT Inc.	**Contact Name:** Richard Beadleston **Phone:** (619) 515-2590 **Email Address:** richardb@fhcsd.org
Family Health Centers of San Diego **Central Region** Provide coordinated delivery of a host of child health & development services for children 0-5 in Central Region, including new-baby home visitation, health & developmental screenings, developmental treatment services (e.g., Speech, OT, PT, behavioral), parent support and empowerment, and consultation and assistance to Early Care & Education providers and related families. Collaborative partners: • Exceptional Family Resource Center • Welcome Home Baby • Union of Pan Asian Communities (UPAC) • Shiley Eye Center • YMCA Childcare Resource Service • Home Start, Inc. • San Diego Center for Children • KIT Inc.	**Contact Name:** Richard Beadleston **Phone:** (619) 515-2590 **Email Address:** richardb@fhcsd.org
Palomar Pomerado Health **North Inland Region** Provide a comprehensive continuum of health, developmental, behavioral, vision, hearing, speech screening, assessment treatment services to all newborns of first-time mothers children ages 0-5 living in greatest poverty. Partners project include: • Welcome Home Baby • Exceptional Family Resource Center • North County Health Services • Children's Hospital and Health Center • YMCA Childcare Resource Service	**Contact Name:** Annamarie Martinez **Phone:** (760) 796-6859 **Email Address:** Annamarie.Martinez@pph.org

South Bay Community Services
South Region

Provide a comprehensive continuum of health, developmental, behavioral, vision, hearing, speech screening, assessment and treatment services to all newborns of first-time mothers and children ages 0-5 living in greatest poverty. Partners for this project include:

- Exceptional Family Resource Center
- Episcopal Community Services
- Children's Hospital & Health Center
- Paradise Valley Hospital
- Operation Samahan
- Imperial Beach Health Center
- Chula Vista Community Collaborative
- National City Collaborative
- Reachout to Families Collaborative
- San Ysidro Health Start Collaborative
- Parents as Teachers
- American Lung Association
- MCSD
- YMCA Childcare Resource Service
- Shiley Eye Center
- UCSD – Division of Community Pediatrics

Contact Name:
Jo Ann Leone
Phone:
(619) 420-3620 Ext. 157
Email Address:
jleone@csbcs.org
Website Address:
www.southbaycommunityservices.org

4. Intergenerational Project

Bayside Community Center
Giant Steps – Generation to Generation

The Giant Steps program (described above) was expanded to incorporate a senior mentor literacy component for children 0-5. The seniors read to children, and promote literacy and a love of learning in low-income children 0-5 in the Linda Vista community. Whenever possible, senior mentors include parents in the literacy component.

Contact Name:
Monica Fernandez or Nancy Coate
Phone:
(858) 278-0771
Email Address:
mfernandez@baysidecc.org
ncoate@baysidecc.org
Website Address:
www.baysidecc.org

Casa de Amparo **Take 5 for Tots** The Senior Mentor Volunteer program at Casa de Amparo, an agency providing a continuum of services for abused and neglected children and their families in the North County area of San Diego County, provides additional support and resources to children, families, and staff. The Senior Mentors support two different programs: the Child Development Center (a therapeutic preschool & child care center with an emphasis on child abuse prevention by stabilizing the complete family system) and Casita de Amparo (an emergency residential group home that provides a safe, nurturing, therapeutic, and developmentally focused environment for children who have been removed from their homes due to abuse/neglect.) The Take 5 for Tots program focuses on 1) Senior Mentors creating meaningful relationships with these children in order to help them develop trusting relationships with adults and on 2) Senior Mentors participating in individual and small group activities with the children in order to improve overall development, including self-confidence, socialization skills, and beginning reading skills.	**Contact Name:** Chelle Sutyak or Lori Piccirillo **Phone:** Chelle – (760) 754-5500 Ext. 21 Lori – (760) 754-5800 **Email Address:** csutyak@casadeamparo.org lpiccirillo@casadeamparo.org **Website Address:** www.casadeamparo.org
Grossmont Cuyamaca Community College District **Grossmont College Child Development and Family Studies Department** The Seniors 4 Kids Program is part of the Child Development and Family Studies Program at Grossmont College. The primary emphasis is helping young children with early earning and pre-reading activities for school readiness in nine sites throughout the county.	**Contact Name:** Lorraine Martin or Barbara Fletcher **Phone:** Lorraine – (619) 644-7891 Barbara – (619) 644-7398 **Email Address:** lorraine.martin@gcccd.net barbraf@msn.com
Jewish Family Services of San Diego **The Wisdom Alliance** The Wisdom Alliance is a home visiting program for low-income families with 1-4 year olds, providing parents with the modeling of critical parent-child interaction designed to prepare the whole family for a successful school experience. Senior mentors visit the families and engage in play sessions with the parent(s) and child(ren) together per the Parent-Child Home Program curriculum. They also visit an alternative high school for teen parents.	**Contact Name:** Cheryl Alexander or Alison Roland **Phone:** Cheryl - (760) 944-7855 Alison – (760) 944-7855 Ext.139 **Email Address:** cheryla@jfssd.org alisonr@jfssd.org **Website Address:** www.jewishfamilyservicesd.org
Neighborhood House Association **Project Generation A to Z (PGAZ)** Senior volunteers provide enhanced literacy services to special needs children and other Head Start children. Seniors offer literacy instruction to children, read to entire classrooms and instruct literacy group activities related to core curriculum.	**Contact Name:** Lenette Javier **Phone:** (858) 715-2642 Ext. 269 **Email Address:** ldimitui@neighborhoodhouse.org **Website Address:** www.neighborhoodhouse.org
South Bay Community Services **Enhancing School Readiness of Children Traumatized by Domestic Violence and/or Homelessness** Program activities target families with children 0-5 residing in South Bay Community Services domestic violence shelters and transitional living facilities. Senior mentors are trained to work with children and their families who have been	**Contact Name:** Jo Ann Leone or Nancy Pratt **Phone:** Jo Anne – (619) 420-3620 x157 Nancy – (619) 420-0166 **Email Address:** jleone@csbcs.org npratt@csbcs.org

traumatized by domestic violence and/or homelessness, and work with a child development specialist to provide parenting classes and play groups on-site. They also work with 0-5 year olds and their mothers on activities that enhance literacy and increase the confidence of parents to support school readiness.	**Website Address:** www.southbaycommunityservices.org
St. Clare's Home Little Angels Learning Center **Intergenerational Learning Program** This program increases learning and reading readiness of children 0-5 by enriching their daycare experience and educating their mothers on how to better prepare their children for school. Seniors implement specific educational activities under the supervision of program personnel in the classroom.	**Contact Name:** Jennifer Enriquez or Jessica Adamo **Phone:** Jennifer - (760) 738-7099 Jessica – (760) 741-0122 Ext. 107 **Email Address:** Jennifer - littleangelctr@sbcglobal.net Jessica - grantwriter@stclareshome.org **Website Address:** www.stclareshome.org
YMCA Childcare Resource Service **HealthLine Intergenerational Program** Seniors will culturally and linguistically augment the HealthLine Services Department programs by assisting with workshops, hearing exams and developmental assessments, and also by providing general classroom and on-going one-on-one support with children enrolled in childcare who are receiving behavioral health services.	**Contact Name:** Catherine Padilla **Phone:** Catherine – (619) 521-3055 Ext. 2326 **Email Address:** cpadilla@ymcacrs.org **Website Address:** www.ymcacrs.org
YMCA Youth & Family Services **Kinship Support Services Program-KSSP** This program works with kinship families providing critical assistance to help keep families together. KSSP offers support and resources to families, ensuring children 0-5 remain with relatives and out of the formal foster care system. Seniors conduct home visits, organize and facilitate enrichment and school readiness activities, and offer needed support to the relative caregivers involved in the Kinship Program.	**Contact Name:** Annie Moore or Vanessa Potier Watts **Phone:** (619) 691-1331 **Email Address:** amoore@ymca.org vpotierwatts@ymca.org **Website Address:** http://yfs.ymca.org/ymcasd_fscs.htm

5. School Readiness Initiative

Cajon Valley Union School District This program serves two elementary schools. Twice-monthly playgroups are available for two age groups at each school. KinderCamp Pre-Kindergarten Academies offer instruction for children who have not had a preschool experience and who may be at risk for school failure. Parent resources include home-based parenting instruction provided by Parents as Teachers (PAT), and a Community Based English Tutoring (CBET) Program as well as regularly offered educational series for parents and caregivers. Also provided are a behavioral specialist, nurse, a speech therapist, and a Family Resource Center.	**Contact Name:** Virginia Pinkerton **Phone:** (619) 593-4576 **Email Address:** pinkertonv@cajonvalley.net **Website Address:** www.cajonvalley.net

Chula Vista Elementary School District Provides outreach to eight elementary schools with activities such as Kinder Camp, the Latino Family Literacy Project and Listos para Leer. Other programs and services include Family Readiness Advocates, the Early Intervention Mental Health Care and the Spirit of Caring Mobile Health Care Clinic. Promotoras (outreach workers) from the Family Resource Center conduct community-based outreach and referrals. Training in Enhanced Transition to Kindergarten is available to local agencies.	**Contact Name:** Barbara Rensink or Nancy Kerwin **Phone:** Barbara - (619) 425-9600 Ext. 1760 Nancy - (619) 425-9600 Ext. 1511 **Email Address:** brensink@cvesd.k12.ca.us nkerwin@cvesd.k12.ca.us **Website Address:** www.cvesd.k12.ca.us
Escondido Union School District Serves seven elementary schools. Family resources are provided including Parent/Child Education Classes, the Parent/Child Activity Center, Parent Resource Library, parent education, parent to parent support, and home-based services. Early Literacy classes, KinderPrep Classes, a KinderPrep Summer Program, and Kindergarten Transition and Orientation are available as well as the Resource Library for pre-school and care providers . The program offers a variety of screenings including behavior and health consultation, vision, hearing, dental, nutrition, development and health screenings, and behavior support services to families, care providers, and preschools.	**Contact Name:** Jan Zelasko **Phone:** (760) 489-4131 **Email Address:** jzelasko@eusd4kids.org **Website Address:** www.eusd4kids.org
National School District ReadySet-Learn! is a classroom-based program that serves five elementary schools. The program encompasses various smaller projects including the Community-Based English Tutoring (CBET) Family Literacy Program, the Parents As Teachers (PAT) Program, and school-based Pre-Kindergarten Academies. The National School District Family Resource Center and Health Team coordinate linkages to social services, speech and hearing screenings, health examinations and education, and referrals. Access to the Words on Wheels (WOW) Mobile Library is also available.	**Contact Name:** Rita Palet **Phone:** (619) 336-8672 **Email Address:** rita.palet@national.k12.ca.us **Website Address:** http://nsd.us/
Oceanside Unified School District Serves four elementary schools through the Listos(Ready) Learning Center. This drop-in center is designed to be an educational supplement for preschool age children and a precursor to preschool for children ages 0-3. The district partners with community service providers to bring health and social services to the center. Family support services are provided through Mommy and Me classes, prenatal education, insurance enrollment, and case management for families in crisis. Health services include dental screenings, wellness checks, and follow-up on family referrals for direct medical treatment. Community Based English Tutoring (CBET) is available.	**Contact Name:** Maria Theresa (Teri) Porter **Phone:** (760) 966-1923 **Email Address:** tporter@oside.k12.ca.us **Website Address:** www.oside.k12.ca.us

San Diego Unified School District Early Link serves 19 elementary schools in 36 classrooms. The program provides an Infant/Toddler Center, a preschool for deaf and hard of hearing children, a blind preschool program, use of the Pebble Soup Curriculum and the Second Step Program. A preschool coach will provide on-site training, and there is a Kindergarten Transition Program. In addition, there are Teen Parent Education services. Other parent resources include a Community Based English Tutoring (CBET)/ English as a Second Language (ESL) Program, Parent University, and Family Literacy Instruction. Vision and dental screenings are available, along with a family service specialist, a behavioral psychologist, and behavioral counseling as well as child development counseling. Special needs referrals are provided.	**Contact Name:** Carol Berridge **Phone:** (858) 496-8126 **Email Address:** cberridg@mail.sandi.net **Website Address:** http://www.sandi.net/
San Ysidro School District Serving five schools, this program provides a family literacy program, First Steps for Preschool and District Preschool (a program for families that are not eligible for State Preschool). Parenting resources are found in the Family Advocates for Home Visit Program and in the Parent Institute. A School Readiness facilitator/case manager coordinates services at the Children and Family Resource Center. Consejeras (counselors) from Por La Vida provide parenting programs. Parent training is also available via the Hope Infant Program. Health and developmental screenings are available, as are a behavior specialist, a psychologist and a speech therapist.	**Contact Name:** Stella Ohnersorgen **Phone:** (619) 428-4476 Ext. 3583 **Email Address:** sstella@sysd.k12.ca.us **Website Address:** www.sysd.k12.ca.us
Vista Unified School District La Senda al Futuro (The Pathway to the Future), serves Olive Elementary School. La Senda provides parent education and developmentally appropriate pre-school services to 4-year-old children with sub-standard childcare or that receive no services. Instruction in parenting skills, positive discipline, kindergarten expectations, developmental activities, leadership, and healthy lifestyles to remove barriers to school success is offered to parents and caregivers. Health, speech, language, and psychological screenings are available, and referrals to available and appropriate services are given. Professional development training is provided to instructional and support staff.	**Contact Name:** Analilia Sanchez **Phone:** (760) 724-7129 Ext. 5310 **Email Address:** analilia325@cox.net **Website Address:** www.vusd.k12.ca.us

6. Non-initiative Contractors and Activities Community Strengthening and Awareness

San Diego State University Foundation: KPBS (Health & Oral Health Campaign) In partnership, KPBS & KGTV have developed projects focusing on strengthening a parent's ability to help their children become ready-to-learn increasing children's immunizations (Immunization campaign), and increasing awareness of health and oral health issues for children (Health & Oral Health Campaign), using interstitials, newscasts, radio programs, print materials, and online content.	**Contact Name:** Cathy Lloyd **Phone:** (619) 594-7152 **Email Address:** Clloyd@kpbs.org **Website Address:** www.kpbs.org

UCSD Regional Perinatal System **Kit for New Parents: San Diego Welcome Baby Program** **(Direct Services)** Develops partnerships with local agencies to distribute the Kit for New Parents to new mothers in San Diego County. Packaged in a colorful box, the Kit includes six parenting videos, parenting education brochures, and a resource guide.	**Contact Name:** Lizette Lozano **Phone:** 858) 536-5090 Ext. 113 **Email Address:** lglozano@ucsd.edu **Website Address:** www.regionalperinatalsystem.org

Provider Capacity Building and Support

YMCA Childcare Resource Service: **San Diego CARES Program** This program works to improve the quality of local childcare and encourage professional development by providing monetary stipends to early care and education (ECE) providers for completing college units, attending school readiness training and obtaining a child development certificate.	**Contact Name:** Karen Shelby **Phone:** (619) 521-3055 Ext. 2300 **Email Address:** kshelby@ymcacrs.org **Website Address:** www.ymcacrs.org
Children's Hospital and Health Center: **Partnership for Smoke Free Families** Known as PSF, the Partnership for Smoke-Free Families program has created a highly successful model for systematically screening pregnant women and new mothers for tobacco exposure and linking them to targeted interventions. This model includes an expeditious process for clinicians that is easily replicated and does not create a burden on the health care system. Key elements include: standardized screening system; consistent messages from clinicians across the childbirth continuum; proactive links to interventions; transparent, seamless interventions delivered from outside the clinician's office, but seemingly come from the clinician; collaboration with community partners; clear, concise, and simple roles for clinicians and office staff members; a focus on staff and clinician retention in the program and retraining; and dedicated program staff.	**Contact Name:** Nicole Howard **Phone:** (858) 576-1700 Ext. 3547 **Email Address:** nhoward@chsd.org **Website Address:** www.smokefreefamilies.org

Systems Change

Capital Campaign

California State University San Marcos Foundation: Cal State San Marcos Center for Children and Families	Grant Hubbard (760) 750-4701
Child Abuse Prevention Foundation (Polinsky Children's Center): Serenity Cottage	Tonya Torosian (858) 278-4400
Chula Vista Elementary School District: New Beginnings Child Development Program & Pre-School Program	Nancy Kerwin (619) 425-9600 Ext. 1511
Fallbrook Union Elementary School District: Fallbrook Early Childhood Learning Center	Stacy Everson (760) 723-7018
Family Health Centers of San Diego: Expansion & Integration of Child Development, Pediatrics. Obstetric & Health Ed. Services	Fran Butler-Cohen (619) 515-2301
INFO Line of San Diego County: 2-1-1 Capital Endowment Project	Betty Timko (858) 300-1302
Mental Health Systems, Inc.: The Family Recovery Center	Richard Bradway (760) 439-6702
National School District: Preschool/School Readiness Program	Rita Palet (619) 336-8672

Neighborhood Health Care: Neighborhood Healthcare Capital Project	DeWan Gibson (619) 520-8313
North County Health Services: NCHS Encinitas Maternal & Child Health Center	Michelle D. Weedon (760) 736-8661
Operation Samahan: Samahan Clinic Perinatal and Pediatric Care Project	Fe Seligman (619) 477-4451
San Diego Family Care: Reproductive Health Pavilion Equipment Project	Roberta Feinberg (858) 279-9676
San Diego Public Library: Preschooler's Door to Learning Centers	Esther Siman (619) 702-8702
San Ysidro Health Center, Inc.: Maternal Child and Health Center	Ed Martinez (619) 662-4104
San Ysidro School District: Sunset Preschool	Stella Ohnersogen (619) 428-4476 Ext. 3583
Scripps Mercy Hospital: Enhancing Capacity for Healthy Babies	Tom Gammiere (619) 686-7100
St. Andrews Parish Day School: Project Playground	Moira Douglas (619) 469-5330
St. Vincent de Paul Villages: Child Development Center	Mathew Packard (619) 687-1031
U.S. Department of Navy, Navy Region Southwest Child Development Centers	Cyndy Padilla (619) 556-9752

Innovative Grants

AMERICAN LUNG ASSOCIATION OF SD & IMPERIAL COUNTIES **Asthma Tele-Counseling** Provides asthma education and coordination services for families of children ages 0-5 with asthma who live in North County, East County and rural areas.	**Contact Name:** Lorna Hardin **Phone:** (619) 297-3901 **Email Address:** lorna@lungsandiego.org **Website Address:** www.lungusa.org
Home Start, Inc. **Project Priority: A Parent-Child Relationship Program for Military Families** Provide Parent-Child Interaction Therapy (PCIT) and parent education/process groups to strengthen families with children ages 18 months to 5 years old and who are affected by the war in the Middle East.	**Contact Name:** Layla Ines Davis **Phone:** (619) 692-0727 **Email Address:** ldavis@home-start.org **Website Address:** www.home-start.org
JEWISH FAMILY SERVICE OF San Diego **Preschool in the Park** Offers parenting instruction, community-based early learning preparation, medical access and play for children ages 0-5 and their parents. It will also provide weekly theme-based curricula to encourage learning, socialization, fine and gross motor skills, and emotional and intellectual growth.	**Contact Name:** Cheryl Alexander **Phone:** (760) 944-7855 **Email Address:** cheryla@jfssd.org
JOY OF SPORTS FOUNDATION **Healthy Preschoolers Program** Combats childhood obesity at the pre-school level by providing physical activity and nutritional education for children, parents and Head Start staff.	**Contact Name:** Molly Moran **Phone:** (619) 294-9585 **Email Address:** molly@joyofsports.org

La Cuna, Inc. **Individualized Therapy and Support Project** Provide a therapist to work with La Cuna's foster children to ensure their social and emotional development is not stifled by their early life experiences. It will also provide ongoing, consistent and intensive therapy to all of its foster parents and children.	**Contact Name:** Rachel Humphreys **Phone:** (619) 521-9900 **Email Address:** rachel@lacuna.org **Website Address:** www.lacuna.org
Multi-Cultural Community and Family Services **Kinder Success Program** Addresses the lack of preschool experience to a majority of the refugee and immigrant children in San Diego County.	**Contact Name:** Amaka Okeke **Phone:** (619) 464-6417 **Email Address:** amaka@multiculturalcomm.org **Website Address:** www.multiculturalcomm.org
National School District **Comprehensive Behavior Intervention Program** Provides teacher training, parent education and ongoing comprehensive behavioral interventions for preschool age children with behavioral challenges.	**Contact Name:** Rita Palet **Phone:** (619) 336-8672 **Email Address:** ritap@national.k12.ca.us **Website Address:** www.nsd.us
Nile Sisters Development Initiative **HIPPY Refugee Innovative Grant Program** Provides staff and utilizes the Home Instruction for Parents of Preschool Youngsters Program to refugees in City Heights, North Park, Southeast San Diego, Linda Vista and El Cajon.	**Contact Name:** Elizabeth Hissen **Phone:** (619) 265-2959 **Email Address:** sistersinitiative@sbcglobal.net
Riding Emphasizing Individual Needs & Strengths (REINS) San Diego **Therapeutic Consulting Partnership** Provide therapeutic riding lessons to children with a variety of disabilities.	**Contact Name:** Shauna Jopes **Phone:** (760) 731-9168 **Email Address:** shauna@reinsprogram.org **Website Address:** www.reinsprogram.org
San Diego Family Care **Connections! Early Literacy Promotion Project** Expands the continuum of its existing pediatric care/well child care with a literacy component.	**Contact Name:** Roberta Feinberg **Phone:** (619) 563-0015 **Email Address:** Feinberg@cts.com **Website Address:** www.sdfamilycare.com
SDSU Foundation Exceptional Family Resource Center (EFRC) **Systematic Neonatal Intensive Care Unit Referral Project** Plan and develop written protocol/process for referring families of infants receiving care in the 13 countywide hospitals NICU for family support services.	**Contact Name:** Sherry Torok **Phone:** (619) 594-7394 **Email Address:** storok@projects.sdsu.edu **Website Address:** www.EFRConline.org

Social Advocates for Youth (SAY) San Diego, Inc. **Stepping Up Start Smart** Replicate the core Start Smart weekly parent/child interactive class model with additional innovative components of (a) collaborating with local housing managers to hold weekly classes at 4 low income apartment communities in the southeast/south central neighborhoods of San Diego, b) adding a second weekly class meeting at each site run as playgroup by the parents themselves, and c) introducing a formalized parent pledge engaging the parents' commitment to continue a positive learning environment at home.	**Contact Name:** Rachel Burnage **Phone:** 619-582-9056 Ext.236 **Email Address:** Rachel@saysandiego.org **Website Address:** www.saysandiego.org
South Bay Union School District **Reader's Theater: The Brain Game** Created and produced a bilingual Reader's Theater called The Brain Game, a 15-20 minute dramatization on what parents of 0-5 year olds can do to help a child's brain grow.	**Contact Name:** Reina Menasche **Phone:** (619) 628-0989 **Email Address:** menasche@sbusd.k12.ca.us **Website Address:** www.sbusd.k12.ca.us
St. Vincent de Paul Villages **Emergent Literacy for Families** Provides age-appropriate, computer based learning activities for children 1-5 and their parents who reside at St. Vincent de Paul Villages.	**Contact Name:** Anthony Griffin **Phone:** (619) 687-1031 **Email Address:** agriffin@neighbor.org **Website Address:** www.fatherjoesvillages.org
Whittier Institute **Project Dulce** Provides support to mothers of children 0-5 who are overweight, have gestational diabetes mellitus, and/or are high risk for diabetes/obesity by providing education, support and opportunities to learn & practice beneficial behaviors.	**Contact Name:** Elizabeth Bustos **Phone:** (858) 626-5638 **Email Address:** bustos.elizabeth@scrippshealth.org **Website Address:** www.whittier.org
YMCA of San Diego County **Child Care Nutrition and Physical Activity Certification Program** Creates a countywide Child Care Nutrition and Physical Activity Certification program to help child care providers create a healthier environment for children ages 0-5 in their care.	**Contact Name:** Layne Harlow **Phone:** (619) 521-3055 **Email Address:** lharlow@ymcacrs.org

Systems Change 2-1-1 San Diego

Info Line of San Diego County/2-1-1 San Diego **2-1-1 San Diego Implementation** Provides the new comprehensive, 24/7 information and referral line in San Diego County.	**Contact Name:** Betty Timko **Phone:** (858) 300-1302 **Email Address:** btimko@211sandiego.org **Website Address:** www.211sandiego.org

Appendix B
Further Notes about the Methodology

Harder+Company Community Research utilized a mixed methods approach for this evaluation. This approach, which combines quantitative (numbers) and qualitative (stories) methods was developed for two reasons: 1) no single data collection method can capture the impact of First 5 and 2) readers interact with data differently - some are drawn to "hard" numbers while others connect more with stories.

As in past years, the 2005-2006 evaluation plan was still coordinated by its adherence to the Evaluation Framework, however, the application of the Framework was tailored to each Commission initiative. Each initiative has at its center a quantitative data collection strategy to gather information about children, parents and/or service providers who participated in First 5 funded programs. These data collection strategies included parent surveys, child observation, and aggregated patient chart data. Additionally, the report includes quantitative data from a funded program survey, from the monthly or quarterly progress reports submitted to the Commission, from individual funded programs' evaluations when they were not part of an initiative, and secondary indicator data (including data from the First 5 San Diego Family Survey). These methods were complemented by qualitative methods to collect data from different vantage points and perspectives. Each initiative engaged parents and providers via these qualitative methods, which included case studies, focus groups, intercept interviews, participatory photography, and key expert ("stakeholder" interviews. Below is a detailed description of each method. Individuals desiring additional information about the evaluation's methodology are invited to contact Harder+Company Community Research directly at (619) 398-1980.

Quantitative Methods

The evaluation included three quantitative designs: 1) initiative-specific quantitative data collection strategies, 2) the funded program survey, and 3) secondary indicator data, including data from the 2005 Family Survey. Analysis of typically included basic descriptive statistics and, as appropriate, chi-square tests for statistical significance.

Initiative-Specific Quantitative Data Collection Strategies

Healthcare Access Initiative

Each Healthcare Access contractor engages in the same types of activities to achieve three goals:

1. Increase and sustain enrollment of eligible children ages 0-5 and pregnant women in existing health plans (Medi-Cal, Healthy Families, AIM)
2. Link enrollees to a medical home

3. Support the appropriate utilization of services ensuring that children and pregnant women receive preventative health services and families get the help they need to navigate the healthcare system.

Contractors collectively developed a survey to address the same five outcomes: 1) enrollment status, 2) linkage to a medical home, 3) utilization of health care, 4) utilization of dental care, and 5) utilization of the emergency room. The survey consists of 14 questions and was translated into Spanish. The survey is conducted at 6-, 12-, and 18-month intervals by the contractors' line staff during normally scheduled follow-up calls to all families they have enrolled. Paper copies of the survey were submitted to Harder+Company on a monthly basis and entered into a database. Additionally, HAI utilizes a excel spreadsheet tracking tool that each region submits monthly and that corresponds with the "number of people reached" table. It tracks the process numbers of assisted/confirmed enrollments, outreach activities, retention, etc. It also tracks the demographics of the population.

Exhibit B.1
Healthcare Access Initiative Evaluation Table

Data Elements	Related Goal(s)	Method of Collection
Demographic data		
Children ages 0-5: ethnicity, language, age, special needs	Goals 1-3	Tracking Tool
Process measures data		
Number of families with children 0 to 5 assisted and enrolled in Medi-Cal/Healthy Families	Goal 1	Tracking Tool
Number of children ages 0-5 assisted and enrolled in Medi-Cal/Healthy Families	Goal 1	
Number of pregnant women who are enrolled in Medi-Cal/AIM.	Goal 1	
Number of families with children ages 0-5 linked to a medical	Goal 2	
Number of children ages 0-5 linked to a medical home	Goal 2	
Number of families, pregnant women and children ages 0 to 5 reached through outreach and in-reach activities.	Goal 1	
Number of Welcome Baby Kits distributed to new parents.	Goal 3	
Number of children ages 0-5 assisted with reactivation and renewal of insurance enrollment	Goal 1	
Outcomes data		
Increase health insurance enrollment of eligible children 0 to 5 and pregnant women	Goal 1	Survey Administered at 6, 12, 18 month intervals
Increase the number of families with a medical home	Goal 2	
Increase the utilization of health care	Goal 3	
Increase the utilization of dental care	Goal 3	
Reduce the utilization of emergency room visits for non-emergency room purposes.	Goal 3	

Oral Health Initiative

The largest component of the Oral Health Initiative (OHI) relates to direct services, wherein more than a dozen subcontractors across the County provide oral health services in six goal areas:

1. Increase oral health screening of children 0-5 coupled with parent education
2. Increase the number of children 0-5 and pregnant women who received dental examinations
3. Increase the number of children 0-5 and pregnant women with identified oral health issues who receive appropriate treatment services/follow-up
4. Provide oral heath care coordination services such as referral, case management, and follow-up to children 0-5 and pregnant women
5. Increase the number of parents and other caregivers who are knowledgeable about how to promote children's oral health needs
6. Increase the number of providers who are knowledgeable about how to promote children's oral health.

These goals were further refined and expressed as process measures and outcomes. The evaluation centers on five outcomes: 1) identifying previously unidentified oral health concerns in children ages 0-5 and pregnant women; 2) reducing the proportion of children ages 0-5 and pregnant women with untreated dental decay; 3) increasing the proportion of children ages 0-5 and pregnant women who have visited a dentist in the past year; 4) Connecting children ages 0-5 and pregnant women with needed oral health services (exams, treatment, etc.); and 5) increasing providers' knowledge of how to promote the oral health of children ages 0-5.[1]

Each month OHI subcontractors report these data elements in aggregate. In the interest of minimizing duplicating data collection, each subcontractor tracks their data in the way that makes the most sense for their site (i.e. they track pre-defined data elements but the data "lives" in different places at each site.[2]) All subcontractors then report their aggregated monthly data in a customized, OHI Excel-based "tracking tool".

[1] "Providers" refers to prenatal care providers, general dentists, and other primary care providers.
[2] For example, there is a common OHI definition of "dental exam" but partners track exam data via billing software, appointment calendars, manual counts, or a combination of data tracking systems.

Exhibit B.2 Oral Health Initiative Evaluation Table		
Data Elements	**Related Goal(s)**	**Method of Collection**
Demographic data		
Children ages 0-5: ethnicity, language, age, special needs;	Goals 1-4	Tracking Tool
Process measures data		
Number of children ages 0-5 & pregnant women who receive oral health screenings	Goal 1	Tracking Tool
Number of children ages 0-5 & pregnant women who receive dental exams	Goal 2	
Number of children ages 0-5 & pregnant women who receive	Goal 3	
Number of children ages 0-5 & pregnant women who receive care	Goal 4	
Number of children ages 0-5 & pregnant women who receive	Goal 5	
Number of providers trained in relevant maternal & child oral health topics **	Goal 6	
Number & type of preventative services (sealants, fluoride	Goals	
Number & type of restorative services (fillings, crowns, extractions, pulpotomies) to children ages 0-5 & pregnant women	Goal 3	
Outcomes data		
Identify previously unidentified oral health concerns in children ages 0-5 & pregnant women	Goals 1-2	Tracking Tool
Reduce the proportion of children ages 0-5 & pregnant women	Goal 3	
Increase the proportion of children ages 0-5 & pregnant women	Goal 3	
Connect children ages 0-5 & pregnant women with needed oral	Goal 4	
Increase providers' knowledge of how to promote the oral health of children ages 0-5 **	Goal 6	

Data for the capital and media campaigns are tracked in two ways:

1. Capital grant recipients reported the number of individuals served the year prior to receiving First 5 funding for capital improvements and the number of individuals served the year following completion of the improvements to demonstrate change. Narrative progress reports added context.
2. For the media campaign, the contractor tracks its activities and outcomes and reports them to the evaluation team at the end of the Fiscal Year.

Health and Development Services

The first six months of Health and Development Services (HDS) was devoted to planning both services and the evaluation that would capture the complexity of the service system. The future evaluation will draw upon the quarterly progress reports of HDS contractors for demographics and process data elements for each service category. Outcome data will be collected twice a year, wherein contractors measure indicators as appropriate to their programs. The systems-level evaluation examines the implementation and development of the HDS system of care.

Exhibit B.3 Health and Development Services Evaluation Table	
Data Elements	**Method of Collection**
Demographic data	
Children ages 0-5: ethnicity, language, age, special needs, within or outside priority zip codes	Quarterly Progress Report
Process measures data	
Number of screenings, assessments, and treatment units	Quarterly Progress Report
Number of parent education classes, workshops and home visits	
Number of new children ages 0-5 and families served	
Number of children ages 0-5 and families receiving on-going services	
Number of referrals within and outside of HDS service network	
Breastfeeding at time of initial newborn home visit	
Households in which someone smokes	
Outcomes data	
Child Outcomes	Semi-annual reports individualized by service category
Breastfeeding at six weeks and six months	
Children identified as needing assessment who receive assessment	
Children identified as needing treatment who receive treatment	
Children receiving treatment who demonstrate gains related to the funded service they receive	
Parent Outcomes	
Increased knowledge of how to promote child's physical, cognitive, and social/emotional health	
Improved skills to promote child's physical, cognitive, and social/emotional health	
Utilization of appropriate health care and cognitive/social emotional care resources to benefit children age 0-5	

Intergenerational Initiative

The Intergenerational contractors engage in a variety of different activities from direct services for children to capacity-building for teachers. The diversity of their activities required the development of two surveys by key target population: parents and providers. Seven of the nine contractors participated in the provider (or "teacher") survey, and seven contractors participated in the parent survey. Six contractors participated in both. Outcomes were organized as follows:

1. Teacher outcomes were measured via seven questions on the teacher survey. They include: enhanced positive learning environment, language and learning activities, attention to children, and communication with parents.
2. Child outcomes were measured via five questions on the teacher survey and four questions on the parent survey. They include: increased early learning skills, positive attitude toward learning, social emotional skills and adult-child interaction.

3. Parent outcomes were measured via four questions on the parent survey. They include: increased knowledge of child's development, awareness of school readiness, and early learning activities.

Both parent and teacher surveys were conducted as point-in-time, without a pre/post designation, during May 2005 (FY 04-05) and April 2006 (FY 05-06). Paper copies of the survey were submitted to Harder+Company and entered into a database. In addition, contractors submitted monthly progress reports to the Commission outlining numbers served, demographics, and narrative updates.

Exhibit B.4
Intergenerational Initiative Evaluation Table

Data Elements	Method of Collection
Demographic data	
Children ages 0-5: ethnicity, language, age, special needs; Families: ethnicity, language	Monthly Progress Report
Process measures data	
Number of new children ages 0-5 and families served	Monthly Progress Report
Number of children ages 0-5 and families receiving on-going services	
Senior Mentor count	
Senior Mentor total hours spent with First 5 children and their families	
Total number of service contacts by Seniors	
Other program staff hours spent with First 5 children and their families	
Outcomes data	
Provider/ Teacher Outcomes	Provider and Parent Survey Administered Annually
Enhanced positive learning environment	
Increased language and learning activities	
Increased attention to children	
Increased communication with parents	
Child Outcomes	
Increased early learning skills	
Increased positive attitude toward learning	
Increased social emotional skills	
Increased adult-child interaction	
Parent Outcomes	
Increased knowledge of child's development	
Increased awareness of school readiness	
Increased early learning activities	

School Readiness Initiative

The School Readiness evaluation follows State First 5 mandated evaluation guidelines. Under a new State First 5 Evaluation Framework, adopted in Spring 2006, School Readiness programs are required to select at least one indicator from a menu of indicators for each State Result Area and report their progress according to these indicators. The four Result Areas are:

1. Improved family functioning
2. Improved child development
3. Improved child health
4. Improved system of care

The table below lists the indicators and data sources selected by First 5 San Diego's School Readiness Initiative Coordinators. Although this framework was adopted mid-fiscal year, most of the data collection for these elements was already underway and will require minimal modifications. For the FY 2005-2006 evaluation report, the primary data drawn upon are the monthly progress reports submitted to the Commission and child progress data. The monthly progress reports provide process numbers according to State mandated categories and narratives. Child progress data includes the Desired Results Developmental Profile (DRDP) for classroom-based contractors and the Ages and Stages Questionnaire (ASQ) for center-based contractors. Contractors are currently revisiting the utility and effectiveness of the ASQ and are considering other tools for future evaluation years. In addition, contractors submitted monthly progress reports to the Commission outlining numbers served, demographics, and narrative updates. In FY 2006-2007, contractors will be administering a standardized parent survey based on the Parents As Teachers parent survey.

Exhibit B.5
School Readiness Initiative Evaluation Table

Data Elements	State Result Area (RA)	Method of Collection
Demographic data		
Children ages 0-5: ethnicity, language, age, special needs Pregnant women: ethnicity, language	n/a	Monthly Progress Reports
Process measures data		
Number of parents taking classes focused on supporting child physical cognitive and socio-emotional development	RA1	Tracking Tool
Number and percent of children 3-5 that are screened and identified with disabilities or special needs in the last 12 months	RA3	
Number and percent of children who participate in school-linked transition practices that meet NEGP criteria	RA4	
Outcomes data		
Number and percent of parents who demonstrate increased knowledge (confidence and competence) to promote child's optimal development and school readiness.	RA1	Parent survey
Number and percent of children making developmental progress in the areas of cognitive, social, emotional, language, approaches to learning and health/physical development	RA2	DRDP and ASQ*
Number of participants reporting satisfaction with the content, quality, and family centeredness of services	RA4	Parent survey

Funded Program Survey

To understand the effect and value added of First 5 on funded programs as organizations, Harder+Company updated the funded program survey from past years. This survey was initially created with the assistance of the Evaluation Leadership Team. This year, the surveys were tailored by initiative to address particular issues of concern for each initiative. The surveys were then distributed a mail survey to contractors (and in some cases, subcontractors) that had been funded for at least six months (not including capital or innovative grants). The survey was developed specifically to understand key areas of systems change, such as the leveraging of additional funds, and program's experiences with First 5. Surveys were sent to 50 contractors and subcontractors and 46 were completed and returned (92.0%).

2005 First 5 San Diego Family Survey

The First 5 San Diego Family Survey was conducted in 2005 as a Random Digit Dial (RDD) survey of 1200 parents/caregivers of children ages 0-5 with quotas in each Health and Human Services Agency. The primary purpose of the survey was to gather community-level data about key indicators related to child outcomes via parental self-report and parent perceptions and attitudes toward the service system for children 0-5 and their parents.

The survey was developed in collaboration with Commission staff and members of the Commission's Evaluation Leadership Team. Selected measures from this survey are presented in this report as they related to the particular. The full results of the First 5 San Diego Family Survey was submitted in a separate document to the Commission in Fall of 2005. It is anticipated that this survey will be administered every two to three years to keep and maintain trend data on children 0-5 and their families.

Qualitative Methods

Case Studies

The evaluation team conducted four case studies to understand in-depth the value of First 5 in parents and providers' lives. The case studies centered on the effects of First 5-funded services on parents' and children's lives. These case studies included both an interview with the parent, often in their home, and an interview with one or more of his or her service providers.

Exhibit B.6 Case Studies Overview				
	Initiative	**HHSA Regions**	**Contractor(s)**	**Modality**
1	IG	Central	*Neighborhood House Association- Project Generation A to Z*	Direct services
2	HAI	North Inland	North County Health Services- Healthy Families	Direct services
3	HAI	North Inland	North County Health Services- MediCal	Direct services
4	OHI	Central	Three Community Clinics Health subcontractors Network: *Children's Hospital, La Maestra, San Diego Family Care*	Direct services

Focus Groups

Five focus groups were conducted across San Diego County to hear directly from parents and providers about First 5's effect in their lives. Focus groups were identified based on an assessment of additional or contextual information needed to complete the picture of each initiative's impact.

The evaluation team contacted the selected contractors and asked for their assistance in recruiting participants. The protocols were developed in collaboration with Commission staff. Parent participants were offered a $20 incentive, and food and childcare was provided. For each focus group, the evaluation team strove to have eight to 12 participants. Focus groups were conducted in both English and Spanish.

Exhibit B.7 Focus Group Overview					
	Initiative	**HHSA Region**	**Grantees/ Contractors**	**Focus Group Topic**	**Language**
1	IG	South	YMCA Youth & Family Services- Kinship Support	Relative caregivers' benefit from participating in IG program	Spanish
2	OHI	Countywide	Subcontractors of the Community Clinics Health Network	Care Coordinators' perception of the benefits and challenges of OHI	English
3	SR	East	Cajon Valley School District	SR participants' experience in the program (participatory photography site)	English and Spanish
4	SR	South	Chula Vista Elementary School District		Spanish
5	SR	North Coastal	Oceanside Unified School District		Spanish

Intercept Interviews

Fourteen parents who were accessing Oral Health Initiative services shared their experiences via intercept interviews. Harder+Company staff conducted the interviews in English and Spanish at two OHI subcontractors' sites. Participants were given children's toothbrushes as incentives.

The purpose of the intercept interviews was the same as for the focus groups (explained above). Intercept interviews with parents were pursued in lieu of a focus group because parents come to dental clinics infrequently; it is more effective to speak with parents one at a time while they wait for their child's appointment rather than to schedule a separate meeting for parents to discuss the topic as a group. For this reason the number of completed interviews is consistent with the number of participants that might be expected at a focus group.

Exhibit B.8
Intercept Interview Overview

	Initiative	HHSA Region	Grantees/ Contractors	Topic	Language
1	OHI	North Inland	Neighborhood Healthcare	Access to dental care, dental care behaviors	Spanish/ English
2	OHI	North Inland	North County Health Services		Spanish/ English

Participatory Photography

In the context of this evaluation, participatory photography is a parent-driven means of expressing the benefits families have experienced from projects funded by First 5. Facilitated by Harder+Company Community Research and The AjA Project (a local non-profit organization specializing in participatory photography), parent-photographers learned how to use a camera to tell their stories and document significant changes in their lives.

Diverging from the previous two years of participatory photography, wherein each parent has worked independently to create a single piece of artwork, this year's photography project engaged three groups of parents to create three collective pieces. Four to six parents participated at each of three sites. Each group centered on a different School Readiness site. The sequence of the project was as follows:

1. ***Introductory meetings*:** parents at each site met with the evaluation team for an introduction to the project. As part of that meeting, parents participated in a focus group facilitated by Harder+Company staff to identify ways children, parents, families, schools and communities have benefited from the School Readiness programs. A consultant from The AjA Project provided technical training in photography techniques.
2. ***Taking pictures*:** Participants were given cameras at the introductory meetings and spent a week taking pictures of what they felt expressed the benefit of their participation in a First 5 School Readiness program. Participants then returned their film to the evaluation team for developing.

3. ***Individual meetings*:** Once the film was developed, members of the evaluation team and The AjA Project consultant met with the participants at each site to look at the groups' photos and record the photographers' comments to give context to the photos.
4. ***Creating the collage:*** The AjA Project consultant took the participants' pictures and quotes and created a collage for each site on a four by eight foot banner using the photographs participants selected and their explanations of the photographs' importance.
5. ***Final group meeting*:** Each site celebrated the unveiling of their artwork at a "mini-exhibit." First 5 staff, funded program staff, and community leaders attended the events.
6. ***Exhibition at the First 5 Statewide Conference*:** In May 2005, the banners were exhibited at the San Diego Grand Hyatt as part of the statewide First 5 conference, which was attended by Commissioners, commission staff, and First 5 supporters from across California. A brief write-up explaining the program accompanied each banner. Participatory photography products from the previous two years were also displayed as part of the exhibition.

Participants received incentives for each meeting and food and childcare were provided. Participants kept their cameras and were given a framed picture of their favorite photograph. Each of the participating school sites also received a four by eight foot banner of the groups' artwork. Schools plan to use the banners to publicize their programs and recruit participants.

Key Expert ("stakeholder") Interviews

The key expert interviews were an opportunity to speak with influential members of the San Diego community who are outside of the First 5 San Diego but have insight about the system of care for young children and the Commission's work. Key experts were selected by initiative in collaboration with the First 5 Commission Staff. The stakeholder interviews helped identify the different initiatives' successes and challenges and if the Commission has nurtured an enduring obligation to services and support to families and early childhood development in San Diego among service providers, funders, and county decision-makers. In addition to initiative-specific questions, all stakeholder interviews addressed:

1. The perceived role and successes of the Commission in improving services to children and in forming a strong system of support for San Diego families of young children;
2. The impact of the Commission in raising awareness of early childhood issues and in increasing the sense of community, community engagement, and parent empowerment and advocacy;
3. Whether stakeholders have increased their commitment to the support of families with young children as a result of First 5.

Harder+Company contacted the selected individual from each entity five times before abandoning the interview effort. In total, 14 interviews were conducted.

Appendix C

Issue Area 1: Children's Health

Desired Results	Level I Indicators	Strategy Code**	Priority Strategies**: Direct Services	Community Strengthening & Awareness	Provider Capacity Building, Support & Infrastructure	Systems Change
IA1: Children's Health						
1.1 Children are born and stay healthy	a. % of children who are enrolled/stay enrolled in health care	1B	1A) Health Assessment, Treatment, Parent Ed	1E) Breastfeeding and optimal infant feeding	See IA4	See IA4
	b. % of children utilizing appropriate health care resources (both preventative and urgent)	1B	1B) Health Insurance Enrollment			
	c. % of children receiving screenings compared to target "universe"	1A 3C	3C) School Readiness Initiative [cross reference with IA3]			
	d. % of children identified as needing assessment who receive assessment	1A 3C				
	e. % of children identified as needing treatment who receive treatment/follow-up	1A 3C				
	f. % of children receiving treatment who demonstrate improved health conditions related to the funded services they receive	1A 3C				
	g. % of children being breastfed at all at the time of hospital discharge, at 6 weeks, at 6 months	1E				
1.2 Children have access to preventative and comprehensive health care services	a. % of children who are enrolled/stay enrolled in health care	1B 1D	1A) Health Assessment, Treatment, Parent Ed	1C) Immunization campaign	See IA4	See IA4
	b. % of children utilizing appropriate health care resources (both preventative and urgent)	1A 1B 1C 1D	1B) Health Insurance Enrollment	1D) Insurance & oral/health campaign		
	c. Providers collaborate across disciplines and skill sets to provide health services to children	1A 1B				
1.3 Families have the knowledge, skills and resources they need to promote their children's optimal health	i. % of families who demonstrate increased knowledge about how to promote their child's health	1A 1C 1D 1F 3C	1A) Health Assessment, Treatment, Parent Ed	1C) Immunization campaign	1F) Smoking cessation and interventions through provider training	See IA4
	j. % of families who demonstrate improved skills to promote their child's health	1A 1B 1F	1B) Health Insurance Enrollment	1D) Insurance and oral/health campaign		
	b. % of families utilizing appropriate health care resources (both preventative and urgent)	1C 1D	3C) School Readiness Initiative [cross reference with IA3]			
	k. % of households in which someone smokes	1F				

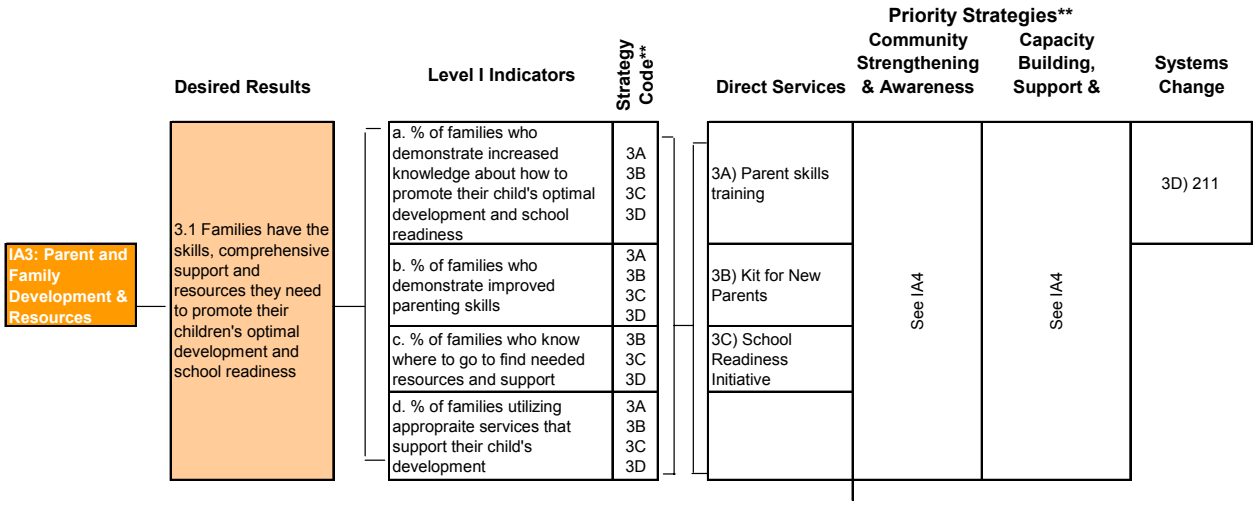
* Black print indicates updated 2004-2009 strategic plan
** Numbering matches that of the strategic plan.See plan for complete wording of strategy.

Issue Area 2: Children's Learning and Social-Emotional Health

Desired Results	Level I Indicators	Strategy Code**	Priority Strategies**: Direct Services	Community Strengthening & Awareness	Provider Capacity Building, Support & Infrastructure	Systems Change
IA2: Children's Learning and Social-Emotional Health						
2.1 Children have access to quality services that promote their early learning	a. % of parents from diverse cultural and linguistic backgrounds who utilize preliteracy services compared to target "universe"	2D 3C	2D) Culturally and linguistically sensitive preliteracy services		2E) CARES	2H) Preschool for All
	b. % of providers who exhibit high standards as defined by best practices in their field	2E 2H 3C	3C) School Readiness Initiative [cross reference with IA3]		2G) Early learning/Pre-literacy training to providers	2I) Preliteracy services integration through multidisciplinary partnership and collaborative long range planning
	c. Providers collaborate across disciplines and skill sets to provide early learning and preliteracy services to children	2G 2I 3C				
2.2 Children are socially and emotionally healthy	d. % of children receiving screenings compared to target "universe"	2B 2F 3C	2B) Developmental/behavioral assessment and treatment; parent ed		2F) Health and behavioral health consultant services for early care/education providers	See IA4
	e. % of children identified as needing assessment who receive assessment	2B 2F 3C	2C) Other behavioral service (filling service gaps)		See IA4	
	f. % of children identified as needing treatment who receive treatment/follow-up	2B 2F 3C	3C) School Readiness Initiative [cross reference with IA3]			
	g. % of children receiving treatment who demonstrate behavioral/developmental gains related to the services received	2B 2C 2F 3C				
2.3 Children are cognitively developing appropriately	d. % of children receiving screenings compared to target "universe"	2B 2F 3C	2B) Developmental/behavioral assessment and treatment; parent ed		2F) Health and behavioral health consultant services for early care/education providers	2I) Preliteracy services integration through multidisciplinary partnership and collaborative long range planning
	e. % of children identified as needing assessment who receive assessment	2B 2F 3C	3C) School Readiness Initiative[cross reference with IA3]		2G) Early learning/Pre-literacy training to providers	
	f. % of children identified as needing treatment who receive treatment/follow-up	2B 2F 3C				
	g. % of children receiving treatment who demonstrate cognitive/developmental gains related to the services received	2B 2F 3C				
	h. Children are seamlessly connected from one partnering organization to another	2I 3C				
2.4 Families have the knowledge and skills they need to support their children's learning and social-emotional health	i. % of families who demonstrate increased knowledge about promoting their child's cognitive and social/emotional health	2A 2B 3C	2A) Parent Ed supporting pre-literacy		See IA4	See IA4
	j. % of families who demonstrate improved skills to promote their child's cognitive and social/emotional health	2A 2B 3C	2B) Developmental/behavioral assessment and treatment; parent ed			
	k. % of families utilizing appropriate cognitive/social emotional care resources to benefit their child age 0-5	2A 2B 3C	3C) School Readiness Initiative [cross reference with IA3]			
	l. % of families who read/tell stories to their child more often	2A 2D 2H 3C				

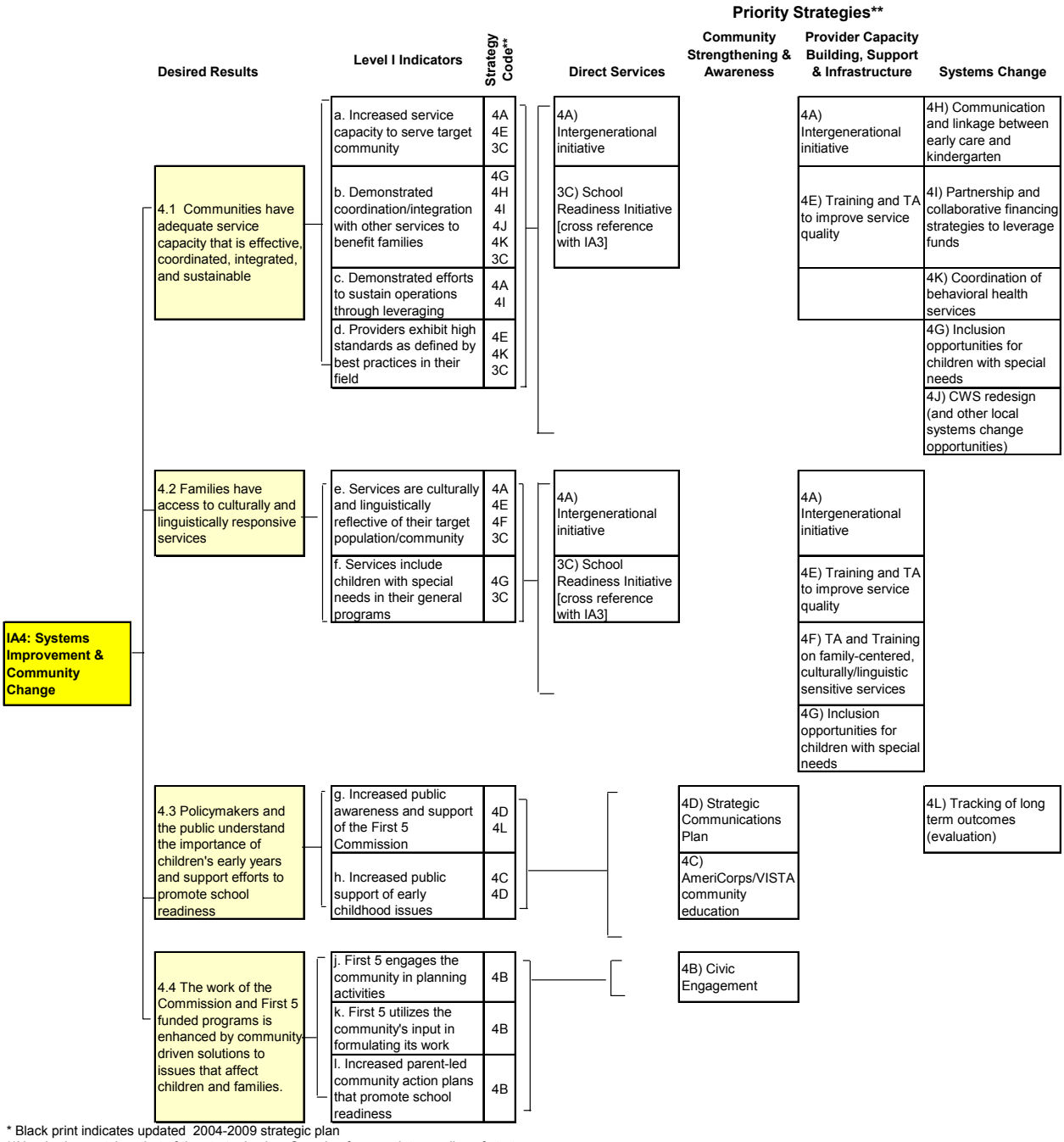
* Black print indicates updated 2004-2009 strategic plan
** Numbering matches that of the strategic plan. See plan for complete wording of strategy

Issue Area 3: Parent and Family Development and Resources



* Black print indicates updated 2004-2009 strategic plan
** Numbering matches that of the strategic plan. See plan for complete wording of strategy

Issue Area 4: Systems Improvement and Community Change

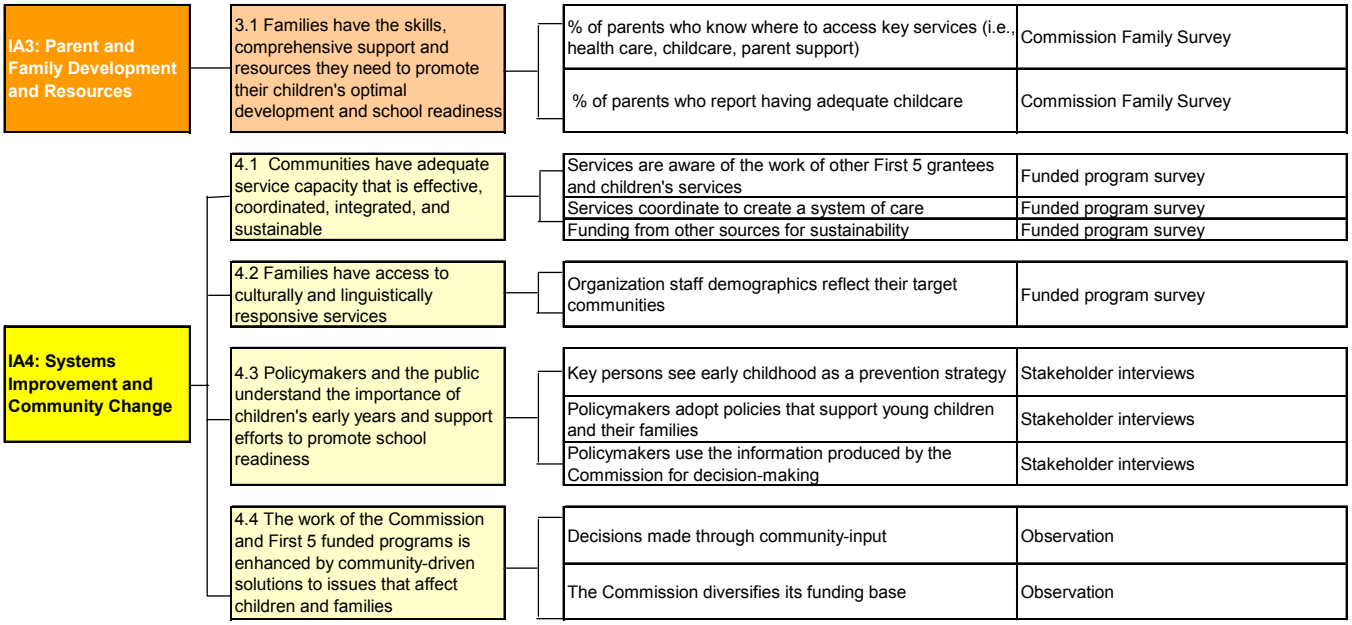


* Black print indicates updated 2004-2009 strategic plan
**Numbering matches that of the strategic plan. See plan for complete wording of strategy

Community Context (Level II) Indicators

Definition: Community Context (Level II) Indicators are cross-county, preferably population-based, data elements that track if "big-picture" changes are happening over time for children ages 0-5 and their families in San Diego County. (See *San Diego First 5 Indicators* document for details.) These indicators address (or are a proxy for) Commission identified issues of concern. Depending on the data available, these indicators may be used for trend analysis and GIS mapping. In cases where there is no preexisting, ongoing data source for the County's 0-5 population the information will be gathered by the Commission through various primary data collection efforts. In many of these instances there is reliable State- and National-level data and/or data for children 0-18 available from preexisting, ongoing data sources external to the Commission. These other sources will provide comparisons to the data gathered by the Commission at the County-level.

Issue Area	Desired Results	Community Context (Level II) Indicators (Indicators included in the 2004-2009 strategic plan are marked with an asterisk)	Source (See *San Diego First 5 Indicators* document for details)
IA1: Children's Health	1.1 Children are born and stay healthy	% of low birth weight births (under 2,500 grams), % of very low birth weight births (under 1,500 grams)*	County HHSA Stats
		% of live births where mother received first trimester prenatal care*	County HHSA Stats
		% of women who drank alcohol during pregnancy	County HHSA Stats
		% of women who smoked during pregnancy*	County HHSA Stats
		Rates of births to teen girls ages 15-17 (births per 1,000 populations)	County HHSA Stats
		% of Kindergarteners who received the recommended vaccinations	County HHSA Stats
		% of children who breastfed at hospital discharge, at six weeks, and at six months*	Commission Family Survey [Comparative State data from MCH]
		% of parents who self-report their children's health is "very good or excellent"	Commission Family Survey [Comparative State data from CHIS]
	1.2 Children have access to preventative and comprehensive health care services	% of children who received well-baby and child checkups by age 2*	Commission Family Survey[Comparative State (sub-population) data from State First 5]
		% of households with children with medical insurance coverage	County HHSA Stats/Commission Family Survey
		% of children receiving vision screenings	Commission Family Survey
		% of children with a regular source of medical care	County HHSA Stats/Commission Family Survey
		% of children receiving regular dental care*	Commission Family Survey
		% of children who have had developmental assessments*	Commission Family Survey
		% of children with up to date and on time immunizations	County immunization survey [proxy data from Commission Family Survey]
	1.3 Families have the knowledge, skills and resources they need to promote their children's optimal health	% of households in which someone smokes	Commission Family Survey
		Also cross-reference with subset of indicators for Desired Results 1.2 and 3.1 (i.e., insurance, childcare, parent support, etc.)	
IA2: Children's Learning and Social-Emotional Health	2.1 Children have access to quality services that promote their early learning	% of children who have access to resources that promote their early learning (access to reading and writing materials)	Commission Family Survey/YMCA
	2.2 Children are socially and emotionally healthy	% of children that exhibit age-appropriate self-soothing and self-regulation behaviors	Commission Family Survey
		% of children entering kindergarten ready for school (soc-emo)*	Longitudinal study (special project TBD)
		% of children with high levels of interaction with their parents/other children	Commission Family Survey
	2.3 Children are cognitively developing appropriately	% of children with disabilities and other special needs who participate in early childhood care and education programs*	TBD - YMCA may have data
		% of families who report reading, telling stories, singing regularly to their children*	Commission Family Survey
		# of hours children spend watching television	Commission Family Survey
		% of children entering kindergarten ready for school (cog)*	Longitudinal study (special project TBD)
		% of children identified with disabilities or as high risk who receive development and/or behavioral services by kindergarten entry	Longitudinal study (special project TBD)
	2.4 Families have the knowledge and skills they need to support their children's learning and social-emotional health	% of parents practicing positive discipline techniques	Commission Family Survey
		% of parents reporting high level of confidence in their parental roles	Commission Family Survey


IA3: Parent and Family Development and Resources
3.1 Families have the skills, comprehensive support and resources they need to promote their children's optimal development and school readiness
% of parents who know where to access key services (i.e., health care, childcare, parent support)
Commission Family Survey
% of parents who report having adequate childcare
Commission Family Survey
IA4: Systems Improvement and Community Change
4.1 Communities have adequate service capacity that is effective, coordinated, integrated, and sustainable
Services are aware of the work of other First 5 grantees and children's services
Funded program survey
Services coordinate to create a system of care
Funded program survey
Funding from other sources for sustainability
Funded program survey
4.2 Families have access to culturally and linguistically responsive services
Organization staff demographics reflect their target communities
Funded program survey
4.3 Policymakers and the public understand the importance of children's early years and support efforts to promote school readiness
Key persons see early childhood as a prevention strategy
Stakeholder interviews
Policymakers adopt policies that support young children and their families
Stakeholder interviews
Policymakers use the information produced by the Commission for decision-making
Stakeholder interviews
4.4 The work of the Commission and First 5 funded programs is enhanced by community-driven solutions to issues that affect children and families
Decisions made through community-input
Observation
The Commission diversifies its funding base
Observation