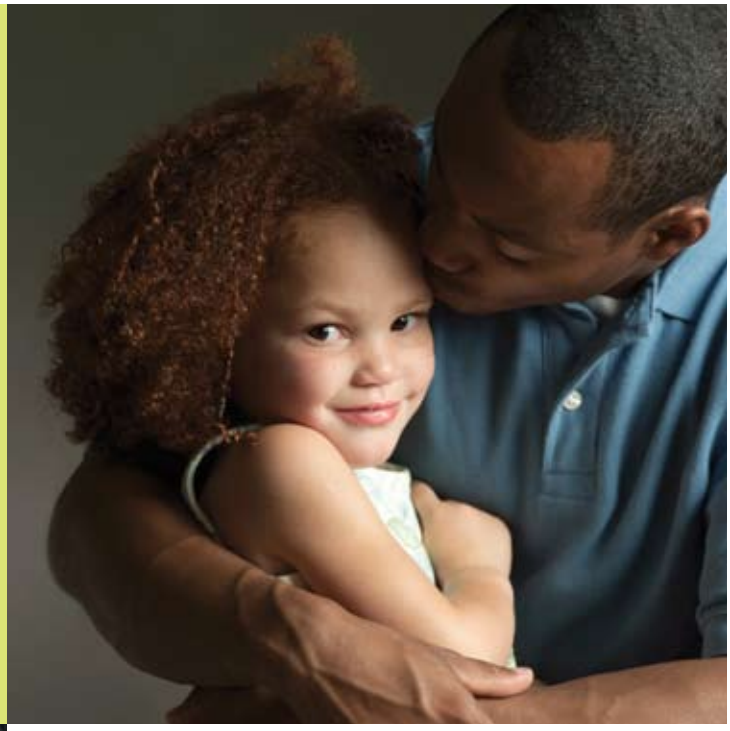
First 5 San Diego

First 5 Commission of San Diego County

Improving the lives of children 0 to 5



harder+company community research

Improving the Lives of Children 0-5

First 5 Commission of San Diego County

Annual Evaluation Report 2006-2007

October 2007

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

This report represents a profoundly collaborative process, bringing together the efforts of community partners such as contractors, families, and stakeholders. Contractors were often required to expand their view of evaluation from program specific to initiative level. 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." Families and stakeholders took time out of their busy days to be asked questions of themselves and their families as well as to reflect on the impacts First 5 San Diego 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:

- The Commissioners of the First 5 Commission of San Diego County for their commitment to positively affect the lives of children ages 0-5 in this county: Bill Horn (Chair 2006), Ron Roberts (Chair 2007), Dr. Nancy Bowen (2006), Jean Shepard, Carol Skiljan, Charleen Tressler, and Dr. Wilma J. Wooten (2007).
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- Two non-First 5 programs, Neighborhood House Association and the SDSU Foundation Southeast Office (WIC program) that opened their doors for focus groups with pregnant women.
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Executive Summary

"There is no single effort more radical in its potential for saving the world than a transformation of the way we raise our children."

—Marianne Williamson

In FY 2006-07, the First 5 Commission of San Diego County (First 5 San Diego) fully transitioned from funding individual programs to supporting a network of interconnected initiatives to address the needs of children ages 0-5. Some initiatives (i.e., Oral Health and Healthcare Access) honed their services and sought new opportunities to leverage Commission resources. Other initiatives (i.e., Preschool for All and Health and Development Services), implemented their first full year of direct services. Still others (School Readiness, CARES, 2-1-1) were in bridge years, completing their previous direct services contract with the Commission while simultaneously refocusing their efforts for new contracts and new challenges. Only one initiative sunsetted (Intergenerational).

This report contains an analysis and synthesis of the data collected during FY 2006-07. It is a macro analysis of initiative and program successes as well as the areas for further study and/or needed improvement. The summary is organized by the four Issue Areas of the Commission's Strategic Plan:

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

Children's Health

In the result area of Children's Health, First 5 San Diego targets the following Desired Results:

- 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.

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

Results-Based Accountability

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.
- Funded efforts target Strategic Plan priorities as well as specific, measurable outcomes listed in its Evaluation Framework.
- Each initiative incorporates direct services, community strengthening, provider capacity building and systems change strategies.
- Where possible, contractors are required to use evidence-based or promising practices.
- Evaluation designs specify process and outcome data to provide feedback for program improvement, monitoring contractor performance, and aggregating results to show county level impact and how the results intersect with First 5 efforts across the state.

Numbers Served

- ***First 5 for Parents:*** An estimated 973 parents received education to support their child's health and promote healthy family behaviors.
- ***Health and Development Services (HDS):*** In FY 2006-07, almost 29,000 individual children were served across regional networks. The initiative provided over 8,000 newborn medical home visits, over 7,000 at-risk home visits, and over 30,000 screenings (developmental, behavioral, vision, hearing, language). Nearly 9,000 hearing screenings and over 9,000 vision screenings were performed.
- ***Healthcare Access Initiative (HCA):*** During FY 2006-07, contractors extended outreach to 148,311 families. Health insurance enrollment assistance was provided to families of 24,462 children (an increase of 47.1% from last fiscal year). Of these, 48.1% of assisted applications became confirmed enrollments, a decrease compared to last fiscal year.
- ***Oral Health Initiative (OHI):*** Over 20,000 children ages 0-5 and 2,190 pregnant women received oral health screenings. In addition, 12,463 children ages 0-5 and 1,385 pregnant women obtained routine dental treatment, and 576 children ages 0-5 obtained specialty dental treatment. Over 19,000 parents, caregivers, pregnant women, and dental and healthcare providers received trainings about the importance of early dental health care.
- ***School Readiness Initiative (SR):*** This initiative pursues a "whole child" approach that includes some health outcomes. As a part of these programs, School Readiness contractors provided 1,910 children health screenings.

Improving Children's Health	
Desired Results	**Highlights**
Children are born and stay healthy	■ The overall rates of breastfeeding at 6 weeks of age (77.6%) and 6 months of age (59.2%) for families receiving HDS newborn medical home visits and at-risk home visits met or surpassed the Healthy People 2010 goal.
	■ The number of pregnant women receiving OHI screenings increased by 94.7%, for exams by 131.0%, and for treatment 303.8% from last fiscal year.
Children have access to preventative and comprehensive healthcare services	■ Due to HCA's follow-up efforts, 93.4% of families were still enrolled in health insurance at 18 months, surpassing County comparison data (91.3%).
	■ In an attempt to ensure that the dental health system of care is seamless, OHI providers increased care coordination efforts by 58.0% for children and 65.6% for pregnant women.
	■ Over 70 percent (70.6%) of children receiving core School Readiness services (i.e., early care and education services) were screened for developmental delays, including fine motor and gross motor skills.
	■ Nearly 17 percent (16.7%) of all children attending First 5 funded PFA sessions were screened for health and developmental delays.
Families have the knowledge skills and resources they need to promote their children's optimal health.	■ As part of the follow-up process, HCA contractors provide education and support to families to ensure appropriate use of medical services. At a six month follow-up, 94.2% utilized health care and 94.2% utilized dental care (exceeding county comparison data).
	■ Most referrals within HDS Regional Networks (71.5%) resulted in successful initiation of additional services. In addition, nearly 2,000 referrals were provided by HDS partners to other First 5 funded initiatives.
	■ Families accessing HCA services exhibited consistently lower usage of emergency room services (4.5%) than their county comparison (21.8%).
	■ OHI provided pediatric dentistry education to 19,509 primary caregivers of children (parents, pregnant women, and childcare providers) and 137 general dentists.
	■ 2-1-1, a resource and referral hotline, provided information on community health resources to approximately 23,100 parents of children ages 0-5.
	■ 47,360 Kits for New Parents containing valuable information about children's health, basic child care, safety knowledge, and accessing resources were distributed to parents. This was the highest number ever distributed in San Diego County since the program's inception in 2001.
	■ First 5 funded a Health and Oral Health Campaign that provided information via television announcements, news segments, a website, phone banks, community events, and bus tails.

Children's Learning and Social-Emotional Health

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

- 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.

The Commission funded early learning and social-emotional programs that focused on services to support children's early education and school readiness, parent knowledge and skills to promote their child's development and behavioral health, early screenings and referrals to treatment, and provider collaboration. The following is a brief summary of some of the key numbers served and results achieved in the Issue Area of Children's Learning and Social-Emotional Health.

Numbers Served

- ***School Readiness Initiative (SR):*** The main thrust of the School Readiness Initiative programs has been to provide high quality early education settings for young children. This year, 4,381 children, including 417 children with disabilities or other special needs, and their parents and caregivers participated in early care and education activities. This exceeded the initiative's goals by 14.5% based on previous fiscal year benchmarks. Furthermore, 2,350 children participated in kindergarten transition activities to ease their transition into school.
- ***Preschool for All (PFA):*** FY 2006-07 marked the first full year of the PFA Demonstration Project. The initiative provided 104 sessions in the six targeted communities, providing quality preschool experiences to over 3,000 children.
- ***Parent Education Initiative (PE):*** An estimated 2,614 parents received education to support their child's early learning.
- ***Health and Development Services (HDS***): A large component of this county-wide project includes screening, assessing, and treating children for developmental, speech and language, and behavioral concerns. The initiative provided 13,275 screenings to identify developmental concerns, 11,622 children and 645 behavioral screenings were provided to 466 children during this fiscal year. Half of these children were identified as needing further assessment (50.8%).
- ***Intergenerational Initiative (IG):*** This was the final year of the three year Intergenerational Initiative and many providers completed services by mid fiscal year. Over 4,400 children frequently received the services of a Senior Mentor to strengthen their early learning. Senior Mentors volunteered for more than 25,000 hours during FY 2006-07 and for a total of over 77,000 hours during the course of the Initiative.

Improving Children's Learning and Social-Emotional Health	
Desired Results	**Highlights**
Children have access to quality services to promote their early learning	▪ PFA promoted quality in Early Childhood Education settings by using the ECERS-R and FDCRS tools. These tools assess the quality of an early education setting. The San Diego County Office of Education then provides PFA sites with technical assistance to help them improve quality in identified areas.
	▪ The CARES program provides stipends to early education providers so they can further their education and ultimately improve the quality of early care environments. In FY 2006-07, 1,120 early care educators utilized San Diego CARES.
	▪ The majority of children accessing HDS services who were tracked through the evaluation received the services they needed to address development, speech, and behavioral concerns (88.2% of children needing an assessment received services and 79.4% of children needing treatment received services).
	▪ The majority of SR preschool teachers (86.0%) were educated at or past the Associates degree level.
Children are socially and emotionally healthy	▪ Almost half (45%) of all children receiving HDS developmental, speech and language, or behavioral services demonstrated gains as a result of services. The majority of children not showing gains remain in programs for further treatment or are being referred for additional services, either within HDS or to an outside agency.
	▪ The majority of children participating in classroom-based School Readiness Initiative program activities showed improvement in the social emotional areas of the DRDP-R: Personal-Social (96.7%) and Problem-Solving (96.7%). The average increase per child for all social-emotional developmental areas was the highest in three years. These findings were higher for children attending full-time programs and lower for those attending part-time programs.
Children are cognitively developing appropriately	▪ Parents and teachers observed that the Intergenerational Initiative's Senior Mentors often directly affect children's cognitive skills by assisting in the classroom, conducting home visits, reading as part of literacy programs, and supporting children with special needs.
	▪ Children participating in PFA preschool sites exhibited statistically significant improvements in each of the five developmental areas measured by the DRDP-R. The most improvement was in the area of "effective learning" (i.e., cognition, math ability, and literacy).
	▪ The majority of children participating in classroom based School Readiness Initiative program activities showed improvement in the cognitive areas of the DRDP-R: Personal-Social (96.7%), and Problem-Solving (96.7%). The average increase per child for all cognitive developmental areas was the highest in three years. These findings were higher for children attending full-time programs and lower for those attending part-time programs.

Improving Children's Learning and Social-Emotional Health	
Desired Results	**Highlights**
Families have the knowledge and skills they need to support their children's learning and social-emotional health	▪ 47,360 Kits for New Parents were distributed to parents of children ages 0-5 containing valuable information about how to support the learning and social-emotional development of their children and accessing resources. This was the highest number ever distributed in San Diego County.
	▪ Parents participating in School Readiness Initiative parenting classes showed increases in each of the parenting practices areas (knowledge, confidence, ability and connection to their child and other families).
	▪ Parents participating in PFA activities rated themselves higher on all Parenting Survey items (such as knowledge, confidence, ability, and behavior) with the increases being statistically significant for all items ($p<.001$).

Parent and Family Development and Resources

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

- Families have the skills, comprehensive support and resources they need to promote their children's optimal development and school readiness.

Although only one initiative solely focuses on parent education (First 5 for Parents), all current Commission funded initiatives have parent education components that contribute to reaching the goal listed above. These projects strive to educate families about available resources and empower them to effectively access these services for their children. The following is a brief summary of families served and key results achieved in these areas.

Numbers Served (direct service initiatives only):

- ***First 5 for Parents:*** In the first year of the initiative, 3,381 parents participated in parent education classes and workshops built on best or promising practices. In turn, nearly three children ages 0-5 were reached for every parent that participated.

Key Parent and Family Development and Resources Results

Improving Parent and Family Development and Resources	
Desired Results	**Highlights**
Families have the skills, comprehensive support and resources they need to promote their children's optimal development and school readiness.	■ First 5 for Parents parent education programs supported parents in learning positive parenting skills, enhancing their children's early literacy, and improving child and family health behaviors.
	■ The primary thrust of HCA is to increase child and family utilization of appropriate services. The positive outcomes of this initiative is a testament to its ability to link families to needed resources and to educate them about how to appropriately utilize health services.
	■ Parents reported that they are benefiting from HDS programs to optimize their child's health and development, including increasing their knowledge (99.2%), enhancing their skills (99.0%), and becoming empowered to address the health and developmental needs of their children (98.5%).
	■ OHI contractors provided care coordination to 6,769 children (a 58.0% increase) and 1,485 pregnant women (a 65.6% increase) to ensure that the dental health system of care is seamless for children and pregnant women.
	■ Parents participating in PFA activities rated themselves higher on all Parenting Survey items (such as knowledge, confidence, ability, and behavior) with the increases being statistically significant for all items ($p<0.001$).
	■ Parents participating in School Readiness based parenting classes showed an increase in each parenting practice area (knowledge, confidence, ability and connection). Parents participating in more intensive, long-term parenting classes, such as sequential parent and child together (PACT) classes, consistently showed the most change in their knowledge, confidence, ability, and connection.
	■ Families with children ages 0-5 have access to a 24/7 information and referral line (2-1-1) to support their knowledge of, and access to, services.
	■ 47,360 Kits for New Parents were provided to families of children ages 0-5 to support their knowledge of and access to services.

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 improvement approach to funding. The Desired Results for System Improvement and Community Change include:

- 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.

Key Systems Improvement and Community Change Results

The aspects of the Commission's initiatives and projects addressing Systems Improvement and Community Change focus on enhanced 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.

Systems Improvement and Community Change	
Desired Results	**Highlights**
Communities have adequate service capacity that is effective, coordinated, integrated, and sustainable.	▪ Broad scale-initiatives such as Healthcare Access, Health and Developmental Services, and the Oral Health Initiative seek to support, link, and, as needed, create a network to enhance the continuum of services needed to serve families. Contractors assist families from the initial contact through the completion of any treatment services so that families do not fall through the cracks. This requires coordinated and integrated service delivery. The hope is that such efforts will create provider relationships that are sustained beyond the life of the Commission's funding.
	▪ The regional structures characteristic 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 resources and avoiding service duplication.
	▪ Stakeholders uniformly noted that First 5 funded services were culturally and linguistically responsive. However, a more concerted approach to understanding and assessing cultural and linguistically responsive services is needed.
Families have access to culturally and linguistically responsive	▪ The majority of families served were identified as Latino/Hispanic. For example, 78.3% of SR children accessing early care and education services and approximately 65.0% of HDS's service contacts were Latino.

Systems Improvement and Community Change	
Desired Results	**Highlights**
services.	▪ Overall parent satisfaction rates with key initiatives are 99.3% for the School Readiness Initiative and 79.4% for PFA. This includes both English and Spanish speaking parents.
Policymakers and the public understand the importance of children's early years and support efforts to promote school readiness.	▪ Policymakers and key stakeholders are aware of First 5; however, they are not very familiar with the programs and results of the work of First 5 San Diego.
	▪ The Commission is in the process of hiring a communications project coordinator to address improved dissemination of information about the work of the Commission and the importance of the first 5 years.
The work of the Commission and First 5 funded programs is enhanced by community-driven solutions to issues that affect children and families.	▪ The Commission engages the community in planning through various leadership teams and advisory bodies.
	▪ Key stakeholders offered mixed opinions of the Commission's role in engaging the community at large. If additional staffing resources were added, the Commission could pursue additional community planning and input strategies.

Other System-Level Notes

Fiscal Year 2006-07 marked a year when the Commission implemented significant projects. This marked the first year of two of the initiatives (Parent Education and Preschool for All) while the School Readiness Initiative was operating under revised guidelines to better target measurable results. Change and innovation on this scale took concentrated effort and collaboration on the part of contractors and Commission staff to troubleshoot challenges and devise solutions. Some of the challenges were because 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 these systems' problems, which in turn, affects a contractor's ability to meet its targets. This is especially true with Healthcare Access contractors where the health plan enrollment system is fraught with delays in processing and changes in the overall funding for health insurance.
- ***New funding opportunities:*** There are a number of new funding streams (i.e., Proposition 63) that have or may intersect with First 5 initiatives. Although this will improve the sustainability of programs, it will be challenging to weave together the different funders' goals and requirements.
- ***The importance of Commission partners:*** As the Commission builds more regional systems, the role and performance of the countywide coordinators and regional lead contractors are critical to the overall success of each 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 and the San Diego County Office of Education (SDCOE) for Preschool for All.

These contextual issues are woven throughout the chapters of this report and are key contextual factors when examining the work of the Commission and its contractors in meeting goals and producing outcomes that benefit San Diego's children and families.

Conclusion

The First 5 Commission of San Diego has fully transitioned from funding discrete programs to funding a network of interlinking initiatives that address the needs of the whole child. This strategy is built upon the approach of making multiyear investments in deep community change that produce measurable results for young children and their families. This comprehensive approach has honed the Commission's perspective as it addresses challenges in a more efficient and methodological manner based upon a vision of the results it seeks to achieve and an ongoing assessment of the impact of its funding decisions. 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.

Introduction

"Children are our most valuable natural resource."

—Herbert Hoover

In 1998, the passage of Proposition 10 authorized the use of a tobacco tax to fund services for children ages 0-5 and their families. This unprecedented decision to support early childhood programs created the First 5 Commission of San Diego County (First 5 San Diego), and gave this Commission the flexibility to determine its structure, approach, and focus in response to local community needs. Now, nearly a decade later, the Commission has developed as an organization, a key funder of services, and an agent of change. It will continue to play a vital role as San Diego County grows. Estimates forecast that the county's total population will reach 3.6 million in 2020, up from 3 million in 2004,[1] and that the number of children 0-5 years of age will increase by 9.2%, rising from 250,677 in 2004 to 273,767 in 2020.[2]

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. In doing so, the Commission can make informed decisions about modifications and support to existing funded programs and look toward future funding opportunities. The Commission has continued to place a high value on the lessons it learns as a key facilitator of services for young children and their families, and to carefully consider how the systems and services it supports could be improved.

The purpose of this report is to document the overall impact of First 5 San Diego's work from July 2006 through June 2007 (FY 2006-07). It is an impact evaluation report, which seeks to address the successes and challenges of the Commission's initiatives and activities on the children and families who access the services, the collective programs it funds and the health, education and family systems in this community. In addition, this report also highlights:

- The service system First 5 has enhanced and how it interconnects with existing systems
- Emerging needs and trends among San Diego's 0-5 population and their families
- Promising practices

The report synthesizes the most 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

[1] SANDAG Regional Data Workbook: http://datawarehouse.sandag.org/defm_for_web.xls. Accessed: 10/8/2007.
[2] First 5 San Diego Strategic Plan: http://www.first5sandiego.org/uploads/Strat_Plan_2003-06.pdf

funded initiatives. The report's intent is to compile this information in a central location to inform the State and local First 5 Commissions and the San Diego County community about First 5 San Diego's efforts. It also provides information to inform First 5's future decision making.

Improving Outcomes and Strengthening Systems: First 5 San Diego's Evaluation Design for FY2006-07

First 5 San Diego has fully transitioned to funding multi-year initiatives that build on existing services, concentrate on community impact, and ensure that funded programs are strategically linked both to the Commission's Strategic Plan and its vision. "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 Health and Development Services Initiative (HDS), funds six regional leads to coordinate a network of services that provide physical and developmental support services for young children and their families. By doing so, First 5 hopes to provide critical needed services for young children while building and strengthening relationships between providers that are sustained with or without First 5 funding.

In addition to strengthening systems, this strategic concentration of funding has allowed the Commission to effectively and appropriately track and report contractor progress toward meeting the goals and objectives of its strategic plan.

The approach to evaluating the Commission's work is a partnership between the Commission staff, contractors, and Harder+Company Community Research. This approach is depicted in Exhibit A.

Key Components of the First 5 2006-07 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.

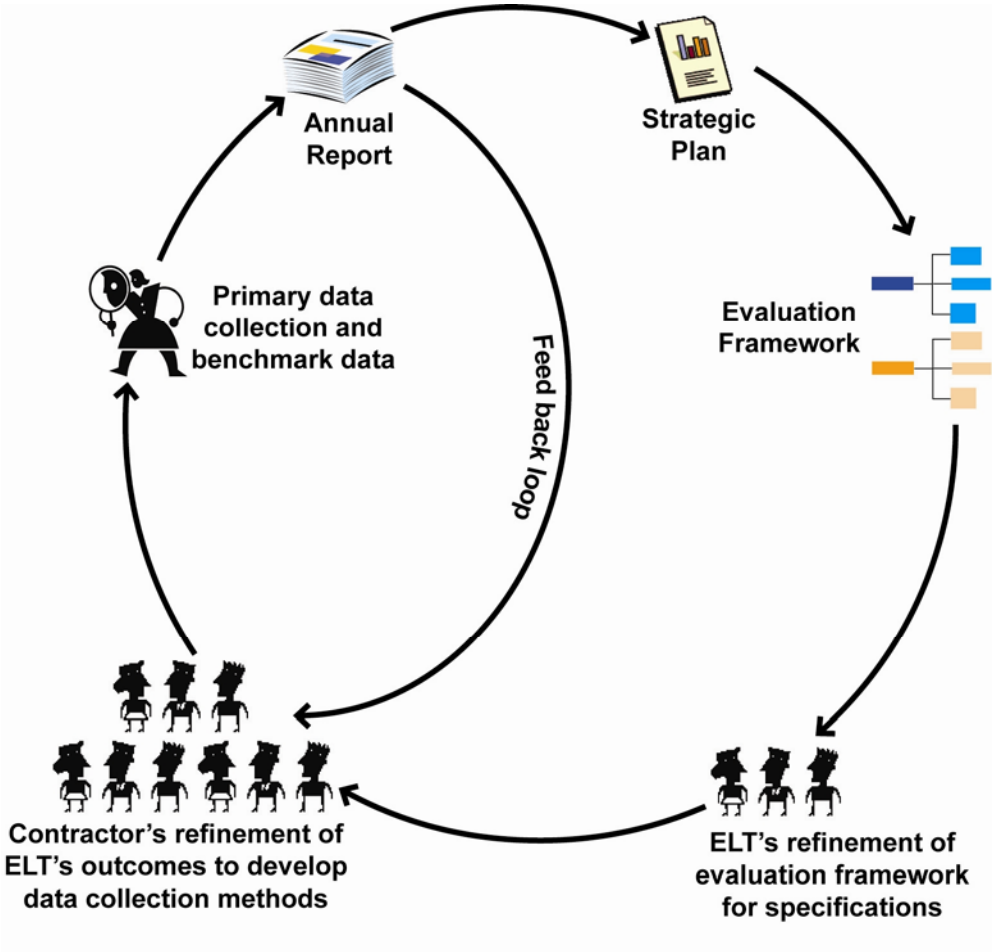
The evaluation begins with the Evaluation Framework (see Appendix C). This framework was developed by Harder+Company and the Commission's Evaluation Leadership Team (ELT) to broadly define objectives and indicators of success. Using this Framework as a road map, the Commission selects from the Framework's indicators when developing new initiatives. These indicators are then refined by Harder+Company and the ELT in the context of the particular initiative 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 a consensus on common data collection tools and implementation strategies. The initiative evaluations include individual, program, initiative, and system level analysis.[3] As a

[3] Program level findings are not presented in Annual Reports. Individual findings by lead contractors are provided at a later date as part of the Commission's "learning community" approach. At these meetings, initiative contractors meet with their peers to

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 for young children and their families.

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.

Exhibit A: Commission Approach to Evaluation



discuss their individual findings in relationship to the initiative as a whole. These meetings frequently provide opportunities to share successes, challenges, and possible solutions to program issues to improve future outcomes.

CHAPTER 1

Healthcare Access Initiative

"[We're] giving these children a chance at a healthy start"

—First 5 San Diego HCA Provider

Key Results

+ **Continued high level of results for children and families.** Several key outcomes and process numbers remain at high levels, while some have plateaued.

+ **Increased health insurance enrollment application assistance.** Application assistance increased each year for the past three fiscal years.

+ **Maintenance of high enrollment rates.** Consistently high health insurance enrollment for the past three fiscal years.

+ **Increased dental health utilization rates.** Increased and high utilization of dental care from FY 2004-05 to FY 2006-07.

+ **High rates of appropriate medical care usage.** Consistently high utilization of medical care and low utilization of emergency care for the past three fiscal years.

Summing It Up

Children and Families Reached

+ 148,311 families were reached through outreach services, an increase of 2.7% from last fiscal year.

+ 3,421 pregnant women were enrolled, a decrease of 18.2% from last fiscal year.

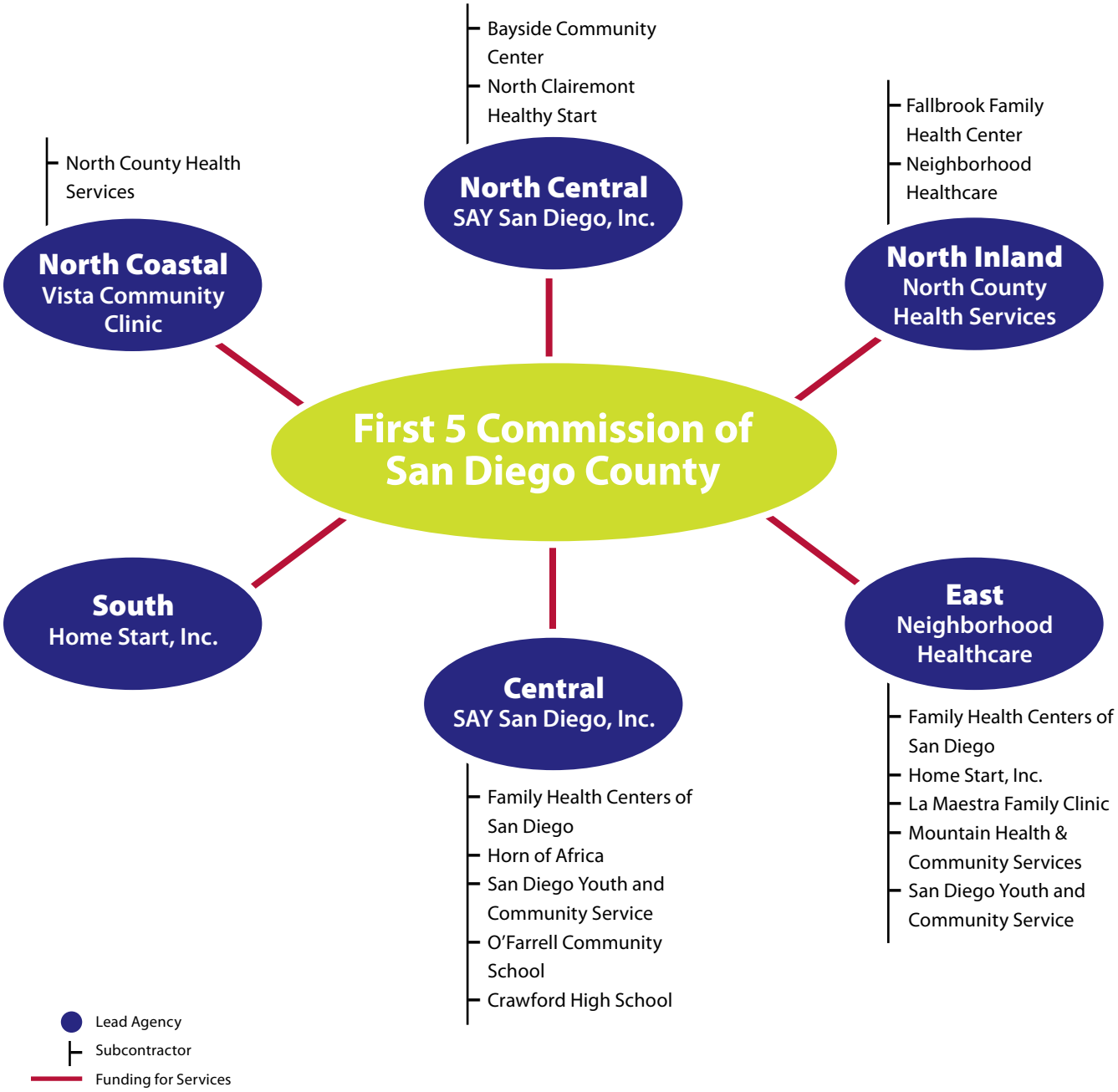
Children Assisted and Enrolled

+ 24,462 children were assisted with applications, an increase of 47.1% from last fiscal year.

+ The number of confirmed enrollments in FY 2006-07 increased by 2.0% from last fiscal year.

+ 48.1% of families receiving application assistance were successfully enrolled in health insurance in FY 2006-07, a decrease of 21.3% compared to last fiscal year.

Healthcare Access Initiative Structure*



* Includes First 5 funded Lead Agencies and Partners.

Introduction

Providing children with health insurance is a critical step in ensuring that they are healthy and entering school ready to learn. Research illustrates that children with health insurance are more likely to access regular health care,[4] while those without health insurance are more likely to have delayed care or utilize hospital emergency departments as their primary source of care.[5] An estimated 8.7% of San Diego's children ages 0-5 are without insurance.[6] This percentage is consistent with the national statistics, but slightly higher than California. In 2005, 8.7% of the nation's households had children without medical insurance; within California, 5.5% of households did not have medical insurance for their children.[7] To increase the number of children with health insurance, the First 5 Commission of San Diego County (First 5) funded the Healthcare Access Initiative (HCA) to outreach to families in need of insurance and care, assisted families with the enrollment process, and provided retention and education services to ensure that families stay enrolled in insurance and also learn to utilize appropriate health care services.

In FY 2006-07, HCA completed its third year of outreach activities and direct services. Launched in February 2004 in response to the high number of uninsured children birth to five years of age in the county, the Commission awarded two-year contracts to six programs. There is one program in each of the six County Health and Human Services Agency (HHSA) regions. These include North Coastal, North Inland, North Central, Central, East, and South. These programs focus on children eligible for Healthy Families or Medi-Cal for Children and pregnant women eligible for Medi-Cal or AIM (Access for Infants and Mothers program). Due to the success of and need for the services of this initiative, the six HCA providers were each awarded two contract extensions, in effect through June 2008.[8] Funding is distributed proportionally by the estimated number of uninsured children in each of the regions. The total funds allocated for the initiative from FY 2005 through FY 2010 is $11,683,400, with $3,087,583 allocated for FY 2006-07.

This chapter presents findings from the FY 2006-07 HCA evaluation as well as a comparison of these outcomes to those from previous fiscal years. The findings come from various data sources, which represent the provider, client, and community perspective. For the providers' perspective, the evaluation team reviewed monthly provider reports submitted to the Commission, which include provider capacity building, support, and infrastructure activities, and conducted interviews with one or two key individuals at each of the contracting agencies. The client perspective was represented by follow-up surveys conducted by providers with their clients to assess the retention and health access outcomes of families enrolled and accessing services at six, 12, and 18 month points, by four focus groups with pregnant women conducted by the evaluation team, and one case study with input from a mother whose children are enrolled in Medi-Cal and the family's case manager. Finally, interviews conducted with members of the health community, who served as expert observers, provided insight on the initiative's contribution to systems improvement and community change.

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[4] Federal Interagency Forum on Child and Family Statistics. America's Children: Key National Indicators of Well-Being, 2007. Washington D.C. Accessed August 22, 2007. <http://www.childstats.gov/pdf/ac2007/ac_07.pdf>

[5] 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.

[6] First 5 San Diego. San Diego Family Survey. San Diego, CA: 2005.

[7] University of California, Los Angeles. California Health Interview Survey (n=8,526). 2003. Accessed August 22 2007. <www.chis.ucla.edu>.

[8] The initial 2-year contracts ended January 2006. The first extension for 18 months brought the initiative program year in line with the Commission's fiscal year and the most recent extension is for 12 months

Key Elements of this Initiative

The primary goal of the Healthcare Access Initiative (HCA) is to increase and sustain health insurance enrollment for eligible children ages 0-5 and pregnant women in Healthy Families, Medi-Cal, and AIM. HCA is a key strategy that 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 initiative accomplishes this through outreach, application assistance, enrollment, retention and appropriate utilization, which include the following elements:

- Identifying and reaching out to families in need of health care
- Assisting families in completing enrollment applications
- Providing ongoing support to families to ensure they remain enrolled in insurance despite challenges such as financial hardships and annual health plan renewal tasks
- Educating families to ensure enrollees are linked to medical homes and utilizing available health care services
- Working in collaboration with a large network of subcontractors and community partners to maximize resources

Summing it Up: Number of Children Reached

The Healthcare Access Initiative strives to reach and enroll the remaining 8.7% of uninsured children in San Diego County who are eligible for insurance, but not yet insured. HCA not only enrolls families and children in Healthy Families, Medi-Cal, and AIM, but also assists them in retaining coverage and encourages them to utilize health care services. The majority of providers agree that all of the components of the HCA are equally important and key to the initiative's success. As one provider noted, "Each component builds upon another and you don't always find that [in projects]."

Exhibit 1.1 shows the total number of families who received outreach services, children who were assisted with applications and enrolled into insurance, and pregnant women enrolled into insurance. It is important to note that outreach numbers increased dramatically between FY 2004-05 and FY 2005-06, but have since plateaued to more modest increases. Additionally, although application assistance numbers have increased each fiscal year, annual increases in numbers enrolled are becoming more difficult to achieve and the number of pregnant women enrolled has decreased.

Enrollment Process

HCA outreach is the beginning of a broader intervention of support for families. Agencies continued to reach a large number of families through their outreach methods. As Exhibit 1.1 shows, in FY 2006-07 outreach services were provided to 148,311 families, a slight increase compared to the last fiscal year. This suggests that agencies may be reaching as many families as possible, given their resources. Certified Application Assistants (CAAs) used a variety of outreach methods and locations. They set up information tables and sharing information at health fairs, community events, malls, grocery stores, schools, daycares, and churches. Some CAAs are co-located at Family Resource Centers throughout the County in order to share information and assist with applications. They also networked with individuals who have relationships with families, such as teachers.

Exhibit 1.1 Number of People Reached by the Healthcare Access Initiative					
Enrollment Activity	**FY 2004-05**	**FY 2005-06**	**FY 2006-07**	**% Change ***	**3 Year Total (FY 04-07)**
Families who received outreach services	84,266	144,312	148,311	+2.7%	376,889
Children ages 0-5 assisted	12,843	16,624	24,462	+47.1%	53,929
Children ages 0-5 confirmed enrolled**	8,008	11,541	11,777	+2.0%	31,326
Pregnant women enrolled	3,836	4,185	3,421	-18.2%	11,442

**Indicates percent of increase or decrease from the previous year.*
***Includes children enrolled into Medi-Cal, Healthy Families, and other types of insurance such as Kaiser*

CAAs outreach to families with children ages 0-5 and pregnant women who are likely to be eligible for Medi-Cal, Healthy Families, and/or AIM, and assist them with the application process. In FY 2006-07, 24,462 children were assisted with applications, an increase of 47.1% from the last fiscal year. This increase may be due to successful practices within agencies, and the proactive methods of some CAAs, who personally follow-up with clients they meet at outreach events. Additionally, having provided this service for several years, the agencies have likely become more trusted and well-known in the communities they serve over time and, as a result, families may feel more comfortable sharing personal information with them.

"With the outreach [efforts] they are picking up people in the community who might be reluctant to enter the system."

– Key Expert

Personalized assistance is key to the success of the HCA Initiative. Due to the details required for the application and complex verification processes, applying for health insurance can be an overwhelming undertaking for families. A number of verification documents are required, both for initial enrollment and renewals, including verification of income, residence, citizenship, identity, and property. The CAAs ensure that applications are complete and that all certificate documents are in place in order to prevent long wait times for results, re-application requests, or enrollment denial.

Assisted and Confirmed Enrolled

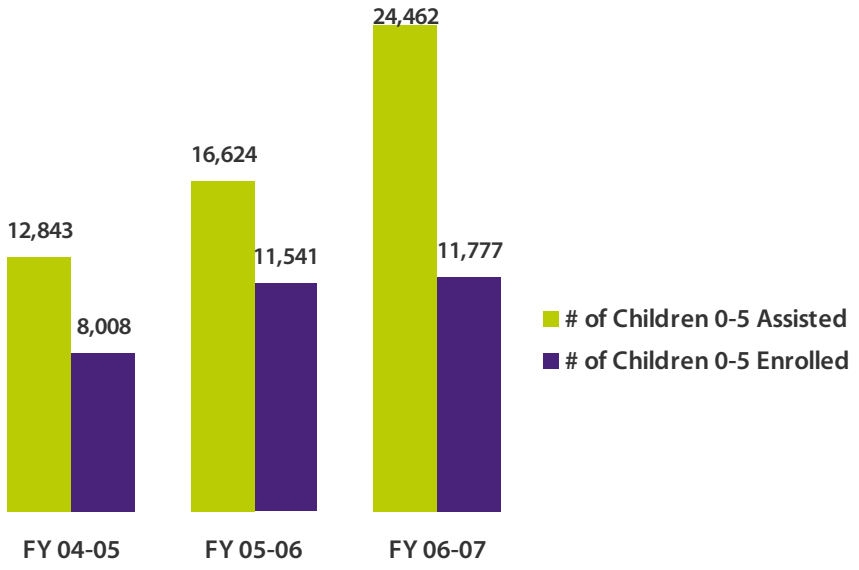
To understand the number of families served by this initiative, it is important to make a distinction between the terms "assisted" and "confirmed" enrollment. CAAs make every effort to ensure that families are eligible for insurance before providing application assistance (i.e., assisted). Application assistance may entail multiple visits with families to help complete forms. 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 understand the services available to them and know how to properly use their insurance card.

Of the 24,462 children assisted with applications in FY 2006-07, 11,777 were enrolled into insurance. Exhibit 1.2 shows the number of children assisted with applications and the number of children enrolled over the past three fiscal years. Although the number of children assisted with applications has increased 47.1% since FY 2005-06, the number of children enrolled has only increased slightly by 2.7%. Additionally, the percentage of

children confirmed has decreased. In FY 2005-06, 69.4% of children assisted were confirmed, but in FY 2006-07, only 48.1% of children assisted were confirmed.

There are four possible reasons for these trends. First, agencies may have already enrolled many of the children in the target population: the more children they successfully enroll each year, the smaller the applicant pool. In addition, according to the providers, many of the children they assist with applications are ineligible for services because they are not legal U.S. residents. Second, even in families where some children are legal residents, other children and/or the parents may not be. Many of these families may be afraid of the legal ramifications if they provide their personal information. Third, given the overlapping objectives of the HCA and Outreach, Enrollment, Retention, and Utilization (OERU) – a program that offers the same services as the HCA but targets children and young adults ages 0-18 – some children under five may be counted as OERU enrollees as opposed to HCA enrollees. Fourth, in February 2005 the Federal Deficit Reduction Act (DRA) was signed into law, making it a requirement, effective January 2007, that all applicants for Medi-Cal show proof of citizenship status. In the past, only legal immigrants and naturalized citizens were required to prove their status. Other states implementing this law reported drops in enrollment as well as delays in processing applications;[9] the same may be true in California.

Exhibit 1.2 Children Assisted Versus Children Confirmed Enrolled



The number of pregnant women enrolled has appeared low for the past three fiscal years, ranging from 3,421 to 4,185. In FY 2006-07, the number decreased by 18.2% compared to last fiscal year, which is the lowest it has been in three years. This is an enrollment area that providers have been focused on improving for the past few years, working closely with organizations that serve pregnant women. Despite these efforts, providers have been unsuccessful in increasing the enrollment of pregnant women. One reason for this may be that there is a very small window of time from the initial contact made with the women to the birth of their child. If, as many providers and clients report, it takes several months to become enrolled, a woman may have already had their

[9] Robert Wood Johnson Foundation. "Issue Brief: The Deficit Reduction Act's Citizenship Documentation Requirements for Medicaid Through the Eyes of State Officials in December 2006 and January 2007. Princeton: July 2007. Accessed August 29, 2007. <www.rwjf.org/pdf/CKFissuebrief3.pdf>

child and no longer be eligible by the time her application is processed. Providers also report that most pregnant women already have health insurance. Because they seek medical care early in their pregnancy and are quickly connected to health services, they do not require the assistance of CAAs. The First 5 Commission was interested in exploring this issue further. Harder+Company facilitated four focus groups with pregnant women to learn more about the barriers to enrolling in and maintaining health insurance coverage (see Focus Group: Pregnant Women's Perspective).

Making a Difference: Healthcare Access in Action

Once enrollment is confirmed by families, follow-up appointments are scheduled to ensure families understand their benefits and service-access instructions, 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 at six, 12 and 18 month intervals. These surveys inquire 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 data on utilization and insight into the challenges families face in maintaining their insurance coverage.

"I think we give them hope, particularly for the families who are just arriving here."

– First 5 Provider

The retention and utilization data highlighted in the remainder of this section are based on the results of 18,530 follow-up surveys: 2,834 in FY 2004-05, 7,327 in FY 2005-06, and 8,369 in FY 2006-2007. It is important to note that follow-up surveys counts do not include children who could not be reached for follow-up.

In September 2006, the follow-up survey was altered to modify certain questions and also to add more questions (see text box below). Some of the changes make it difficult to compare FY 2006-07 to previous fiscal years: the old survey asked whether or not children have utilized care *since being enrolled* and the new survey asks whether care has been utilized *in the past six months.* Thus, this section incorporates the results of both the old and new surveys when possible. Detailed outcomes can be found in the Data Compendium.

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 are features of the HCA Initiative that result in a high rate of retention and appropriate utilization. Although no direct comparison data is available, the percentage of children who have health insurance for their children in San Diego County is 91.3%[10], while the percentage of children enrolled through the HCA who have health insurance at follow-up ranges from 93.3% – 93.8% (see Exhibit 1.2). One key expert interviewed for this evaluation noted that the case management approach was a proven and effective method in ensuring continued enrollment, and the case study in this chapter further highlights the success of the model.

[10] First 5 San Diego. Family Survey Report. San Diego, CA: 2005.

Focus Group
Pregnant Women's Perspective

Pregnant women are eligible for medical benefits though Medi-Cal and AIM. Medi-Cal is health insurance that pays for medical services for children and adults with a limited income. Pregnant women who are ineligible for full benefits due to citizenship status may be eligible for pregnancy benefits under Medi-Cal. AIM is low-cost health insurance for middle-income pregnant women who make too much to qualify for Medi-Cal.

The number of pregnant women enrolled in health insurance through HCA decreased this fiscal year and is the lowest it has been for the past three fiscal years. In order to learn more about the barriers pregnant women face when enrolling in insurance, Harder+Company facilitated four focus groups with a total of 29 pregnant women between the ages of 14 and 39. A brief survey was also administered. Two groups with a total of 11 women were held at First 5 provider locations while two with a total of 18 women were held at non-First 5 locations.

Enrollment and Retention

The majority of participants (75.9%) were enrolled in Medi-Cal insurance, 10.3% had AIM, and the rest either had other types of insurance or no insurance. Most women said they had health insurance because they were pregnant and would not be eligible to receive benefits afterwards. While several women felt that there were no barriers to enrolling and staying enrolled in health insurance during their pregnancy, the majority of women noted barriers. These barriers included:

- Income requirements for enrollment: Many women believe they are not eligible for any type of health insurance, and may not understand why their application is denied. In one woman's words: "I tried to apply for Medi-Cal but I made too much [money], but then for other insurances I made too little."
- Complexity and length of the application process: One woman described her experience: "For me, the first time I went to apply it took me four hours, the second time for my interview it took, like, three. Just to get it. Then it took, like, three months to actually get it [become enrolled]."
- Documentation required for enrollment: Women felt the requirements were cumbersome: "They should just ask you what was necessary and that's it."
- Not understanding how to maintain coverage: One woman expressed her frustration with the process: "My first pregnancy they cut my Medi-Cal like every three months and you don't know when they cut it off so it's just like you go to the doctor and they say it's been cut off. Then you have to wait a week to get it back. I don't know why they cut mine off every three months."

Despite the difficulties involved in enrolling and staying enrolled in insurance, most of the women (82%) planned on insuring their children. They said that health insurance for children was less expensive, had fewer requirements, and a less complex application

Utilization

Out of the 29 women, 24 had received prenatal medical care and one had not (four women did not answer this question). Only 12 women had received dental care since becoming pregnant, a critical step in ensuring a healthy baby (discussed further discussed in Chapter 2).

Sources:

Access for Infants and Mothers. "Welcome to AIM." 2000. Accessed 20 September 2007. <http://www.aim.ca.gov/english/welcome.html#aim>.
Contra Costa County. "Insurance Programs for Pregnant Women." 2000-2007. Accessed 20 September 2007, <http://www.cchealth.org/insurance/pregnant_women.php>.
State of California "Medi-Cal Care Services." 2004. Accessed 20 September 2007. <http://www.dhs.ca.gov/mcs/medi-calhome/>.

The retention rates from six to 18 months decreased compared to the previous fiscal year, but the decrease ranged from 1.9% – 3.3%. The high retention rate for the past three years is, in part, attributed to the CAA 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. One provider notes that some families do not maintain coverage because they cannot afford it and that follow-up calls make families aware of services such as the hardship fund[11] that may be able to support them.

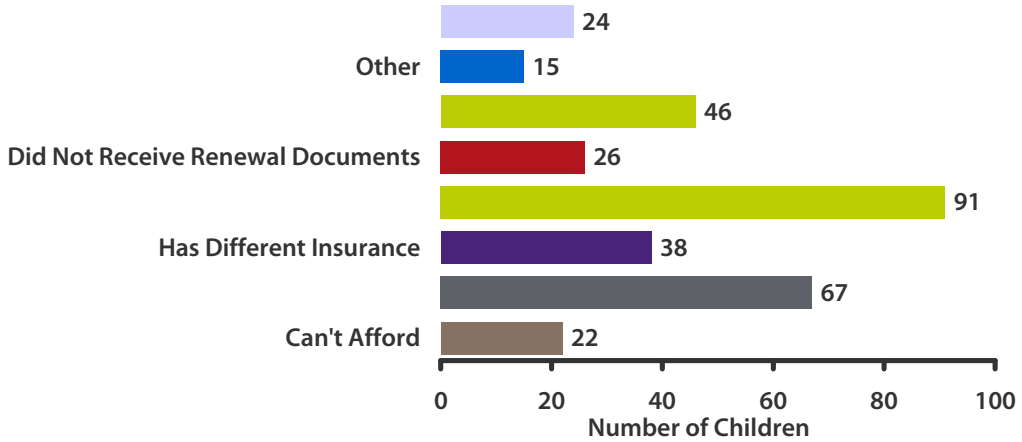
The positive results of the CAAs work extend beyond merely assisting clients with the application and calling to verify their continued enrollment. CAAs build relationships and develop trust, assisting families with everything from acquiring basic necessities to scheduling doctor's appointments. They 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.

Why Families Are No Longer Enrolled

There are various reasons children become disenrolled in health insurance. The way this question was asked changed in September 2006, when the survey was modified to strengthen the tool. Thus, Exhibit 1.3 does not represent the entire fiscal year, but rather all of the data collected from the new surveys. More detailed outcomes, as well as the results from the old survey, can be found in The Data Compendium.

Most parents cited multiple reasons for no longer being enrolled in health insurance. The majority of parents said that they did not know why they were disenrolled – a finding that supports the importance of the First 5 model of continued follow-up to families by the CAAs or other staff. Other frequently mentioned reasons were that they could not provide verification (income, residence, property, and/or citizenship verification), and that they were no longer eligible.

Exhibit 1.3 Reasons Children Are No Longer Enrolled in Health Insurance (n=291)*



**Categories are not mutually exclusive*

[11] The hardship fund assists families with maintaining their insurance coverage in times of urgent need. The fund alleviates some of the financial burden of paying monthly premiums by assisting families with basic necessities. Many families in need are given items such as baby supplies and grocery store gift cards. Policies for use and administration of these funds are set by each agency.

Maintaining Linkage to Medical Home

The second goal of the Healthcare Access Initiative is to link families enrolled in health insurance to medical homes. A medical home extends beyond having a regular doctor. It is an enhanced model of "primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective."[12] Having an ongoing relationship with a health provider has been 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 – a proxy measure for a medical home.[13]

"Families feel comfortable with their CAA to always come back for assistance and for help."

– Key Expert

In FY 2006-07, the number of children ages 0-5 linked to a medical home at follow-up remained high and ranged from 98.3%–99.6%. The percentages are higher than the county comparison of 91.2%.[14] From FY 2005-06 to FY 2006-07, there was a very slight increase – less than 1.0% for each follow-up period – in the percentage of clients who could name their child's clinic or doctor. The fact that retention and medical home linkage is high and has changed so little in the past few years indicates that service delivery is of high quality and at an optimal level.

Appropriate Utilization of Services

The third goal of the Healthcare Access Initiative is to support the appropriate utilization of services by parents to ensure their children are receiving the necessary preventative health services. A key to ensuring proper utilization of services is educating families so that they learn how to navigate the health care system and become advocates for their children's health. This addresses the Commission's goals that children will have access to preventative and comprehensive health care 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 primary utilization outcomes tracked through survey data: utilization of health care (visits to the doctor), dental care (visits to the dentist), and the emergency room since being enrolled in insurance. In Fall 2006, follow-up surveys were modified to measure utilization in the past six months. Also in the Fall, questions were added to record the reasons for the doctor, dentist, and emergency room visits, as well as whether or not the child received immunizations.

Visits to the doctor

To determine whether children were utilizing health care regularly, parents were asked at each survey interval if they had taken their child to the doctor or clinic. The percentage of children visiting the doctor since enrollment has remained consistent and high, at over 95.0% for each follow-up point in the past three fiscal years. The results from the new survey indicate that the percentage of children who visited the doctor in the past six months is lower and ranged from 92.8% to 94.8%. County comparison data states that 94.0% of families have taken their child to the doctor within the year, which is similar to the utilization rate of the families served by the HCA.

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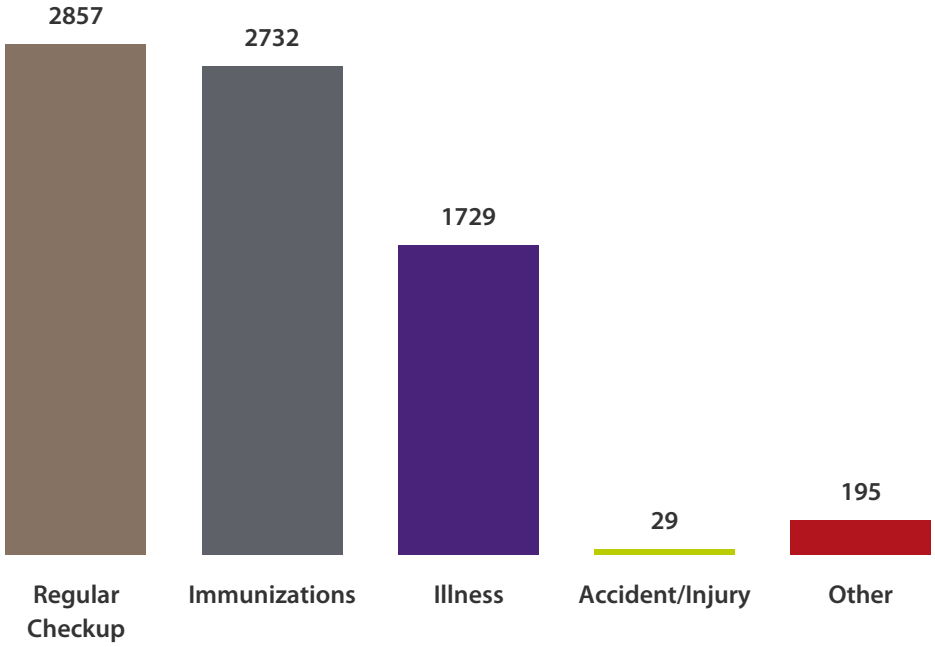
[12] American Academy of Pediatrics. "The Medical Home." Pediatrics. 110 (2002): 184-86. Accessed 19 September 2007. < http://aappolicy.aappublications.org/cgi/content/full/pediatrics;110/1/184>.

[13] 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.

[14] First 5 San Diego. Family Survey Report. San Diego, CA: 2005.

Parents who were administered the new survey were also asked the reason for the doctor's visit and if their child had received immunizations. Exhibit 1.4 shows that the most common reasons for visiting a doctor were to receive a regular check up and to receive immunizations – both preventative measures that indicate that families are promoting their child's optimal health and utilizing services appropriately.

Exhibit 1.4 Reasons for Visiting Doctor or Health Care Provider in the Past 6 Months*



Categories are not mutually exclusive

Visits to the dentist

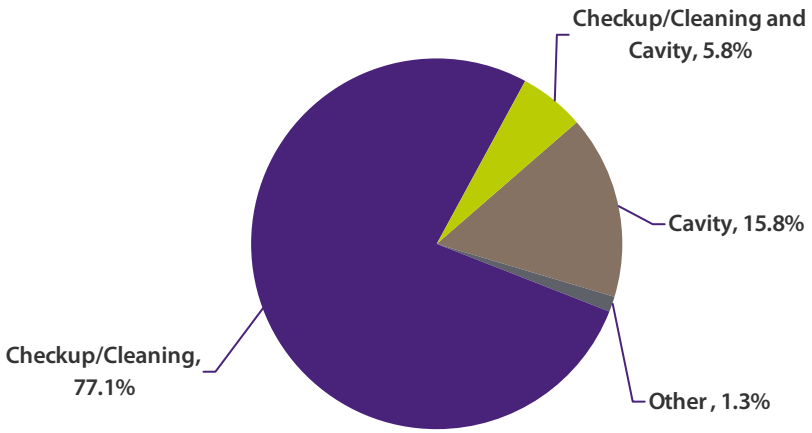
For children two years of age and older, parents were asked if they had taken their child to the dentist.[15] As Exhibit 1.5 shows, the percentages of children receiving dental care since enrollment has increased though the years. Within FY 2006-07, the percentage of children visiting the dentist in the past six months ranged from 59.9%–77.0%. These numbers are higher than the local benchmark data, which states that 52.8% of children ages one to five visited the dentist in the past year.[16] It is important to note that these comparisons are not direct, as HCA follow-up surveys only include children two to five years of age, while county data includes children one to five years of age, and HCA data spans the past six months, while county data spans the past year. Since January 2007 the HCA is also tracking the reasons for the dental visit, and as Exhibit 1.6 shows, most children (77.1%) visited the dentist for a checkup/cleaning, indicating parental knowledge and utilization of preventative care (only 15.8% accessed dental services for a known cavity). The steady increase in the utilization of dental services coincides with the implementation of the First 5-funded Oral Health Initiative, however, it is unknown if the dental services access by HCA families are First 5 funded.

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

[16] First 5 San Diego. Family Survey Report. San Diego, CA: 2005.

Exhibit 1.5 Utilization of Dental Care

Exhibit 1.6 Reasons for Visiting the Dentist in the Past Six Months*



**Categories are mutually exclusive*

Visits to the Emergency Room

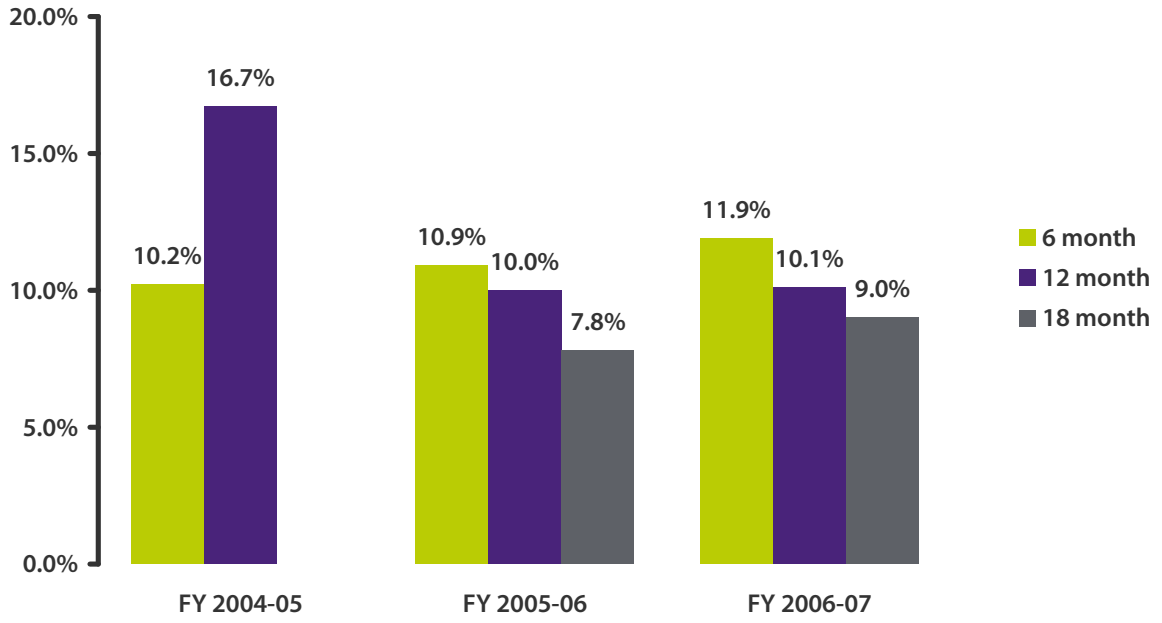
Use of the emergency room for non-emergency needs has financial consequences for the family, the health care system, and the community-at-large. Several providers believe that the HCA Initiative benefits the community at-large primarily by encouraging the appropriate use of health care services, therefore preventing unnecessary use of the emergency room. 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. The intent of this coaching is to reduce inappropriate use of the emergency room (e.g., for sore throats, ear infections, or coughs).[17]

To capture the pattern of emergency room visits, clients were asked if they had visited the emergency room. As Exhibit 1.7 shows, the percentage of children visiting the emergency room since enrollment ranged from 9.0% – 11.9% in FY 2006-07. This is a slight increase from FY 2005-06. Within FY 2006-2007, the percentage of children who visited the emergency room in the past six months was lower and ranged from 4.1% – 5.6%. County comparison data indicates that 21.8% of children visited the emergency room in the past year, which is higher than the utilization rates for HCA families.[18]

"Having medical attention is very important for the families. It gives them peace of mind."

– First 5 Provider

Exhibit 1.7 Emergency Room Utilization



[17] Connecting Kids to Healthcare Through School. "The Path to Good Health: A Toolkit for Parents." Accessed 25 September 25 2007. <http://www.connecting-kids.com/whatsnew.shtml>.

[18] University of California, Los Angeles. California Health Interview Survey (n=8,526). 2005. Accessed 22 August 2007. <www.chis.ucla.edu>.

Out of the 270 children who visited the emergency room in the past six months, about 150 specified the reason they visited the emergency room. The reasons given indicate that the emergency room utilization is generally appropriate. These reasons include accidents and broken bones.[19] In the next fiscal year, there will be additional data to understand the appropriateness of emergency room usage.

The New Follow-Up Survey and Future Changes

A new follow-up survey was introduced in Fall 2006 and used by agencies beginning in September or October of 2006. The survey was changed because providers wanted to streamline the process and focus on additional areas.

The following questions were changed:

- The old survey asked whether the child had utilized health care (doctor, dentist, or emergency room) since enrollment but the new survey asks whether the child has utilized health care in the past six months.
- The reasons for disenrollment were standardized across all follow-up periods.

The following are additions to the new survey:

- Reasons children visited the doctor, dentist, or emergency room
- Whether children visiting the doctor received immunizations
- Unique identifiers for each child were created so that next fiscal year the analysis will be able to follow individual children through their six, 12, and 18 month follow-ups, and determine more specifically when and how they became disenrolled.

Making the Connection

HCA is one of the few health insurance enrollment programs in the county. Other programs include San Diego Kids Health Assurance Network (SD-KHAN) and Outreach, Enrollment, Retention, and Utilization (OERU), which are both funded through Maternal, Child, and Family Health Services. SD-KHAN provides a telephone line to help families apply for health insurance, and it assists children and young adults ages 0-20. OERU, like the HCA, offers a broad range of services, but it targets a broader age range of children and young adults ages 0-18. HCA is unique as it is the only insurance enrollment program in the county that focuses on only pregnant women and children ages 0-5 and has a strong focus on insurance retention and appropriate utilization.

"We make it relatively simple for them to come in and fill out an application without being intimidated by the system."

– First 5 Provider

HCA providers collaborate with various other groups – they work closely with subcontractors and collaborate with other organizations that serve children and families. In addition, they utilize OERU funding to

[19] Connecting Kids to Healthcare Through Schools. "The Path to Good Health: A Toolkit for Parents." Accessed 20 September 20, 2007. <www.connecting-kids.com/HKHS/products/pathtogoodhealth/PDF/english.pdf>

complement First 5 funding. One key expert said that First 5 and their providers are "establishing linkages within the community" because working together is the only way to make sure that families stay enrolled in health insurance and utilize the health care system. The case study this year highlights ways in which different systems, such as First 5's HCA providers and non-First 5 funded programs collaborate to assist children (see Case Study: Healthy Systems, Healthy Families).

Subcontractors

First 5 contracts with lead agencies, that, in turn, often collaborate with subcontractors in order to reach the population within their region. Five out of the six lead providers work with subcontractors and believe that the lead/subcontractor model is effective and successful for various reasons. The model allows community clinics and community-based organizations to work together, which expands the breadth of families reached. Each agency attracts different types of clients in terms of ethnicity, income, and need. One provider pointed out that these collaborations have also changed the way the agencies work: they used to be more territorial but are now more team oriented, working together to help children and their families. The relationship also has challenges. According to lead providers, the fact that services are not co-located can make it harder to stay informed of relevant staff and policy changes at subcontracting agencies. Overall, most lead agencies and subcontractors have a positive outlook on the partnership and the impact it has had on the community as a whole.

"There are healthier children in the county because of First 5."

– Key Expert

Community Connections

HCA providers have varying levels of interaction with different community partners – some are informal cross-referring partnerships and others allow the HCA provider to use space at a partnering organization in order to connect with clients. Throughout the initiative's history, providers have recognized the efficacy of partnering with non-funded agencies to gain access to their target populations. Partnering with schools and daycares is a very common strategy to access uninsured children and families, and schools frequently provide HCA providers with the names of families interested in obtaining insurance for their children. Other common partnerships include those with Family Resource Centers (FRCs) and with Women, Infants, and Children (WIC), an organization that provides food and nutrition education to pregnant and postpartum women and children ages 0-5. FRCs and WIC have allowed HCA providers to station staff at WIC locations in order to enroll pregnant women and children. Many providers see these community connections as having a "huge impact." This kind of partnerships is most common in the South region, making subcontractors in that region less necessary.

As recipients of OERU funding, providers have been able to leverage funding to supplement their First 5-funded activities. With OERU funding, agencies are able to outreach to all of the children in a family, not just the children ages 0-5. Most agencies used the funding to hire more staff and one provider was able to hire a much-needed retention specialist to supervise the follow-up process.

Though OERU was originally funded through June 2009, the future of OERU funding is currently unclear. At the time this report was written, Governor Schwarzenegger had line item vetoed (or "blue penciled") the funding for OERU grants in the State budget. If this funding stream is lost, then the HCA will be the only health insurance enrollment project in San Diego County that also focuses on retention, and utilization.

Case Study
Healthy Systems, Healthy Families

Ignacia* is the mother of two daughters, Alicia, 7, and Rosa, 4, and one son, Carlo, 6. She and her husband moved to the United States 10 years ago and had their first daughter shortly afterwards. Ignacia became connected to First 5 services though Vista Community Clinic (VCC). In addition to offering First 5 funded services through the Project Sombrilla, which is funded through the HCA Initiative and the Oral Health Initiative, VCC also assists families through a non-First 5 funded initiative called Rayos de Salud. Rayos de Salud is a program that provides a variety of services such as home visitation, health education, and case management. Through the services offered at VCC, parents like Ignacia are connected to a wide-range of services within their clinic and other community resources as needed. This case study highlights the pathways connecting different systems and how First 5 works within an existing system to ensure a families needs are met.

Getting Connected

Ignacia periodically took her children to VCC for medical care, and at one visit several years ago, the doctor told Ignacia that Alicia was becoming overweight. To address this challenge, monthly home visitation was provided, and it was through the home visitation that Ignacia learned of the many services available to her children through Rayos de Salud and Project Sombrilla. Ignacia was assigned a case manager through Rayos de Salud, who served as her guide as she navigated the system.

"My life has become easier because when you're by yourself it's so much harder. You don't know what to do."

-Ignacia, First 5 Parent

One of Ignacia's goals was to keep her children in Medi-Cal, so her case manager, Dara*, connected her with the HCA Initiative through Project Sombrilla. Although Ignacia and her husband were initially able to enroll their children in Medi-Cal before connecting with the HCA Initiative, they were often disenrolled. Ignacia explains, "I had problems before with my Medi-Cal because they kept cutting it off and I didn't know why." This posed problems on multiple occasions for Ignacia's family, including a time when Alicia was bitten by a dog and needed emergency care. In this instance, Ignacia did not know that Alicia had been disenrolled, and the family received many unanticipated bills for ambulance services and medical treatment.

With HCA's help, Ignacia and her case manager were able to keep her enrolled in insurance. Ignacia feels that receiving assistance enables her to stay enrolled in medical insurance and also learn how to utilize medical services. She also finds it especially helpful to receive the information in her native language. "When Medi-Cal would get shut off they would help me to fill out the forms so that I could get it back, that was every year," said Ignacia.

**Names were changed to protect confidentiality.*

How it Works

Rayos de Salud is one of the many community programs that connects parents to the multiple First 5-funded services, such as Project Sombrilla, available at VCC. According to Dara, there are many opportunities for clients to connect to First 5 services at VCC. "This [Rayos de Salud] is one avenue through which families can access First 5 services. We help them access First 5 services…and help them follow up with the outcomes of their services," said Dara.

"We saw her more confident in her parenting skills, communication style, and her confidence in taking her child to services."

– Dara, Case Manager

In this instance, two programs worked together to help keep Ignacia's children safe and healthy. Ultimately, the convergence of Project Sombrilla and Rayos de Salud at VCC enabled Ignacia to receive health insurance and medical services. As a result, Ignacia's children are healthy and she has peace of mind.

Challenges

Despite the continued overall success of the HCA Initiative and an increase in most outcomes, agencies experienced the following challenges:

- *Working within the system:* There are many systemic challenges that HCA providers have no control over. One is the internal processes of Medi-Cal, which continues to delay enrollment for many families. The changes in the Medi-Cal citizenship requirements asking all applicants to provide proof of citizenship status may lead to longer delays in the future as well as a decline in applications and enrollments.
- *Collaboration across First 5 Initiatives:* Half of the Program Coordinators and Managers surveyed at the lead agencies said that, with the exception of the subcontractors, they were either not working with other First 5 partners or did not know if they were. Although it is likely that they do work with First 5 partners, HCA contractors are not aware of all the contractors and subcontractors that are funded across First 5 San Diego's other Initiatives, despite efforts of Commission staff to encourage cross-initiative collaboration.
- *Sustainability:* Agencies do not know how they will continue to provide the service when First 5 funding is discontinued. The fact that OERU funding may not be available in the future (FY 2007-08) may put the quality of First 5-funded services in jeopardy until providers recover from the funding loss. Providers used OERU funding to hire staff and enhance their services.

Lessons Learned

- *Working within a network of lead agencies and subcontractors:* Most agencies felt that working with subcontractors was beneficial because it made services accessible to more families. Not only do subcontractors help expand the geographic area the HCA Initiative can reach, they often attract different types of clients other than the lead provider, which helps ensure more demographics are served.
- *Collaborating with community partners:* All of the lead providers and subcontractor partners have expanded their service net to various organizations not funded by First 5. Partnerships may involve providers visiting other organizations to assist families with applications or they may serve as cross-referrals. Both are helpful and allow providers to better serve their clients, and to expand the kinds of services families receive. "A lot of times when clients come in, their needs are a lot more than the funded service can provide," said one of the lead providers.
- *Creative outreach:* Agencies have excelled in reaching children ages 0-5. Their outreach numbers appear consistent and high for the past two years, although there is no comparison data. Agencies alter their methods based on the time of year, such as going to malls or other places that host a Santa during the holiday season and attending community events during the summer months.

Recommendations

+ **Collaborate with other First 5 Initiatives.** Although a few of the lead providers collaborate with other First 5 Initiatives, this effort could be more organized. Collaboration with the Oral Health Initiative, in particular, would be especially beneficial in increasing dental care utilization. First 5 could facilitate this by providing agencies with information about other First 5 providers in their region.
+ **Assist agencies in developing sustainability plans.** Most key experts interviewed felt that First 5 raises awareness of sustainability issues among providers but could do more to facilitate the process and help agencies identify additional funding sources. This may include providing agencies with information regarding funding opportunities. Given the current political climate and the potential policy changes at both the state and national level, new funding opportunities may arise. Providers may need to be flexible and prepared to shift their focus to ensure sustainability.
+ **Continue to enroll pregnant women, but decrease the focus on increasing enrollment numbers.** HCA providers have spent the past several years working with each other, First 5, and other agencies to try to increase the number of pregnant women enrolled in health insurance though the HCA. They have found that most pregnant women in their target population already have health insurance and are connected to the system when they seek medical care early in their pregnancy. In addition, the long wait time for enrollment may make it difficult for pregnant women to become enrolled before they give birth. While providers should continue to target pregnant women, First 5 may need to decrease expected enrollment numbers.

A Final Word on the Healthcare Access Initiative

For the past three years, the Healthcare Access Initiative has been successful in providing outreach and support services that increase health insurance enrollment, retention, and utilization for children ages 0-5 and pregnant women in San Diego County. Despite the continued challenges of working within the Medi-Cal system and enrolling pregnant women, the number of children who are enrolled in health insurance and the percentage of those children who are retained have been consistently high from year to year.

CHAPTER 2

Health and Developmental Services Initiative

"[First 5] requires collaborative relationships, and people are stepping up and doing that and it creates a much richer service delivery to families."

—Stakeholder (Public Health Nurse)

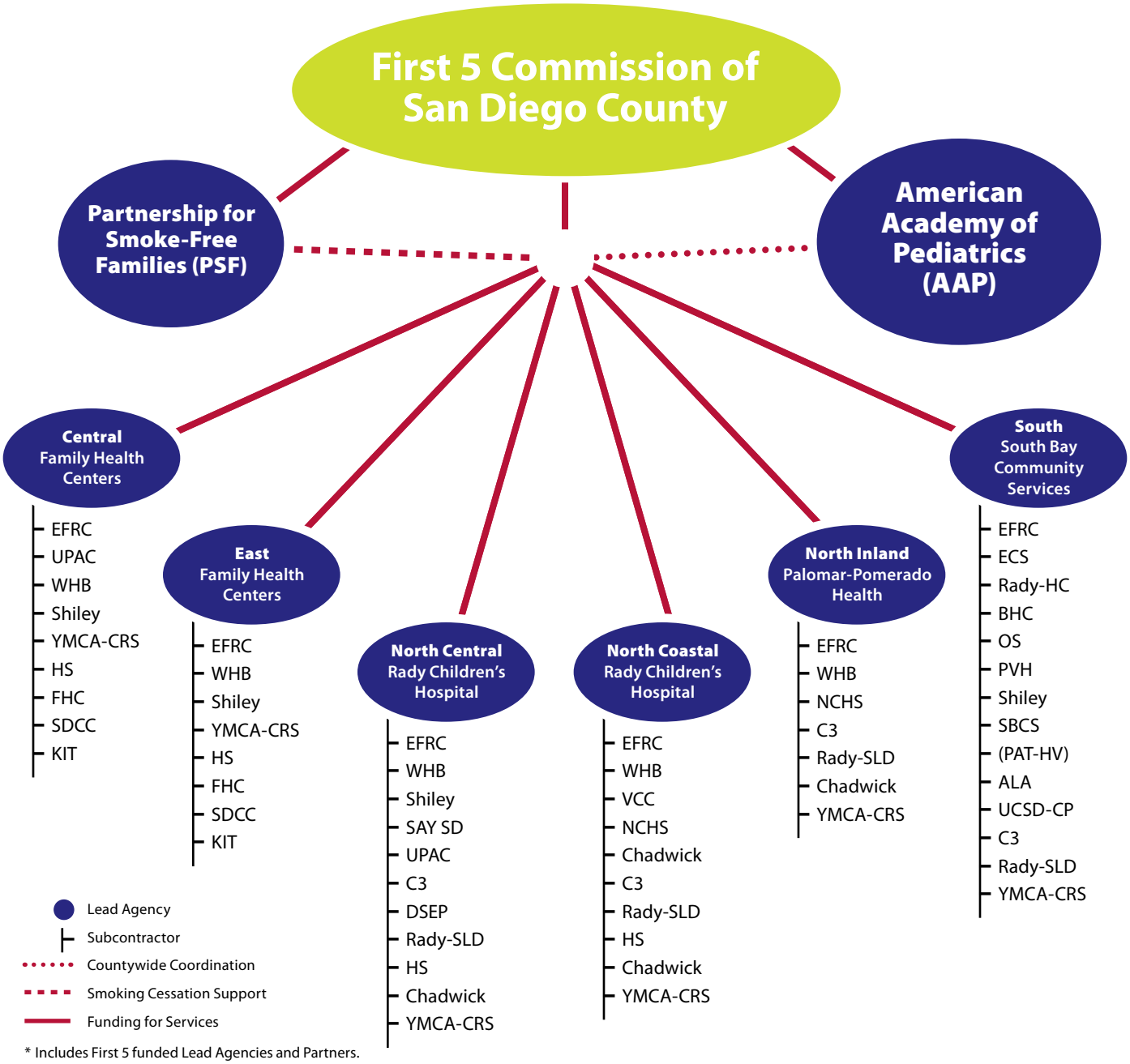
Key Results

+ **Children received needed services.** The majority of children identified with developmental, speech, and/or behavioral concerns received needed services: 88.2% of children needing an assessment received it and 79.4% of children needing treatment received it.
+ **Children exhibit developmental gains.** Almost half (45%) of all children receiving developmental, speech and language, or behavioral services demonstrated gains. The majority of children not showing gains remain in programs for further treatment or were referred for additional services (either within HDS or to an outside agency).
+ **Increased parent empowerment.** Parents reported that they benefit from HDS by increasing their knowledge (99.2%), enhancing their skills (99.0%), and becoming more empowered to address the health and developmental needs of their children (98.5%).
+ **Increased collaboration and service coordination.** The service integration of HDS regional leads, their subcontractors, and key community partners resulted in 9,225 children being referred to critical services within the HDS network. Most of these children (71.5%) were successfully connected to services. In addition, children were linked to other services: HDS made 17,302 referrals to providers outside the HDS network and nearly 2,000 of these were to other First 5 funded projects.
+ **Increased outreach to health providers.** Regional leads and AAP have successfully outreached to a number of key medical providers, including birthing centers and pediatric offices, in order to increase the number of children being referred into the HDS system of care.

Summing It Up

+ Almost 29,000 individual children were served across regional networks in FY 06-07.
+ Parent Support and Empowerment contractors provided approximately 3,079 sessions with 2,109 parents, including one-on-one sessions and group workshops and classes.
+ Over 8,000 newborn medical home visits and over 7,000 at-risk home visits were provided.
+ A total of 13,275 developmental screenings were provided to 11,622 children.
+ Over 6,000 children received a screening for speech and language delays (for a total of 7,774 screenings).
+ A total of 645 behavioral screenings were provided to 466 children during this fiscal year, half of whom were identified as needing further assessment (50.8%).
+ Almost 9,000 hearing screenings and 9,130 vision screenings were performed.
+ A total of 901 consultations were given to parents, including 750 phone and 151 face-to-face consults. Provider consultations were also via phone (690) and face-to-face (173), for a total of 863 consults.
+ Partnership for Smoke-Free Families worked with obstetricians and pediatricians throughout the county to provide almost 8,000 tobacco screenings during medical visits and home visitors completed over 2,400 screenings to identify smokers and refer them to the Smoker's Helpline.

Health and Developmental Services Initiative Structure*



* Includes First 5 funded Lead Agencies and Partners.

ALA=American Lung Association
C3=Children's Care Connection
Chadwick=Chadwick Center for Children and Families
DSEP=Developmental Screening and Enhancement Program
ECS=Episcopal Community Services
EFRC=Exceptional Family Resource Center
FHC=Family Health Centers of San Diego
HS=Home Start, Inc.
IBHC=Imperial Beach Health Clinic
KIT=Kids Included Together, Inc.
NCHS=North County Health Services
OS=Operation Samahan Clinic
PAT-HV=Parents as Teachers Home Visiting
PVH=Paradise Valley Hospital
Rady-HC=Rady Children's Hospital Home Care
Rady-SLD=Rady Children's Hospital Speech and Language Department
SAY SD=Social Advocates for Youth San Diego
SBCS=South Bay Community Services
SDCC=San Diego Center for Children
Shiley=UCSD Shiley Eyemobile
UCSD CP=UCSD Community Pediatrics
UPAC=Union of Pan-Asian Communities
VCC=Vista Community Clinic
WHB=Welcome Home Baby
YMCA-CRS=YMCA Childcare Resource Service

Introduction

Early identification of a developmental or physical delay is critical to ensuring children enter school ready to learn. According to the Centers for Disease Control and Prevention, 17% of children ages 0-17 have developmental or behavioral disabilities and even more have delays in language or other areas. Yet, less than 50% of these children are identified as having a delay prior to entering school, by which time the delay may become more significant and opportunities for treatment are missed. [20] In response to this need, the First 5 Commission of San Diego County funded the Health and Developmental Services Initiative (HDS) in January 2006. The Initiative's primary goal is the early identification and treatment of health problems and developmental delays that can negatively affect a child's ability to learn. First 5 San Diego has allocated $51.6 million over four and a half years for this project, over $13 million of which was allocated for the first 18 months (12 of these months were in FY 2006-07).[21]

Key Elements

The HDS Initiative has a number of key elements:

- **Systems Change:** HDS aims to transform the system of care for health and developmental services for young children by creating a more coordinated and comprehensive system built upon existing networks, resources, and services. HDS seeks to develop and strengthen connections between existing programs, expand existing services, fund new programs that fill service gaps, increase provider capacity to deliver high quality services, and leverage funding.
- **Regional Service Networks (RSNs):** In each of the six Health and Human Services Agency (HHSA) regions within San Diego County, a lead agency and its funded partners form a coordinated network to keep children in need from "falling through the cracks" by improving coordination of referrals and services, reducing service duplication, and filling service gaps.
- **Comprehensive Services:** Each RSN provides the following health and developmental services to children ages 0-5 and their families:[22]
    - Regional coordination of services, case management, and referrals.
    - Parent Support and Empowerment (PS&E) services that assist parents of children with special needs in navigating the system of care and/or provide parents of young children education and skills related to child development.
    - Newborn Medical Home Visits (NMHV) for all first time parents that include screening and referrals for health and developmental needs, as well as referrals to ancillary services for the family and children such as insurance enrollment and smoking cessation.
    - Ongoing home visiting for families considered "at-risk" (i.e., At-Risk Home Visitation or ARHV) including support and case management to meet a variety of family needs.
    - Screening, assessment and treatment for children in the areas of vision, hearing, development, speech and language, and behavioral services.

[20] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities. Accessed 28 September 2007. <http://www.cdc.gov/ncbddd/child/devtool.htm>

[21] The HDS Project began in January 2006 and the first "year" contracts were for 18 months (January 06-June 07). For all additional data throughout this report, only the fiscal year timeframe (July 06-June 07) will be referenced.

[22] For a list of all subcontracted service providers, see the agency listings under HDS in Appendix A.

- Health and behavioral consultation services for licensed and license-exempt early care and education providers and the families they serve.
- Tobacco use screening and cessation referral services.

- **Countywide Support and Capacity Building:** The American Academy of Pediatrics (AAP), California Chapter 3, is contracted to oversee and coordinate HDS' countywide implementation. AAP's role is to identify screening protocols and clinical pathways, develop referral guidelines, organize uniform and standardized reporting, share best practices, and design quality improvement resources and support. AAP coordinates trainings as needed, develops and utilizes an advisory committee, creates linkages with key healthcare and community-based organizations, and promotes fiscal leveraging. AAP also ensures the countywide vision of HDS is present in all outreach activities and materials and in collaboration with the Commission's community engagement strategies.

"We serve as a bridge between the regional lead and First 5 world, and we make sure all the voices are heard."

– AAP, HDS Countywide Coordinator

HDS is a comprehensive system, centered around four key goals:

- To promote early identification of needs by increasing access to screening, assessment, and treatment for cognitive, behavioral, and developmental delays
- To assure children receiving health and developmental services are showing appropriate gains
- To provide all first time parents with a free newborn home visit and provide at-risk families with ongoing in-home support services
- To empower parents to acquire the knowledge and skills necessary to support and/or improve their children's health and development

Summing it Up

As of July 2006, HDS was fully operational, providing all contracted services. Therefore, the following FY 2006-07 data is much more comprehensive than FY 2005-06 data and demonstrate the results of HDS providers' outreach strategies to access children and families in need.

It should be noted that in the beginning of the Initiative (January 2006), HDS providers established targets for services and numbers served, but these targets were based on little or no benchmark data and with little standardization across the regions or among subcontractors. For these reasons, this report does not compare the projected and the actual numbers.[23]

[23] For FY 2007-08, AAP and First 5 established a more standardized approach to developing targets with the regional leads. It is anticipated these targets will be compared to service numbers in the next annual evaluation report.

During FY 2006-07, HDS served approximately 58,000 children ages 0-5, as seen in Exhibit 2.1.[24] This number is a combination of all children served in the categories listed and includes a duplicated count of children who received services in multiple categories. To provide a more accurate picture of unduplicated children served, AAP has designated four service components as primary "gateway" services in which children are likely to enter into the HDS system:

- Newborn Medical Home Visitation
- Developmental Screening
- Vision Screening
- Parent Support and Empowerment Services (indirectly served children)

By combining the number of unduplicated children served through these four service components, a more conservative estimate of total minimum children served is calculated – equaling almost 29,000 children. The following section provides more information related to each HDS service component and those served.

"This year's greatest success has been the sheer number of children who have received services who would not have otherwise."

– HDS Regional Lead

Exhibit 2.1 Total Children Served by Service Category*

Service Area	Total Children Served
Parent Support and Empowerment**	1,999
Newborn Home Visitation	6,396
At-Risk Home Visitation	3,187
Vision Screening	8,921
Vision Assessment/Treatment***	959
Hearing Screening	8,952
Developmental Screening	11,622
Developmental Assessment/Treatment***	5,801
Speech and Language Services***	8,771
Behavioral Services***	1,209
Behavioral Consultation (Assessment only)	90
Total Maximum Children Served**	**57,907**
Total Minimum Children Served**	**28,938**

**Total number of children served may include duplicate counts as the same child may have accessed services in more than one category.*
***Children are only indirectly served through this service; parents are the primary clients.*
****Number of children served within this service category may include duplicate counts as the same child may have accessed more than one service (screening, assessment, and/or treatment) within this category.*
*****Maximum children served is a total of all children served for each service area; Minimum children served is a total of all children served through the four gateway service areas: Parent Support & Empowerment, Newborn Medical Home Visits, Vision Screening, and Developmental Screening.*

Parent Support and Empowerment

While the primary focus of HDS is to ensure early identification and treatment of children's delays, it is important to include parent support services in this project. Parents often lack the knowledge and resources needed to navigate complex health and social service systems or may not feel empowered to advocate for their children's needs. Parent Support and Empowerment (PS&E) providers seek to educate parents about

[24] All process numbers in this section originate from contractors' quarterly reports to the Commission. Quarterly reports are produced by each region and include aggregate counts of services and client load for each service category. Therefore, it is not possible to determine a true unduplicated count of all children served for the entire project.

child development and available resources in an effort to optimize children's physical and cognitive growth. PS&E providers also support families of children with special needs through peer mentor services.

In FY 2006-07, PS&E contractors provided approximately 3,079 sessions with 2,109 parents, including one-on-one sessions and group workshops and classes. Nearly 2,000 children were beneficiaries of the PS&E services. (See Exhibit 2.2).

Exhibit 2.2 Parent Support & Empowerment Services

Sessions	3,079
Parents Served	2,109
Children Served Indirectly	1,999

Home Visitation

Home visiting models are found to be highly effective in providing services to hard-to-reach and at-risk populations, as well as improving family health and self-sufficiency.[25] One of the primary components of HDS is offering a medical home visit by a nurse to all first time parents in San Diego County within the first two weeks of an infant's life. This Newborn Medical Home Visit (NMHV) serves many purposes, including assessment of the mother's and newborn's health, and the mother's risk for postpartum depression. The nurse examines the child's feeding and assists with breastfeeding support as needed. The home visit also includes a general screener for home safety and smoking in the household, and identifies needs for referrals and resources. Additionally, the home visitor provides brief parent education about child development, including distribution and presentation of the Kit for New Parents (See Chapter 8 for a discussion of the Kit for New Parents).

Exhibit 2.3 Home Visitation Services

	Newborn	At-Risk
Visits	8,037*	7,098
Children Served	6,396	3,187

**Number includes initial visits, follow-on visits and phone calls*

During FY 2006-07, the NMHV service providers conducted over 8,000 visits, which included the initial visit, and any necessary follow-on visits or phone follow-up, to over 6,000 infants and their families (refer to Exhibit 2.3). Of the reported children, 5,353 (83.7%) were breastfeeding at the time of the visit and 382 (6.0%) were living in a household with a smoker.[26]

During this first year of the Initiative, HDS RSNs and AAP worked diligently to build relationships with local birthing centers, to ensure first-time mothers are referred to NMHV. New mothers from 17 of 21 San Diego County birthing centers are currently referred to HDS. During the 2006 calendar year, 44.2% of these first time mothers were referred for a HDS newborn medical home visit.[27] As Exhibit 2.4 shows, there appears to be a gap between the number of referrals that were given this year and the number of children being served by HDS.[28] Of those referred, 62.0% received a newborn medical home visit. In addition, the bar graph shows the gap between the number of referrals and the estimate of new mothers served by the birthing centers. It is important

[25] A. Goodman. Grants Results Special Report. The Story of David Olds and the Nurse Home Visiting Program. July 2006. Robert Wood Johnson Foundation. <http://www.rwjf.org/files/publications/other/DavidOldsSpecialReport0606.pdf>

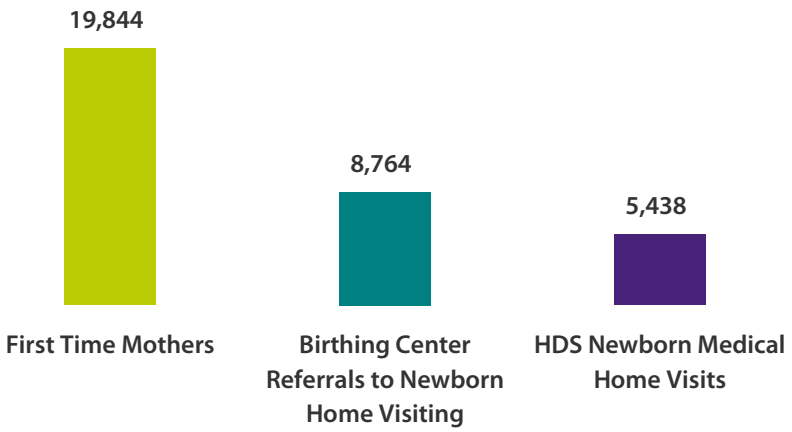
[26] The Centers for Disease Control's National Immunization Survey estimates that between 75-77% of babies are breastfed at some point before 3 years of age. Source: Centers for Disease Control and Prevention. National Immunization Survey. 2005. Accessed 9 September 2007. <www.cdc.gov/nis>

[27] In order to make accurate comparisons, calendar year data was used, as the number of new mothers in 2007 was not available.

[28] It is important to note that there is a lag time between when the referral is given and when the home visit occurs, and therefore any referrals made at the end of the calendar year will likely not have resulted in reported visits. It is unknown how many of these referrals were pending or lost to follow-up.

to note that not all birthing centers are currently participating in the NMHV referral process.[29] AAP and the RSNs worked diligently during 2006-07 to build relationships and establish Memoranda of Understanding with the outstanding hospitals.[30]

Exhibit 2.4 2006 Newborn Medical Home Visiting Referrals and Visits Compared to Number of First Time Mothers*



**Source: State of California, Department of Health Services, Center for Health Statistics. Birth Statistical Master Files. Prepared by County of San Diego, Health & Human Services Agency, Maternal, Child & Family Health Services (MCFHS)*

"A lot of times when parents are stressed, they're maybe not being the best mom or dad that they can be but this [program] can alleviate some of that stress on the parents.."

– HDS Provider

Separate, but often an extension of NMHV services, are the home visits provided for families considered at-risk (i.e., At-Risk Home Visitation or ARHV). These visits assist families who will most likely need additional services to prevent child abuse and neglect, improve health outcomes, and strengthen family skills. As seen previously in Exhibit 2.3, there were approximately 7,098 home visits given to 3,187 at-risk children and their families (an average of 2.2 visits per child). Not surprisingly, less than half of the children seen at the first at-risk home visit were breastfeeding (n=1,304; 40.9%).[31] Additionally, only 77 children (2.4%) considered at-risk were living in a household with someone who smokes.

At-Risk Home Visitation has the most partners of any of the HDS service areas. The definition of at-risk varies among these agencies, as well as the services that are delivered. In FY 2007-08, AAP, First 5 and the RSNs will be developing a more standardized service protocol for ARHV.

[29] Birthing centers that are not actively referring new mothers to NMHV services include Kaiser Permanente Zion, Paradise Valley Hospital (maternity services now pending), Camp Pendleton, and Best Start Birth Center.

[30] For more information related to HDS outreach activities and the birthing hospital relationships, see the systems evaluation section of this chapter.

[31] The ARHV providers serve families with children through age five, and thus many are not of breastfeeding age.

Developmental, Speech/Language and Behavioral Services

Early identification and treatment of delays or concerns in children's development, speech and language, and behavior is critical for children's later success in school and life. AAP recommends developmental screening be administered regularly at 9, 18, and 24 or 30 months or whenever a parent or provider concern is expressed. In addition, school readiness screenings are recommended prior to attendance at preschool or kindergarten.[32] In the 2005 First 5 San Diego Family Survey, approximately 65.0% of parent respondents reported that their child received some type of developmental screening or assessment.[33] Consequently, First 5 San Diego determined developmental screening a top priority for HDS and a primary gateway for most other HDS services. Exhibit 2.5 shows the number of screenings, assessments, and treatment units provided, as well as the number of children receiving those services for development, speech, and behavior during FY 2006-07. It is important to note that these three service areas often overlap and therefore the numbers may not be completely representative of what the HDS system has provided. For instance, some developmental service providers screen for speech and behavioral delays during the developmental screen, as the issues are not always distinguishable. These services may not have been captured consistently across all providers.

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 are placed in foster care, relative care, or the Polinsky Children's Center. Depending on the children's developmental and behavioral needs, DSEP refers them for further evaluation and related services. The results support increased permanency in the foster home and assist children in school readiness.

During FY 2006-07, DSEP conducted 1,296 screenings on 1,230 foster children.

Developmental Services

Of all HDS service areas, developmental services provided the largest number of service units to the most children during the fiscal year. A total of 13,275 developmental screenings were provided to 11,622 children. Approximately 40.3% of children screened were determined to need some type of follow-up after screening.[34] Developmental assessment and treatment contractors conducted over 3,000 assessments and provided over 11,000 treatment units (averaging four treatment units per child served).

[32] American Academy of Pediatrics. Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening. Pediatrics, 118:1, July 2006, 405-420

[33] The survey question was asked of parents with a child of at least one year of age: "Has a doctor or other professional ever had your child pick up small objects, stack blocks, throw a ball, or recognize different colors?" It is unknown whether parents defined such an occurrence as a developmental screening or assessment. It is also unknown whether any of these children were in need of a developmental assessment.

[34] The number of children needing follow-up does not match the number of children served in the assessment or treatment categories, as some children are referred to services outside of HDS for follow-up. The percentage needing follow-up is based on all children receiving the service (i.e., a duplicated count of children served, not the unduplicated count).

Exhibit 2.5 Developmental, Speech/Language and Behavioral Services			
	Developmental	**Speech & Language**	**Behavioral**
Screenings	13,275	7,774	645
Children Screened	11,622	6,442	466
Assessments	3,371	972	460
Children Assessed	3,045	931	203
Treatment Units*	11,329	9,532	2,858
Children Treated	2,756	1,398	540

**Treatment units include: parent and child workshops, classes, and one-on-one therapy sessions. Subcontractors' curricula are derived from evidence-based models such as the Hanen model for Speech & Language and Parent-Child Interaction Therapy (PCIT) for Behavioral services.*

Speech and Language Services

Although it is not a gateway to other HDS services, speech and language service contractors served a relatively high number of children. Over 6,000 children received screenings for speech and language delays (for a total of 7,774 screenings). About a quarter of the children (27.3%) screened were found to need further assessment.[35] Nine hundred and thirty-one children were assessed through speech and language service contractors and 1,398 children received treatment, for a total of 9,532 treatment units (an average of 6.8 units per child). As seen later in the chapter, the speech and language service category received one of the highest numbers of referrals from other service areas, potentially indicating a critical need for children.

Behavioral Services

A total of 645 behavioral screenings were provided to 466 children during this fiscal year, half of which were identified as needing further assessment (50.8%).[36] Behavioral assessments (n=460) were given to 203 children, and 540 children were provided a total of 2,858 behavioral treatment units (average of 5.3 units of service per child).

Vision and Hearing Services

Ensuring children have access to vision and hearing screenings is another service component of the HDS. These types of screenings are often provided via mobile programs that visit preschools, child care programs and other organizations where children are present.

During FY 2006-07, there were 8,953 hearing screenings performed (see Exhibit 2.6). Of those children screened, 10.4% were found to need further assessment. Hearing screening providers refer all children who need additional assessment or treatment outside of HDS to a primary physician for services.

Exhibit 2.6 Vision and Hearing Services		
	Hearing	**Vision**
Screenings	8,953	9,130
Children Screened	8,952	8,921
Assessments	-	797
Children Assessed	-	794
Treatment Units	-	162
Children Treated	-	83

[35] Ibid.

[36] Ibid.

Vision service providers also conducted a large number of screenings (n=9,130) during FY 2006-07. Of those children screened for vision problems (8,921), approximately one quarter of them (25.4%) were noted as needing additional services. [37] Vision service contractors also assessed 794 children and treated 83 children with an average of two units of service each (totaling 162 treatment units).

Health and Behavioral Consultation Services

Consultation services are offered to child care providers and parents of children who are in need of additional assistance related to children's health and/or behavior. These consultation agencies provide action plans and behavioral modification techniques for children with behavioral concerns.

Exhibit 2.7 Consultation Services

Family Consultations	901
Provider Consultations	863
Workshops	217
Workshop Attendees*	2,521
Assessments	548
Children Assessed	90
Treatment Units	51

**Includes an unduplicated count of parent, provider and child attendees per month (not unduplicated for year)*

Exhibit 2.7 reports the types and numbers of services provided by the contracted consultation service providers during FY 2006-07. A total of 901 consultations were given to parents, including 750 phone and 151 face-to-face consults. Provider consultations were also provided via phone (690) and face-to-face (173), for a total of 863 consults. This service area also held 217 workshops throughout the year, with over 2,500 attendees who were primarily providers and parents (1,250 and 1,070, respectively), although 201 children were direct participants as well.

Over 500 behavioral assessments were given to 90 children. Additionally, there were 51 behavioral treatment units provided.[38] In many cases, children identified by consultants as needing behavioral treatment are referred to behavioral services (both within and outside HDS), explaining the low number of treatment units in this service category. A more standardized protocol for assessment and treatment provided through Behavioral Consultations will be established in the coming fiscal year.

Tobacco Use Screening and Treatment Referral Services

As a separate but integral part of HDS, the Partnership for Smoke-Free Families (PSF) is a nationally recognized, countywide tobacco control program operated through Rady Children's Hospital and partially funded through First 5 San Diego. PSF was developed through a collaborative between Rady Children's Hospital, Sharp Healthcare, and Scripps Health.[39]

[37] Ibid.

[38] In FY 2006-07 quarterly reports, consultation service providers were not required to specify the unduplicated number of children treated. The forms have been modified so that all behavioral assessment and treatment services will be reported on one form in FY 2007-08 to provide an unduplicated service count.

[39] 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.

The goal of PSF is to train clinicians across the childbirth continuum to implement evidence-based practices for treating tobacco use.[40] PSF's Quit Link program creates systems-level change by training providers (obstetricians, home visitors, and pediatricians) to identify tobacco use among the pregnant women, new parents, caregivers, and the at-risk families they see and refer these families to the California Smoker's Helpline smoking cessation program. Quit Link's primary objective is to change the behavior of providers so that they consistently address parental tobacco use/exposure and make referrals to treatment for identified parental smokers.[41]

A total of 7,950 tobacco screenings were conducted in medical offices across San Diego County, 76% (n=6,033) in obstetric offices, and 24% (n=1,917) in pediatrician offices. Of these screenings, 1,959 (24.6%) identified parental smokers. Additionally, PSF continued to expand the number and type of providers included in the Quit Link program. Newly recruited and trained providers represent a wide variety of healthcare settings including private doctors, large hospitals, family clinics, military medical centers, and community clinics.[42]

Partnership for Smoke-Free Families: FY 2006-07 Numbers At-a-glance

- 359 obstetric and pediatric providers were recruited and trained to participate in Quit Link.
- Providers completed a total of 7,950 screenings across San Diego County. Of these, 1,959 (24.6%) identified parental smokers.
- 33 home visitors were recruited and trained to implement Quit Link at home visits with new parents and at-risk families. These home visitors completed 2,418 screenings and identified 118 smokers (25.7% of those identified in the home visitor quarterly reports).

Beginning in January 2006, PSF began working with the HDS RSNs to incorporate tobacco screening, advice, and referral into the home visits (both NMHV and ARHV) in all regions. At these visits, the home visitor provides parents with smoking cessation information and parents complete a tobacco use screening form. This form is sent to PSF for follow-up if the parent requests resources to help them quit smoking. As of June 31, 2007, 2,418 PSF Quit Link for Home Visitor tobacco screening forms were submitted to PSF, an increase from the initial 259 new mother screenings reported in FY 2005-06 when the program began working with NMHV providers. Of the 2,418 screenings, 118 smokers were identified and will be contacted by the California Smoker's Helpline for smoking cessation counseling. This identification of 118 smokers represents 25.7% of those children who reportedly lived in a household with a smoker, according to the quarterly process reports submitted by the NMHV (n=382) and ARHV providers (n=77). This finding indicates that there are opportunities to expand the tobacco screening and referral in the home visitation programs.[43]

[40] 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.

[41] The Commission first authorized PSF funding in February 2000. It was incorporated into HDS in January 2006.

[42] For more details, see Partnership for Smoke-Free Families quarterly progress reports for FY 2006-07.

[43] PSF protocol changed in December 2006 such that only families with newborns who reported a smoker in the household would complete a full screening, whereas all families identified 'at-risk' would complete the screening. However, the NMHV contractor in the South region has continued screening all households. Therefore, it is not possible to calculate the percentage of visits in which a screening was conducted as intended.

Making a Difference: Outcomes

The outcomes measured in HDS were specified by First 5 San Diego in the original HDS Request for Proposals. This design was developed in partnership with the Commission's Evaluation Leadership Team (ELT) and operationalized by the HDS Evaluation Workgroup during the first seven months of the project. [44] The evaluation was implemented in August 2006. The evaluation's indicators, along with the service areas responsible for collecting them, are listed in Exhibit 2.8.

Because of the wide range of service provision models and existing data collection procedures across HDS, individual client-level data collection was not integrated into the first year outcome evaluation design. Therefore, the HDS Evaluation Workgroup worked with Harder+Company to design Excel workbooks in which to enter and report aggregate outcomes on a *sample* of children served twice a year, with the expectation that client-level data will be entered and/or imported into a First 5-sponsored data system in the future.[45] The collection and reporting of the FY 2006-07 outcomes occurred during two time periods:

- August – December 2006 → reported in February 2007
- January – May 2007 → reported in July 2007

Exhibit 2.8 HDS Outcome Indicators and Assigned Service Areas

Indicator	Service Areas
1. Percent of children being breastfed at six weeks and at six months of age	Newborn Medical Home Visiting At-Risk Home Visiting
2. Percent of children identified as needing assessment who receive assessment	Developmental Services Speech / Language Services Behavioral Services Consultation Services Vision Services
3. Percent of children identified as needing treatment who receive treatment	
4. Percent of children receiving treatment who demonstrate gains related to the funded services they receive	
5. Percent of families who demonstrate increased knowledge about how to promote their child's health and development	Parent Support & Empowerment At-Risk Home Visiting Developmental Services Speech / Language Services Behavioral Services Consultation Services
6. Percent of families who demonstrate improved skills to promote their child's health and development	
7. Percent of children utilizing appropriate health and cognitive/social-emotional care resources	**Health Care Access/Use:** Parent Support & Empowerment Newborn Medical Home Visiting At-Risk Home Visiting Developmental Services
	Referrals: All Service Areas

[44] The HDS Evaluation Workgroup meets regularly and is made up of First 5 project staff, Harder+Company, AAP, and lead and evaluation staff from each Regional Service Network.

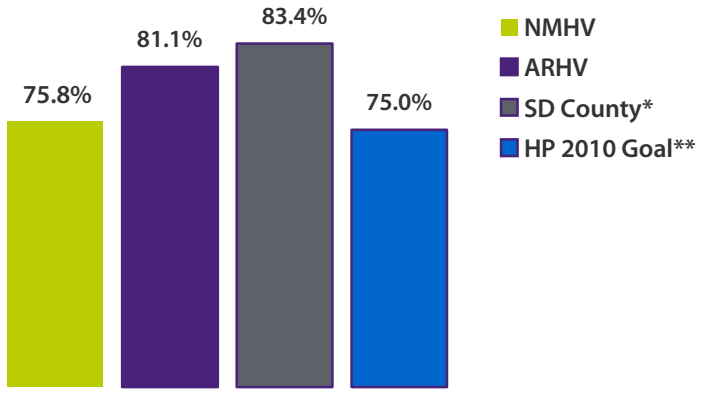
[45] The First 5 database is anticipated to be operational during FY 2007-08.

There are obvious limitations to how aggregate outcome data can be analyzed and reported.[46] Data reported in July 2007 was added to that reported in February 2007 for a comprehensive review of outcomes for the fiscal year; however, there are no comparisons made between reporting periods, regions, or service categories. For more specific details about the outcomes data, please refer to the Data Compendium. In addition to quantitative data collection, two case studies were conducted to capture the stories of HDS impact on parents and their children. These are found further on in the chapter.

Outcome #1: Breastfeeding

Research has shown that breastfeeding provides nutritional, health, immunological, developmental and psychological benefits for infants and children.[47, 48] The Centers for Disease Control estimates that between 75-77% of babies in the Unites States are breastfed at some point before 3 years of age.[49] The First 5 San Diego breastfeeding indicator aims to measure the percent of children who are breastfeeding over time – specifically at six weeks and six months of age. This indicator was a required data element during FY 2006-07 for the NMHV and ARHV providers, because breastfeeding support is often a part of their service delivery. The nurses providing the newborn visits educate the new mother about the benefits of breastfeeding, as well as present helpful techniques to increase breastfeeding success. The at-risk home visitor provides breastfeeding assistance as well, but only as needed.[50]

Exhibit 2.9 Breastfeeding rates at six weeks of age



**Source: First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.*
***Source: Office of Disease Prevention and Health Promotion, "Maternal, Infant and Child Health." Healthy People 2010: Volume II. Washington DC: U.S. Department of Health and Human Services, 2000. Accessed 5 September 2007. <www.healthypeople.gov>*

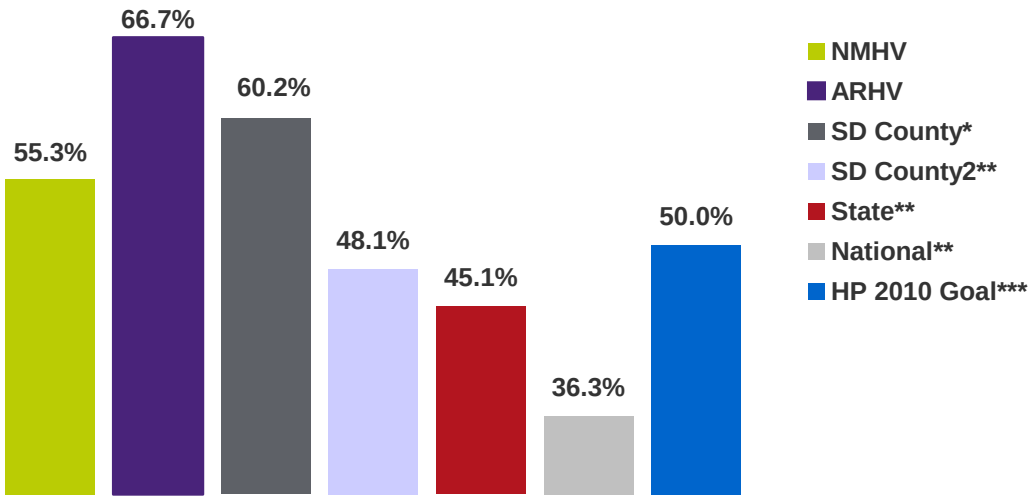
Home visitors were responsible for calling parents whom they had previously visited when their children were six weeks and six months of age to determine if the child was doing *any* breastfeeding. Findings can be seen in Exhibit 2.9 and 2.10. As expected, the rate of breastfeeding decreased between those responding at the six week and the six month age time points. For the NMHV group, 75.8%

[46] The outcomes evaluation for FY 2006-07 allowed reporting of a random sample of client outcomes. Service providers were asked to provide outcome data for at least 25% of all clients, however many service providers reported 100% of clients or as many clients as possible. Many modifications to the design of the outcomes evaluation have been made for the 2007-08 fiscal year.
[47] Bright Futures Children's Health Charter. "Nutrition Issues and Concerns." Bright Futures in Practice: Nutrition. Washington, DC: Georgetown University, 2002.
[48] American Academy of Pediatrics Work Group on Breastfeeding. "Breastfeeding and the Use of Human Milk." Pediatrics, 100 (1997): 1035-39.
[49] Centers for Disease Control and Prevention. National Immunization Survey. 2005. Accessed 9 September 2007. <www.cdc.gov/nis>
[50] Lactation support is not part of all at-risk home visitors' protocol therefore caution should be used when interpreting the long-term breastfeeding findings. These outcomes may not actually be a result of the service.

indicated some breastfeeding at six weeks of age and 55.3% were breastfeeding at six months of age. For ARHV, there was a slightly higher rate of breastfeeding at six weeks and six months of age (81.1% and 66.7%, respectively).

Exhibit 2.9 and 2.10 also show the rates of breastfeeding from various secondary data sources. The bar graph in Exhibit 2.9 shows that the rates of breastfeeding at six weeks of age for both NMHV and ARHV children met or surpassed the Healthy People 2010 goal, although rates were not as high as the general San Diego population's breastfeeding rates at six weeks as measured by the 2005 First 5 Family Survey.[51] Exhibit 2.10 presents similar findings. It is unknown why ARHV showed higher breastfeeding rates than NBHV. One reason may be that families receiving ARHV are benefiting from the ongoing support of a home visitor. Further investigation will be made in the coming year to examine this trend.[52]

Exhibit 2.10 Breastfeeding rates at six months of age



**Source: First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.*
***Centers for Disease Control and Prevention. National Immunization Survey. 2004. Accessed 3 January 2006. <www.cdc.gov/nis>*
****Source: Office of Disease Prevention and Health Promotion, "Maternal, Infant and Child Health." Healthy People 2010: Volume II. Washington DC: U.S. Department of Health and Human Services, 2000. Accessed 5 September 2007. <www.healthypeople.gov>*

Outcome #2 & #3: Assessment and Treatment

As HDS is designed as a system of care, a critical measurement is the success of referrals across the system and the initiation of services. Data were collected on the percent of children who received an assessment and treatment after being identified as needing these services. Data were collected in five service areas: developmental, speech/language, behavioral, behavioral consultation, and vision. Providers also reported on cases where the assessment/treatment were not completed, classified by the following reasons: the family

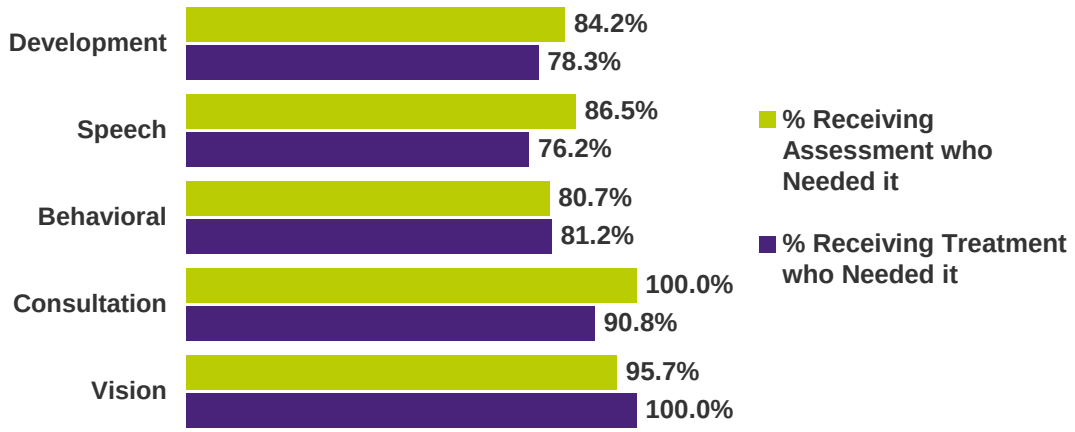
[51] Since the First 5 San Diego Family Survey was a retrospective study the breastfeeding rate from that report may be inflated due to recall bias (participants unable to remember accurate information). Source: First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.

[52] Breastfeeding rate data collection has been modified for FY 2007-08 to track a matched sample of families so that breastfeeding rates over time (from childbirth to six months of age) can be examined.

declined services, the child was referred to another HDS provider or a provider outside the project, or the family was lost to follow-up.[53, 54]

The findings related to assessment and treatment are seen below in Exhibit 2.11. It is evident from the chart that the majority of those children needing services received them (combined 88.2% for assessments and 79.4% for treatment). Additionally, a total of 67.1% of children who were reported as receiving an assessment were subsequently identified as needing treatment. It is important to note that due to the aggregate nature of the outcome data collection, progression from screening to assessment to treatment is not tracked.

Exhibit 2.11 Children receiving assessment or treatment based on need*



**Includes the valid percent of children receiving services (pending services were not included). For more details, see the Data Compendium.*

There was a relatively low rate of children not receiving the services they needed (11.8% for assessments and 20.6% for treatment). The most common reasons for children not receiving services included that the family was lost to follow-up (5.8% for assessments and 15.2% for treatment overall) and the family declined services (4.3% for assessments and 2.4% for treatment overall).

Data on pending services (i.e., the number of children who were on assessment and treatment wait lists) were not included in the calculations above, though it should be noted that there were some instances of large numbers of pending services for some service areas, most notably speech and language assessments (52.0% of all reported clients) and developmental assessments and treatment (35.7% and 21.5% of all reported clients, respectively). These large numbers are likely a result of a long lag time between identification of need and initiation of services, and indicate a need for more resources at the assessment and treatment provider agencies. Some HDS-associated providers mention that the large increase in screenings has created an increased need for further assessment and treatment as children are identified with delays. In general, the assessment and treatment components are more costly and require a greater number of qualified providers, and therefore the quantity of available services is less than what is needed to meet the growing demand (see the

[53] Providers were also allowed to designate assessments or treatment as pending; however, those cases were removed from analysis to make a valid set of results based on completed cases.

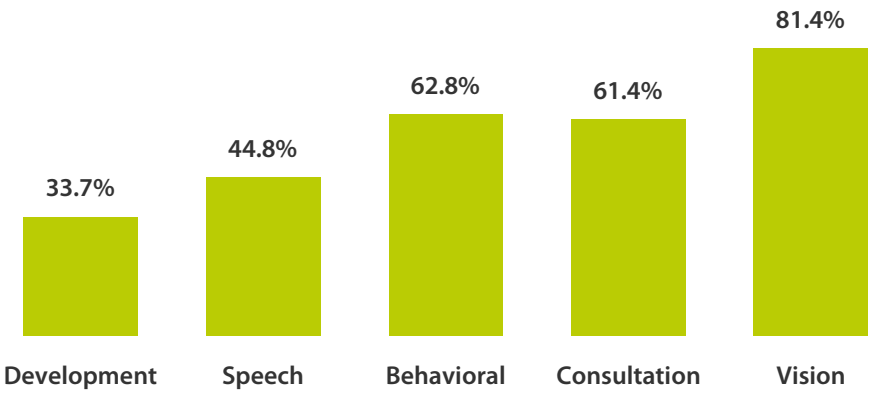
[54] "Lost to follow-up" is defined as a family who has not been successfully contacted because the family has moved, has a wrong or disconnected phone number, or has not returned messages.

systems evaluation component of this chapter for more information).

Outcome #4: Child Health and Developmental Gains

One of the most important, but also most challenging, HDS outcomes to measure is a child's health and developmental gains as a result of treatment. HDS primarily funds existing agencies whose service delivery models are already established and based on varying evidence-based curricula and oftentimes include a pre-existing validated measurement tool to track outcomes. It is not feasible or appropriate to use a universal instrument, therefore, agencies utilize a variety of tools to measure health and developmental gains and results are reported in the aggregate.[55] Given the variety of instruments used, it would be a misrepresentation to collapse or compare data across agencies. Exhibit 2.12 shows the combined percent of children with gains in each service area as a result of the treatment. Across the project, almost half (45.0%) of all children tracked showed gains.[56]

Exhibit 2.12 Child gains due to HDS treatment by service*



**Includes the valid percent of children reported as showing gains (does not include missing data).*

When tracked children did not demonstrate a gain, the following reasons were reported:

- Child did not show gain and continued in program (24.8% overall)
- Child did not show gain and was referred to another HDS provider for additional services (7.2% overall)
- Child did not show gain and was referred to another non-HDS provider for additional services (17.5% overall)
- The measurement of the gain was unclear, which may point to additional needs (5.5% overall)

In sum, although the 45.0% gain rate might appear low, it is important to note that the majority of children not showing gains are remaining in programs for further treatment or are being referred for additional services in HDS or an outside agency.

Outcome #5 and #6: Parent Knowledge and Skill Increase

As mentioned previously, HDS sets out to not only improve child health and developmental outcomes, but also to assist parents in learning about children's health and developmental needs and how to navigate complex systems of care. While the PS&E subcontractors are directly charged with this task, First 5 San Diego created

[55] Regional leads, regional evaluation staff, and Harder+Company reviewed and approved all instruments used for this outcome indicator. When available and appropriate, normed and validated tools were utilized.

[56] See the Data Compendium for more details.

HDS with the vision that parent engagement would play a role in all service areas. Indeed, most intensive services, like those seen in child treatment and ARHV, include a parent component where the parent is directly participating in classes, workshops, or one-on-one sessions (for a narrative report of the impact one HDS provider had on a parent, see the case study entitled, "Life on the Spectrum.")

The service areas collecting outcome data related to parent knowledge and skills during FY 2006-07 included Parent Support and Empowerment, At-Risk Home Visitation, Developmental, Speech/Language, Behavioral, and Consultation services. Programs used different interventions and therefore a variety tools to measure results.[57] Each program used a pre- and post-measurement tool to assess parent mastery of key topics and skills (some examples can be seen in Exhibit 2.13). The variability of data collection required reporting of increased knowledge and skills in aggregate form.

Exhibit 2.13 Program-Specific Measurement of Knowledge and Skills

Increased Knowledge	
PS&E	Parents are able to list available health and developmental resources
Developmental Services	Demonstrated understanding of fine motor skills
Behavioral Services	Demonstrated understanding of how to give children praise
Increased Skills	
ARHV	Observation of parents based on Family Risk Scale
Speech and Language	Observation of parent's use of speech development strategies

As part of the post test, parents were all asked the extent to which they agreed with a set of three, standardized, general statements:

- As a result of the program, I know more about the health and developmental needs of my child. (Knowledge)
- As a result of the program, I can do more to help my child's health and development. (Skills)
- As a result of the program, I will be able to meet the health and developmental needs of my child in the future. (Empowerment)

Results of the three general parent questions follow in Exhibit 2.14. Not surprising, the numbers of parents who agreed with these statements were high, ranging from 96.7% to 100.0% (overall percents include 99.2% for knowledge, 99.0% for skills, and 98.5% for empowerment). Although these items do not specify what the parent has learned or increased as a result of the program, these responses do indicate that, according to parents, they are benefiting from HDS programs.

The percentages of parents reported as increasing knowledge and enhancing skills, directly related to the intervention, are seen in Exhibit 2.15. Though many tracked parents exhibited improvements, the results were somewhat mixed, depending on the service area. Over eighty percent of parents receiving services through PS&E, Behavioral, and Behavioral Consultations exhibited knowledge and skills gains. In addition,

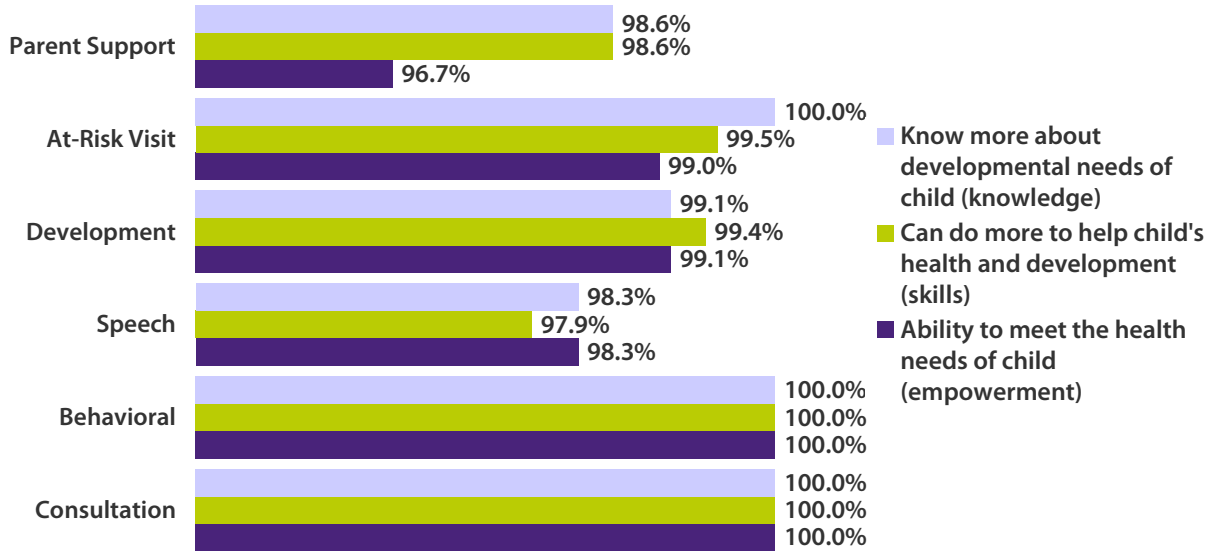
"If a child is lagging, especially if it's a first child, mom or dad might not have any real life experience to know if this is normal or lagging or something to watch."

– First 5 HDS Provider

[57] Regional leads, regional evaluation staff and Harder+Company reviewed and approved all instruments. When available and appropriate, normed and validated tools were preferred. Otherwise, it was recommended that each instrument be created with a pre/post test design and have a minimum of three questions measuring key knowledge related areas and three key skills.

over 90% of parents participating in Developmental services demonstrated increased skills. Parents showed far lower increases in the service area of At-Risk Home Visiting (20.2% knowledge; 28.1% skills). Reasons for minimal increases between pre and post test scores could be a result of: the pretest score being high (indicating existing knowledge/skills)[58], a parent's lack of knowledge gain, and/or an unclear result or score (perhaps indicating additional needs). One service area with high pretest scores was ARHV, with 71.6% for knowledge and 54.4% for skills. This suggests that parents may already be knowledgeable and skillful at some level. Further assessment is needed to determine whether the appropriate population is being served through ARHV, some ARHV-served families need more specific services and should be referred to other HDS providers, or the measurement tools are not sufficiently sensitive to detect changes in parents' knowledge and skill level.

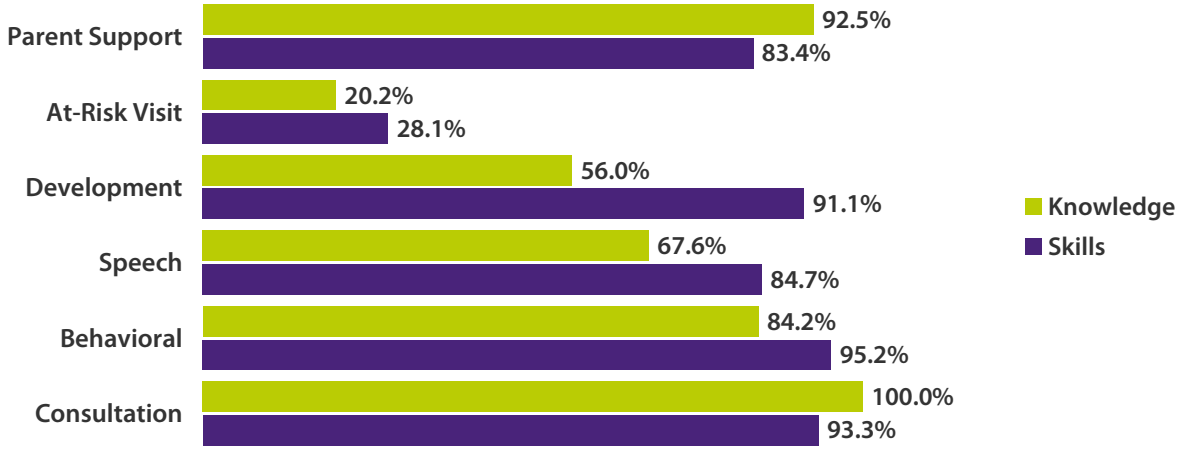
Exhibit 2.14 Parent affirmative responses to general knowledge and skills questions by service area*



Valid percents (unknown or missing response removed)

[58] The HDS indicator specifies an increase or improvement of knowledge and skills, therefore parents scoring high on a pretest were not considered "improving."

Exhibit 2.15 Parent increases in knowledge/skills on program-specific tools by service*



**Valid percents (unknown or missing response removed)*

Life on the Spectrum

Curious Behaviors

When Adrian* was three and a half years old, he displayed many typical behaviors. His mother, Lisa*, describes him as a "comedian" and a "kind" boy. Being the only child, Adrian's parents did not have another child to compare to Adrian in terms of development, yet Lisa sensed that something was not right. She describes some of the "curious behaviors" that were becoming increasingly hard for her and her husband to manage. Adrian did not enjoy playing with other children. He engaged in repetitive behaviors like spinning in circles and rocking his head. It was sometimes difficult to understand him when he talked. Lisa reports that she pressed Adrian's physicians for answers for a year and a half, and that during that time she grew more and more isolated. For example, she was afraid Adrian would get hurt if they went to the park since he would often ignore her and run away. Eventually Adrian's pediatrician did an initial developmental screening and referred him to Children's Care Connection (C3), a First 5 funded program at Rady Children's Hospital that provides a wide range of developmental services. Screenings are the first step at C3. If the screening tools indicate a developmental concern, staff then conduct developmental assessments and provide treatment through a variety of parent-child classes for children who have mild-moderate delays. C3 also refers children to additional services when they have more severe delays or have additional needs related to speech, language, and behavior.

"I was afraid to leave my house for a while because of [Adrian's] safety."

-Lisa, First 5 Parent

Connecting to Resources

C3 was a gateway to services for Adrian. Though the family is still awaiting an official diagnosis from a clinical psychologist, C3 staff immediately recognized some of the "red flags" associated with children on the autistic spectrum. C3 conducted a developmental screening and administered the Ages and Stages questionnaire. Adrian was referred outside HDS to the Regional Center and the local school district for additional developmental and behavioral evaluations. It is important that he complete these evaluations and secure a clinical diagnosis so that he can obtain an Individualized Education Plan (IEP) and the additional support from the schools before he enters kindergarten. C3 also referred Adrian to a private doctor for a hearing screening. (HDS offers that service but because Adrian has insurance he did not need an HDS-sponsored hearing screening).

Within HDS, Adrian participated in several group classes at C3 that are designed for children with special developmental needs. The group setting and expert staff both challenge and support children like Adrian. Parents observe classes, and in doing so, see 1) how their children's behaviors can present problems in a classroom and 2) how behavior management techniques can help their children succeed in a classroom. Lisa further refined the behavioral management techniques she observed in the classes through one-on-one behavioral coaching with C3 staff. In addition, C3 referred Adrian to its HDS partner, Rady Children's Hospital Speech and Language Department.

"Finally, when we got that referral to C3, it was like, 'boom,' all these doors opened up for me."

-Lisa, First 5 Parent

Navigating a Complex System

Several different entities have evaluated Adrian's development. The system is not linear – there are many paths into, through, and out of HDS and related non-HDS services. The system tends to be tiered -- a series of stairways connected by gates where each assessment or evaluation is the key to entering the next level of services. HDS is attempting to offer an array of services with a "no wrong door" approach, where a family can enter the system at any place in the service spectrum and be connected to the services it needs. A child may need a variety of services from different providers and will not always get all services within the HDS system. Although there is a way to track referrals between HDS providers, there is no structured countywide case management to usher families from one provider to the next. To succeed in this system, parents and caregivers must be vigilant and organized.

Equipping Parents to be Advocates

Lisa did everything she could to maximize the services available to her son. As one of the C3 staff observed, Lisa "…was willing to do anything, and she did. I could tell she was implementing [what she learned at C3]." Yet this level of involvement takes a lot of a parents' time. One of the C3 staff noted how parents may feel "…overwhelmed, there is so much to read…between working with [their children] and trying to read up on programs it becomes a full time job for most parents." For a parent to initiate and sustain this level of involvement in their child's care, he or she must be willing to first accept that there is a need for care. Both Lisa and the providers at C3 noted that families need to be open to receiving services for needs that are often stigmatized. "I think parents are afraid to admit there is something going on with their child. It's that stigma, that old school, 'don't talk about it and maybe it will go away,'" explained Lisa. The providers at C3 echoed this sentiment: "We run a fine line between parents being in denial, not knowing because they don't want to know, or not knowing because they haven't been exposed to it." The staff at C3 felt it might be beneficial for families to have additional case management support as they begin to explore their child's developmental delays and learn to advocate for their child.

Adrian Today

Lisa and the C3 staff have observed how Adrian's language skills have improved. He is smiling, making eye contact and engaging people more. He is happier. The relief and gratitude in Lisa's voice is evident when she speaks about Adrian today and about her experience with C3. She is a more confident mother and Adrian is receiving the services he needs. Looking ahead one year to the day Adrian enters kindergarten, his family, service providers and teachers have every reason to believe he will succeed in school. Certainly he will have an easier time than he would have had without HDS.

"What [C3] gave me was invaluable. You cannot put a price tag on it. … My life is night and day, and it's day now. The sun is shining. … The growth and the transformation he made just from those classes was astounding. … If he can [behave] here [at the C3 classes], he can do it at home, at the playground, and at school."

-Lisa, First 5 Parent

**All names were changed to protect confidentiality*

Outcome #6: Children and Families Use of Health and Developmental Resources

The final HDS outcome aims to measure the appropriate use of resources by children and their families in two areas:

- Health care (both preventative and urgent)
- Cognitive and social-emotional care

In order to measure these indicators, a two-fold design was crafted that includes reporting results of four questions related to the children's use and access of health care, as well the tracking and reporting of referrals to other HDS service providers and agencies outside of HDS.

Children's Access and Use of Health Care

This section includes data related to four elements of children's access and use of health care: 1) the status of children's health insurance, 2) primary medical provider (i.e., medical home), 3) annual well child preventive exam, and 4) immunizations. All four of these items are important in terms of ensuring appropriate health care for children. Primary gateway services in HDS (PS&E, NMHV, ARHV, and Developmental) collected and reported this data during FY 2006-07. All were asked to collect this data at baseline (entry into services), and all but Developmental services providers collected data at follow-up (at six months of child's age for NMHV; others typically at case closure). Data was not matched, but rather collected on separate samples, which prevents the analysis from including a true comparison over time. In the new fiscal year, although data will still be collected in aggregate, service providers will report how specific clients changed from pre to post.

For these four items (i.e., health insurance, medical home, well child visits, current immunizations) aimed at measuring HDS children's use of appropriate health care resources, most children appear to meet the outcome goal. By combining the rate of children meeting the goals across service areas at follow-up only, the rates for utilizing resources are as follows:[59]

- Health Insurance: 95.6%
- Medical Home: 94.4%
- Well Child Visit: 98.0%
- Current Immunizations: 98.0%

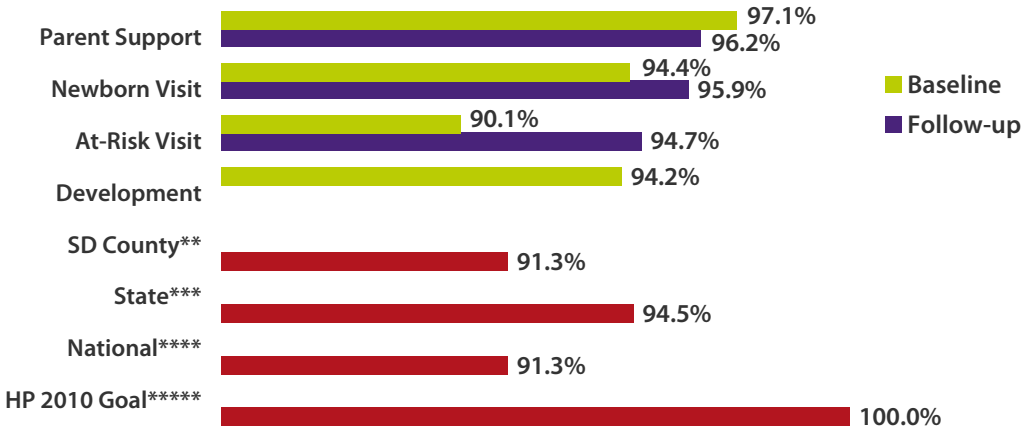
The following subsections offer details of each of the four children's access and use of health care outcomes.

Health Insurance

Health insurance is an important indicator of access to healthcare and is tracked by government and health agencies alike, making for meaningful comparisons. In Exhibit 2.16, data from these secondary sources are shown alongside the rates of health insurance as reported by HDS service providers. HDS children's health insurance rates were at, or above, 90%, which generally coincides with other county, state, and national data. While Parent Support and Empowerment had a slight decrease in those with insurance from baseline to follow-up, the home visitation providers' data present a higher rate of insured children at follow-up.

[59] These calculations only include the follow-up rates, and therefore Developmental service provider results are not included.

Exhibit 2.16 Children with health insurance*



**HDS data includes valid percents (does not include unknown or missing responses)*
***Source: First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.*
****Source: University of California, Los Angeles, California Health Interview Survey. 2005. Accessed 30 May 2007. <www.chis.ucla.edu>*
*****Source: Centers for Disease Control and Prevention. National Survey of Early Childhood Health (n=2,068). 2000. Accessed 14 October 2005. <www.cdc.gov/nchs>*
******Source: Office of Disease Prevention and Health Promotion, "Maternal, Infant and Child Health." Healthy People 2010: Volume II. Washington DC: U.S. Department of Health and Human Services, 2000. Accessed 5 September 2007. <www.healthypeople.gov>*

Medical Home

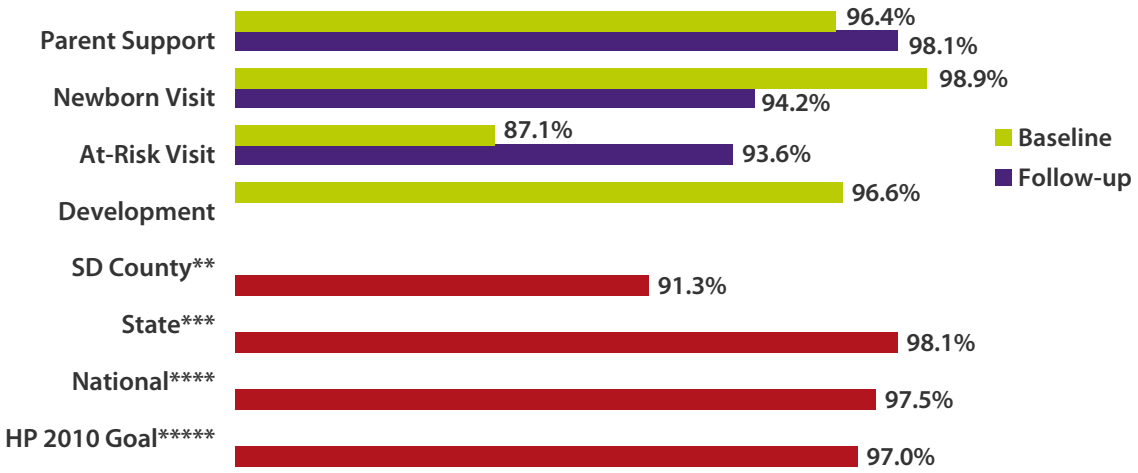
Children who have a medical home are more likely to use appropriate preventive and urgent health care resources. For the purposes of this outcome, any response that the child normally received care from a primary care physician/group, community clinic, or military medical facility was considered an appropriate medical home. Exhibit 2.17 illustrates the rates of children with a medical home from the HDS service providers, along with secondary data sources. Rates among children tracked were mostly in the 93-98% range, which were often higher than rates reported for the county, but did not always meet the state or national rates. There was a notable increase in the rates of medical home for ARHV between the children reported at baseline (only 87.1%) to follow-up (93.6%). Additionally, there were surprisingly fewer children with a medical home at follow-up (94.2%) than baseline (98.9%) for NMHV.

Well Child Visits

Well child check-ups are important for appropriate preventive care, and may reduce the incidence of child illness. HDS service providers were asked to collect this item by asking parents if their child had received their initial medical visit (for children 2 months and under) or if their child had had any well-child checkup within the last year (for children older than 2 months). The only available comparison data is the average number of general well child visits that children ages 0-2 have had within the past year (2.7 for San Diego County, 3.0 for the state, and 3.1 nationally).[60, 61] While these data show the county is lagging behind in this area, they cannot be used for comparison to HDS results.

[60] First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.
[61] The Urban Institute. National Survey of America's Families (n=34,332). 2002. Accessed 11 October 2005. <www.urban.org>

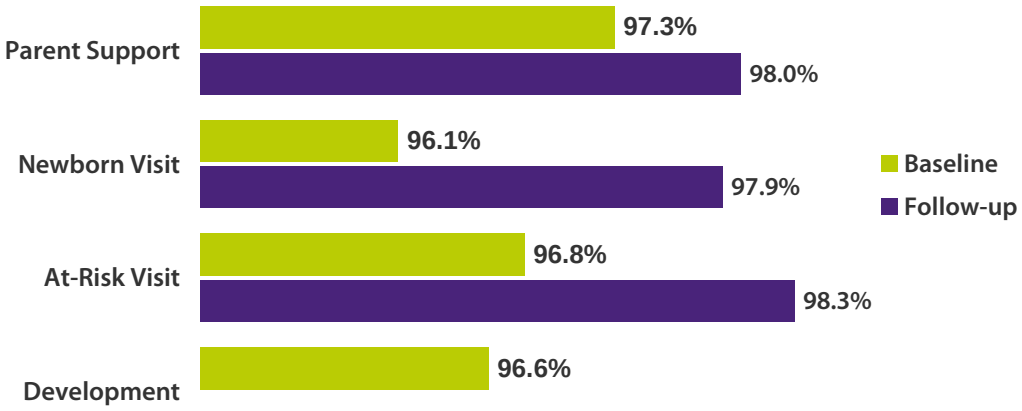
Exhibit 2.17 Children with a medical home*



**HDS data includes valid percents (does not include unknown or missing responses)*
***Source: First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.*
****Source: University of California, Los Angeles, California Health Interview Survey. 2005. Accessed 30 May 2007. <www.chis.ucla.edu>*
*****Source: Centers for Disease Control and Prevention. National Health Interview Survey.(n=12,249). 2003. Accessed 8 October 2005. <www.cdc.gov/nchs/nhis>*
******Source: Office of Disease Prevention and Health Promotion, "Maternal, Infant and Child Health." Healthy People 2010: Volume II. Washington DC: U.S. Department of Health and Human Services, 2000. Accessed 5 September 2007. <www.healthypeople.gov>*

Exhibit 2.18 displays the rates of HDS children having received an annual well child exam. For all three service areas that asked both a baseline and follow-up cohort (i.e., PS&E, NMHV, and ARHV)), there was an increase in the percentage of children with an annual preventive visit.

Exhibit 2.18 Children with an annual well child visit*



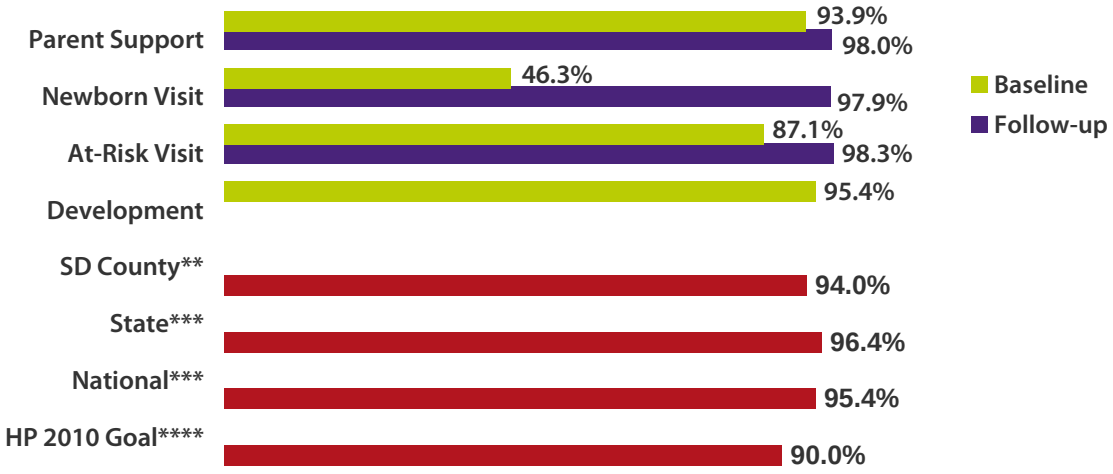
**HDS data includes valid percents (does not include unknown or missing responses)*

Child Immunizations

Children who use appropriate preventive health care resources typically have up-to-date immunizations. HDS providers were asked to collect immunization status for children over two months old by using a parent self-report method or by checking the child's immunization card (more feasible for the home visitation providers). As many parents are not actually aware of the recommended vaccination schedule, parent self-report is sometimes unreliable in determining rates of up-to-date immunizations. Therefore, the verification method (i.e., reviewing the card) was preferred whenever feasible. Exhibit 2.19 presents the findings. Secondary data is presented in the graph as well; however, the rates of current immunizations for the county, state, and nation are only based on children entering kindergarten, not on a population of children ages 0-5.

The findings show that most of the children tracked were up-to-date on their immunizations. The only two groups that did not surpass the Healthy People 2010 goal were the NMHV baseline group (46.3%), as well as the ARHV baseline group (87.1%). It is unknown why there was such a low percentage of children with current immunizations at the first newborn visit.[62] While 46.3% of the tracked children were not up-to-date in their immunizations at the time of the delayed newborn visit, 97.9% of children tracked at follow-up were up to date.

Exhibit 2.19 Children with up-to-date immunization status*



**HDS data includes valid percents (does not include unknown or missing responses)*
***Source: California Department Health Services, Immunization Branch, "2006 Kindergarten Assessment Results," Accessed 4 September 2006.*
****Source: Centers for Disease Control and Prevention, "Vaccination Coverage Among Children Entering School, United States 2005-2006 School Year," October 20, 2006 SS(41) 1124-1126*
*****Source: Office of Disease Prevention and Health Promotion, "Maternal, Infant and Child Health." Healthy People 2010: Volume II. Washington DC: U.S. Department of Health and Human Services, 2000. Accessed 5 September 2007. <www.healthypeople.gov>*

[62] Most first visits occur during the first two weeks of life. This data was only collected on children whose first NMHV was at age 2 months and up, when the child was eligible for a vaccination.

Children's Use of Referrals

The second part of the measurement of the "use of appropriate resources" indicator includes tracking and reporting of referrals for children from HDS providers to other HDS network services, as well as to agencies outside the HDS network. This is the first large effort on behalf of an entire First 5 San Diego initiative or project to track referrals and the successful initiation of services. During FY 2006-07, HDS providers were required to track a sample of the completion of referrals among the HDS Regional Service Network. All referrals made outside of HDS were also counted and reported by category, but not tracked for successful linkage.

Referrals Made* Within *the HDS Network

One of the goals in creating HDS as a network of services is to enhance the coordination of providers who are serving young children and their families. Under the direction of the regional leads, HDS providers share resources and coordinate referrals. Yet, measuring referral outcomes across all service areas in HDS is challenging. The referring agency is responsible for reporting the number of children given out-going referrals. The referring agency also follows up with the agency to which they referred to track the results for a sample of those referrals.[63] Following up with the family is conducted as a last resort if not other information is available.

Exhibit 2.20 presents the referrals among service components, with the first two columns indicating the total amount of referrals made by each service area and the percent of referrals resulting in an initiation of services. The third and fourth columns on the right indicate the number of referrals made to certain service categories followed by the percent of those referrals where services were initiated. This table reveals the frequency of referrals made by each service area, as well as the most referred-to service areas.[64] During FY 2006-07, approximately 9,225 HDS network referrals were made on behalf of children and their families.

"It has been a remarkable experience to be able to assist families in receiving other services through regional partners. We have never received so many requests for services or provided so many referrals."

– HDS Subcontractor

The table shows that two of the primary gateway service areas, NMHV and Developmental, provided referrals to the most children, making up 93.8% of all children referred across the networks. All of NMHV referrals were to PS&E and ARHV, while most of Developmental service referrals were to Speech and Language.[65] The table also shows that those three service areas (i.e., PS&E, ARHV, and Speech) received the largest number of referred children.

All referring service areas reported that at least 70% of their tracked outgoing referrals were successful, with the exception of Developmental services, which reported a 55.8% success rate. The most commonly noted reason for referrals not being successful was that many of the families were lost to follow-up (overall 22.4%), pointing to the need for more case management resources for families in the HDS system. PS&E, NMHV, ARHV, and Developmental services had the highest referral success rates (between 80-100%). Results for Behavioral services were slightly lower at 71.0%. Vision, Hearing, Speech/Language and Health/Behavioral Consultations were on the low end, reporting a referral success rate of between 51-57%. Again, the primary reason why

[63] As previously noted, the sampling size for outcomes was a minimum of 25%.

[64] For a more detailed table that includes each service area on both axes (creating a crosstab) and reveals the amount of children referred by each HDS service area to other HDS service areas, see the Data Compendium.

[65] See complete referral data table in the Data Compendium.

referrals did not result in initiation of services was families being lost to follow-up (22.4%), with providers refusing the referral (5.5%) and families refusing services (0.6%) making up a much smaller proportion.

Exhibit 2.20 Referrals Within HDS Network

Service Area	Total Children Referred OUT (n)*	Initiated Services (Valid %)**	Total Children Referred IN (n)*	Initiated Services (Valid %)**
Parent Support and Empowerment (PS&E)	84	76.9%	2,913	97.0%
Newborn Medical Home Visitation (NMHV)	5,210	86.9%	1	100.0%
At-Risk Home Visitation (ARHV)	47	72.2%	2,718	84.4%
Vision Services***	-	-	140	56.5%
Hearing Services***	-	-	152	53.2%
Developmental Services	3,444	55.8%	321	80.6%
Speech / Language Services	318	71.1%	2,596	51.4%
Behavioral Services	46	80.6%	298	71.0%
Health / Behavioral Consultation Services	76	86.6%	86	51.1%
Total	**9,225**	**71.5%**	**9,225**	**71.5%**

**Includes total children referred by HDS service areas to other HDS services.*
***The valid percent of referrals (NOT children referred) resulting in an initiation of services includes only those where the outcome of the referral was tracked and determined (pending referrals waiting to receive confirmation from referred-to agency were not included). Initiation of services was reported by referring agency, not the referred-to agency, therefore this may be an underreporting of completed referrals.*
****Vision and hearing service components had no outgoing referrals.*

Referrals Made Outside *the HDS Network*

HDS providers were not required to track the results of referrals made to agencies outside of the HDS system of care, but were asked to report the total number of referrals for different health and social services.[66, 67] The list of outside services included six broad categories and specific service organizations or types of services within each category:

- **Health Care Services:** includes primary care physician, First 5 San Diego's Healthcare Access Initiative, public health nursing, other health-related services.
- **Dental Care Services:** includes First 5 San Diego's Oral Health Initiative and other dental services.
- **Parent/Family Support Services:** includes First 5 San Diego's First 5 for Parents Project and other parent support and education services.

[66] For referrals to outside agencies, it is unknown the extent to which subcontractors defined "referral" in the same manner. For instance, some providers may have thought that referrals were only defined as contact information given to parents as a result of an actual need for services vs. other providers who may have given a number of resources to parents in case they were interested in certain services.

[67] Note that the number of referrals is not necessarily the same as the number of children as a child could have received multiple referrals

- **Child Services:** includes child care/day care, First 5 San Diego's School Readiness Initiative, child education services like Head Start and preschool, and other non-HDS child development services.
- **Early Intervention Services:** includes Regional Center, California Early Start, School Districts and other intervention services.
- **Other Services:** includes services not reported in the categories above, such as mental health care, basic and urgent needs, teen services, and other services as designated by the HDS providers.

Exhibit 2.21 Referrals to agencies / services outside HDS by service area

Service Area (HDS)	Referrals Made	
	(n)	(%)
Parent Support and Empowerment	1,979	11.4%
Newborn Medical Home Visitation	1,095	6.3%
At-Risk Home Visitation	3,227	18.7%
Vision Services	3,544	20.5%
Hearing Services	5,226	30.2%
Developmental Services	1,657	9.6%
Speech /Language Services	385	2.2%
Behavioral Services	53	0.3%
Health / Behavioral Consultation Services	136	0.8%
Total	**17,302**	**100.0%**

Exhibit 2.21 presents a table with the numbers of referrals (n=17,302) made to outside agencies/services from each of the HDS service areas.[68] Both Hearing and Vision service providers reported the highest number of outgoing referrals to outside agencies (5,226 and 3,544, respectively). One reason for this may be that most of the children who are screened or assessed for vision and hearing are then sent to a primary care physician or other medical home for treatment. Additionally, children served by Vision and Hearing providers may be referred for additional health services that are outside the HDS system. At-Risk Home Visitation reported a large number of referrals as well (n=3,227), which is not surprising since the families being visited are typically in need of many services to help them meet more urgent and basic needs.

In the following table (Exhibit 2.22) are the numbers of referrals to outside HDS services by the six categories mentioned above. The category with the most referrals is "Other," which includes a variety of service organizations and programs. One quarter (26.3%) of the "Other" referrals were for basic and urgent needs, such as food and shelter. In the other service categories, referrals were most commonly provided for health care services (20.4%), over half of which were to a primary medical provider (56.7%). Early intervention services were also

Exhibit 2.22 Referrals to services outside HDS by referred-to service category

Service Category (non-HDS)	Referrals (n)	Referrals (%)
Health Care Services	3,530	20.4%
Dental Care Services	1,126	6.5%
Parent/Family Support Services	1,829	10.6%
Child Services	1,631	9.4%
Early Intervention Services	2,143	12.4%
Other	7,043	40.7%
Total	**17,302**	**100.0%**

[68] For a more detailed table that includes service areas on both axes (creating a crosstab) and reveals the amount of referrals by each HDS service area to the six outside service categories, see the Data Compendium.

important (12.4%), and referrals to California Early Start, School Districts and the Regional Center made up 4.0%, 3.4% and 2.0% of the total referrals.

As part of the First 5 San Diego movement towards a greater system of integrated services, First 5 is particularly interested in knowing how the various First 5 initiatives and projects intersect. In terms of HDS referrals to other First 5 funded projects, nearly 2,000 referrals were provided by HDS to these other First 5 services, as seen in Exhibit 2.23. This subset of referrals (n=1,819) was 10.5% of all referrals to outside programs/services.

Exhibit 2.23 HDS referrals to other First 5 funded initiatives/projects

First 5 Project	Referrals (n)
Healthcare Access Initiative	215
Oral Health Initiative	1,103
First 5 for Parents Project	474
School Readiness Initiative	27
Total	**1,819**

Making the Connection: System-Level Changes

The HDS system-level evaluation is based on the Substance Abuse and Mental Health Services Administration's (SAMHSA) design for evaluating systems of care.[69] 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, as well as countywide. The system level evaluation of HDS is designed to collect information on specific performance indicators. The performance indicators are determined by the intersection of the Initiative's "Core Principles" (fundamental ideas or assumptions of the Initiative) and "Infrastructure/Service Domains" (key components of program operations) (see Exhibit 2.24).

[69] 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 27 August 2007. <http://www.mentalhealth.samhsa.gov/publications/allpubs/CB-E200/arc05toc.asp>

Exhibit 2.24
System-level Evaluation: HDS Service Components

Domains: Key Components of Program Operations

Infrastructure Domain

- Leadership and Partnership
- Management and Operations
- Evaluation and Quality Assurance

Service Delivery Domain

- Service Provision
- Provider Capacity Building to Delivery Quality Services
- Parent Education, Support and Empowerment
- Linkages to Ancillary Supports

Core Principles: Fundamental Assumptions of the Initiative

For each domain 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

Numerous data collection activities were conducted during FY 2006-07 to assess the developing HDS system of care. First, interviews were conducted with the Countywide Coordinator (AAP) and staff from each Regional Service Network (regional leads) to assess progress towards achieving the goals in each of these areas described above. Second, results from the HDS subcontractor survey provided the perspective of several HDS service providers regarding the creation of regional service networks across the county.[70] The third and final data collection activity was interviews with a group of community stakeholders. Collectively, these data measure the evolution of HDS over time in each Core Principle and Domain of the Evaluation Framework. The system-level data show that there has been much change in each of the regional service networks across the core principles. Key findings for each core principle, along with definitions, are provided in the following section.

Comprehensive

Definition: A combination of new and existing multi-disciplinary and multi-agency services promoting children's health and development are responsive to the individual needs of children and families within the target population in each region.

During the first 18 months of HDS, the regional leads as well as AAP analyzed the details of each subcontractor's service delivery model and used this information to "build a pathway in the network" to make referrals. This has involved working with individual agencies to make changes in business practices in order to deliver integrated, comprehensive services across the region. At

"We have been able to provide services to families without insurance that otherwise we wouldn't have in the past."

– HDS Subcontractor

[70] All HDS subcontractors (n=24) were invited to complete the online survey. Agencies with subcontracts in multiple regions or across multiple service categories were instructed to complete the survey only once. A total of 16 responses were received, a total response rate of 66.7%. For more detail and results of the subcontractor survey, see the Data Compendium.

times, this has been a difficult process. For example, one lead expressed hesitation in asking subcontractors to modify practices that they feel are operating effectively under their existing service models.

Many regional leads also shared that tracking referrals from one agency to another has been challenging, as there is not a centralized data system. One regional lead has implemented a systematic method of first following up with subcontractors regarding the status of referrals and subsequently calling families if the "referred-to agency" does not supply the information, or in cases where a required follow-up was not been conducted. In the coming year, subcontractors in this region will be required to initiate referral services within three weeks. The regional leads anticipate that new rapid response and reporting mechanisms will continue to improve responsiveness to collaborative partners' referral requests.

The degree to which the relationships between the lead contractors and their subcontractors are positive is critical to the success of the comprehensive system of care. Findings from the subcontractor survey indicate that service providers have a moderately high level of satisfaction with their regional leads. Roughly two-thirds of participants agreed that regional leads are friendly and approachable, responsive, clearly communicate expectations, provide helpful feedback, and disseminate information (66.7% for each item). Additionally, subcontractors were asked if the regional leads' expectations were "reasonable" related to the target numbers, outcomes, and the quality of services based on the allocated funding. While the majority of subcontractors (62.5%) felt that the expected outcomes were reasonable, fewer thought that there were reasonable service expectations in regard to target numbers (31.3%) and that the expectations of quality of services in relation to funding was reasonable (50.0%) (see Exhibit 2.25 below).

Exhibit 2.25 Subcontractors' perspective: Are regional lead's expectations reasonable? (n=16)

Facilitating the expansion of comprehensive services is one of the key roles of the Countywide Coordinator, AAP. This was a new role for AAP, and additionally, a new relationship between AAP and the regional lead contractors. Overall, regional leads were pleased with AAP's performance during the fiscal year. One regional lead called them "approachable and responsive" as they have provided a lot of encouragement and helped address conflicts. Another regional lead noted that it initially took AAP time to understand services before they could play a facilitative role among the regional leads. AAP also acknowledged they initially needed a clearer understanding of how regional networks and services were functioning before they could fully assume their role as Countywide Coordinator.

Coordinated and Integrated

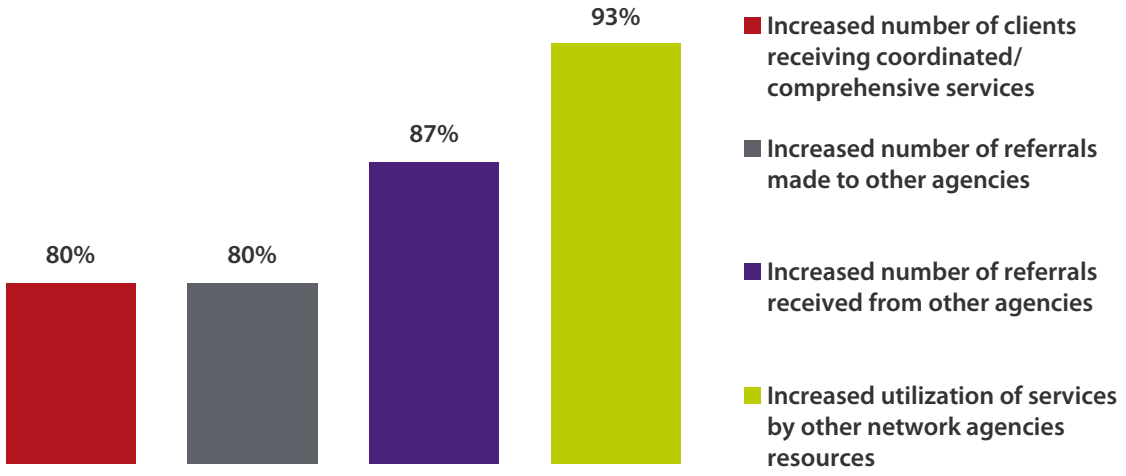
Definition: Agencies/providers work in a complementary manner to avoid duplication of services, eliminate gaps in care, share information, and utilize outside resources.

> **"[First 5] requires collaborative relationships and people are stepping up and doing that and it creates a much richer service delivery to families."**
>
> **– Stakeholder (Public Health Nurse)**

Over the course of the project, HDS regional leads continually improved their collaboration with subcontractors, with each other, as well as key partners that are outside the realm of HDS. An example of this is the sheer number of referrals HDS providers are making to other HDS services (n=9,225 children referred) and to agencies outside the HDS network (n=17,302 actual referrals).[71] As part of the subcontractor survey, providers were asked to specify how the HDS Initiative had specifically affected certain aspects of their programs. The subcontractors noted an increase in clients who receive more coordinated and comprehensive services, more referrals made and received within the network, and more utilization of program resources by the network (see Exhibit 2.26).

AAP and the regional leads have also worked together, along with their network partners, to avoid service duplication, share information, optimize resources, and address gaps.

Exhibit 2.26 Subcontractors' Perspective: Program Improvement due to HDS



Countywide Coordination

Regional leads noted that having AAP as the countywide coordinator brings credibility to the HDS Project. The physicians at AAP are invaluable in their discussions with others in the medical field and help the leads "talk doctor." For example, AAP has been instrumental in bringing all but four birthing centers on board to refer first-time mothers to the HDS newborn home visiting services. Another regional lead pointed out the difficult role AAP has to play since they are a countywide coordinator, while the individual lead organizations still report directly to First 5. "[AAP has] been given accountability and responsibility without decision-making power," this lead stated.

[71] For more information about referrals, see the outcomes evaluation section of this chapter and the Data Compendium.

Cross Regional Collaboration

Initially, it was difficult for the regional leads to talk about their regional challenges with the other leads. This year, most of the leads reflected that they have become more comfortable sharing issues and strategies with one another as they have enhanced their understanding of what their own region provides and its gaps. One regional lead talked about the importance of sharing information while maintaining regional independence, "We strive for a balance of being collaborative, moving forward, and also still being able to make decisions about our own region." One change that was implemented this fiscal year to encourage cross-regional collaboration was the separation of the monthly Regional Coordination meetings into two meetings, one for Operations staff to discuss day-to-day challenges and an Executive meeting for key decision makers from each region to work on high-level issues such as budgeting and project management. AAP has worked diligently to bring the regional leads together and the leads recognize that, as the countywide coordinator, they have a unique perspective. "We want a common vision [for HDS] that comes from them," one lead shared.

Referrals from Primary Medical Care

Primary medical care providers are key resources for screening children or identifying families who would benefit from HDS services. AAP and the regional leads focused much of their efforts during the year on working with both birthing hospitals to coordinate newborn home visits and with pediatricians to screen children for developmental delays (see above for numbers of referrals from birthing hospitals). One barrier encountered was in coordinating referrals from countywide or cross-regional birthing hospitals to the Newborn Medical Home Visitation providers. The hospitals do not have the time and resources to determine the appropriate referral pathway. In response, the leads in several regions have started to coordinate the birthing hospital referral process, with one regional lead acting as the "hub" and sorting the referrals to the appropriate region. It is a major accomplishment that 13 out of 17 birthing centers are now working with HDS. Efforts will continue to bring the remaining four birthing centers on board.

The regional leads and AAP acknowledge that there is still work to be done in coordinating developmental screenings in pediatric offices. One challenge is promoting the importance of developmental screenings – AAP's (national organization) recommendation on developmental screenings was issued in 2006 and all pediatricians may not yet incorporate this in their practice. As one lead said, "Even if [physicians] don't believe all kids need a developmental screening, [HDS] is getting the word out." Another barrier is helping primary care physicians and pediatricians understand how their practice intersects with HDS. Regional leads have sent letters to primary care physicians to assure them that a referral to HDS does not mean they will lose their patient. AAP is also communicating directly with pediatricians to inform them of HDS and how to work with the regional networks. One stakeholder, a practicing pediatrician said, "Pediatrics and public health pediatrics don't interact much with the mental health world, but in discussions you can see where the path of HDS and the path of mental health are going to intersect. It's not current, it's future."

An additional challenge to face is the medical billing systems, including Medi-Cal and others. Pediatricians do not have a code to bill for the developmental screens, nor can they bill for processing referrals. This was mentioned both by AAP and a pediatric stakeholder: "There needs to be a charge code for [making referrals]. Pediatricians get nine minutes per patient. If it takes five to find the number and 15 to talk, they've lost two patients. They need to be paid for that time." Applying for Medi-Cal reimbursement is also time consuming, coverage can be denied, and reimbursement does not always match the cost of services.

Connection to Public Health Nursing

In the beginning of HDS, there was a lack of coordination that led to some lack of trust, role confusion, and duplication of services between the HDS home visitors and public health nurses. AAP and the regional leads have helped to facilitate a process to build cooperation and avoid duplication. This is acknowledged by the public health nurses. "We often see the same families. We try to coordinate so we're not both going into the same household," a public health nurse shared. Another public health nurse said that having newborn home visiting has addressed a gap in San Diego as it provides "…a safety net for women with newborn babies that would not have gotten public health nurse services. We couldn't possibly have seen them all."

Opportunities for Further Coordination and Integration

Leads are identifying opportunities to integrate existing services within their network. For example, teams conduct a comprehensive assessment that identifies developmental, speech, and behavioral concerns. In addition, some regional leads have talked about incorporating vision and hearing services into other service categories, such as developmental, in order to group services that are typically needed together. Additionally, regional leads continue to look for ways to coordinate with other First 5 funded programs and initiatives. For example, the HDS subcontractors reported 1,819 referrals to other First 5 programs during FY 2006-07.[72] This intra-First 5 coordination is further facilitated by the fact that a number of contractors and subcontractors have multiple contracts with First 5. For example, one regional lead is part of an organization that participates in the Oral Health Initiative.

"[Before HDS], these services were not really accessible to our families."

– HDS Regional Coordinator

Stakeholders and AAP agreed that there are opportunities for more collaboration with the public school system. One stakeholder from the school system applauded AAP's efforts saying, "One of the things they're trying to do is have the health professionals in the area aware of the preschools. [Children] go to childcare and preschool every day, but only go to the doctor every once in a while."

Early Intervening

Definition: Children are screened/ assessed as early as possible and enter into services for optimal prevention and/or treatment of health and developmental problems or delays.

Stakeholders agreed that HDS seems to be leading to improved screening and identification of delays. For example, one stakeholder noted, "There have been more children who have been screened who otherwise would not have…we're getting more to the borderline kids whereas before we were just screening the higher risk." One stakeholder recommended coordinating with existing systems to identify children: "There are systems in place for children with special needs, there are also gaps in those services in terms of eligibility." It may also be that HDS goes beyond just serving children who fall outside federal and state eligibility guidelines for services. As one regional lead stated, "At the beginning there was this idea that we would find all these kids with mild to moderate delays but there are lots of severe need kids that haven't been identified before."

[72] See the outcomes evaluation section of this chapter, "Making a Difference", for more information.

Family Focused

Definition: The family is central to the care of children ages 0-5 and the system and service processes are designed to maximize family involvement and empower families to navigate and utilize systems of care.

Regional leads shared that there are a number of positive ways they involve families in HDS services. For example, one regional lead shared that providers have parents join their child during the last half hour of treatment sessions and then encourage parents to reinforce the treatment at home. A major barrier, however, to increasing family focused care is that parents are often unaware of developmental or behavioral problems or do not acknowledge that there is an issue. Regional leads stressed the importance of educating families about developmental and other delays and empowering them to participate in services that will benefit their child. One regional lead noted that their program provides some services in class settings rather than one-on-one. The intent is that a class can be structured for children at multiple levels and therefore minimize the stigma associated with special needs.

Many regional leads recognize the importance of providing opportunities for families to give input on the system and are taking steps to incorporate this practice into their networks. One region is planning a case study to follow up on a sample of families to improve services to those families and to obtain feedback on the project as a whole. Another regional lead recommended that HDS put together a parent advisory group with members from all regions.

Responsive to Cultural, Linguistic, and Special Needs

Definition: Agencies/providers are sensitive to differences in race/ethnicity, religion, language, gender, sexual orientation, abilities/disabilities, socioeconomic background, and other community-specific characteristics in order to maximize client participation and service quality.

All regional leads spoke about their efforts to ensure children throughout their regions receive the services they need. Originally, the service design had priorities for specific age groups and zip codes; however, there were many children outside of these targets that came to HDS providers needing services. First 5 responded to this issue and allowed all children ages 0-5 across the county access to services. As AAP shared, this is an example of First 5's willingness to "…look at what is happening out in the field and use [that information] to make interim changes [to the project design]."

In order to ensure that families are aware of HDS, regional leads are reaching out to culturally appropriate media, such as Spanish language newspapers. As more diverse families seek services, a deficiency in resources becomes evident in the system of care. Regional leads shared that there is a lack of bilingual, bicultural staff to adequately service families, particularly from Asian and Latino communities (see barriers in the section, *Readily Accessible*, for more information).

"Families [have] multiple issues that make completion of our services more challenging and difficult. Several families drop out prematurely because they are too overwhelmed to commit".

– HDS Subcontractor

Readily Accessible

Definition: Agencies/providers identify and address barriers, such as physical location and building accessibility (i.e., ADA compliant), transportation, hours of operation, financial constraints, cultural and linguistic barriers, and insurance status to increase access to services.

While there are barriers to providing and accessing services, HDS service providers are undertaking efforts to address them. For example, regional leads cited limited public transportation and child care as factors that affect families' abilities to bring their children in for services. One regional lead addresses these barriers by creating a "one-stop-shop" on specific days at their main clinic site, wherein subcontractors go to the clinic to provide services. Regional leads also addressed the importance of providing services in locations where families tend to be (e.g., homes, family resources centers, libraries, clinics, preschool, churches). Other regional leads shared that their network is looking into telemedicine opportunities (using satellite technology and video-conferencing to allow medical professionals to consult with patients in remote areas) to bring HDS services to rural areas.

Another barrier cited by regional leads and AAP is the lack of qualified providers in some service areas, such as speech pathologists, occupational and physical therapists, and staff for behavioral services. In particular, as mentioned above, bilingual/bicultural staff are needed in order to appropriately serve families. A lack of qualified staff affects families because the regional networks may create a need by initiating a screening and assessment and then do not have the capacity to meet treatment demands.

"There is merit to [newborn home visits], and families appreciate them, but is it something we can afford and sustain for every newborn?"

– Stakeholder

One key issue identified by regional leads and AAP that affects families' access to services is the families' need for assistance to navigate the network of services. Families need the "personal touch", especially if there is fear or confusion surrounding developmental needs and services. As one stakeholder said, "Reinforce the concept of the quarterback. Who is the overall quarterback of care? You think the physician should be, but many don't pay attention to developmental factors, social factors, family factors." This issue was at the crux of a case study conducted with an HDS family entitled, "Navigating a Complex System: Who Holds the Map?" following this section.

Accountable

Definition: Agencies/providers (on a countywide basis) acknowledge and carry out responsibility for agreed upon program goals and service outcomes.

As mentioned above (Comprehensive and Coordinated sections), the regional leads are striving to understand their subcontractors' service delivery systems and strengthen relationships, in order to ensure that all service providers are meeting their obligations as an HDS provider. From the beginning of HDS, leads reported that they meet regularly with their subcontractors to review how services are working. They are now enhancing tracking requirements to ensure that services are being provided as agreed-upon in the contracts. There has also been a much stronger push by First 5 to ensure that HDS lead contractors and subcontractors adequately track referrals to ensure that children are receiving needed services. One lead noted that leads would benefit from more technical assistance from First 5 to learn how to address subcontractors' accountability.

A majority of subcontractor survey respondents felt that HDS group members are accountable to one another and that people involved in HDS have a clear understanding of their roles and responsibilities (68.8% and 75.0%, respectively).

Sustainable

Definition: Agencies/providers organize ongoing efforts and develop strategies to ensure continuation of services, system-wide values, interagency relationships, and program outcomes.

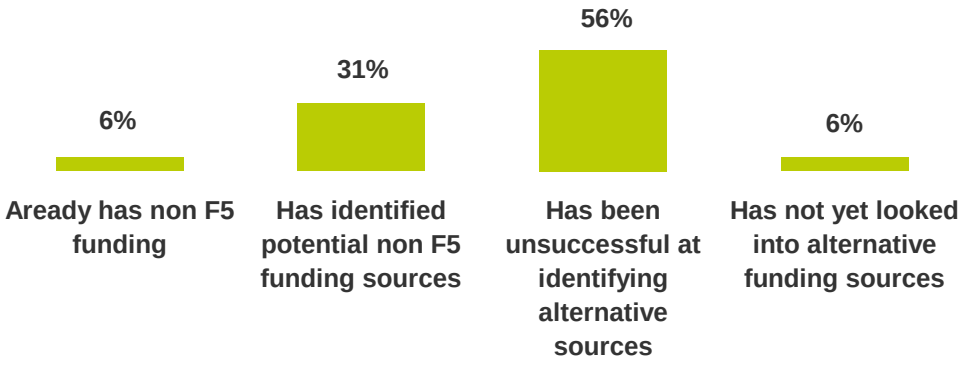
Sustainability appeared to be a concern for regional leads that are unsure of how to identify additional funding sources. One stakeholder expressed concern that "if you put things in place for a short time…people see it as something here today and gone tomorrow. And why make changes to the system because those services aren't going to be there." Regional leads want to help subcontractors think creatively about how to provide services without increasing service costs. Some leads shared that they are looking into whether they are maximizing leveraged funding but did not provide specific information.

Investment of Regional Service Networks in the Sustainability of HDS

In order to ensure that Regional Leads are contributing to the investment in HDS, lead contractors were required to provide a 10-15% match for the first 18 months of the contract, followed by a 20% match for the remaining three years of HDS.

Subcontractors also shared concerns about sustainability. In the subcontractor survey, 81.3% of respondents said they disagreed with the statement that HDS is adequately funded and 87.5% agreed that they do not know where the money to sustain HDS will come from after First 5 funding is discontinued. In addition, only 25.0% of respondents agreed that HDS will likely continue after First 5 funds have ended (for more information, see the Data Compendium). Similarly, very few subcontractors have identified sources of funding to sustain the project (see Exhibit 2.27 below). Many subcontractors shared that participation in HDS requires a significant investment in administrative staff time and support of these responsibilities is needed for services to continue effectively. This sentiment was echoed by regional leads and AAP alike.

Exhibit 2.27 Subcontractors' identification of funding sources to sustain HDS (n=16)



Recommendations

- **Continue collaboration & strengthen commitment to countywide vision.** HDS has made significant strides in collaboration between network service providers, regional leads and AAP. In 18 months, it has launched six regional networks of services – quickly creating new systems, ramping up services, and generating significant outcomes. All parties reported that there is still more progress to be made in collaboration between regions as well as collaboration with outside agencies and entities, such as schools.
- **Support Coordination.** The need for more support and resources for coordination was a key theme for the 2006-07 fiscal year. Families are in need of case management to help them navigate the network of services within HDS and outside the realm of HDS. Additionally, regional leads and subcontractors alike noted that there is not a sufficient amount of time or resources to provide case management or to create a regional network system-of-care. A larger investment in administrative staff time is needed for services to continue effectively under this new model.
- **Maximize Outreach.** A larger effort is needed in order to maximize outreach and raise community awareness around the importance of early childhood health and developmental services available to families. Families and stakeholders are still largely unaware of HDS, and regional leads reported that parents are often in denial about the need for developmental services for their child.
- **Examine opportunities for standardization.** HDS programs and the program evaluation would benefit if the definitions of services and the program-specific measurement tools were standardized as much as possible. For instance, there was too much variability in the delivery of services in At-Risk Home Visitation. AAP will be leading efforts to create more standardization in this service component. Additionally, the outcomes for child gains would be more meaningful if the evaluation protocols and measurements were more consistent within specific service areas.
- **Strengthen capacity building activities.** Barriers to services during FY 2006-07 were often attributed to a lack of trained specialists in the HDS service areas, particularly speech pathologists, occupational and physical therapists, and trained staff for behavioral services. Regional leads shared that there is also a lack of bilingual, bicultural staff to adequately serve families, particularly from Asian and Latino communities. Methods of staff capacity building within pre-existing agencies or others should be researched and implemented to establish an enhanced market of professionals. Additionally, training or capacity building should be offered to HDS contractors to address sustainability issues. First 5 and AAP should continue to help regional leads understand how they might leverage resources and enhance sustainability.

A Final Word on the Health and Developmental Services Project

The past fiscal year has seen full implementation of HDS. With an estimated minimum 29,000 children served, HDS partners are clearly reaching children ages 0-5. In addition, a successful system for referrals is being established – particularly for assessments and treatment services for speech and language, developmental, and behavioral needs. Although there is still work to be done in strengthening partnerships and referral networks to serve clients with multiple needs, the regional networks are utilizing creative strategies to ensure children ages 0-5 and their families receive HDS services. In the coming years of the project, there is great potential to not only improve the delivery of these services throughout the County but to document these changes and the ways in which they lead to improved outcomes for children.

Navigating a Complex System: Who Holds the Map?

Meet Tyler and Shannon

Tyler* was 15 weeks premature and spent 99 days in the hospital. He is now almost a year and a half old and thriving, but faces complications common to premature infants such as acid reflux, susceptibility to respiratory infections, and delayed motor development. His mother, Shannon*, is a single parent and was 19 when Tyler was born. She works part-time (for minimum wage), goes to school full-time and dedicates Mondays to Tyler's appointments with doctors and specialists. She is stretched thin in many ways: financially, time, and emotionally as a young mother to an infant with special needs.

Connected but Confused

Shannon's situation is complex. She is at the same time organized and scattered as she reflects on her experience navigating the service system over the past year and a half. She can list a dozen agencies she has worked with since Tyler was born, yet because there are so many, she cannot articulate what services she has received from each. The neonatal intensive care unit was Shannon's entry point into this complex arena comprised of services both affiliated and unaffiliated with HDS. Shannon recalls a social worker gave her stacks of information and referrals. Shannon says she called every agency. At least one call connected her to an HDS program. The HDS service provider's account of Shannon's involvement in the HDS program is fragmented as well. Reviewing Shannon's file, the provider recounts a series of phone calls with Shannon and a referral to another HDS agency (for developmental services). "That's about as much of the timeline as I have of my contact with her. I talked to her five times, perhaps mailed her something on prematurity and did the First 5 referral [to a second HDS program]." Shannon was not sure if she ever connected with the second HDS program and the service provider did not have confirmation of a completed referral in Shannon's file. The provider explains, "I don't know if I didn't get a report back or if it's just not in this file….I know [the second HDS program] contacted her because when I talked to Shannon on [date], she said that they did." This disconnect points to some of the challenges of developing a coordinated, integrated system of care: which program(s) are responsible for tracking families as they navigate the system? And how much responsibility do parents have? When should programs hold parents' hands, and when should parents be their own advocates?

A Service by Any Name can be Beneficial

Though Shannon is unable to pinpoint the HDS service(s) she had worked with, she reflects on the services she received, both those affiliated and unaffiliated with HDS, and reports that as a result of these services collectively she is more confident, more informed and less stressed than she was when Tyler was born. It does not matter to Shannon if a service is affiliated with HDS or not, she needs what she needs and is grateful for help from any and all sources.

"When I first spoke to Shannon…she seemed very concerned for her child and confused and a little timid, maybe not wanting to make waves. She seemed to come around; she got stronger and knew what she needed to do and where she was going. It really made her a stronger mom."

-First 5 HDS Provider

**Names were changed to protect confidentiality.*

CHAPTER 3

Oral Health Initiative

"Early detection is always important, for cavities, cancer and diabetes. The earlier you get in the easier it is to treat and the less expensive."

—Oral Health Stakeholder

Key Results

+ **Increased outreach and services for pregnant women.** From last fiscal year the number of pregnant women receiving screenings increased by 94.7%, for exams by 131.0%, and for treatment 303.8%.

+ **Care coordination increased.** OHI providers increased care coordination efforts in an attempt to ensure that the dental health system of care is seamless for children and pregnant women.

+ **Increased efforts to educate caregivers and providers.** OHI also made a determined effort to outreach to general dentists as well as primary caregivers of children (parents, pregnant women, and childcare providers).

Summing It Up

+ 20,957 children 0-5 and 2,190 pregnant women participated in oral health screenings.

+ 11,983 children 0-5 and 1,399 pregnant women received dental exams.

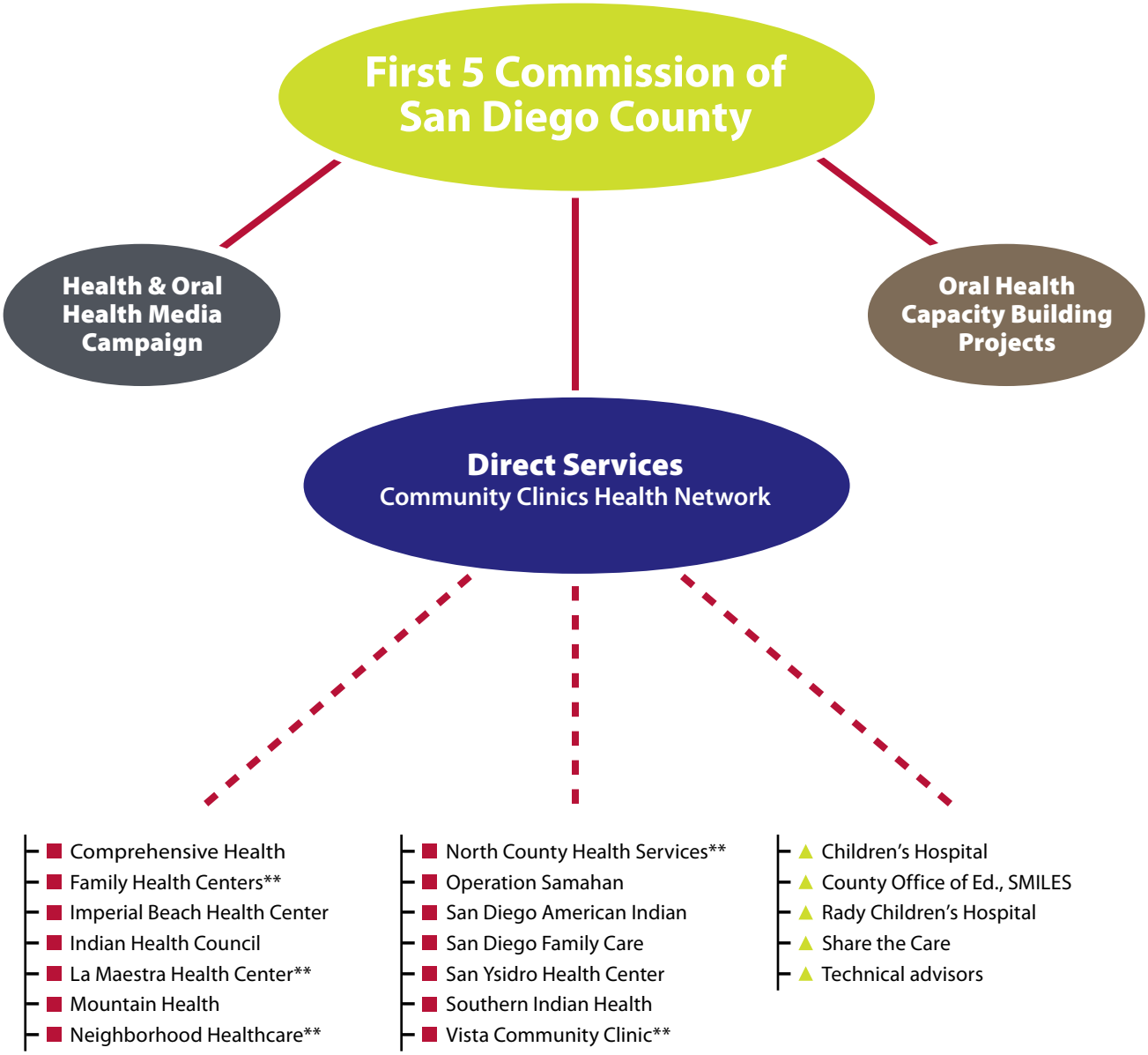
+ 12,463 children 0-5 and 1,385 pregnant women obtained routine dental treatment, and 576 children 0-5 obtained specialty dental treatment.

+ 6,769 children 0-5 and 1,485 pregnant women participated in care coordination- both increased from last fiscal year.

+ Over 19,000 parents, caregivers, and pregnant women received oral health education- a large increase from last fiscal year.

+ More than 180 dental and healthcare providers were trained about oral health issues. General dentists accounted for the majority of those trained.

Oral Health Initiative Structure*



*** These partners have an Oral Health Capacity Building Contract directly with First 5 San Diego.*

Lead Agency

This componet has been completed and is not included in this report

This component is nearing completion

Subcontractor

Funding for Services

Funding for Subcontractor

Clinical Programs

Other Programs

* Includes First 5 funded Lead Agencies and Partners.

Introduction

Tooth decay is, according to the U.S. Surgeon General, "the single most common chronic childhood disease – five times more common than asthma." [73] It affects more than a quarter of children ages two to five years old in the United States and more than a quarter of kindergarteners in California (27.9%).[74, 75]

While the general population frequently considers a cavity to be an isolated problem, easily repaired with a filling, it is actually evidence of a systemic bacterial infection. Untreated dental disease may cause pain, affect a child's nutritional status or sleep patterns and appearance, impair psychological status and social interaction, and cause problems with speech and language development.[76, 77, 78] The pain of untreated tooth decay can lead children to miss school.[79] Given the range of problems caused by the disease, poor oral health affects children's ability to function in school.[80] Addressing children's oral health before they enter school helps ensure they arrive ready to learn. For pregnant women, the mother's oral health has a direct relation to their unborn child's health. Studies have demonstrated an association between gum disease and poor birth outcomes including preterm delivery and low birth weight babies.[81, 82]

The First 5 Commission of San Diego launched the Oral Health Initiative (OHI) in 2005 to address oral health, given the pervasiveness of the issue and its connection to school readiness. The Commission has dedicated up to $5.1 for OHI from its launch through FY 2009-10.[83]

[73] Satcher, D. Oral Health in America: A Report of the Surgeon General. Washington, DC: U.S. Department of Health and Human Services, 2000.

[74] 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 >

[75] 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.

[76] 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 >

[77] Satcher, D. Oral Health in America: A Report of the Surgeon General. Washington, DC: U.S. Department of Health and Human Services, 2000.

[78] 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

79 Ibid.

[80] Satcher, D. Oral Health in America: A Report of the Surgeon General. Washington, DC: U.S. Department of Health and Human Services, 2000.

[81] 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.

[82] 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.

[83] Does not include the health and oral health media campaign part of OHI in FY 05-06, as it was not exclusively about oral health; does include capacity building; represents the maximum funding should the Commission exercise all option years.

Key Elements

The intent of OHI is to meet oral health needs of young children and pregnant women on a coordinated, comprehensive, countywide basis, while also meeting the unique needs of geographic and culturally diverse communities. OHI provides services from Alpine to Vista, working to increase the number of children ages 0-5 and pregnant women free from oral health disease. The Community Clinics Health Network (referred to as "the lead agency") oversees the project, which supports and unites more than a dozen programs (referred to as "OHI programs") across the County. Some programs operate at more than one site, creating an expansive network of care and providing services in six goal areas:[84]

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

Summing It Up

In FY 2006-07, OHI reached thousands of children ages 0-5, pregnant women and others across the County.[85] As Exhibits 3.1 and 3.2 illustrate, there was steep growth in services for pregnant women and less marked increases for children ages 0-5. This may be due in part to the effect of a change in Medi-Cal billing codes for pregnant women that took effect just prior to the start of FY 2006-07. OHI programs have also made conscientious efforts to increase outreach to pregnant women over the past year.

Notable Numbers

- All six services provided to pregnant women increased from FY 2005-06 to FY 2006-07.
- The number of individuals served increased by 50% or more from FY 2005-06 to FY 2006-07 in at least one aspect of all six goal areas.
- Caregiver education increased for all target audiences: parents of children ages 0-5, pregnant women, childcare providers, and staff of community organizations.

[84] 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).

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

Exhibit 3.1 Number of Children ages 0-5 Receiving Direct Services
FY 2005-06 and FY 2006-07

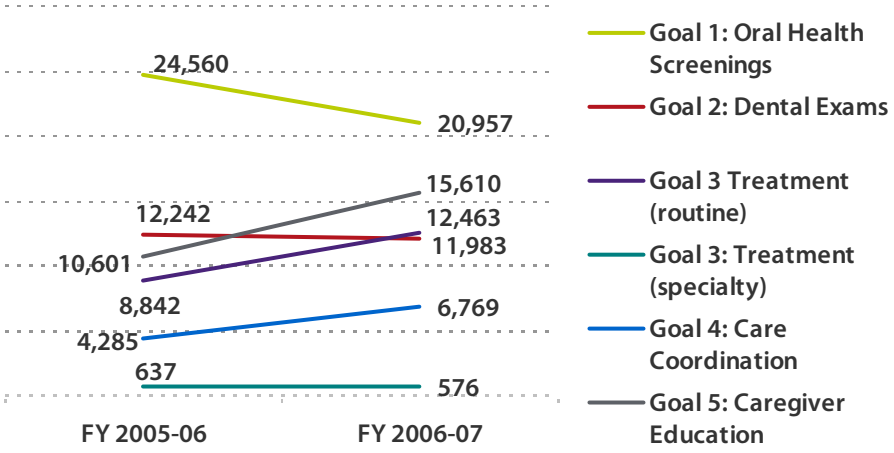
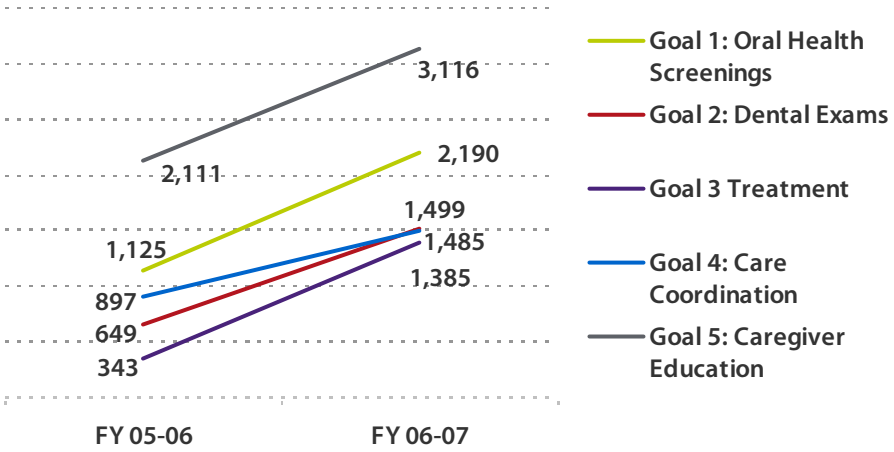


Exhibit 3.2 Number of Pregnant Women Receiving Direct Services
FY 2005-06 and FY 2006-07



In the previous year's Annual Evaluation Report, the actual number of individuals served was compared to 12-month targets (i.e. the number of individuals partners aimed to serve each year within a given area). The targets were set at the Initiative's start for planning and budgeting purposes. In the previous report, the actual number served was compared to the targets, as there was no other benchmark to reference. This year, however, the actual number served can be compared to the actual number served in the previous year. Comparing actual numbers year to year, and disregarding the targets, offers a more realistic sense of how services are (or are not) growing. Compared to FY 05-06, the number of individuals served increased for at least one population for all six goal areas (see the Data Compendium for detailed data tables).

Exhibit 3.3 Overview of OHI Goals, Comparing FY 2005-06 to FY 2006-07

Goals		Increase (+) or Decrease (-) in numbers served from FY 2005-06 to FY 2006-07		
		Children ages 0-5	Pregnant Women	Providers
Goal 1:	Oral health screening of children ages 0-5 coupled with parent education	- 14.7%	+ 94.7%	n/a
Goal 2:	Children ages 0-5 and pregnant women who received dental exams	- 2.1%	+ 131.0%	n/a
Goal 3:	Children ages 0-5 and pregnant women with identified oral health issues receive appropriate treatment services/follow-up	+ 41.0% (routine treatment) - 9.6% (specialty treatment)	+ 303.8%	n/a
Goal 4:	Oral health care coordination services to children ages 0-5 and pregnant women	+ 58.0%	+ 65.6%	n/a
Goal 5:	Caregiver education	+ 47.3%	+ 47.6%	+ 126.3%
Goal 6:	Provider training	n/a	n/a	+ 95.7% (general dentists) - 68.9% (prenatal providers) - 49.2% (primary care providers)

Making a Difference

Early Intervention for the County's Youngest Children

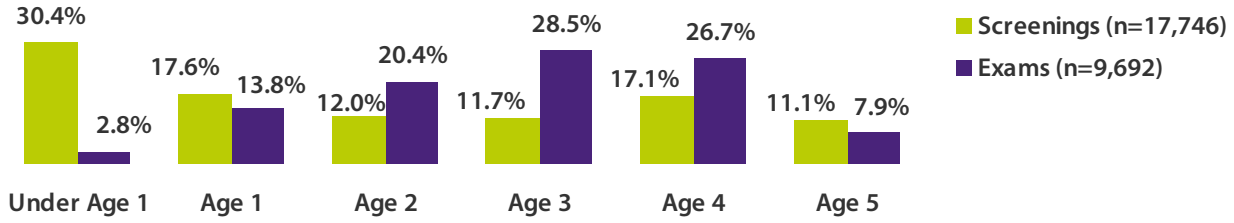
Both the American Academy of Pediatrics and the American Academy of Pediatric Dentistry recommend that every infant should receive an oral health risk assessment from a qualified pediatric health professional by six months of age.[86, 87, 88] Similarly, the American Academy of Pediatric Dentistry's guidelines specify that children should visit a dentist for an exam no later than age one, and routine exams should be repeated every six months.[89] Dental exams are a particularly important oral health service since these visits are the foundation of a child's dental home.

Considering these clinical guidelines, it is notable that 30.4% of children screened and whose ages were reported were under one year of age (Exhibit 3.3).[90, 91] In contrast, the number of exams peak at age three. This is the age that providers and parents have generally considered to be the appropriate time to initiate dental exams.

Pregnant Women's Perspectives

Most pregnant women who participated in focus groups thought they should take their babies to the dentist after age one, not before, as is recommended. Many thought a baby should see a dental provider when he or she gets his or her first tooth. No focus group participants mentioned pediatricians having any role in children's oral health care. Considering how many children under one year of age OHI partners screened, it may be that parents do not equate an oral health screening by a pediatrician as oral health care (see the text box, "Expecting to See the Dentist," on Page 69 for more findings from the focus groups with pregnant women.

Exhibit 3.4 Ages of Children Screened and Examined, FY 2006-07



[86] American Academy of Pediatrics. "Oral Health Risk Assessment Timing and Establishment of the Dental Home." Pediatrics 111.5 (2003): 1113-1116.

[87] American Academy of Pediatric Dentistry. "Guideline on Infant Oral Health Care." Clinical Guidelines. Chicago, IL: Author, 2004. 68-71.

[88] "Pediatric health practitioners" include pediatricians, family practitioners, nurse practitioners, and physician assistants; in general, any licensed Medi-Cal practitioner.

[89] 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

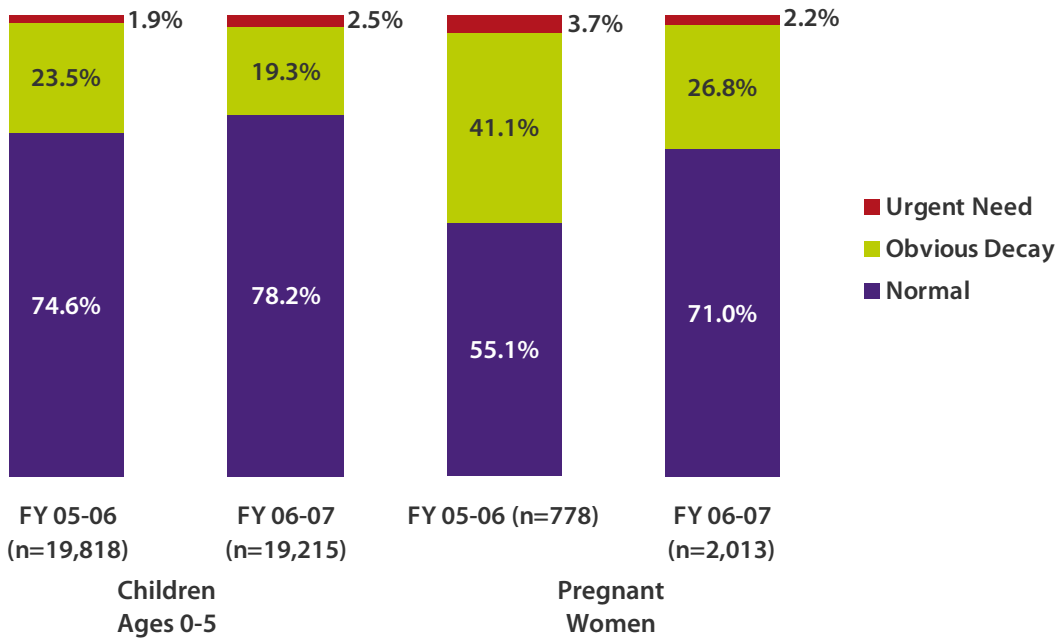
[90] OHI programs reported age data for 84.7% of children ages 0-5 screened and 80.1% of children ages 0-5 examined. The number of children who were less than six months of age at the time of screening was not reported.

Detecting Previously Undetected Oral Health Concerns

Results of oral health screenings

Oral health concerns were identified in thousands of children ages 0-5 and pregnant women through the screenings OHI partners provided during FY 06-07. OHI partners found obvious decay or urgent dental needs in a little more than a fifth of children ages 0-5 and more than a quarter of pregnant women for whom OHI partners reported screening results (see the Data Compendium for detailed data tables).[92, 93, 94]

Exhibit 3.5 Results of Oral Health Screenings, FY 2005-06 and FY 2006-07



[91] Similarly, in FY 2005-06, 31.7% of children screened were under age one.

[92] No population-based comparison data is available for pregnant women or for children ages 0-5 at the county-level.

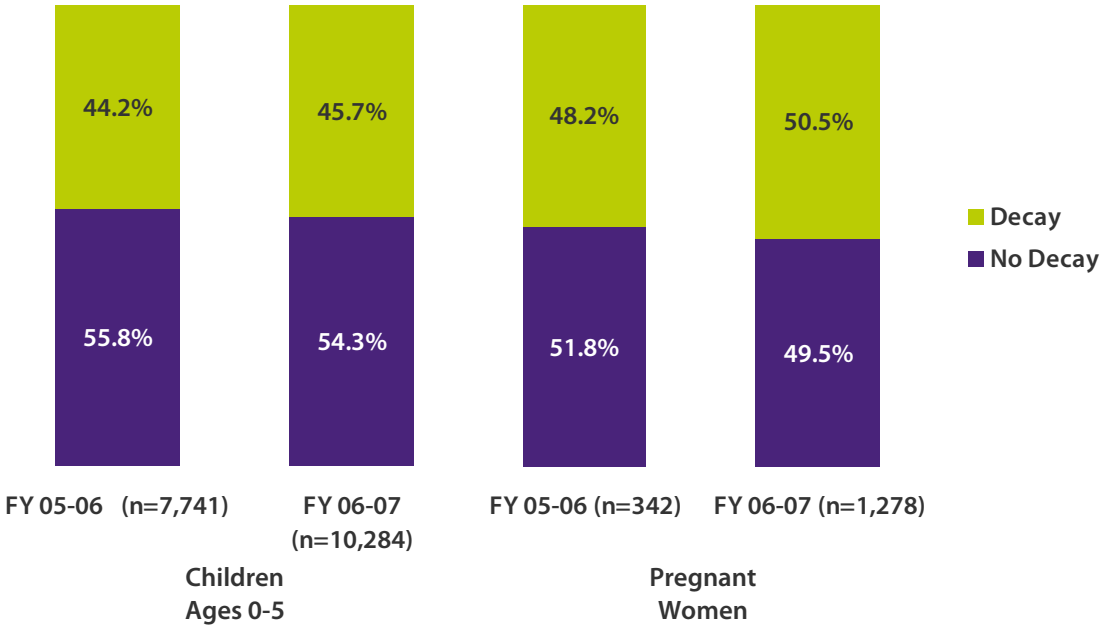
[93] In California, slightly more than 20% of kindergarteners screened needed early dental care and approximately 4% needed urgent dental care. Dental Health Foundation. Mommy, It Hurts to Chew, the California Smile Survey; An Oral Health Assessment of California's Kindergarten and 3rd Grade Children. Oakland, CA: Author, 2006. Dental Health Foundation screenings and OHI screenings do not use the same protocol, but both use similar methods to screen children and categorize the extent of decay in three roughly analogous categories.

[94] While there was an increase in normal results in FY 2006-07 compared to FY 05-06 (78.2% versus 74.6% of children and 71.0% versus 55.1% of pregnant women), that change may be because programs reported results for a more representative sample this year compared to last: in FY 2005-06, OHI programs submitted screening results for 80.7% of children ages 0-5 and 69.2% of pregnant women screened, and in FY 2006-07, OHI programs submitted results for 91.7% of children ages 0-5 and 94.0% of pregnant women screened. Additionally, the number of pregnant women screened more than doubled from FY20 05-06 to FY 2006-07. It is possible that OHI programs' outreach efforts attracted women who had healthier mouths than last year's patients.

Results of dental exams

Dental exams confirmed decay in roughly half of children ages 0-5 and pregnant women for whom OHI partners reported exam results (see the Data Compendium for detailed data tables).[95] The number of individuals confirmed to have decay declined slightly for both children ages 0-5 and pregnant women from FY 2005-06 to FY 2006-07. Without knowing how many individuals are "recall exams," meaning how many individuals are returning patients, it is difficult to draw conclusions about why these figures have changed.

Exhibit 3.6 Results of Dental Exams, FY 2005-06 and FY 2006-07



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 56% of children and adults to have visited the dentist within the past year.[96, 97] To simplify data collection, OHI programs reported the length of time since patients' last dental exams in the following three categories: never visited the dentist; last visited the dentist more than one year ago; and last visited the dentist within the past year. The findings presented below

[95] Individuals examined may or may not have had an oral health screening from an OHI partner prior to the exam.

[96] Healthy People Objective 21-10 includes children over age two. 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. For this reason, OHI programs do not report last dental exam data for children under age two.

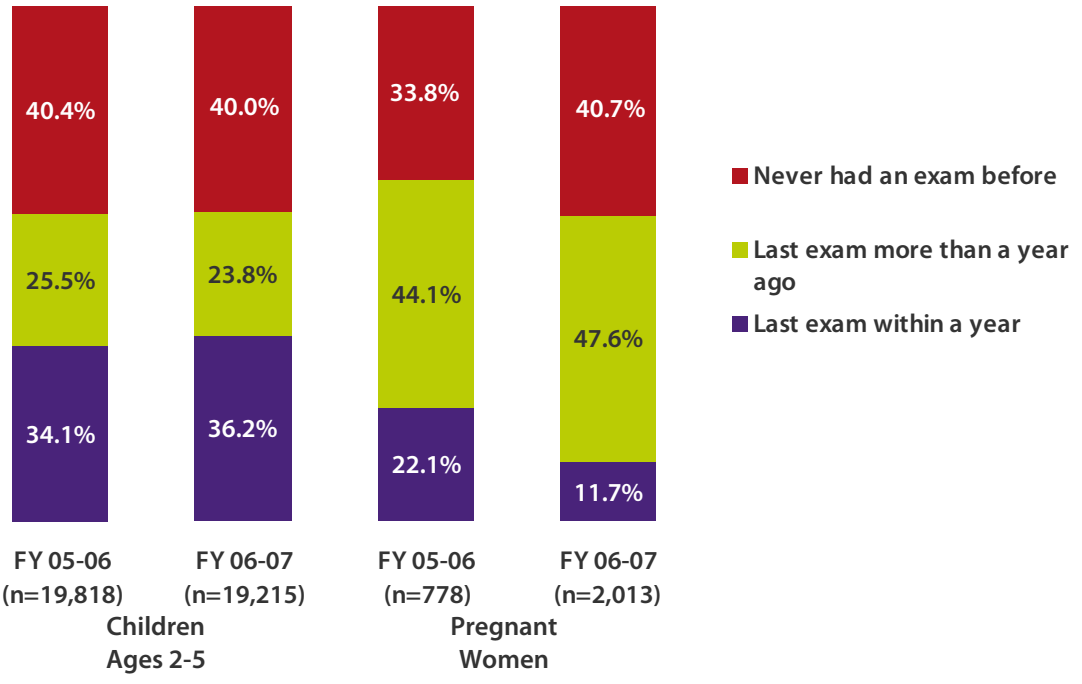
[97] Office of Disease Prevention and Health Promotion. "With Understanding and Improving Health and Objectives for Improving Health." Healthy People 2010: Volume II. Washington, DC: U.S. Department of Health and Human Services, 2000. Accessed 13 July 2006. <www.healthypeople.gov>

indicate that the Initiative is bringing dental services to children and women who need them, and who may not receive this necessary care in the absence of such an effort.

There was relatively little change in the time since last exam from last fiscal year among children ages 0-5. In FY 2006-07, OHI programs report 40.0% of examined children ages two to five had never received a dental exam and another 23.8% received their last dental exam more than a year ago (see the Data Compendium for detailed data tables). These findings contrast sharply with figures for the county and state. In San Diego County, 60.5% of children ages two to five years old had visited the dentist within the past year, according to the 2005 First 5 Family Survey.[98] A recent statewide study found that 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% had never been to a dentist.[99]

The time lapsed since the last dental exam for pregnant women was more severe this fiscal year, compared to last. For pregnant women, 40.7% had never received a dental exam and 47.6% received their last exam more than a year ago (see the Data Compendium for detailed data tables). Consider that most pregnant women who participated in focus groups reported that it had been anywhere from a few months to four years since their last dentist visit (see text box, "Expecting to See the Dentist," on Page 69). No one volunteered that they had never had a dental exam before, but not all participants answered the question. Furthermore, consider that an estimated 67.0-84.3% of pregnant women in California (ages 18-44) have received dental care in the past year.[100]

Exhibit 3.7 Lapse of Time Since Last Dental Exam



[98] First 5 San Diego. San Diego Family Survey. San Diego, CA: Author, 2005.
[99] 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.
[100] 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>

Expecting to See the Dentist…or Not: Pregnant Women Share Their Experiences

Oral health services for pregnant women are important because a mother's dental home often becomes her child's dental home. Furthermore, studies have found an association between gum disease and poor birth outcomes including preterm delivery and low birth weight.[i] Reaching pregnant women has been a challenge since the inception of OHI. The following are findings from four focus groups with pregnant women.[ii]

- ***Limited understanding of the importance of dental care during pregnancy:*** When asked how important prenatal dental care is for mother and baby's health there seemed to be a difference in the way participants at OHI sites answered compared to groups held at unaffiliated sites. Participants at OHI sites were more likely to rate dental care as important (even though they may not go to the dentist) than participants at unaffiliated sites. In all groups, OHI and unaffiliated, several women felt that as long as an expectant mother brushes her teeth at night and drinks milk she should be okay. At least one to two women in each group articulated that dental care is important because babies "pull nutrients from the mother's teeth," referring to calcium depletion.

- ***Lack of information from prenatal care providers:*** Several women said their prenatal care providers have not mentioned seeing a dentist and that they have not asked about it. Women who have talked about oral health with their providers report their providers have recommended going to the dentist but their providers have not talked about it at length, in some cases offering a pamphlet but not explaining the importance of a dental visit. One woman's doctor made a dental appointment for her. Findings were consistent between OHI and unaffiliated sites.

> **"With this pregnancy they never sent me to the dentist."**
>
> **– Focus Group Participant**

- ***Need for one-on-one education:*** When asked what OHI programs could do to encourage pregnant women to access dental services, women said they want someone to explain the information, not just put it on a sign or in a pamphlet. OHI Dental Care Coordinators can play a vital role in one-on-one education; however, their time is already split between many other responsibilities.

- ***Many women in their third trimester had not been to the dentist during pregnancy:*** Ten women in their third trimester completed a survey as part of the focus groups. Half had received dental care since becoming pregnant and half had not. The points below refer to these 10 women.

    - ***Dental care is too expensive:*** Two of the 10 women indicated in their surveys that dental care is too expensive. One woman pays cash for dental care and the other did not say how she pays.
    - ***Do not know how to get dental care.*** One of the 10 women cited a lack of information. She participated in a focus group at a site that is not part of OHI, suggesting a need for outreach.
    - ***Minimal service available through Medi-Cal:*** Two of the 10 women did not indicate in their surveys why they had not yet received dental care. Both have Medi-Cal and participated in groups at OHI sites. Medi-Cal offers minimal coverage for dental care during pregnancy. As one woman commented, she thought the dentist would just do a cleaning and tell her what her problems were and that her insurance would only cover the cleaning. If she has Medi-Cal, that is essentially true.

[i] 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.

[ii] See Page 6 of this report for more details of the focus group.

Dental Professionals Increase Capacity to Treat Young Children

For the second year, OHI convened dental professionals in February, National Children's Dental Health Month, for a training about oral health issues that affect young children and pregnant women. In all, more than a hundred professionals participated.[101] Below are some of the highlights from the survey that participants completed following the training (see the Data Compendium for detailed data tables).[102]

- ***Building a foundation to treat children ages 0-5 and pregnant women:*** 93.7% gained knowledge about providing treatment to pregnant women (n=95), 97.9% gained knowledge about when to treat and when/where to refer children ages 0-5 (n=93) and 90.3% gained knowledge about providing anticipatory guidance (n=93).
- ***Cultivating developmentally and culturally responsive services:*** 96.8% enhanced their understanding of cultural competency (n=94), 92.6% had a better understanding of providing care to children with special needs (n=95) and 90.4% gained knowledge about managing behavior of very young children (n=94).
- ***Planning to increase services to children ages 0-5 and pregnant women:*** 94.6% indicated they were more likely to encourage treatment in pregnant women (n=93), 94.3% indicated they were more likely to screen children beginning at age one (n=91) and 86.9% indicated they were more likely to treat children beginning at age one (n=92). In sum, 94.5% plan to apply the clinical skills they learned (n=92).

Reflecting on Results

Nearly a quarter of survey respondents from the February 2007 training also attended the first OHI-sponsored provider training in February 2006. These repeat attendees commented about how they and their practices have changed since attending the first training a year ago:

- "[I am] a little more confident"
- "More preventative oriented"
- "[I] have more programs [that are] affordable for low-income patients"
- "Increased [the] number of children [in my clinic's dental department] by collaborating with [our] pediatric [department]"
- "More 0-2 year old visits"
- "Seeing more 0-5 kids"
- "[I] started seeing children"

These actual changes speak powerfully to the importance of provider training as a strategy to improve the oral healthcare system in San Diego County for children ages 0-5 and pregnant women.

"The syllabus described cultural concerns and I thought it to be insignificant. After attending the lecture, I see how important understanding different cultures really is."

– OHI Provider Training Attendee

[100] Additional dental, primary care and prenatal providers participated in smaller training events during the FY.

Making the Connection

In the Commission's 2005-2006 Annual Evaluation Report, the provision of dental services to young children and pregnant women was OHI's most significant accomplishment. Strong service provision remained at the Initiative's core in FY 2006-07; however, there are several important system-wide changes to report that have the potential to affect the oral health of entire populations in San Diego County. While the local oral health community has been pressing for these changes for many years, the Commission and OHI's support of these efforts is noteworthy, as system-wide changes often require system-wide collaboration.

The Context: Why OHI Can Have a Systems-level Impact

OHI's six goal areas are interrelated; activities in one area can strengthen outcomes in other areas. OHI is notable in that it has both breadth – reaching thousands of individuals each year – and depth – addressing oral health issues at many levels. OHI has both prevention and treatment components. In looking at OHI's role in improving children's oral health outcomes in general, it is useful to look at a model called the "Spectrum of Prevention." The Spectrum is a framework for discussing the multiple avenues that must be addressed to ensure a robust prevention system. It identifies six complementary levels for strategy development, that, when used together, "produce a synergy that results in greater effectiveness than would be possible by implementing any single activity or linear initiative."[103] The Spectrum asserts that activities at one level will lead to interrelated actions and outcomes at other levels of the Spectrum. Consider the below Spectrum, adapted for OHI.[104] This Spectrum identifies the multiple OHI and Commission activities currently underway that are positively affecting children's oral health.

The Spectrum of Prevention		Oral Health Initiative Examples
6. Influencing Policy & Legislation: Developing strategies to change laws and policies to influence outcomes	→	Commission exploration of community water fluoridation
5. Changing Organizational Practices: Adopting regulations & shaping norms to improve health	→	Responding to Assembly Bill 1433 (mandated oral health screening for kindergarten entry)
4. Fostering Coalitions & Networks: Convening groups & individuals for broader goals and greater impact	→	OHI Care Coordinator meetings; OHI Dental Director meetings
3. Educating Providers: Informing providers who will transmit skills and knowledge to others	→	OHI Goal 6: Training for prenatal and primary care providers, general dentists
2. Promoting Community Education: Reaching groups of people with information and resources to promote health	→	OHI Goal 5: caregiver education for parents of children ages 0-5 and pregnant women
1. Strengthening Individual Knowledge and Skills: Enhancing an individual's capability of preventing illness	→	OHI Goal 5: caregiver education for parents of children ages 0-5 & pregnant women

[101]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.

[103] Prevention Institute, "Spectrum of Prevention", http://www.preventioninstitute.org/pdf/1PGR_spectrum_of_prevention_web_020105.pdf, Accessed August 30, 2007.

[104] Cohen L, Swift S. The spectrum of prevention: developing a comprehensive approach to injury prevention. Injury Prevention. 1999;5:203-207

As this model illustrates, the oral health system for young children and pregnant women has a number of activities that are interconnected. A change at one level of the Spectrum will affect other levels, which shifts the balance of the entire system. For example, strengthening parents' knowledge of the importance of children's oral health (level 1 on the Prevention Spectrum) can lead to an increased demand for dental exams, which requires more providers to be educated about how to manage the behavior of young children (level 3). In turn, an increased need for treatment services that some families cannot afford necessites policies and legislation to fund low-cost services (level 6).

This prevention spectrum, when added to the treatment services that are also funded by First 5, are the foundation for developing a strong pediatric oral health system of care in San Diego County. Two of the biggest issues listed in the Spectrum that may affect the long term oral health outcomes of children are community water fluoridation and recent legislation (AB-1433).

A New Network

Another accomplishment at the systems-level in FY 06-07 is the initiation of OHI Dental Director meetings. The Dental Directors of the community clinics affiliated with OHI convene regularly to share best practices and network (Spectrum level 4). Furthermore, the involvement of Dental Directors serves to boost OHI's efforts in health clinics, in both dental and Medi-Cal departments, as Directors are key leaders in the clinics who shape the clinics' decision-making and operations (Spectrum level 5).

Community Water Fluoridation

Many studies have established that fluoridating public water supplies is an effective way to prevent and reduce tooth decay. In 1999, the Centers for Disease Control and Prevention listed fluoridation as one of the 10 greatest public health successes of the 20th century.[105] Despite being one of the most populated states in the country, California ranks 45th in fluoridated public water systems. San Diego County is the largest metropolitan area in the United States that does not have a completely fluoridated water system.[106, 107, 108]

The First 5 Commission of San Diego began to explore taking a role in community water fluoridation in the Spring of 2007. The local oral health community has pursued fluoridation in San Diego well before OHI began. The Commission's commitment to children's oral health, however, gave the movement new traction, as evidenced by a Commission meeting in June 2007. An expert interviewed for the evaluation noted the exceptional nature of that meeting: "This last [Commission meeting] was filled with dentists [who were there] about fluoridation..." This comment highlights how interested parties are mobilized around the fluoridation issue and participated in the Commission's process. First 5's Desired Result 4.4 states that "the work of the Commission…is enhanced by community-driven solutions that affect children and families." The June 2007

[105] American Dental Hygienists' Association. CDC Releases Guidelines on Fluoride Use to Prevent Tooth Decay. 2005. http://www.adha.org/profissues/cdc_fluoride_guidelines.htm

[106] Most populous state & least populous state. People. Populations Estimates and Projections. 2005. https://ask.census.gov

[107] Centers For Disease Control. Fluoridation Statistics 2002: Status of Water Fluoridation by State. <www.cdc.gov/fluoridation/fact_sheets/states_stats2002.htm>

[108] Fluoridation of San Diego County Water Supply. County of San Diego 1999/2000 Grand Jury Reports. 2000. <www.sdcounty.ca.gov/grandjury/reports/1999_2000/flouride.html>

Commission meeting is an example of how OHI addresses this aspect of systems improvement, and how First 5 can increase public participation by joining forces with systems change efforts that already have momentum in San Diego County.

In response to the groundswell of interest, the Commission authorized the formation of an informal advisory committee to take a closer look at an investment in community water fluoridation of parts of San Diego County.[109] Moving forward with this plan will impact OHI in that children ages 0-5 in fluoridated areas would be exposed to fluoride and presumably that would decrease the rates of oral health disease in those children. Media and community efforts that promote consumption of fluoridation water for children 0-5 will ensure community water fluoridation has an impact on children's oral health.

New oral health screening requirement for kindergarten entry

In September 2006 the California Governor signed Assembly Bill 1433 (AB 1433) into law in an effort to decrease the number of children with dental disease through early intervention. The law requires oral health assessments for all children entering public school for the first time (kindergarten or first grade) beginning in January 2007. This law affects children's oral health in three key ways:

- ***Prioritizes children's oral health.*** Similar to school entry requirements for well-child physicals and up-to-date immunizations, the law requires parents to present proof that their child has had an oral health assessment by a licensed dental professional before entering kindergarten.[110] It potentially broadens parents' and providers' perceptions of health to include oral health.
- ***Connects families to oral health resources.*** The Bill calls for schools to notify parents of the requirement and to offer information about local resources that provide oral health assessments. In San Diego County, OHI partners are vital resources to assist schools in meting this requirement.
- ***Closes the dental data gap.*** School districts will submit annual reports of oral health assessment data to the County Office of Education. Currently population-based data about California children's oral health status is limited. New data potentially offers a better perspective of children's oral health for the future.

"I fill out that [required oral health assessment] form five or six times a day and I'm glad to do it. It's fantastic. … I saw a child who had a lot of decay. The only reason the parent brought him in was to get this [required oral health assessment] form signed since he was starting kindergarten."

–Key Expert

Insights from the front lines

Interviews with key experts in the County explored awareness of AB-1433 and how it has (or will have) an impact on agencies and systems.[111] Additionally, roughly 100 dental professionals who completed a survey following their participation in the OHI-sponsored National Children's Dental Health Month training in February 2007 (see section on Page 70 entitled, "Dental

[109] The committee would include a technical expert (such as a water engineer), members of First 5's Technical and Professional Advisory Committee (TPAC), individuals from the public health sector, and experts in community water fluoridation

[110] Or first grade if that is his/her first time attending school.

[111] Key experts asked about AB-1433 included dentists (including one not First 5-funded), HHSA Regional Managers, public health nurses and Superintendents from First 5-funded School Readiness Initiative districts.

Professionals Increase Capacity to Treat Young Children" for details) shared their perspectives on provider capacity to respond to AB 1433. The themes that emerged point to the ways AB 1433 will present both challenges and opportunities for OHI in the coming year:

- ***Knowledge of AB 1433 appears to exist across sectors but is not universal:*** Eleven of 14 key experts interviewed had heard of AB 1433. Among dental professionals surveyed after the OHI-sponsored training, 93.8% (of 96 people) had heard of AB 1433 prior to the training. While there are many providers who are aware of the requirement, there is still a gap in knowledge of the requirements of the new law.
- ***Agencies are still mobilizing to respond:*** Though the Bill's requirements are well-known in San Diego, interview findings suggest there are more opportunities for OHI to support school districts, public health nurses, and others to educate parents about the requirement and connect them to dental services. As one key expert shared, "[AB 1433 impacts our organization because we] help families figure out how to meet the requirement…where to go for a screening and if things are identified, where to go for follow-up."
- ***Increased screening requirements put increased pressure on an already strained system:*** Less than half of the dental professionals surveyed believe that there is enough provider capacity in San Diego County to conduct the required screenings/exams for children (53.5% of 86 respondents). Similarly, less than half (45.2% of 84 respondents) believe that there is enough provider capacity in San Diego County to treat dental problems identified by the required screenings/exams. Key experts' comments further illustrate this concern:
    - *We're not going to accept any new patients who do not have dental insurance.*
    - *We don't have a lot of dental providers who accept Medi-Cal in North County so that's going to be a challenge.*
    - *We're able to do screenings on a limited basis because of our capacity.*
    - *It's a pretty tall order, quite frankly. … And finding the resources at a clinic; I don't know if all the clinics have the capacity [to screen and treat these children].*
- ***AB 1433 has a critical limitation:*** AB 1433 does not require treatment if a problem is identified in a screening. Additionally, many families cannot afford to pay for treatment. One key expert interviewed offered this analogy, drawing on the parallels between AB 1433 and immunization requirements: "It's like a pediatrician sees a child [for immunizations required for school entry] and says, 'you're up-to-date on Hepatitis B and you need a tetanus shot.' but then there's nothing further." It seems absurd for that pediatrician to walk out of the room without giving the child a tetanus shot, yet dental professionals may be in the position of telling families their children have oral health issues, and then having nothing to offer them in the way of treatment. As another expert commented, "the screening is not an issue…but it's a challenge to see a child for a screening because it's a State requirement but then it's not a requirement to have the treatment done."

"It [AB 1433] is a little frustrating. … It really doesn't have, excuse the pun, any teeth in it. Just because you get the assessment, it doesn't imply that the disease is going to be taken care of, and of course a parent can opt out. But it's a start."

–Key Expert

Update on Last Year's Recommendations

The following actions were recommended in the Commission's 2005-06 Annual Evaluation Report. OHI has taken strides to address many of these actions, as is described below.

- ***Expand the use of fluoride varnish:*** During FY 2006-07, OHI offered two fluoride varnish trainings where partners learned to administer this cost-effective preventative service. Fluoride varnish trainings were added to one partner's subcontract to sustain this activity. The rate at which fluoride varnish was administered to children ages 0-5 in screenings and exams more than doubled from 14.1% in FY 2005-06 to 29.6% in FY 2006-07.
- ***Establish the treatment pool for children ages 0-5 and consider one for pregnant women:*** The treatment pool for children ages 0-5 is established ($300,000 total funds available) with two providers performing the treatments. A total of 52 children ages 0-5 were treated via the treatment pool in the eight months following its establishment, and more children are on the waiting list to be seen. The wait is several months and the lead agency estimates the treatment funds will be gone before the end of the next fiscal year.
- ***Solicit OHI partners' feedback to develop strategies to improve care coordination process and ability to track results:*** Care Coordinators continue to meet monthly to share best practices in a supportive learning community. For example, a map was developed to help clinics understand how the complex County Child Health and Disability Prevention (CHDP) Program works to provide oral health care for eligible children and get children ages 0-5 through it quickly as possible. Tracking the results of referrals continues to be difficult. This is a problem that the Commission's new data system may alleviate in the future.
- ***Adopt a common method of providing oral health education and anticipatory guidance to patients, parents and caregivers in the community:*** OHI adopted First 5 California's "Healthy Teeth Begin at Birth" brochure as its standard message, however, the State contractor that distributes the brochure was out of stock. The common method has been revised to include "a personal discussion with the client/patient", allowing OHI partners to include their own materials if they do not conflict with the messages in First 5 California's materials.
- ***Continue to train providers:*** OHI has continued to train providers. In recognition of the need for the entire staff of a dental office to be competent in maternal and children's oral health issues, the Commission has expanded the definition of "provider" to include hygienists, assistants and "ancillary clinic staff," such as case managers and billing staff.
- ***Collaborate with First 5 California to reduce duplication of services:*** In FY 2006-07, this recommendation emerged as an issue of leveraging rather than reducing duplication. The State's trainers did not come to San Diego County FY 2006-07, perhaps because there is a perception that the County has its own oral health provider training program via OHI. The OHI lead agency has been actively cultivating relationships with First 5 California's dental provider training contractors in hopes of bringing this State-funded resource available to all counties to San Diego in the future.
- ***Link OHI services with other First 5 Initiatives:*** This year, OHI Care Coordinators were oriented to several First 5 programs. For example, a meeting with the Health and Development Services project's lead agencies resulted in ideas for partnering at community events (e.g., health fairs), and developing a resource guide and a standardized referral form to use between agencies. The Kit for New Parents and School Readiness programs also presented to Care Coordinators, and planning began for a similar meeting with First 5 for Parents contractors.

[1]*Excludes exams conducted before January 2006, as fluoride varnish data was not collected for exams before that time. Excludes screenings conducted by two OHI partners from July 2005 to March 2006, as they were not yet reporting fluoride varnishes.*

Recommendations

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

- **Play a lead role in organizing key players to respond to AB 1433 requirements.** OHI is well poised to provide information to schools, public health agencies, and OHI and non-OHI affiliated oral health providers. This includes partnering with First 5-funded programs for pre-kindergarten children (i.e. four and five year olds), such as the School Readiness Initiative and Preschool for All.
- **Expand the Circle of Local Support for Oral Health Services.** There is tremendous pressure to increase children's oral health services in the County, First 5-funded and otherwise. The Commission is not able to fund screenings and necessary treatment services for every child in the County who is entering school, but the Commission can promote partnerships to attract more funders to this pressing issue. Community water fluoridation may present an opportunity for the Commission to collaborate with other funders to positively impact young children's oral health.
- **Sustain and expand provider capacity building efforts.** Dental services for children ages 0-5, particularly treatment services, continue to log long wait lists. To meet this influx of young patients, the number of dentists willing and able to screen, examine and treat children – including those children on Medi-Cal and other government sponsored insurance plans – needs to increase. In addition to OHI's training activities, the Commission can explore increasing collaboration with private practice dentists to attract, train and retain qualified providers
- **Maximize the potential benefits of community water fluoridation.** The Commission has taken steps that may lead to community water fluoridation in more areas of the County. OHI providers are in a position to promote fluoridated water among populations that may not drink it until they believe tap water is safe and understand the benefits of optimal exposure to fluoride. New York City and other local governments have launched campaigns to promote the fluoridation of their municipal tap water. As the Commission considers investing in local water systems, it may wish to learn more about these efforts and incorporate elements of these campaigns in OHI programs.
- **Explore how to offer pregnant women more individualized, one-on-one education about the importance of oral health and low-cost dental services.** Continued efforts are indicated to address the ongoing need for easy-to-understand information about dental care during pregnancy, and about the importance of early oral heath care for babies. Pregnant women state that they could benefit from more personalized attention to facilitate accessing care.
- **Consider a treatment pool or other funding mechanism for pregnant women.** Many pregnant women, even those covered by Medi-Cal, cannot afford the costs of treatment even when they know the benefits and where to go for dental health care. First 5 San Diego might take a close look at how Medi-Cal funds dental care for pregnant women and identify how to align its funds to maximize women's access. It may also wish to explore advocating at the State-level for Medi-Cal funding that is more responsive to the oral health needs of pregnant women.

A Final Word about the Oral Health Initiative

In FY 2006-2007, OHI programs delivered crucial preventative and restorative dental services to tens of thousands of children 0-5 and thousands of pregnant women. One of OHI's greatest accomplishments this fiscal year is the increase in the number of pregnant women served across all goals – screenings, exams,

treatment, care coordination and education – compared to FY 2005-2006. Direct services, including provider training, remained central; however, the Commission and the Initiative's focus expanded to encompass more community-wide oral health topics, such as mobilizing to respond to the new mandate for oral health assessments at kindergarten entry and discussions of community water fluoridation. As the Initiative moves forward, OHI partners established direct services that offer a ready platform for any intervention or services that may be necessary to compliment and enhance the community-wide changes that are taking place in the oral health arena.

CHAPTER 4

School Readiness Initiative

"You see the difference between someone who has gone to preschool and someone who hasn't. It was important for me to give them a running start."

—School Readiness Parent

Key Results

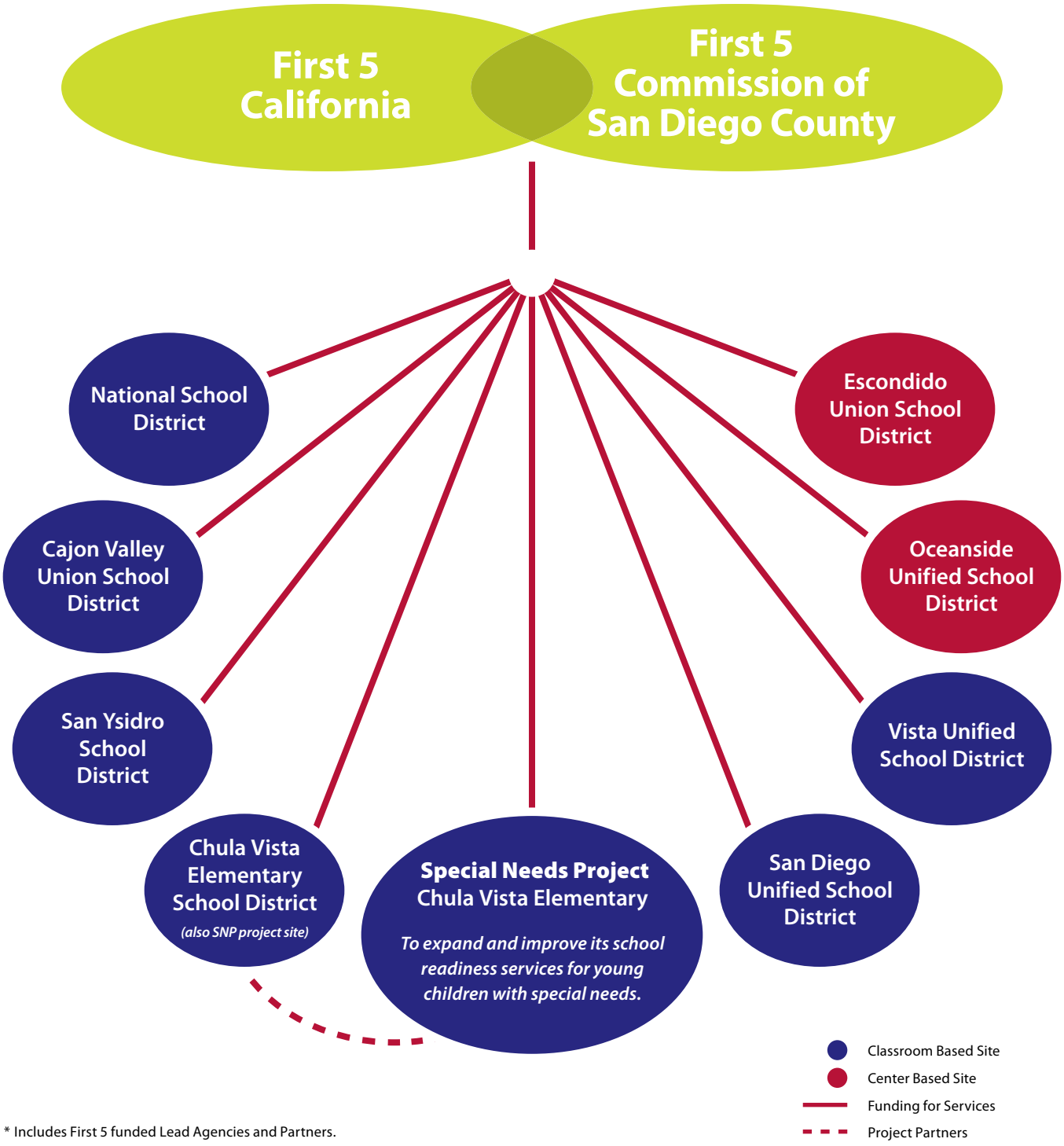
+ **Children improved in each of the five developmental domains:** Approximately half of children participating in School Readiness Initiative program activities showed improvement in all five developmental domains: Communication, Gross Motor, Fine Motor, Personal-Social and Problem-Solving (an increase from one-third in FY 2005-06).
+ **Parents increased ratings in each of the four parenting practice areas:** Parents participating in parenting classes demonstrated increases in each of the parenting practices areas (Knowledge, Confidence, Ability and Connection). Additionally, 99.3% of parents indicated overall program satisfaction with the School Readiness Initiative.
+ **Intensive parenting programs exhibited the most change in parenting outcomes:** Parents participating in more intensive, long-term parenting classes, such as sequential parent and child together (PACT) classes, consistently showed the most change in their knowledge, confidence, ability and connection.
+ **Children are receiving developmental screenings:** Over two-thirds of children participating in SR early care and education activities received developmental screenings. Thirty percent of these were referred for further assessment and/or treatment.
+ **Staff are articulating with elementary schools and participating in professional development:** Over half of preschool teachers and specialty service providers (58.3%) share formal transition plans for children preparing to enter kindergarten with elementary staff. Almost all staff participated in professional development activities, an average of 7.8 activities this year per person.

Summing It Up

The School Readiness Initiative served 10,912 children 0-5, 6,438 parents and caregivers, and 695 staff during FY 2006-07:

+ 4,381 children (including 417 children with disabilities or other special needs) and their parents and caregivers participated in early care and education activities, exceeding their goals based on previous fiscal year benchmarks by 14.5%.
+ 5,808 parents and caregivers participated in parenting and family support services.
+ 4,181 children received health and developmental services, including 1,756 developmental screenings.
+ 2,350 children participated in kindergarten transition activities and 630 parents had transition conferences with teachers.
+ 695 program and community service staff members attended professional development activities.
+ 501 children were screened by the Special Needs Demonstration Project, exceeding their goal this year.

School Readiness Initiative Structure*



* Includes First 5 funded Lead Agencies and Partners.

Introduction

Each year, a half million children enter California kindergarten classrooms.[112] But not all of these children arrive with the necessary skills that make them ready to learn, and often they perform at significantly lower levels than other children their age.[113] The need to develop a comprehensive approach that works with children, families, and schools is evident in the widening gap in literacy and numeracy scores by the third grade. Employing such a comprehensive approach will assist children to enter kindergarten ready to learn.[114] Participation in preschool programs has been found to have a positive impact on children's health and development into early adulthood, including higher rates of high school graduation and lower rates of juvenile arrest.[115]

The School Readiness Initiative was launched in 2002, a joint project between First 5 California and local county Commissions. In San Diego County, eight programs in local school districts with low Academic Performance Index (API) scores were selected to participate. The Commission has dedicated $11,531,398.50 to the Initiative since inception, including $2,927,047.50 in FY 2006-07. Matched funds from First 5 California bring the total investment to $23,062,797 since the Initiative's inception. The School Readiness Initiative is based on the First 5 California School Readiness Framework, redesigned last year, and the National Education Goals Panel's "Five Essential and Coordinated Essential Elements."[116, 117] First 5 California's four result areas include:

- Result Area 1: Improved Family Functioning: Parent and Family Support
- Result Area 2: Improved Child Development: Early Care and Education
- Result Area 3: Improved Child Health: Health and Social Services
- Result Area 4: Improved Systems of Care: Schools' Readiness for Children & Program Infrastructure, Administration and Evaluation (a combination of two NEGP elements)

New in School Readiness

- Implementation of the First 5 California School Readiness Framework Redesign
- Standardized Quarterly Progress Reports (QPR)
- Parent Retrospective Survey
- Preschool Teacher and Specialty Service Provider Surveys

School Readiness (SR) programs are designed to improve the transition from early care and education environments to elementary schools by fostering children's physical, social, emotional, and cognitive

[112]First 5 California "School Readiness 2001." 20 March 2001: 2 Accessed 17 August 2006. http://www.ccfc.ca.gov/pdf/sr5.pdf
[113] Ibid.
[114] Ibid.
[115] Reynolds, Arthur J., Judy A. Temple, Dylan L. Robertson, and Emily A. Mann. "Long-term Effects of an Early Childhood Intervention on Educational Achievement and Juvenile Arrest." Journal of American Medical Association 285.18 (2001): 2339 Accessed 17 August 2006. http://www.ccfc.ca.gov/PDF/SRI/chicago_cpc_jama.pdf
[116] Early Connections: Technology in Early Child Development. Five Areas of Child Development. 2005. Accessed 17 August 2006. <http://www.netc.org./earlyconnections/index1.html
[117] First 5 San Diego's School Readiness Initiative aligns its goals and objects with both those of the State Commission and the First 5 San Diego Strategic Plan.

development. The SR Initiative also supports families in preparing their children for entering school through parent inclusion, education, and support services. SR programs also encourage integration between early care providers and schools systems through joint trainings and articulation planning meetings.

A complementary component of the School Readiness Initiative is the Special Needs Demonstration Project (SNP). The Chula Vista Elementary School District, also a SR program, was one of 10 sites across the state selected by First 5 California to implement the Demonstration Project. This pilot project was designed to enhance School Readiness services in a specific geographic area by early identification of children ages 0-5 with disabilities, developmental delays, and other special needs. The program also provides coordinated services to children and their families, and initiates systemic change around inclusion and special education practices. This chapter highlights the results of both SR and SNP.

Key Elements

The School Readiness Initiative (SR) addresses each of the four Issue Areas in the First 5 San Diego Strategic Plan. As a partnership between First 5 San Diego and First 5 California, School Readiness is the longest running Commission initiative. During its five years of program activity, SR has evolved from a series of discrete programs in school districts that broadly addresses similar objectives, to a focused collective of unique programs pursuing common outcomes and goals. School Readiness programs consist of the following key elements:

- ***Variation in design***: Five programs are classroom-based and are located on elementary school sites, two are parent-child activity centers located in neighborhoods, and one has developed a resource center which provides outreach and on-site services at locations throughout the school district.
- ***A "whole child" approach:*** All program models are based upon the National Education Goals Panel (NEGP) "Five Essential and Coordinated Elements" of school readiness and each program addresses First 5 California's four result areas and five essential elements.
- ***Regular communication:*** School Readiness program coordinators meet monthly to discuss successes and challenges and collaborate with each other and Commission staff.
- ***State Activities***: Each program implemented the First 5 California School Readiness Framework Redesign and continues to receive State funding through 2010.

Summing It Up

In FY 2006-07, the School Readiness programs provided services to 10,912 children 0-5, 6,438 parents and caregivers, and 695 staff and service providers.[118] Most children participating in SR activities were three years of age and older, of Hispanic/Latino descent, and primarily spoke Spanish in the home (see the Data Compendium for demographic details). The following section provides the results of services provided to children, parents/caregivers, and staff/service providers this fiscal year. In response to a recommendation in FY 2005-06, the reporting process was strengthened through the introduction of a customized quarterly progress report (QPR) that was mapped into the four key result areas of the State Framework Redesign. For this section of the report, similar services across each SR program were aggregated to highlight the main services provided throughout the county.[119]

What's in a goal?

New to the School Readiness Initiative is the use of program progress goals. Along with the Commission, each program established goals for measuring the delivery of key services provided. Based on trends from FY 2004-05 and 2005-06, goals represent an attainable amount above previous service delivery counts. It is the intention of the Commission and programs to meet or exceed goals set each year to help ensure program sustainability and expansion.

Improved Child Development

Early Care and Education (ECE) services include a variety of program components designed to increase the school readiness of children: full-time and part-time preschool, parent and child activities in learning centers, and service enhancements to programs funded through other sources.[120] These various program services address First 5 San Diego's Strategic Plan "Issue Area 2: Children's Learning and Social-Emotional Health," Desired Result to *provide children access to quality services that promote their early learning and fill a gap in ECE services.*[121, 122]

"My daughter has learned … to express herself more."

- School Readiness Parent

Exhibit 1.1 displays the number of unduplicated children served through ECE services.[123] Over 4,000 children were served through the ECE activities, exceeding the projected goal of 3,826 by 14.5%. ECE activities include full-time preschool (n=628, 119.8% of goal), which consists of classroom-based instruction five days per week; and part-time preschool (n=624, 118.0% of goal), held two to four days per week, often for shorter periods of time per day. Parent and child

[118] May include duplicate counts within and between services. See each result area findings for more specific information.
[119] Due to this change in reporting, comparisons to FY 2005-06 and FY 2004-05 are limited.
[120] Includes curriculum, behavioral and health enhancements provided to California Department of Education preschools, First 5 of San Diego Preschool For All Demonstration Project preschools, and some community and faith-based programs.
[121] See Appendix B for more information related to Desired Results.
[122] These services also address the First 5 California School Readiness indicator "number of children making developmental progress in the areas of cognitive, social, emotional, language, approached to learning, and health/physical development" (Result Area 2: Improved Child Development, Service Area: Children have Access to High-Quality and Developmentally Appropriate Preschool Activities Prior to Entering Kindergarten).See below for results of child outcomes (Desired Results Developmental Profile – Revised and the Ages and Stages Questionnaire).
[123] FY 2004-05 and 2005-06 reports included data from service counts. Due to the shift in collecting unduplicated children, parents and caregivers, and staff participating in School Readiness, comparisons cannot be drawn between the years. However, the change in unit of measurement has strengthened the ability to understand who is being served in the School Readiness Initiative.

activities (n=1,678, 104.9% of goal) include staff guided parent-child interaction in learning centers and parental free time with their children in developmentally appropriate focus areas. Support to other ECE services, described as service enhancements[124] (n=1451, 123.7% of goal) were also a portion of the SR program.

This year, almost ten percent of children served in all ECE activities had special needs (n=417, 9.5%). Most notably, almost twenty percent (19.5%, n=283) of children receiving service enhancements and 16.3% (n=102) of children participating in part-time preschool had special needs.[125] These findings suggest that the School Readiness programs are making progress towards serving the 0-5 special needs population, as it is estimated that between 8%-17% of children have special needs.[126, 127] (The children with special needs reported in the SR results are not duplicate children served by the Special Needs Project Demonstration Project).[128, 129]

Exhibit 4.1 Total Served through Early Care and Education (n=4,831)*

Service	Children			Children with Special Needs	
	Number	Goal	% of Goal	Number	% of Served
Full-Time Preschool	628	524	119.8%	10	1.6%
Part-Time Preschool	624	529	118.0%	102	16.3%
Parent & Child Activities**	1,678	1,600	105.9%	22	1.3%
Service Enhancements***	1,451	1,173	123.7%	283	19.5%
Total	**4,381**	**3,826**	**114.5%**	**417**	**9.5%**

**Includes unduplicated counts within services; may include duplicate counts between services.*

***Includes 150 intensively served and 1,528 "light touch" children.*

****Includes service enhancements such as curriculum and access to health, behavioral and social services.*

[124] Service enhancements include services to children with classroom time funded by other entities (i.e. California Department of Education, First 5 San Diego Preschool For All Demonstration Project), such as behavioral consultation, health screenings and curriculum investment.

[125] Using the First 5 of California definition of special needs: includes children with disabilities and other special needs, such that they "are protected by the Americans with Disabilities Act (ADA), or have or at risk for a chronic condition whether physical, developmental, behavioral, or emotional and who also require education, 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.)

[126] HDS and PFA initiatives both use CDC statistics for benchmarking the number of children with developmental delays. However, the CDC's statistics encompass ages 0-17 http://www.cdc.gov/ncbddd/child/devtool.htm accessed September 26, 2007. A sample based national study, conducted in 2001, estimated that approximately 8% of children aged 0-5 had special needs: U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. The National Survey of Children with Special Health Care Needs Chartbook 2001. Rockville, Maryland: U.S. Department of Health and Human Services, 2004. Accessed 10 September 2007 http://mchb.hrsa.gov/chscn/index.htm

[127] Note that the percent of children with special needs is quoted from a 2001 publication. Other intiatives in the Commission utilize the CDC percentage of

[128] The Special Needs Project (SNP) reports child-level data to the First 5 California Commission, which should isolate the Special Needs Project data from the School Readiness Initiative. Through advances in program capacity around the state database and program database, duplication is minimal.

[129] See the end of this chapter for results from the local Special Needs Project evaluation.

The results of the satisfaction portion of the Parent Retrospective Survey were overwhelmingly positive about the SR ECE programs. In addition, parents also noticed a difference in their children's social and personal development. As one parent commented in the survey, "My daughter has learned to socialize, to interact with other children and to express herself more." Another parent noted, "It was a very positive experience for my daughter – she really thinks she can't do things. The [staff] helped her and her self esteem. It reassured her and reassured me."

Improved Family Functioning

The Parent and Family Support service element of the School Readiness Initiative addresses the needs of families through parent education classes, literacy programs, parent and child together (PACT) sessions, and home programs. Research has demonstrated that these types of parent services have a direct impact of the developmental progress of children.[130, 131, 132]

Parent and Family Support services were delivered in several formats this fiscal year. One distinct variable in this year's reporting is the duration of services: some classes or groups were held as "drop-in" classes, open to the public at any time, while others were sequential, requiring enrollment and consistent participation in classes over a six to 40 week period. The subject matter of classes also varied and included topics such as child development, discipline, and nutrition.

"It gives me more ideas how to work with my kids at home."

- School Readiness Parent

Overall, 5,808 parents and caregivers received services through Parent and Family Support, 107.7% of the yearly goal of 5,392. As seen in Exhibit 1.2, the majority of these parents participated in single session parent classes (n=3,480, 208.5%).[133] Sequential parent and child together (PACT) classes also had attendance of almost double the goal (n=331, 189.1%) and home programs exceeded the goal as well (n=303, 126.3%). However, sequential parent classes and single session PACT classes fell below the goal, at 50.0% (n=1,580) and 86.8% (n=217), respectively.

Through SR's parenting classes, many parents are now better prepared to recognize learning opportunities with their children, plan developmentally appropriate activities, and understand their children better (see below for results of the Parent Retrospective Survey). As one parent said: "It helps me see the world more through my son's [point of view] and how to calm myself." Another parent described how the program has changed her confidence and family environment. "My husband and I learned how to set goals with our daughter. Also, we built confidence in our discipline. Our home has a more relaxed environment due to our daughter's positive behavior."

"As a family it integrates us more and we obtain experience from the other parents."

- School Readiness Parent

[130] 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>

[131] 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.

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

[133] These parents attended at least 443 classes during the fiscal year, 189.3% of the goal.

Exhibit 4.2 Total Served through Parent and Family Support (n=5,808)*			
Service	Parents & Caregivers		
	Number	Goal	% of Goal
Sequential Parent Classes	1,580	3,158	50.0%
Single Session Parent Classes**	3,480	1,669	208.5%
Sequential Parent & Child Together (PACT)	331	175	189.1%
Single Session Parent & Child Together (PACT)	217	250	86.8%
Home Programs	303	240	126.3%
Total	**5,808**	**5,392**	**107.7%**

**May include duplicate counts within and between services.*

***These parents and caregivers participated in approximately 443 classes (189.3% of the goal of 234).*

Improved Child Health

The School Readiness Initiative provides a variety of health and social services to participating children and families, following a "whole child" approach to preparing children for kindergarten.[134] These services may be funded directly by First 5 School Readiness funds (e.g. the SR contract may fund 50% of a school nurse) or SR programs may reach out to other available services (such as the State's First Smiles project or the First 5 San Diego Oral Health Initiative). Services directly funded as part of a First 5 San Diego SR program or through other sources (i.e. indirectly), were counted as part of their overall children's health service counts to demonstrate the wrap-around services provided by the schools. Health services provided either directly or indirectly include: screenings (behavioral, dental, hearing, language and speech, and vision), health plan enrollment, health education, referrals for basic healthcare needs, mental health counseling, and specialized services for children with disabilities and other special needs. Together with early care and education programs and parent and family support programs, these services address the cognitive, physical, and social-emotional development of children. Provision of these services directly support the Commission's Issue Area of Children's Health, specifically, that children are born, stay healthy, and have access to preventative and comprehensive healthcare services.

Exhibit 1.3 displays the number of children receiving developmental, health and behavioral services, as well as referrals for further assessments or services and case management. As a whole, the programs fell just short of their goal of 4,374 screenings, at 95.6% (n=4181). However, they far exceeded their goals for health screenings (n=1,910, 140.8% of goal), behavioral services (n=122, 122.0% of goal), and referrals and case management (n=515, 119.2% of goal). The only service short of the goal was developmental screenings, completing only 65.8% (n=1,634) of the goal of 2,485 (every child enrolled in an early care and education activity). This shortfall could be due to the shift to the redesigned State Framework, which caused late implementation and challenges

[134] Many of these services are also available to families whose children do not participate in SR ECE activities.

in securing staff to perform the developmental screenings. All health screenings were funded directly and indirectly by School Readiness.[135]

Exhibit 4.3 Total Served through Health and Social Services (n=4,181)*

Service	Children		
	Number	Goal	% of Goal
Developmental Screenings	1,634	2,485	65.8%
Health Screenings**	1,910	1,357	140.8%
Behavioral Services	122	100	122.0%
Referrals*/Case Management**	515	432	119.2%
Total	**4,181**	**4,374**	**95.6%**

**Includes unduplicated counts within services; may include duplicate counts between services*

***Includes at least 536 dental, 842 language/speech/hearing, and 774 vision screenings; children may have had more than one type of health screening.*

****Includes referrals to district special education, mental health and social services, and home health consultations.*

Parents who participated in the School Readiness Initiative noted the comprehensive nature of the program. Through feedback in a parent focus group and the parent survey, parents expressed deep gratitude for the opportunity to access a variety of health and social services. As one parent shared, "*El programa es … excelente [en] que tenemos los padres una herramienta para el desarrollo físico, psicológico y social de los niños*/ The program is … excellent [in that] we parents have a tool for the physical, psychological, and social development of the children." Another parent noted, "*En nuestro case ha satisfecho las necesidades del nino por arriba de nuestras expectativas*/In our case [the program] has satisfied our child's needs beyond our expectations."

Improved Systems of Care

Schools' Readiness for Children is an important element of SR that addresses planning and communication between school administrators, kindergarten teachers, preschool teachers, ECE providers, School Readiness program staff and parents. It also involves professional development programs, as well as infrastructure, administration, and evaluation. This program portion of the State Framework 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.*[136]

[135] Children in seven programs received developmental screenings directly from program staff. (One program subcontracted them to another agency.) Children in two programs received vision screenings directly from program staff. (Other agencies provided them in four programs and two programs did not offer vision screenings.) Children in three programs received speech, language and/or hearing screenings directly from program staff. (Other agencies provided them in three programs, and two programs did not offer speech/language/hearing screenings.) Children in one program received oral health screenings directly from the program's staff. (Another agency provided them in one program, and six programs did not offer dental screenings.) Children in four programs received behavioral services directly from program staff. (One program subcontracted them to another agency and three programs did not offer behavioral services.)

[136] First 5 San Diego. First 5 San Diego Commission 2004-09 Strategic Plan. San Diego, CA: 2004.

Perhaps one of the most important components of SR systems improvement is the facilitation of communication between the SR programs, elementary schools, and parents. This communication is vital to ensuring that early childhood education programs support the development of those skills that are critical for school readiness, it also encourages schools to prepare for the transition needs of those children and families entering kindergarten.[137] One key community expert described the importance of SR programs taking the lead to ensure clear articulation in this area of systems improvement:

"The relationship with parents can make a huge difference."

- Key Community Expert

> *We've had kindergarten teachers help us figure out what would be the most important skills. We've had joint workshops where preschool and kindergarten teachers come together. Because of First 5, we have had kindergarten teachers sharing with one another what they do for assessments coming to kindergarten, and what kinds of materials they give parents over the summer before kindergarten. We didn't have that kind of articulation before First 5; each school did their own thing. We communicate our top priorities to the for-profit [preschools] and other preschools in the community, which we didn't before.*

This fiscal year there was a tremendous increase in kindergarten transition activities involving children, parents/guardians, SR program staff, and kindergarten teachers. Over 2,000 children participated in kindergarten transition activities (n=1,984, 81.2% of goal), such as KinderCamp (a two to four week intensive program for children with little to no preschool experience), kindergarten visitation, and kinder-readiness assessments (see the Data Compendium). An additional 366 children (182.1% of goal) received in-class support during the first week of kindergarten.

"There are no other schools that have this program, we need more places."

- School Readiness Parent

Parents were also involved with the transitioning of their children to kindergarten. Over 600 parents (139.1% of goal) met with School Readiness ECE program staff to discuss the changes that lay ahead. However, several parents expressed discontent with the quantity and quality of their interaction with staff regarding kindergarten transition. As one parent stated, "One suggestion would be if they could hold parenting classes to help us as parents to be more involved in our children, to better prepare them." And as another parent said, "[The program] needs updates for each kid. [It] needs more conversation and connection between parents and staff."

The final component of kindergarten transition activities is effective communication between early care and education staff and kindergarten teachers. Almost 100 (n=97, 109.0% of goal) School Readiness staff participated in kindergarten articulation meetings with elementary staff (including kindergarten teachers, administrative staff, and support teams). These joint meetings included planning for transition and child reviews to facilitate wraparound curriculum development and preparation for children. The relationships built during these interactions have even led to outreach by kindergarten teachers. "[Through increased visibility] we have kindergarten teachers recruiting for us," said one SR staff member.

[137] Halfon, Neal. et al. Reaching Back to Create A Brighter Future: The Role of Schools in Promoting School Readiness. UCLA Center for Healthier Children, Families, and Communities, May 2001. 10 Accessed 10 September 2007 http://www.ccfc.ca.gov/PDF/SRI/stuart-reaching-back.pdf

Providing for infrastructure, administration, and evaluation activities in the School Readiness Initiative involves coordination of program, district, and First 5 San Diego involvement. Activities such as contract monitoring, fiscal accountability and program evaluation all combine to ensure program maintenance and improvement.

- **Infrastructure:** Program infrastructure includes components such as access to teaching materials, staffing, and adequate program space. First 5 funding has brought expanded curriculum and staff to programs located in school district facilities throughout the life of the Initiative. This year, two SR programs received First 5 capital grants: one constructed a new SR building and the other furnished a site expansion. While there has been success in strengthening infrastructure, some programs still experience difficulties. One SR program is losing its building to a city development project and has yet to secure a new space. As one parent commented, *"Queremos un salón! Son los niños del futuro! Los niños necesitan su propio espacio/*We want a classroom! These are the children of the future! The children need their own space." Waiting lists exist at several programs, and program staff has worked diligently to incorporate more services in-house or through community partnerships.

  "School Readiness has allowed me to have more meetings and discussion with community preschools and Head Start."

  - School Readiness Program Staff

- **Administration:** Program staff received trainings (an average of 7.8 per person) throughout the fiscal year on various topics including innovative child and parent curriculum, home visiting, managing challenging classroom behavior, and other topics. A number of SR programs sought connections with other First 5 funded SR programs across the state and regular meetings with other San Diego SR programs promoted information exchange and linkages with other First 5 San Diego funded services. Finally, some programs provided modeling sessions with mentor teachers and behavioral specialists to teachers requesting further consultation, a best practice as promoting professional support provides stability to early childhood service providers.[138] (See the Data Compendium for details).

  In several cases, SR programs have sought to include parents in their administrative and planning activities. For example, Parent Advisory Committees provide parent and community input and leadership in five School Readiness programs. Committee members assist program and district staff in planning, assessing, evaluating, and problem-solving at each site. Some past committee members (and other parents participating in SR) have remained connected to School Readiness over time by volunteering, participating in staff hiring processes, and working for the program as paid employees.

- **Evaluation:** In FY 2005-06, First 5 California released its School Readiness Initiative Framework Redesign, including more stringent and streamlined reporting requirements. First 5 San Diego SR programs are now fully aligned, using common outcomes, and have successfully implemented common measurement tools and reporting procedures. All eight SR programs have been awarded with funding through 2010.

  In addition to aligning to the state School Readiness framework, program staff has successfully addressed three of last year's evaluation recommendations. First, collecting and reporting child outcomes were fully implemented in all eight programs using two standard measurement tools. Second, all eight School

[138] Halfon, Neal. et al. Reaching Back to Create A Brighter Future: The Role of Schools in Promoting School Readiness. UCLA Center for Healthier Children, Families, and Communities, May 2001. 10 Accessed 10 September 2007 http://www.ccfc.ca.gov/PDF/SRI/stuart-reaching-back.pdf

Readiness programs successfully implemented a pilot of the Parent Survey.[139] Third, a common reporting format for process and outcome data was implemented this fiscal year for all eight SR programs.[140]

While the fourth recommendation from FY 2005-06, enhanced case management, was not fully addressed, the Commission pursued a different method for monitoring referrals. This consisted of screenings, assessments, referrals, and treatment. (Tracking children receiving developmental referrals was introduced this year. Results are detailed further in the chapter).

Building a System to Ensure the Care of Children

First 5 San Diego funds different health services for each SR contractor, depending on their in-house ability to serve the health needs of children. Every SR contractor provides health services, but not necessarily all services. For example, the Escondido Union's nurse is partially funded by First 5 to conduct oral health screenings but not mental health screenings while San Diego Unified uses its First 5 funds to conduct mental health screenings, but not dental screenings. To fill any gaps in health services, and to ensure each SR contractor addresses the State's "whole child" framework, each contractor relies, to some extent, on partnerships with other community agencies to address children's health needs. First 5 San Diego encourages partnerships across its funded initiatives, and has facilitated the process through the creation of a special referral form between SR programs and HDS providers. However, the variability of First 5 funded health services within School Readiness programs is not always clear to other First 5 funded initiatives and has sometimes created confusion with health service providers regarding perceived supplantation of services. For example, one SR contractor not funded to conduct dental screenings reached out to an OHI contractor to obtain these services, but the OHI contractor declined, saying that SR was already funded to do this. Commission staff should continue to facilitate communication between initiatives to ensure children reach appropriate services.

[139] This survey contributed to understanding the impact on parental knowledge, confidence and ability from parenting classes, as well as satisfaction around 18 program areas.

[140] Only one SR program sent outcome data in a different format. The Quarterly Progress Report (QPR) completed by each program provided space for each data element, reducing the likelihood of incorrect, missing or outdated information. The consistency in data submitted facilitated successful and more powerful analysis. This shift in reporting formats better prepares the SR programs to implement the Commission's forthcoming data system.

Experiencing Parent-Child Activity Centers

Entering the activity centers is like stepping into a fantasy land, with vibrant decorations and filled with parents, children, and staff working together throughout. Each activity center had a central theme for learning: barnyard animals and dinosaurs. Inside the activity centers were multiple stations encouraging stimulation of each of the five developmental areas: communication, gross motor, fine motor, personal-social, and problem-solving. While a trained adult may be able to see the developmental activities at each station, to a child, the room was just filled with toys and games and friends. Moving through the stations, children and parents work together on each of the child's five developmental areas.

Communication: Each activity center had clearly defined spaces for children to read and write, either alone, with other children or with an adult. During one site visit, a child approached an adult with a book and asked the adult to read it. Once the adult was reading the story more children gathered to listen. Parents and staff also encouraged language development with children through asking questions and conversing with each other.

Gross Motor: Each activity center had outdoor activities to promote children's exploration and exercise. Included in these outdoor areas were tricycles, balls, and playground equipment. One center even had a campground dramatic play area, complete with a tent and safari gear.

Fine Motor: Stations and activities to build fine motor skills were apparent at each activity center. One had a bin filled with macaroni with dinosaurs, and the other had a small-scale farm with animals and plants. Activities ranged from paper crafts to playing with shaving cream and food coloring.

Personal Social: Dramatic play areas were inviting at each activity center. One center had a dinosaur cave with music playing; and the other two had a dress up stations for boys and girls. During one site visit, a boy and his mother played in the dinosaur cave, acting out parent-child behavior using the dinosaurs.

Problem Solving: During site visits, very little conflict between children was evident. However, when a dispute would arise, like a child holding two toys when another child wanted one of them, staff and parents were quick to facilitate a negotiation between the children.

Making a Difference: School Readiness in Action

The overarching goal of the School Readiness Initiative is to increase the school readiness of children in low Academic Performance Index (API) performing schools through a variety of complementary approaches, including direct education services to children, parent and family support, health and social services, and improving connections between early care environments and staff with kindergarten and elementary school systems. It is hoped that these combined activities will improve child and families outcomes.

Programs utilized standardized tools to measure outcomes for children, families and staff participating in the School Readiness Initiative. Each program successfully implemented and submitted quality data for each outcome measure, which was an improvement over previous years.

Outcome Measurements

- **Child Development:** Desired Results Developmental Profile – Revised (DRDP-R) or Ages & Stages Questionnaire (ASQ)
- **Family Functioning:** Parent Retrospective Survey
- **Child Health:** SR Developmental Screening System
- **System of Care:** Preschool Teacher and Specialty Service Provider Surveys

In addition to the use of standardized measurement tools, visits at select sites, interviews with School Readiness Coordinators, and a focus group with parents were conducted to better understand the day-to-day operations of programs and the partnerships that exist among children, parents, staff and community organizations. The findings from all of these methods and tools are braided throughout the remainder of this chapter.

Improved Child Development

The centerpiece of the School Readiness Initiative is direct education services to children. Classroom based programs used the revised Desired Results Developmental Profile (DRDP-R), a teachers observational assessment for children.[141, 142] The Ages and Stages Questionnaire (ASQ), completed by parents and/or SR staff, was used in center-based settings.[143] All data and findings are for children with both Fall ("pre") and Spring ("post") matched cases. While both tools measure the similar behaviors and skills, limitations in analysis and comparison exist

"Some children will say, 'My mom didn't want to bring me and I say, Mom, you have to!'"

- School Readiness Program Staff

[141] Classrooms receiving California Department of Education funding are required to perform the DRDP-R within 60 days of child enrollment and 6 months thereafter.

[142] The Developed Results Developed Profile (DRDP) was created by the California Department of Education (CDE) in order for educators to document the child developmental progress over time and improve program quality. Trained staff members are required to conduct the DRDP in the child's home language (with assistance if needed) within 60 calendar days of initial enrollment in the program and every six months thereafter. (California Department of Education. Introduction to Desired Results. 6 July 2007. http://www.cde.ca.gov/sp/cd/ci/desiredresults.asp)

[143] In FY2005-06, the Commission and Harder+Company sought recommendations from key developmental psychiatrists – Gary Resnick of Westat and Todd Sosona of the California Institute of Mental Health – for a tool appropriate for center-based interventions that could map to the DRDP. The ASQ was suggested. Additional details are in Appendix B: Methods.

due to differences in administration and scoring. Therefore, results cannot be discussed by developmental areas across both instruments, but rather must be presented individually. With these limitations in mind, results are suggestive but not conclusive of child outcomes.

Classroom Based Programs: Desired Results Developmental Profile – Revised

DRDP-R data come from six School Readiness programs and represent matched scores for 1,312 children or 49.4% of children enrolled in early learning activities.[144, 145] These children were enrolled in both full-time and part-time early learning programs (53.7% and 46.3%, respectively). Almost half of all children had increased scores in all five developmental areas (48.6%, n=637).[146] Overall, the results suggest students enrolled in classroom-based services are increasing their developmental skills.[147] Due to revisions in the original DRDP instrument, direct comparisons with previous program years cannot be made, but general trends are suggested. (See the Data Compendium for the demographics of DRDP children.) Exhibit 1.4 presents the findings of the DRDP-R by the instrument's domains and within each domain the average change from pre to post assessment by all children, those attending full-time, and those attending part-time. (See Appendix B and C for further details of methods and findings.)

"[My daughter] enjoyed playing and learning in so many different things and different ways. I don't think I could prepare all these materials and equipment for kids."

- School Readiness Parent

Key findings of the DRDP-R include:

- The results as a whole indicate that children participating in ECE activities at classroom-based programs are increasing their mastery of each developmental area. All FY 2006-07 DRDP-R domain scores increased from FY 2005-06 and FY 2004-05.
- The largest increase for all students was found in communication, followed by problem-solving and personal-social. These domains also exhibited the largest increase in FY 2005-06 and FY 2004-05.
- Children in a full time program experienced higher results in all five DRDP-R domains than those attending the program part-time, with the largest difference found in fine motor skills. This suggests that increased exposure to SR programs may increase the benefit to children.

[144] In FY 2004-05 and 2005-06 only four districts were required to complete the DRDP for their children enrolled in early learning activities. This year, two districts changed their child outcome instrument from the ASQ to the DRDP-R as their early learning activities were more similar to the other classroom based programs.

[145] Early learning activities at classroom based programs include full and part time preschool funded at least in part by the School Readiness Initiative (with blended or braided funding from the California Department of Education and the Preschool for All Demonstration project), serving 2,655 children during FY 2006-07. This number does not include children who were too young to be observed using the DRDP-R, or who were screened using the ASQ.

[146] To maintain consisitency across program years and to connect findings between the school-based (measured by the DRDP-R) and center-based programs (measured by the ASQ), the desired results of the DRDP-R were recategorized as domains according to the original DRDP tool. See Appendix B for details.

[147] The evaluation team did not have access to comparison data for the DRDP-R to isolate what change is attributed to the intervention at what change would normally occur. See Appendix B for details.

Exhibit 4.4 DRDP-R Developmental Area Mean Score Change By Attendance Type

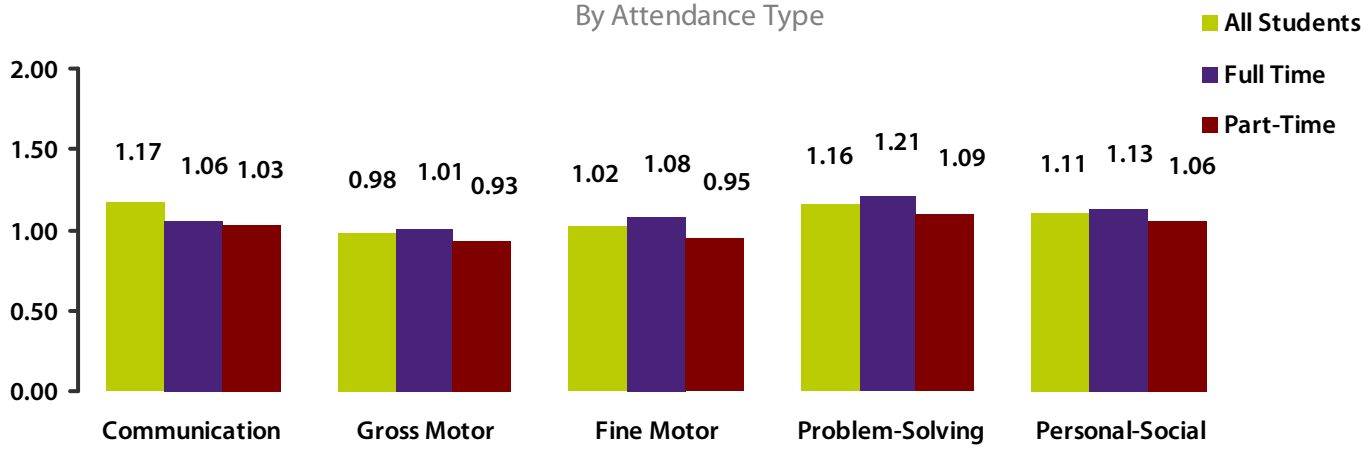


Exhibit 4.5 Change in DRDP Scores from Fall to Spring**

Developmental Area	Increased		No Change		Decreased	
	Percent	Number	Percent	Number	Percent	Number
Communication	95.2%	1,023	2.0%	22	2.8%	30
Gross Motor*	79.5%	995	16.1%	202	4.3%	54
Fine Motor	74.7%	937	21.6%	271	3.7%	46
Problem-Solving	96.7%	1,148	0.9%	11	2.4%	29
Personal-Social*	94.8%	1,118	2.0%	24	3.1%	37

**Percentages do not equal 100% due to rounding.*

***Numbers do not equal total DRDP-R completed (n=1,312) as the analysis only includes children with valid responses for all items in the scale.*

Center Based Programs: Ages and Stages Questionnaire

This year, ASQ data are reported for two center-based programs, totaling 163 matched cases, representing 90.1% of intensively served children at these sites (n=181).[148, 149] The results suggest evidence of age-appropriate developmental progress for the majority of children. Over half of all children had increased scores in all five developmental areas (55.8%, n=91). Parents and guardians participating in a focus group also reported that the results of the ASQ provided guidance for focusing learning activities in the home. A grandmother stated, "I thought it was useful because it helped me as a grandmother. I knew where he was and what I could do to help him."

"We need that hands-on for kids to learn. This is hands-on for parents too."

- School Readiness Program Staff

[148] In FY 2004-05, 21 matched Fall/Spring data were reported; 48 matched Fall/Spring in 2005-06.

[149] Many of the ASQ's were completed by parents with the assistance of School Readiness staff.

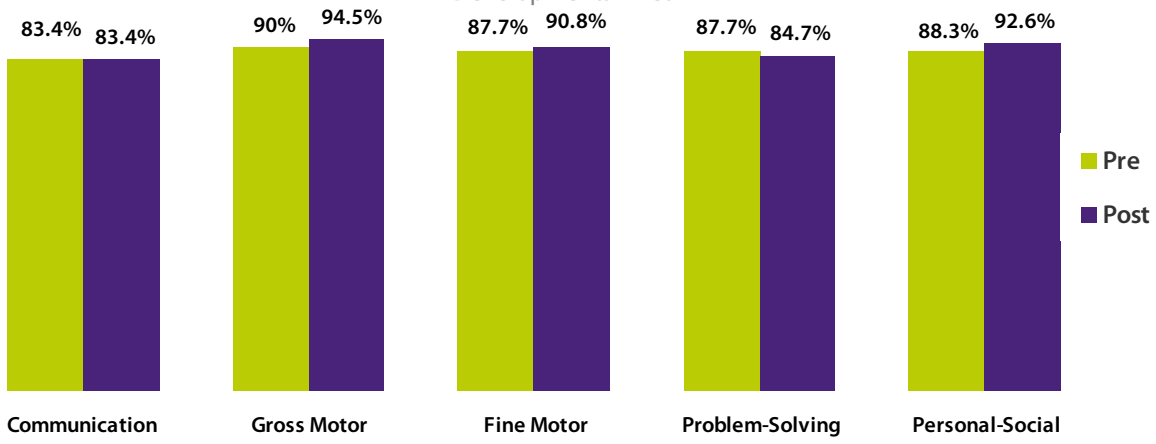
This year's data was analyzed differently than previous years. The changes bring the analysis closer to the intended use of the ASQ as a screener for developmental concerns at various ages.[150] Therefore, the analysis this year was enhanced by utilizing the scientifically set cut-off scores for the ASQ's age-specific instrument, preserving the design of the tool while comparing children's status "above" or "below" the age-specified cut-off score at each point in time.[151, 152]

Most of the children screened were two or three years of age. The average age of children screened with the ASQ was 2.84 years, though ages ranged from one to 61 months (see the Data Compendium).

Key findings of the ASQ include:

- In all five ASQ domains, the majority of children were assessed at being above the cut-off point and continued to be above the cut-off point at retest.
- In descending order, the three domains that had the highest percentage of increases were personal-social, communication, and fine motor. These were similar to FY 2005-06 findings.
- In descending order, the two domains with the highest percentage of decreases from Fall to Spring were problem-solving and communication.
- Communication skills exhibited the highest number of children remaining below the cut-off in Spring.

Exhibit 4.6 Percent of Children At or Above Cutoff in Fall and Spring for Each ASQ Developmental Area



Although the ASQ data is suggestive, there are significant limitations with utilizing its findings in isolation for program improvement. Future evaluation years will look for opportunities to pursue additional data collection strategies to verify the tool's findings.

[150] In FY2005-06, the Commission and Harder+Company sought recommendations from key developmental psychiatrist Gary Resnick of Westat and Todd Sosona of the California Institute of Mental Health for a tool appropriate for center-based interventions that could map to the DRDP. The ASQ was suggested. Additional details are in Appendix B: Methods.

[151] "Above" the cut-off score indicates the child is at or above the skills expected for their age; "below" the cut-off score indicates the child may be behind for their age, and is recommended for further assessment. In this analysis, the cut-off scores used are specific to each instrument used for the screening.

[152] The instrument used at Fall and Spring are likely to be different. Using the "above" or "below" cut-off allows for accurate analysis, regardless of instrument used during the screening.

Improved Family Functioning

Parents are the first and best teachers and models for their children.[153, 154, 155] The School Readiness Program includes a Parent and Family Support Services element to improve parenting skills, literacy, and access to needed services. In response to FY 2005-06 recommendations for improved parent outcomes, the Parent Retrospective Survey was designed as a pilot survey. Administered to parents participating in School Readiness parent education activities in all eight districts, the Parent Retrospective Survey is comprised of two components: a modified "Survey of Parenting Practice" developed by the University of Idaho and a modified "Desired Results for Children and Families – Parent Survey" developed by the California Department of Education.[156] Findings from this year's pilot will inform future versions of the survey and processes of training and administration.

"The parents are the teachers."

- School Readiness Program Staff

Parents participating in a focus group reported that completing the Parent Retrospective Survey was easy and well connected to the content of their parenting class. While transitioning the survey to a longitudinal design is not planned, connecting Parent Retrospective Survey results with child outcomes is under consideration with the Commission's forthcoming data system.

Most surveys were administered in person at the completion of a parent education activity, while others were given to parents at the end of the school year to complete at home and return through the mail. Activities included parent classes (on topics such as behavior, nutrition, etc.), parent and child together (PACT) classes, and home programs (i.e. "Parents as Teachers"). Some of these activities were long-term (i.e. family literacy programs or home programs) or single session (i.e. workshops or playgroups). In order to determine the difference in change and satisfaction, surveys were coded based on their type (see Exhibit 1.7 for distribution).

It is unknown how many completed surveys were duplicates due to parents participating in multiple types of classes, or multiple times of the same class. However, 32.8% (n=221) reported that they participated in other parenting education classes prior to the parenting activity in which they were completing the survey (suggesting potential duplication).

The majority of adults participating in parenting activities were the mothers of the reference[157] children (77.6%,

Exhibit 4.7 Type of Parenting Activity (n=1,472)

Activity Type	Percent	Number
Sequential Parent Classes	55.9%	823
Single Session Parent Classes	11.6%	170
Sequential Parent & Child Together Classes	11.8%	174
Single Session Parent & Child Together Classes	11.0%	162
Home Programs	9.7%	143
Total	**100.0%**	**1,472**

[153] 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.

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

[155] 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>

[156] California Department of Education. "Desired Results Reference Materials and Forms." 2003. Accessed 10 July 2006 http://www.cde.ca.gov/sp/cd/ci/drdpforms.asp

[157] Parents were asked to think about one of their children ages 0-5 when completing the survey.

n=726). Only 17.4% (n=163) were fathers, and 3.2% were grandparents (n=30). Other (1.7%, n=16) adults participating include aunts, uncles and great-grandparents. (See the Data Compendium for details on Parent Retrospective Survey respondent demographics).

Parenting Practices

The "Survey of Parenting Practice" component is a series of statements about knowledge, confidence, ability, and behaviors around parenting. When completing this section of the survey, parents rated their level of knowledge, confidence, ability and behaviors after completing the parent education activity (or "now"). Parents also rated their level of knowledge, confidence, ability and behaviors thinking back to before they participated in the parent education activity (or "then"). Ratings range from zero to six, with the higher the rating, the more knowledge, confidence, ability, or frequent behavior. This method of "retrospective" comparison allows for respondents to more accurately provide baseline data, compared to traditional pre/post methods, when participants tend to rate themselves higher on the pre-test. [158] This portion of the Parent Retrospective Survey addresses the First 5 California School Readiness indicator "number and percent of parents who demonstrate increased knowledge (confidence and competence) to promote children's optimal development and school readiness."

"We need to take it to the next level: the parent as a learner, the parent as a teacher, and the parent as an advocate."

- Key Community Expert

Overall, parents increased their ratings on all items on the parenting practice survey.[159] Exhibit 1.8 shows the mean "then" and "now" outcomes for all 12 survey items, as well as the mean difference between the two. It is of note that parents attending sequential parent and child together (PACT) classes consistently demonstrated the most change.[160] Below is a brief description of findings based on the knowledge, confidence, ability, and behaviors scales.

- *Parental knowledge:* A parent's knowledge of child development is the basis for sound parenting practices.[161] With all types of parenting classes included, parents increased their ratings on all three knowledge statements. Of all 12 survey statements measured, the change in parent rating was the greatest for the statement, "My knowledge of how my child's brain is growing and developing."
- *Parental confidence*: Building on a foundation of child development knowledge, parenting confidence is formed by feedback and recognizing strengths in parenting. [162] Parents increased their ratings on all three confidence statements.
- *Parental ability:* Parents bridge the gap between theory (knowledge and confidence)

"I am very happy because it has helped me to be more confident in how to educate my daughters and how to understand them."

- School Readiness Parent

[158] "Pre-test overestimation is likely if participants lack a clean understanding of the attitude, behavior, or skill the program is attempting to affect." Pratt, C., McGuigan, W. and Katzev, A. (2000) Measuring Program Outcomes: Using Retrospective Pre-test Methodology. American Journal of Evaluation. (21) 341-349.

[159] Increases in knowledge, confidence, ability and connection questions could also be due to participation in the early learning environment, interaction with teachers and other factors.

[160] For full analysis notes and results see Appendix B and the Data Compendium, respectively.

[161] Shaklee, Harrie and Diane Demarest. Survey of Parenting Practice Tool Kit, 2nd Ed. University of Idaho. Boise, Idaho. 2005.

[162] Ibid.

and practice through trainings in child development. [163] Parent ratings increased on all three ability statements. Of all 12 survey statements measured, the statement with the least amount of change, although still statistically significant, was "My ability to keep my child safe and healthy."

- *Parental behavior*: Knowledge, confidence and abilities all add up to parental interaction with their children and other families. [164] Parents who participated in all SR programs reported increased ratings on connections to their child and other families with children.

Exhibit 4.8 Outcomes for Parenting Survey

Survey Item	Mean "Then" (Before SR)	Mean "Now" (After SR)	Mean Difference	Number*
My knowledge of how my child is growing and developing.	3.73	4.93	1.20*	1,232
My knowledge of what behavior is typical at this age.	3.64	4.82	1.18*	1,221
My knowledge of how my child's brain is growing and developing.	3.73	4.94	1.21*	1,220
My confidence in myself as a parent.	4.12	5.15	1.03*	1,220
My confidence in setting limits for my child.	3.86	5.01	1.14*	1,199
My confidence that I can help my child learn at this age.	4.05	5.20	1.16*	1,224
My ability to identify what my child needs.	4.00	5.12	1.12*	1,214
My ability to respond effective when my child is upset.	3.88	4.93	1.05*	1,215
My ability to keep my child safe and healthy	4.61	5.43	0.82*	1,222
The amount of activities my child and I do together.	3.93	5.02	1.08*	1,220
The amount I read to my child.	3.65	4.71	1.06*	1,228
My connection with other families with children.	3.75	4.77	1.01*	1,209

**Statistically significant at p < .001 with alpha set at .05 and .004 (Bonferroni's Correction).*

Parent Satisfaction

Parent satisfaction is a critical element identified by First 5 California's redesign. To measure this, SR providers implemented the "DRDP Satisfaction Survey"-- a survey developed by the California Department of Education that many school-based sites already utilize. The survey is a series of satisfaction questions about components typically included in early care and education programs. (See the Data Compendium for detailed data.) Key findings include:

"I am happy about the length of time [the SR program] lasts, but I would like it to be more available; more days in more schools."

- School Readiness Parent

- Over eighty percent (80.7%, n=1,060) of parents

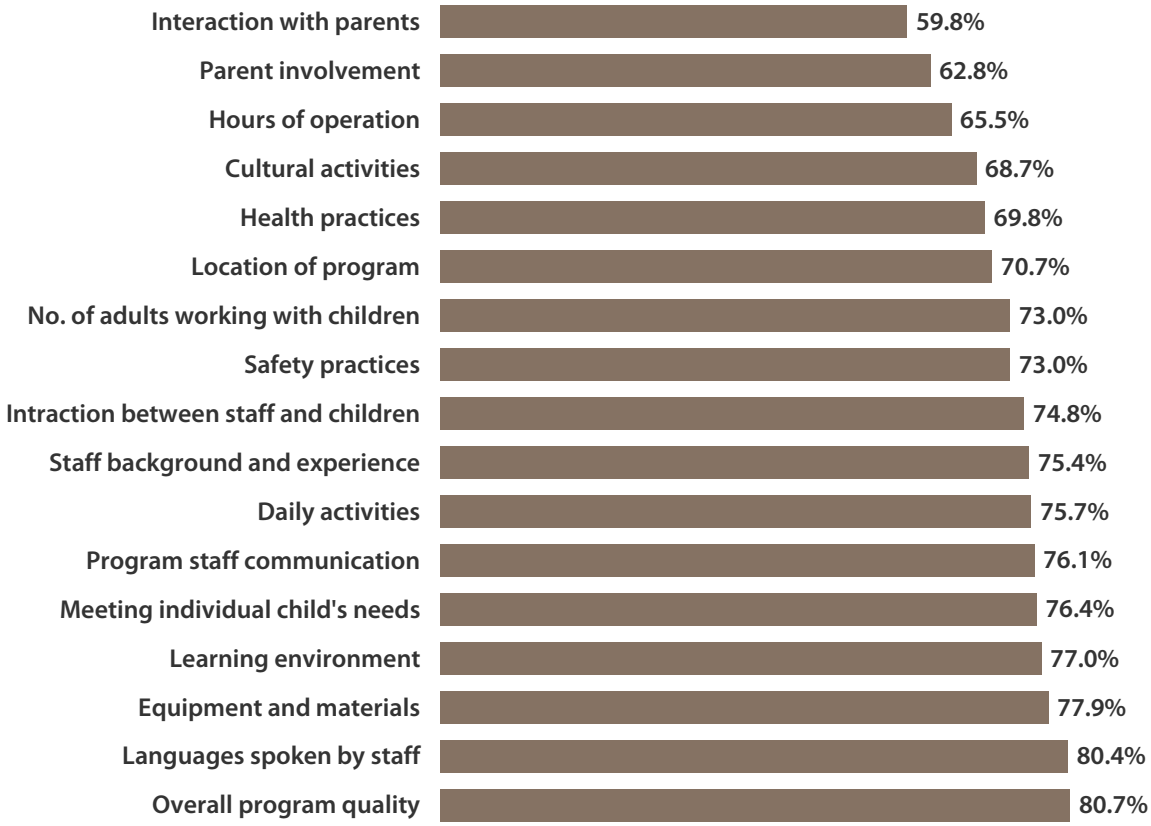
[163] Ibid.

[164] Ibid.

completing this portion of the Parent Retrospective Survey were "very satisfied" with the overall quality of their SR program, regardless of program type (classroom or center).

- For each program component, the overwhelming majority of parents reported they were "very satisfied" or "satisfied" (See the Data Compendium).
- The items with the lowest "very satisfied" ratings were parent-centered (interaction with other parents, parent involvement) and programmatic (hours and cultural activities).
- Results are very similar when examining by each type of parenting activity.

Exhibit 4.9 Percentage of Parents Who Were "Very Satisfied" by Component



Improved Child Health

To provide optimal health and social services to children participating in the School Readiness Initiative, each program began providing universal developmental screenings[165] and referrals in FY 2006-07. Through various developmental screening tools, children enrolled in Early Care and Education

"It's so neat to see the effects of our interventions on these at-risk children."

- School Readiness Program Staff

[165] Developmental screening tools include the Ages and Stages Questionnaire, Developmental Activities Screening Inventory (DASI-II), Beery-Buktenica Developmental Test, Developmental Profile II, Vineland Adaptive Behavior Scale-Parent Edition, parent interview, observations and other district-specific tools.

services were screened and referred for further assessments and/or services. Following the SR Developmental Screening System (see "SR Developmental Screening System" textbox, screenings were provided in-house, by the School Readiness Program, or referred to outside health service providers, such as First 5 San Diego's Health and Developmental Services Initiative. Universal screenings for all children in SR program activities addresses the First 5 California School Readiness indicator "number of children identified with disabilities/special needs who receive developmental services by the time of kindergarten entry" (Result Area 3: Improved Child Health, Service Area: Comprehensive Screening and Assessments).

Over 70% (70.6%) of children receiving early care and education services were screened (1,756 children of 2,485 enrolled).[166, 167] Exhibit 1.10 displays the number and percent of children screened who were referred for assessments, identified with disabilities, developmental delays or other special needs, and receiving services, treatment or supplemental intervention. It is of note that screeners identified nearly a third (30.4%) of all children as needing further assessment, and that 11.7% of those screened were identified as having a disability, developmental delay or other special need. The number identified is in keeping with national statistics that assume between 8%-17% of children have special needs.[168] Over two-thirds of children identified with

SR Developmental Screening System

- Screenings: Using the ASQ or other district-specific tools
- Assessments: Children identified as at-risk are given further testing
- Referrals: Referrals are given based on the assessment results
- Treatment: Appropriate treatment and services

disabilities or special needs subsequently received services or treatment (69.3%, n=142). The number of confirmed services or treatment is significant, considering these children are often referred to different departments in the school district or to outside agencies (where referral tracking can be challenging). However, this finding may also be indicative of the increased staffing in SR programs for behavioral and language/speech/hearing services or the partnership between SR and HDS. See "Navigating Referrals from School Readiness: A Case Study" for the experiences of one family following the SR Developmental Screenings System.

[166] Some SR programs did not begin screening children until the second or third quarter of the fiscal year.

[167] This includes children screened through School Readiness only; it does not include screenings completed by the Special Needs Demonstration Project.

[168] HDS and PFA initiatives both use the CDC statistics for benchmarking the number of children with developmental delays. However, the CDC's statistics encompass ages 0-17 http://www.cdc.gov/ncbddd/child/devtool.htm accessed September 26, 2007. Another study, conducted in 2001, estimated that approximately 8% of children aged 0-5 had special needs: U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. The National Survey of Children with Special Health Care Needs Chartbook 2001. Rockville, Maryland: U.S. Department of Health and Human Services, 2004. Accessed 10 September 2007 http://mchb.hrsa.gov/chscn/index.htm

Exhibit 4.10 Children Receiving Early and Comprehensive Developmental Screening and Intervention		
Service	**Percent**	**Number**
Children Enrolled in Early Care and Education Activities	100.0%	2,485
Screenings Conducted	70.6%	1,756
Of those Screened, Number Referred for Assessment	30.4%	534
Of those Assessed, Number Identified with Disabilities or Special Needs	11.7%	205
Of those Identified with Disabilities or Special Needs, Number Receiving Services or Treatment	8.1%	142
Of those Identified with Disabilities or Special Treatment, Number Receiving Supplemental Intervention[169]	13.4%	236

In the following case study "Navigating Referrals from School Readiness: A Case Study," several families participating in School Readiness programs share their experiences within the SR Developmental Screenings System. These families first entered First 5 San Diego's services through their local School Readiness program and were given referrals to, or received services through, partnering agencies (both within and outside First 5 San Diego funding).

Navigating Referrals from School Readiness: A Case Study

Celina* has been living in Oceanside for four years. She is married and works in a T-shirt factory. She has a two-year-old son, Ismael, whom she has been taking to the Listos parent-child center since he was one month old. In the early days, Celina would read to him. Eventually, when he started crawling, he would reach for objects and play. Nowadays, they go to Listos two to three times a week, for about a two-hour visit. It is easy for Celina to access the program: it is free, and even provides bus passes (which she no longer needs now that she drives). Also, language is not a problem for her because center staff speak both English and Spanish.

Celina did not start going to Listos for any particular need. She found out about it through her sister-in-law and because she was working, wanted to spend her free time with her child in a special setting. *"The time I went there, was to be only with him… instead of being at home and cooking and all that… there I sit and read with him, it's his time."*

The Listos School Readiness program has become an important source of information and support for Celina. She reported: *"I learned about children and sharing and being with other children, and how different children are."* She also got to know other mothers, and as they shared stories about their problems, she realized that *"other people suffer too,"* which has been helpful for her. In a separate interview, Carmen Avila, Listos' School Community Advisor, recalled how Celina has been exposed to other parents from all economic levels and observed the ways that they handle their children. Celina commented on the positive aspect of being with parents from many walks of life: *"I feel comfortable [at Listos] because there are all races there, Americans, Mexicans. My child is with American children, and Black ones… they are all treated the same."*

[169] Includes services to children with mild or moderate disabilities or special needs that do not warrant a referral to an outside agency (e.g. internal language or behavioral services).

The support Celina received from the Listos staff has also been very helpful. Staff regularly asks about how things are going with the children, and give suggestions how to handle specific situations. In Ismael's case, he is a bit *"travieso"* (mischievous) and staff suggested that Celina spend more time with him, and be patient. They also lent her a video for him to watch at home, which he loves. Overall Celina believes the program has been very good for her son, and he has learned many things including coloring, painting and putting puzzles together. More importantly, he has learned to share, and to work toward something he wants. For instance, he knows that if he wants to watch a video at home, first he has to pick up his things. His mother is certain that life would be different with her and her child had they not gone to Listos. *"For example, my sister's child, she barely spends time with her child, she hasn't dedicated time to teach him…I know [my child], and I tell him that if he wants to watch TV he has to pick up, and he knows that and does it, if not there's no TV. While [my nephew] just says no… that's why I think things would've been different."*

A recent concern has been Ismael's vocabulary, because he doesn't speak much. He also sometimes hits other children. Celina spoke to "Sra. Carmen" about it, who told her that his behavior may be linked to the fact that he doesn't speak much, that hitting is his way of communicating. Carmen explained that Listos screened Ismael with the Ages & Stages Questionnaire and referred him to a county program for speech therapy (the HOPE program) but according to his mother, *"he didn't qualify as he isn't disabled… he just needs us to talk to him more, and make him talk…. There is another program but he's too young, we're waiting for him to turn three."* While Ismael did not qualify for services elsewhere, a Listos teacher is currently working with him, and he is starting to talk more. Listos will monitor his progress and refer him to services again if necessary.

The Listos center has also connected Celina to NCHS (North County Health Services). Celina had picked up a pamphlet on parenting classes offered at the Mesa Community Center, and decided to attend a series of classes on handling stress and communicating with children. It was very easy to connect to the classes. She just signed up for them and they were free. Her instructor, Maria Gomez, who is a Parenting Childhood Educator, commented in a separate interview on how Cristina was "very active, eager to learn. She wanted to learn how to handle stress."

For now, Celina continues to manage her job schedule to make sure she can take Ismael to the Listos center; she takes him in the mornings and works in the afternoons. It is important for him to keep learning, and what he takes away from Listos will help him be ready for kindergarten. *"Listos is like his little school where you learn things, and to not be afraid of people…some children are scared, and don't want to share things,"* said Celina.

** Names were changed to protect confidentiality.*

Improved Systems of Care

School Readiness preschool teachers and specialty service providers completed staff surveys. These surveys were analyzed, along with the Parent Satisfaction survey, to address the First 5 California School Readiness indicator "number of schools with procedures that facilitate continuity between early care and education programs and elementary schools as described by NEGP 'ready schools'" and "number of children who participate in school-linked transition practices that meet NEGP criteria" (Result Area 4: Improved Systems of Care, Service Area: Schools' Readiness for Children). Using the National Education Goals Panel, "Ready

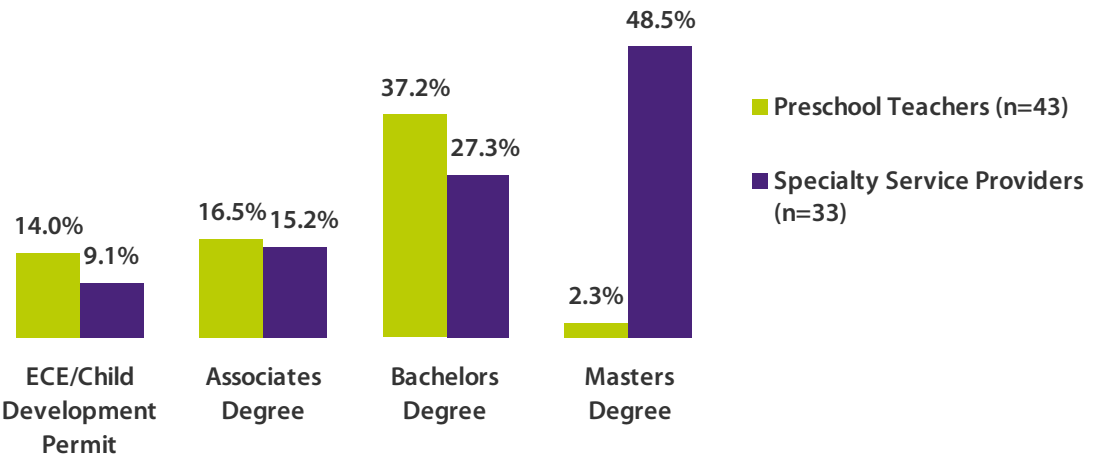
Schools Checklist,"[170] as a foundation, customized surveys were designed to assess the overall status of the School Readiness Initiative from the point of view of staff.

The School Readiness Preschool Teacher and Specialty Service Provider surveys are instruments that gather information about professional development, interaction with parents and kindergartens, kindergarten transition activities, and school readiness awareness. Forty-four School Readiness preschool teachers[171] and 40 specialty service providers (e.g. behavior specialists, language/speech/hearing specialists, school nurses, etc.) completed the surveys. Detailed survey results can be found in the Data Compendium.

Education and Experience

The majority of SR preschool teachers and specialty service providers were experienced in the field of early childhood education, with 65.1% (n=28) of preschool teachers and 30.8% (n=12) of specialty service providers having worked in their positions for over five years. Most of the preschool teachers (86.0%, n=37) and specialty service providers (91.0%, n=30) were educated at or past the Associates degree level, as shown in Exhibit 1.11. Most SR staff were also pursuing additional higher education: 69.0% (n=29) of preschool teachers and 81.6% (n=31) of specialty service providers were enrolled in a degree program at a university or community college; and 64.1% (n=25) of preschool teachers and 88.9% (n=32) of specialty service providers were currently, or had previously participated, in the AB212 or CARES program.[172]

Exhibit 4.11 Level of Education



Most preschool teachers (95.5%, n=42) and specialty service providers (89.2%, n=33) participated in professional development activities, adding to their knowledge and abilities to serve children and their families. Those who participated attended an average of 7.8 activities throughout the year, and the majority felt the knowledge they gained was applicable to their classrooms (97.6%, n=40) or service provision (87.9%, n=29).

[170] National Education Goals Panel. "A Self-Inventory for Ready Schools." Ready Schools, Washington D.C. 1998. Accessed 10 September 2007. http://www.negp.gov/Reports/readysch.pdf

[171] Includes 27 preschool teachers who were dually funded by SR and PFA; see Chapter 5 for PFA Teacher Survey results.

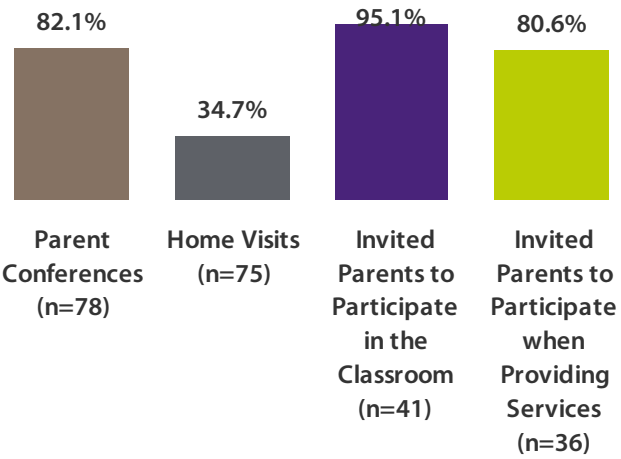
[172] For more information on AB212 and CARES, see Chapter 8.

Interaction with Parents

Overall, preschool teachers and specialty service providers strive to make meaningful connections with the parents of their students. Every SR preschool teacher who responded (n=34) indicated that they met with parents during the first week of school, and 84.1% (n=37) reported meeting with parents prior to the first day of school. The most common parent involvement activity was parent conferences. As Exhibit 1.12 shows, most preschool teachers and specialty service providers held parent conferences (82.1%, n=64). Parents were also invited into classrooms by preschool teachers (95.1%, n=39) and asked to participate in services by specialty service providers (80.6%, n=29). On average, between seven and eight parents volunteered in preschool classrooms each month. Only four of the eight SR programs provided home visitation services, reflected by only 34.7% (n=26) of staff reported to have conducted home visits, 84.6% (n=22) of which were conducted by specialty service providers. This is consistent with the number of Parent Retrospective Surveys (discussed in the previous section), in which only 9.7% of parents who responded participated in home visiting programs.

One possible contribution to high parental involvement in SR programs is the prevalence of bilingual (Spanish/English) staff: 42.5% (n=17) of preschool teachers and 59.0% (n=23) of specialty service providers indicated they spoke Spanish while in the classroom or delivering services. However, it is also of note that Parent Satisfaction survey results (see section above) revealed that "parent interaction" in the programs had one of the lowest "very satisfied" parent scores and the highest "dissatisfied" scores, suggesting that schools still have room for improvement in interacting with parents.

Exhibit 4.12 Activities Involving Parents



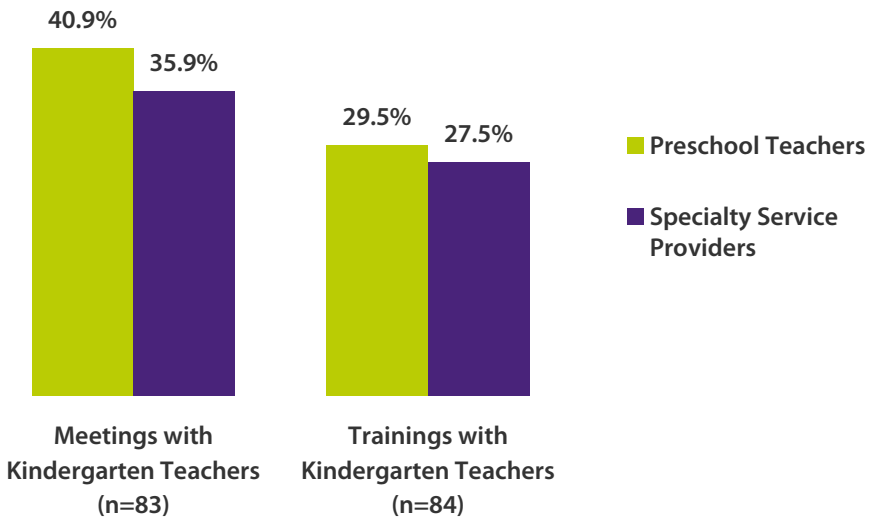
Interaction with Kindergartens

Most SR preschool teachers and specialty service providers do not have regular interaction with kindergarten teachers. As seen in Exhibit 1.13, only 40.9% (n=18) of preschool teachers and 35.9% (n=14) of specialty service providers had meetings with kindergarten teachers during the last school year. Even fewer preschool teachers and specialty service providers participated in trainings with kindergarten teachers (29.6%, n=13 and 27.5%, n=11, respectively).

"I think it is important not to label a child. A fresh start may be [needed] with many children, considering age and maturity."

- School Readiness Preschool Teacher

Exhibit 4.13 Activities Involving Kindergarten Teachers



However, as shown in Exhibit 1.15, there is much more interaction when children are transitioning to kindergarten. Almost three-fourths (73.8%, n=31) of preschool teachers and over half (56.3%, n=18) of specialty service providers have formal transition plans for students entering kindergarten. Exhibit 1.14 displays the types of documents inserted into transition files, as reported by preschool teachers and specialty service providers who indicated that their sites had prepared transition plans for children entering kindergarten. Other information provided in transition plans include:

- Children's and families' strengths and weaknesses
- Children's basic skill levels: behavioral, speech/language/hearing, literacy
- Prior intervention history: Individualized Education Plans (IEP), referrals

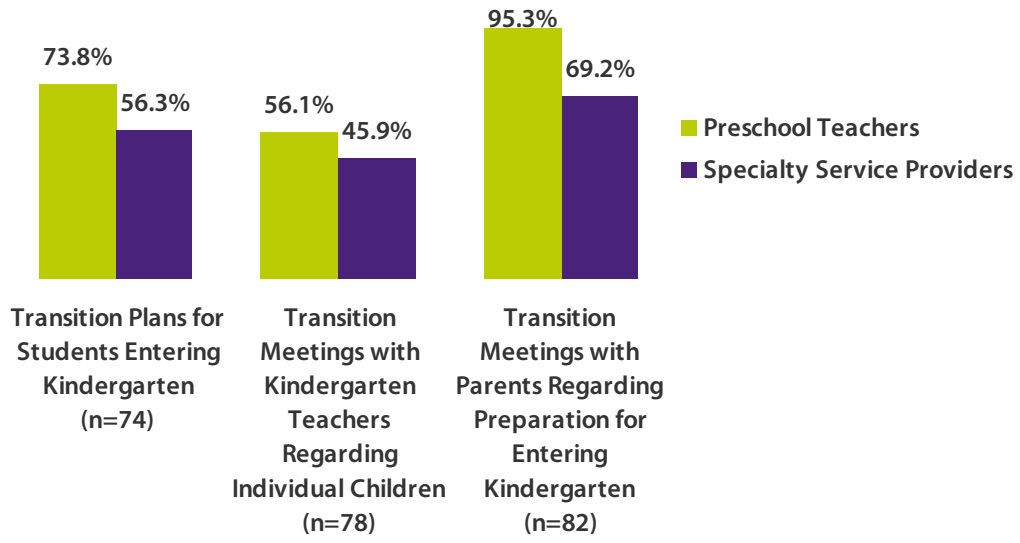
Exhibit 4.14 School Readiness Transition File Contents

Transition Document	Preschool Teacher (n=44)		Specialty Service Provider (n=40)	
	Percent	Number	Percent	Number
DRDP Data	70.5%	31	22.5%	9
Health Information	65.9%	29	17.5%	7
Number of Years in Preschool	45.5%	20	10.0%	4
Parent-Teacher Conference Notes	63.6%	28	12.5%	5
Specialty Service Forms	N/A	N/A	26.1%	12

About half (56.1%, n=23) of preschool teachers and specialty service providers (45.9%, n=17) meet with kindergarten teachers to discuss individual children preparing to enter kindergarten, also shown in Exhibit 1.15. During these meetings, SR staff notify kindergarten teachers of any mild to moderate developmental

delays of individual children that may not be documented in an IEP.[173] And, almost all (95.3%, n=41) preschool teachers and over two-thirds (69.2%, n=27) of specialty service providers meet with parents (either individually or in a group setting) to discuss the transition of their children to kindergarten. These meetings often include discussion of child and parental expectations of kindergartens and elementary schools, as well as school enrollment and attendance logistics. Almost all (97.1%, n=34) preschool teachers and specialty service providers (81.3%, n=26) know which kindergartens their students will attend in the Fall.

Exhibit 4.15 Activities Involving Kindergartens



The results of the Preschool Teacher and Specialty Service Provider surveys suggest that School Readiness staff are well educated and continue to enhance their skills through professional development activities and continued enrollment in university or community college programs. School Readiness staff also have high levels of interaction with the parents of children enrolled in their classes and programs through parent-teacher conferences and parental involvement in classes and services. While regular communication with kindergarten teaching staff is often limited, interaction around transitions activities – both with kindergarten teachers and parents – is a critical component in most SR programs, and provides a way to prepare children, families and schools for children entering kindergarten in the Fall.

Making the Connection

Systems integration and improvement is a core component of the School Readiness Initiative. The systems-level evaluation for School Readiness includes several components, such as inter-school readiness networking, connecting with other First 5 funded agencies, developing collaborative partnerships with community agencies, and providing a venue for more effective articulation between public, private, and community-based preschools and elementary schools. The systems-level evaluation includes observational and secondary data gathered from School Readiness Coordinator meetings, as well as interviews with SR Coordinators and key

[173] Files for children with an Individualized Education Plan (IEP) are automatically shared with kindergarten teachers through school district protocols.

education experts in the San Diego area. Below are important strengths and challenges facing the continued implementation of the School Readiness Initiative.

Strengths

This fiscal year provided several opportunities that improved the quality of the School Readiness Initiative:

- **Alignment to the First 5 California School Readiness Initiative Framework Redesign.** In order to qualify for First 5 California SR funds through 2010, programs were required to implement the new State Framework Redesign. The State Framework was redesigned to focus SR programs across California into four result areas. While this shift was challenging for some, all SR programs successfully fulfilled the new requirements this fiscal year. By aligning with the State, the local SR programs now have common reporting formats, outcome measurements, and share the goal of creating a solid foundation of preparing children for success in school.[174] As one SR staff noted, "I feel that, by the alignment, I have a goal I'm working towards."
- **Blended and braided funding streams.** Several SR programs were able to leverage First 5's School Readiness dollars to secure additional funding for services and activities. Blended funding combines funding from multiple sources into one account, which collectively pays for multiple aspects of a program. A SR program staff describes efforts to blend funding, "I blended pretty well…I covered holes existing in each grant so that I would meet all those needs." Braiding funding is different in that funding from multiple sources is earmarked for specific services, making it easier to attribute services to specific funding sources. Regardless of the method of funding, some SR programs with multiple contracts have been able to create seamless clusters of programs. As one SR program staff stated, "I think it's wonderful for families. They don't care who's paying, it doesn't matter."
- **Increased networking opportunities for program staff.** Since the inception, School Readiness Coordinators have met monthly with Commission staff to discuss best practices, share information and ideas, and work together to solve procedural challenges. This year Commission staff enhanced these meetings with guest speakers from various First 5 funded agencies including Health and Developmental Services (HDS), 2-1-1, and the Kit for New Parents. In addition to these SR Coordinator meetings, some program staff has also attended Quarterly Contractor meetings hosted by the Commission. These meetings provide face-to-face interaction between agencies in various Initiatives that may have never otherwise connected. Additionally, SR program staff were invited to attend the First 5 Association Statewide Conference last May in Orange County.
- **Added community linkages.** Through the networking activities described above, School Readiness programs have connected and built relationships with community agencies throughout the County, within and outside the First 5 network. Agencies have approached SR programs to host their services. For example, C3, an HDS subcontractor, holds parenting classes at SR sites, utilizing their space and reaching out to SR families. As one SR program staff proclaimed, "[SR has] taken off and I think other agencies are seeing that… Other agencies came to us…Through the partnerships with agencies, we have increased our services to parents, which is part of the strengths of our program." (See "Helping Parents Get What They Need – Linkages Between Agencies" in this chapter).
- This year, the School Readiness programs implemented universal screenings to identify potential health and developmental delays and risks. Health screenings were provided by either trained SR specialty service providers or outside agencies. Collaboration with the HDS Initiative was very strong. HDS providers performed developmental, language, speech, and hearing screenings at some SR sites, while SR staff referred families to HDS clinics. Partnerships with the First 5 San Diego Oral Health Initiative also

[174] Alignment to the State Framework Redesign also eliminated some reporting requirements.

provided dental screenings for some children and training for some SR staff ("Navigating Referrals from School Readiness: A Case Study").

The successes listed for the School Readiness Initiative are not exhaustive, as many programs experience success with program participants every day. Key community experts interviewed for this report have recognized the advances SR and First 5 San Diego are making towards preparing children for school. As one such expert commented, "It's been huge. Everything from parents being more registration-ready, having the documents and the physical [exam] ahead of time…We have more kids prepared academically than we used to have."

Challenges

Even in its fifth year, the School Readiness Initiative experiences some challenges. First 5 San Diego is learning from these challenges and working with SR programs to adapt their programs accordingly. Some key challenges include:

- **Administrative Requirements.** Some SR program staff and key community experts felt the administrative requirements associated with the First 5 California School Readiness Framework Redesign were overwhelming at times. The original SR grants changed to cost-reimbursement contracts requiring additional financial reporting. While the child outcome reporting remained the same, the new framework includes new program and outcome measurement requirements such as conducting developmental screenings, administering parent surveys, and distributing surveys to teachers and specialty service providers. SR providers, however, no longer have to administer a lengthy intake survey for every child, which was required under the former framework. SR program staff have also mentioned that the budgeting and invoicing requirements can be cumbersome and confusing, requiring SR program staff to work with school district accountants to adjust different databases for their reports. As one SR program staff explained, "I can understand the accountability, I need that there…But there are compromises we can make to meet the requirements. [The Commission and its contractors] just have to be open to the options." Fortunately, the child outcome requirements and a portion of the parent survey were designed to be the same for SR classroom-based programs as they are for State Preschool Programs in order to reduce the workload. The stress on some programs was amplified because they have multiple reporting requirements to fulfill for other funding agencies, due to blended or braided funding streams. As one community key expert noted, "We're doing more accounting and evaluation for SR than for any other program."

"That's a strength. It's a constant goal of ours to continue to improve."

– Key Community Expert

- **Static funding amount.** Since its inception in 2002, the First 5 School Readiness Initiative was designed to have a flat amount of funding each year. The intention was to build effective programs local school districts and other funded agencies would become committed to supporting with other resources. While some county First 5/Proposition 10 Commissions have required school districts to supply matching funds for SR programs, First 5 San Diego has not. Both First 5 California and First 5 San Diego are supportive of funding through 2010, but maintain initial funding levels. Capped funding while implementing the new redesigned Framework created two challenges for programs. First, school districts had to provide their own resources to support cost of living adjustments and merit pay increases for teaching staff that are part of collective bargaining agreements. Second, the SR programs had to initiate additional programmatic and accountability activities align to the State's new Framework. As one SR program staff stated, "Eventually, something has got to give, either staff or services." To accommodate the new State Framework requirements, some SR programs have reduced contracted services and cut enrollment for kindergarten transition activities like KinderCamp, and reduced professional development activities. Some SR program staff have suggested that minimal cost of living

adjustments would help them provide their contracted services better. "District cost of living is 5%...compensate for inflation. You have the salary and the benefits go up every year, so it wouldn't cut into the program," said a SR program staff member. First 5 program staff continues to encourage SR Coordinators to seek additional funding sources and develop sustainability plans. Some SR programs have sought out additional and alternative funding opportunities to ensure that programs remain strong and will provide contracted services and professional development opportunities. School districts also have the option of using other funds (such as Title I funding) in ensuring the sustainability of SR programs.

- **Dental assessments: AB 1433.** In the 2007-08 school year, children entering kindergarten, or by the age of six years old, must have a dental assessment (or parental waiver) in their school records to enroll in school. While these assessments will provide needed awareness around early childhood dental care, SR program staff and key community experts are concerned about the effect of the requirement on children and school systems. The new legislation mandates screenings but not treatment for childhood dental disease, and a limited pediatric dental system may become overtaxed. (See OHI Chapter 3 for details). SR and school staff may require additional training in proper oral health assessment methods to respond to the mandate for dental assessments, but as noted above, funding streams have not changed to support the increased costs.
- **Variation in data collection procedures.** While the alignment to the State Framework Redesign is being fully implemented, variation in data collection procedures and quality surfaced. Some SR programs had to implement new data warehousing techniques by designing and building databases themselves or by hiring database consultants. Other programs had existing databases that were altered to generate the needed data for the Commission's Quarterly Progress Reports. All programs had to work with their school district accounting departments to accurately complete fiscal reports. The Commission's new data system, due to be funded in FY 2007-08, will be beneficial to the process and quality of data. Ensuring that the Commission's database can link to existing SR program databases will be critical.

Recommendations

The following recommendations were developed based on FY 2006-07.

+ **Encourage collaboration between SR providers and First 5 Initiatives.** Many SR programs successfully partnered with other First 5 agencies and some programs experienced delays or were unable to access other First 5 funded services. In at least one case, there was confusion about whether or not the particular SR program was already funded to provide these services. Other programs have not yet reached out to other First 5 Initiatives, attempting to serve children and families exclusively through district-offered services. In addition, sometimes the feedback loops did not close when tracking referrals from SR to other agencies, making it difficult to track outcomes for successful referrals. First 5 San Diego should strengthen collaboration between SR programs and other First 5 Initiatives by educating providers about the importance of follow-up services for children and families, and actively facilitate the collaboration between SR and other Initiatives. Meanwhile, SR coordinators should utilize dedicated First 5 staff as a liaison when connecting with other First 5 funded Initiatives as well as for other general questions, comments or concerns.
+ **First 5 and School Readiness programs should work together to coordinate administrative requirements.** Given that some SR programs felt challenged by the new administrative and data reporting requirements, First 5 San Diego and SR programs should engage school district support staff (such as school district accounting and information technology professionals) early in the planning process. Early involvement by these stakeholders may eliminate subsequent confusion and frustration regarding evaluation and fiscal management reporting requirements. While accounting staff were present during

implementation meetings, follow-up of school district systems and First 5 requirements is essential to accurate reporting.

- **Nurture mutual understanding.** Continued collaboration between the First 5 San Diego Commission and SR program staff is the foundation for the successful administration of the School Readiness Initiative. SR program staff visit Commission offices regularly, and site visits by Commission staff to each program improve the general understanding of the services each unique program provides to children, families and staff. Commission and SR program staff need to continue working together to make decisions about effective program implementation strategies that will ensure the success of the SR program.
- **Sustaining programs over time.** The extended funding through 2010 does not provide an increase in funding, including cost of living adjustments. As a joint partnership, school districts are expected to locate additional funding to sustain the SR programs in their areas. First 5 San Diego, First 5 California and school districts must work together to address the rising costs and rising demands for services. Ensuring the future sustainability of SR programs is a critical factor in their success. School districts must consider actively seeking out additional funding to supplement and possibly allow for the expansion of these early care and education programs.
- **Continue to improve outcome measurement reporting.** The data submitted this fiscal year was impressive in both quantity and quality compared to previous years. But some SR programs encountered challenges in implementing and reporting on all outcome measurements. Through continued training and technical assistance, SR programs can improve the quality of data throughout the County.

A Final Word on School Readiness

The School Readiness Initiative has had a positive impact on improving children's readiness for school in the fifth year. This year, findings suggest that the Initiative had a positive impact on parenting practices and staff development. Indeed, children exhibited improved outcomes in all five developmental domains; parents exhibited improved outcomes on all four parenting practice topic areas; and staff participated in numerous professional development activities. In addition, the larger systems connected to School Readiness programs are improving upon the previously "stand alone" practices, which often presented a confusing, fragmented service delivery system to those trying to navigate services. In many communities, programs are now operating to capacity, and often with waiting lists, indicating there is continued need for similar quality services in San Diego County.

Helping Parents Get What They Need: Linkages Between Agencies

Harder+Company conducted three case studies of First 5 School Readiness families who accessed at least two First 5 funded initiatives during the current fiscal year. The families selected lived in different parts of San Diego (two in Oceanside and one in San Ysidro) and had varying language capabilities (two spoke only Spanish; one was bilingual but was more comfortable communicating in English). The services received outside of their primary provider agency included parenting classes, speech assessment, and one-on-one guidance.

Case 1 was a mother of three children who was having difficulties with her daughter, a middle child in the family. The daughter was defiant and fought considerably with her older brother. While attending the Listos parent-child activity center (her primary provider), the mother was connected to C3 developmental services (her secondary provider), and received C3 services on site at Listos.

Case 2 was a mother seeking to spend time with her young son in a learning environment. She began taking her son to Listos (her primary provider) when he was one month old. Through Listos she found out about parenting classes offered by NCHS (North County Health Services), her secondary provider. After her son turned two, there were concerns about his speech. Listos staff conducted an ASQ (Ages and Stages Questionnaire) and referred him to a county program for speech therapy (HOPE Infant Program), another secondary provider.

Case 3 was a mother of two children enrolled in the San Ysidro School District preschool program (her primary provider). At the preschool she received flyers and announcements about the school-readiness program called "Off to a Good Start," developed by the First 5 funded UC Cooperative Extension. As a result, she took classes on Literacy, Kindergarten Readiness, and Health/Nutrition through "Off to a Good Start."

Access to the secondary provider

All three mothers found out about the secondary provider parenting classes through their primary provider, either through flyers and/or staff announcements. In all three cases access to the classes was very easy (they just had to sign up) and the sessions were free.

The two mothers who were referred to other agencies for services, other than parenting classes, were able to make the connection. As seen below, Case 1 had easy access to the secondary provider, while Case 2 did not qualify for the referred service.

Benefits of linking to the secondary provider

In all three cases, the women reported that they benefited from the parenting classes. Overall, the classes complemented and/or supported what they learned through the primary provider. Case 1 attended numerous on-site classes (music and movement, behavior classes) offered by C3. When her teacher taught classes at another center, the mother followed her for sessions, such as Baby Massages. According to Listos staff, the mother is now "more comfortable dealing with her children." Due to the classes and additional support (see below), her daughter's behavior has improved. Case 2 had picked up a pamphlet at Listos about NCHS classes, on handling stress and communicating with children, offered at the Mesa Community Center.

Her instructor, a Parenting Childhood Educator, commented that the mother was "very active, eager to learn. She wanted to learn how to handle stress…She really tries. Every week she works on something." Case 3 enjoyed the classes she took and benefited from them. However, she did not feel she received the most out of them because they were mainly in Spanish and, although she speaks some Spanish, she is most comfortable in English.

In addition to parenting classes, Case 1 received support from both the C3 Behavioral Specialist (Lori) and the C3 Bilingual Health Specialist (Frances). As with the parenting classes, access was easy because C3 staff were available on site at the Listos center.

In discussing the challenges the mother was facing with her daughter, Frances was able to get the mother to think about how she treated her daughter differently from her older son (who was more compliant). "Without ever thinking," Frances explains, "we tend to treat [our children] differently, as if they were a problem child." At the time, the mother didn't think she treated her daughter differently, but eventually did come to realize it. "I remember [the mother] coming back and saying 'what you told me, I realized I was doing it'… It took her a while, but she started making changes, and started treating her daughter the same as her son… and now she is much more confident, relaxed, and handling things differently." The mother was also supported in addressing her daughter's behavioral concerns through one-on-one guidance sessions with Lori, who agrees that the mother has grown through the process: "At first she was very quiet, reluctant to ask questions… Now she brings her concerns, shares examples, including what she has learned from a previous session [since she has attended so many]."

The Case 2 referral to the HOPE Infant program for speech therapy did not result in further services because the two year-old son did not qualify. "He isn't disabled," recalled his mother, "he just needs us to talk to him more, and make him talk… There is another program but he's too young, we're waiting for him to turn three." Listos staff confirmed that he did not qualify for speech services because he was "too smart" (which staff attributes to his having attended Listos all his life), and no delays were identified. A Listos teacher is currently working with him, and he is starting to talk more. Listos will look into other services if needed at a later date.

What Helped?

The following are factors that facilitated a successful linking process among agencies, as reported by the clients as well as by their primary and secondary providers:[1]

- *Availability of promotional material at the primary provider*: all three women found out about secondary provider classes offered in their community by picking up pamphlets or flyers at a place they frequently visit (their primary provider). The promotional materials appear to have caught the clients' attention, and the subject matter was of interest to them. This form of passive recruitment is equally important as the active recruitment/referrals described below, where partner agencies work together delivering services.
- *Outreach by the secondary provider:* For C3, outreach to special populations is an important component of its service delivery strategy because parents are not aware of how to access services. By reaching out in the primary provider's location, C3 (the secondary provider) takes a proactive approach of offering services to parents, and addressing parenting concerns, in their early stages.

- *Collaboration between providers:* Having promotional material displayed at another agency is an indication of effective networking strategies between providers, as they work together to make sure that families are aware of and are receiving the services they need. Co-location (such as C3 providing services at Listos) reduces duplication of services, helps fills gaps in services, and increases the chances of reaching hard-to-reach populations.
- *Continued support from the primary provider:* In addition to informing parents about classes offered by other agencies and encouraging parents to attend, Listos staff focuses on ensuring that their clients get the specific type of help they need. For example, Carmen, the Listos School Community Advisor, often sits in and listens to the secondary provider classes that are held on site, and encourages parents to ask questions. Carmen does this when she knows that a parent is facing a specific issue and may be too shy to talk about it, to encourage the parent to speak up.
- *Childcare support by the primary provider:* On-site child care is an essential part of successfully recruiting and retaining parents in parenting classes. At Listos, the secondary provider (C3) benefits from the fact that the primary provider offers childcare in a separate room, where children are engaged in guided play activities while parents attend a C3 session. In contrast, C3 does not offer childcare at its own sites, which can be a barrier to accessing services because parents cannot take their children to those parenting sessions.
- *Language support by the primary and secondary providers:* Some of the C3 classes given at Listos are taught in Spanish. For those that are not, Listos staff is available for translation. For example, the participants in Lori's behavioral sessions at Listos are mostly Hispanic and Lori conducts the sessions in English while Listos staff translates.
- *Transportation support from the primary provider:* When asked about their access to services, Cases 1 and 2 mentioned the availability of bus passes. Transportation assistance to access services at secondary providers is an indirect benefit for the secondary provider.

Challenges Encountered

- *Lack of English classes in areas where services are predominantly targeted toward Hispanic women:* In Case 3, the mother felt that her Spanish was "basic" and was more comfortable speaking in English. As a result, she did not feel she received the full benefit from the classes she attended. In order to meet the needs of the community, parenting classes in English are planned for FY 2007-08 through the First 5 For Parents Initiative.
- *Possible gaps in services:* For Case 2, it appears that the secondary provider did not think that speech therapy was warranted, and that the child was too young to qualify for school district mandated services. However, Listos staff was concerned and staff is working with him and tracking his progress. It is fortunate, in this case, that Listos has the specialized capability and resources to help the child. It is possible that another agency in the same situation may not have been able to provide the additional service. This is also an opportunity to strengthen ties with HDS providers.

Other Linkages

The primary agencies are often an effective link to other, non-First 5 funded community resources. Case 1, for example, uses the Listos center as a resource. "If you need any information," the mother explains, "[staff members will] get it for you. If you need a dentist, or help with school registration…" Also, since the center is closed on Wednesdays, staff encourages parents to go to the library on that day instead. Now on Wednesdays several mothers meet outside Listos and walk to the library together.

Conclusion

It is somewhat difficult, if not impossible, for parents to discern a specific intervention that most helped their children in their quest for school readiness. What is clear is that the families in these case studies were touched by a variety of services that complemented and strengthened each other. In the eyes of the parents, the end result is a noticeable positive change in their children. For Case 1, the daughter's behavior improved, she has learned how to share, and gets along better with others. She now goes to the nearby Head Start center, and her mother believes she is a little more advanced than the other children because of what she learned at Listos. The Case 2 mother says her son has learned many things including coloring, painting and putting puzzles together. More importantly, he has learned to share, and to work toward something he wants. His speech is being tracked by Listos staff and he is talking more. Finally, the children of the Case 3 mother have learned social skills, are familiar with routines and classroom settings, and have gained self-confidence. In addition, the mother has noticed a big change in her niece, whom she also takes to the San Ysidro preschool program. Before starting preschool, the niece was very shy, and now she has made progress. "She has come out of her shell. It has made her social, and she lets me leave her there now… that is something huge for me," said the Case 3 mother.

Special Needs Demonstration Project

In 2005, the Chula Vista Elementary School District (CVESD) was selected by First 5 California to implement a Special Needs Demonstration Project (SNP) called Kids on TRACK. As a joint venture between First 5 California and First 5 San Diego, the Kids on TRACK program is one of 10 selected throughout the State, and delivers services to children and families in four CVESD catchment areas.

[175] This year, the CVESD SNP contract was extended through FY 2008-09 by the local Commission, for a total of $2,000,000 over four and a half years.[176] The project is designed to meet the following State and local goals:

Key Partners

- Chula Vista Elementary School District
- San Diego County Office of Education Hope Infant Support Program
- Kids Included Together
- Exceptional Family Resource Center
- San Diego Regional Center California Early Start Program
- Chula Vista Community Collaborative Family Resource Centers

[175] Originally, the SNP served the catchment areas of three CVESD elementary schools. This fiscal year, the program expanded to include another school in response to the declining population of children 0-5 in the original three school catchment areas.
[176] First 5 California provides $1,000,000 over four years; First 5 San Diego matches those funds and approved a no-cost extension for six months, until June 30, 2009.

- **Screening and Assessment:** Universal access to screening for early identification and diagnosis of physical and developmental issues.
- **Access to Service:** Improve access to, and utilization of, services and supports through the coordination of existing and new resources.
- **Community Participation and Inclusion:** Include and support young children with disabilities, developmental delays, and other special needs in appropriate, typical child care and community settings.

In addition to the goals above, Kids on TRACK provides comprehensive case management for 75 children with special needs identified through the screening process. While the main focus of the SNP is to serve children ages 0-5 with special needs, SNP also supports family members and professional staff. Parents and caregivers receive assistance in navigating complex systems of care, as well as receiving the training needed to become effective advocates for their children. SNP staff also attended professional development trainings and networking meetings to enhance their skills to serve children and families.

Outreach Locations

Between the months of March and July 2007, *Promotoras* reached out to families at 42 events:

- Chula Vista Elementary Schools and School Readiness Programs, including Parenting Classes and Kindergarten Registration (19 events)
- Apartments and Mobile Home Parks (15 events)
- Discount and Grocery Stores (4 events)
- Chula Vista Library (2 events)
- Festivals and Carnivals (2 events)

Screening and Assessment

In order to promote optimal early childhood development and school readiness, Kids on TRACK proactively identifies infants, toddlers, and preschool children with, or at-risk of having, a disability, developmental delay, or special need.[177] The program's annual goal is to provide health and developmental screenings for 500 children living in the CVESD catchment area.

In FY 2006-07, Kids on TRACK effectively increased outreach activities. *Promotoras* went to various locations in Chula Vista to recruit families qualified to participate in the program, often conducting screenings at events and sometimes making appointments for later screenings (see textbox "Outreach Locations"). This fiscal year, the SNP provided screenings to 501 children, meeting their goal this year; demonstrating a 48.6% increase over FY 2005-06.[178]

Once a child has been screened and a concern is identified, the child is referred to the Kids on TRACK Child Study Team (CST). The Child Study Team meets twice monthly and includes members representing SNP key program partners, CVESD Special Education Department and School Readiness Initiative staff. The multidisciplinary CST reviews individual child files and speaks to SNP Family Advocates and specialty service providers who intersect with the child and family. The CST makes decisions to refer the child and family to mandated services (such as IDEA or Mental Health) or other appropriate resources in the community. Often, the referrals suggested for families include services for both parents and children.

[177] California Institute on Human Services, Sonoma State University. "First 5 SNP Screening and Service Protocol" First 5 California Special Needs Project Coordination and Training. Sonoma State University, 2005

[178] In FY 2005-06, 258 screenings were conducted by SNP.

- All 501 children screened received an age-appropriate Ages and Stages Questionnaire (ASQ) and Ages and Stages Questionnaire: Social-Emotional (ASQ:SE) screening, completed by trained "Kids on Track" staff and parents/caregivers together.[179] This is almost double the number of screenings conducted in FY 2005-06, when only 258 children were screened.
- Almost all children given a developmental screening (98.9%, n=495) also received a health screening.[180]
- The majority of parents and caregivers of these children completed a Parent Stress Index: Short Form (PSI:SF) assessment (84.4%, n=423).[181]

Exhibit 1.16 displays the results of all 501 screenings this year, with comparison to FY 2005-06 local and statewide figures.[182] This year the percentage of children recommended for assessment is much higher than last fiscal year, closely matching the statewide percentage. Through increased staffing, more children have been screened by trained screeners and more accurately referred into services. The SNP has also expanded outreach to an additional school catchment area and community events.[183]

Exhibit 4.16. Screening Results by Fiscal Year

Screening Result	FY 2006-07		FY 2005-06*		
	Local		Local		State**
	Percent	Number	Percent	Number	Percent
No Concerns, No Risk Factors	55.6%	278	40.0%	103	58.0%
No Concerns, Risk Factors	26.8%	134	52.0%	134	19.0%
Recommended for Assessment	17.6%	88	3.0%	8	18.0%
Unknown	0.0%	1	5.0%	13	5.0%

**FY 2005-06 data summarized from a Chula Vista Elementary School District PowerPoint presentation to the Board of Education, June 20, 2006.*

***At the time of this publication, FY 2006-07 Statewide data was not available.*

[179] The ASQ is a screener for developmental concerns at various ages. The ASQ:SE was designed as a complementary tool to the ASQ, specifically addressing social and emotional behavior of young children. Squires, Jane, Diane Bricker, and Elizabeth Twombly. Ages and Stages Questionnaires: Social-Emotional (ASQ:SE) Maryland: Paul H. Brooks, 2003

[180] The health screening consists of a "Level 1 Survey" parent report or a "Level 2 Screening", conducted by SNP staff. Elements of the "Level 2 Screening" include California Child Health and Disability Prevention Program (CHDP) standards for health and development, oral and nutritional health, vision, hearing and immunizations.

[181] The PSI:SF was developed to assess the multifaceted system between parents and children, including parent and child characteristics, family context and life stress events. Abidin, Richard R. Parenting Stress Index. 3rd ed. Florida: Psychological Assessment Resources, Inc., 1995

[182] At the time of this publication, FY 2006-07 statewide data was not available.

[183] See the Data Compendium for child demographics.

The ASQ Game

An ASQ screening can be given by a parent, teacher, medical provider, or other adult familiar with the child. It can be administered as a self-report, interview, or as an interactive play between a screener and child. During a site visit to the Special Needs Demonstration Project, the research team was able to observe an ASQ screening. In this particular instance, the screener introduced the ASQ to the child as if she was ready to start a game with quiz-like questions. The screener spent a few minutes speaking to the parent and getting to know the child while addressing the tool's communication questions. The screener moved along, completing ASQ questions while sharing activities the parent could implement at home to develop her child's communication. The child became excited when she saw a picture and a bright colored crayon. She began to color without any direction, providing the screener with information about her problem-solving and fine motor skills. The screener transitioned into new activities with words of encouragement such as "Muy bien!" Next, the screener demonstrated an activity that involved a ball. The screener, mother, and child all enjoyed tossing the ball back and forth, and the screener observed the child's gross motor skills. Throughout the exercises the screener, parent and child shared a few laughs and smiles.

Access to Services

The Kids on TRACK program provides services to children with mild to moderate developmental delays or special needs, or who evidence risk factors based on a screening outcome. SNP funded case management and intervention services include a behavior specialist, language, speech and hearing (LSH) specialist, family advocates, and parenting classes and workshops created in collaboration with existing resources. In addition to the services funded through SNP, CVESD connects to the First 5 funded School Readiness Program, school funded Parent Intervention Program and Special Education Department, and referrals to community organizations.[184]. Families are linked to this array of services by a Family Advocate that assists in navigating the system of care through intensive case management. Family advocates provided 809 service consultations in FY 2006-07. (See the Data Compendium for details of the number of children receiving services and referrals this fiscal year.)

While most services and referrals are delivered through established partnerships in the community, some families need specialized services that the SNP does not provide. In these unique cases, the Child Study Team (CST) reviews case files and discusses the special circumstances surrounding the child and its family. For example, the CST considers the situation of military families and families with parents in college who may have access to services not available to the general public.

Community Participation and Inclusion

During FY 2006-07, the Kids on TRACK program increased both its community participation and inclusion activities. Community participation was accomplished through the efforts of three workgroups. First, the SNP

[184] External referrals include connections to the San Diego Regional Center California Early Start Program, Rayo de Esperanza Family Resource Center, First 5 San Diego Health and Developmental Initiative services provided by South Bay Community Services, and community health and preschool programs.

Leadership Team, which brings together representatives from key partners, and staff from Kids on TRACK and First 5 San Diego. During the Leadership Team monthly meetings, participants discuss Kids on TRACK implementation, brainstorm ideas for program enhancements, and problem-solve challenges. Second, the Community Action Planning Team, comprised of selected members of the Leadership Team and Kids on TRACK service providers. The Community Action Planning team meets quarterly to discuss the same issues faced by the Leadership Team from a community point of view. The team participates in facilitated activities that impact the overall delivery and philosophy of Kids on TRACK. Third, the statewide networking meetings provide a setting for SNP administrative and service delivery staff to connect with staff from the nine other Special Needs Demonstration Project sites across California.

Several important program advances were made by the participants attending the three SNP workgroups:

- ***Establishing the Kids on TRACK definition of inclusion:*** The local SNP definition of inclusion was determined by the aforementioned groups after finding that no relevant descriptions for "inclusion" previously existed (see textbox at right for definition). By thoughtfully defining inclusion, Kids on TRACK is now better able to plan and develop the strategies needed to meet State and local goals for inclusion and full community participation of children with disabilities, developmental delays, and other special needs into supportive environments.
- ***Children with special needs are enrolled through the same procedures as typically developing children:*** Another large-scale change made due to the partnership between community agencies and CVESD is the change in location for district preschool enrollment. Previously, children with disabilities and other special needs were required to enroll in district preschool and elementary school at a separate point-of-entry than children with typical abilities. Through the ongoing participation of CVESD key administrative staff, enrollment for all types of children will occur in one place starting in the 2007-08 school year. This is a key step toward routinely placing children with special needs in classrooms with typically developing children.
- ***Enhancing services for children with special needs:*** Kids on TRACK is now a pilot site for the Center on Social Emotional Foundation for Early Learning (CSEFEL) Positive Behavior Support Program. This program, funded by CSEFEL, delivers specialized training for early childhood educators to support healthy social and emotional development of young children in group care settings. CSEFEL offers staff an understanding of the source of behavior challenges in young children and strategies to help those children participate successfully in school. As part of the partnership, 80 children were screened using the ASQ for delays and special needs.

Additional inclusion activities this year include:

- ***Classroom-based services for children and teaching staff:*** Kids on TRACK staff facilitated 56 services for 50 children with special needs in an inclusive classroom setting[185], exceeding this year's goal (50 services and 25 children, respectively).
- ***In-home services:*** Kids on TRACK staff provided services to 201 families with children with special needs in their homes, exceeding the goal of 150 by 34.0%.

"Inclusion is… when all children experience a sense of belonging as they are supported to successfully participate within a welcoming community. Inclusive practices enrich individuals, families, neighborhoods, and systems."

- Kids on TRACK Definition of Inclusion

[185] An inclusive classroom setting is considered intentional integration of children with and without special needs into typical educational, developmental and natural environments.

- ***Inclusion classes and workshops:*** Kids on TRACK staff, in collaboration with key partners, provided a space for 388 families with and without children with special needs to learn and be active together. The attendance in these classes, including "Music and Movement" and "Baby Yoga", exceeded the goal of 50 by 776.0%.
- ***Workforce development in inclusion:*** Kids on Track collaborated with community partner Kids Included Together, Inc. to offer a series of evening classes on topics supporting inclusive practices in early childhood education settings.

The focus of SNP is on early identification of children with disabilities, developmental delays, and other special needs in order to offer intervention services at a point where those services could have the greatest impact on a child's development. In order to serve this population of children, staff must be trained to support families through a variety of resources and activies. Kids on TRACK addresses this need by providing critical professional development activities to program staff; 76 trainings were offered on topics such as screening tools (ASQ, ASQ:SE, PSI:SF), health screenings, case management, home visiting, Individualized Education Plans (IEP), social-emotional curriculum, brain development, parent-child attachment, and exposure to violence. Attendance of 191 exceeded the project's goals by 211.2%.

Summary

This fiscal year brought about immense improvement in both service provision and data collection for Kids on TRACK. While future challenges do exist, SNP staff continues to innovate and adjust to ever-changing situations.

Current and Anticipated Challenges

While the Kids on TRACK project increased outreach, screenings, services, and referrals this fiscal year, challenges were encountered with this project at both the state and local level. The following challenges may continue to impact the project in FY 2007-08:

- ***First 5 California Evaluation****:* In February 2007, the First 5 California evaluator concluded its contract with the State without an extension or replacement. Consequently, SNP sites were temporarily left without access to the statewide PEDS database. Sites were unable to enter data during this time and once access to the database was granted, families had to be located to signon a new consent form and their data had to be re-entered into the PEDS system. At this point, some historic program data are still inaccessible.
- ***First 5 California Training and Technical Assistance:*** In April 2007, the First 5 California Training and Technical Assistance consultant severed their contract with the State. A new contractor has yet to be named, and SNP sites across California continue to need professional development and implementation consultations.
- ***Goals may not reflect changes in the population.*** The number of children ages 0-5 in the Kids on TRACK catchment areas has decreased over the past year, which will make it more difficult and resource-intensive to identify and screen the required number of children. Kids on TRACK will have to think innovatively to continue to provide 500 screenings next year.

CHAPTER 5

Preschool for All

"Pre-k provides a powerful boost toward success in school and in life."

—Preschool California

Key Results

+ **Year one of the Preschool for All (PFA) Demonstration Project provided 103 quality preschool sessions throughout the six target communities.** Across the County, 1,662 children were given a quality preschool experience through PFA. The variety of setting type varies by community.

+ **Children improved in each of the four domains measured by the DRDP-R.** The most improvement was in the area of "effective learning" (i.e., cognition, math ability, and literacy) but improvements on all subscales were statistically significant ($p<.001$).

+ **Parents participated in numerous education and involvement activities.** Parents were offered, and participated in, numerous parent involvement and education opportunities including volunteering in the classroom or at special events, attending parent/teacher meetings or education classes, or serving on a parent advisory board. Parents reported high satisfaction with the PFA Demonstration Project and indicated that their parenting skills had improved after participation in PFA.

+ **Education levels increased among teachers.** Participation in PFA encouraged teachers to return to school and attend various workshops and trainings offered at their sites. Many teachers felt recognized and validated by playing a part in PFA and as a result took more pride in their work as teachers.

Summing It Up

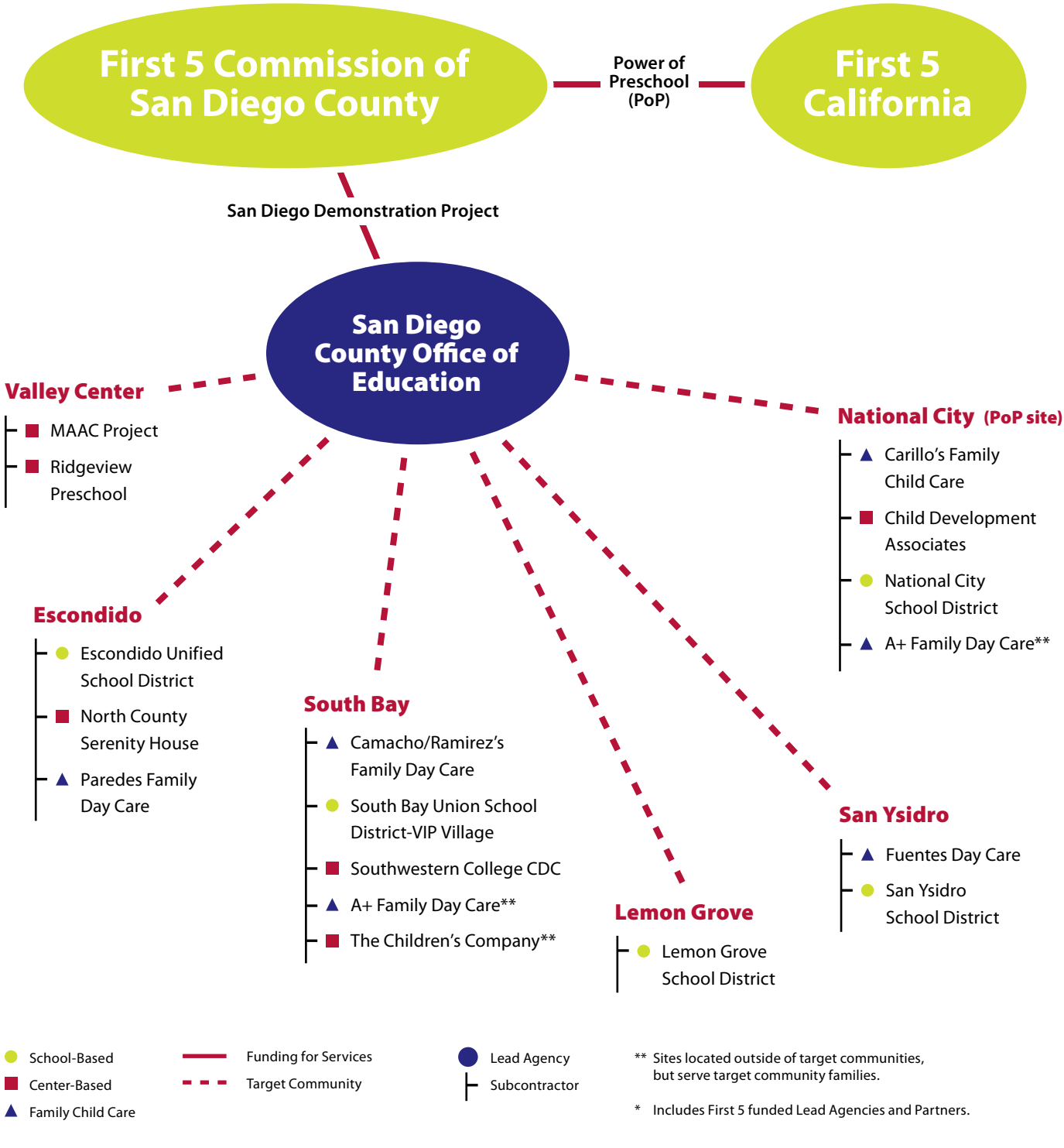
+ 1,662 children received preschool services funded by First 5 San Diego's PFA Demonstration Project (383 new preschool slots were fully-funded by PFA funds and 1,279 existing preschool slots received PFA funds to enhance existing services). Actual enrollment was 69.4% of the target enrollment for Year 1 of 2,394 children.

+ The project provided quality classrooms with mean ECERS-R and FDCRS scores of 5 or higher on each subscale, which equals "good" on a scale of 1 to 7 where 1=inadequate and 7=excellent.

+ A total of 278 children (16.7% of all children attending PFA programs) were screened for health and developmental delays.

+ 279 parent involvement activities were offered.

Preschool for All Demonstration Project Structure*



Introduction

Participating in a high-quality pre-kindergarten program can increase a child's chances of academic, social, and professional success regardless of socioeconomic background. Research has found that children who participate in pre-kindergarten programs are less likely to repeat a grade or require less special education services, and are more likely to graduate from high school and attend college.[186]

To address the need for improved access to quality early education opportunities for San Diego's young children, the First 5 Commission of San Diego County (First 5 San Diego) approved the Preschool for All Master Plan in December 2005 and allocated $30 million over five years to implement a PFA Demonstration Project in six priority communities throughout San Diego County.[187] These communities, which serve approximately 4,400 preschool-age children, were targeted based on their elementary schools' low Academic Performance Index (API) scores of 2004 and population demographics such as number of English language learners and average family income. To carry out the PFA project, First 5 San Diego contracted with the San Diego County Office of Education (SDCOE) to implement the program in each target community. SDCOE in turn contracts with school-based, community-based, and family home providers to provide quality preschool in each community.[188]

Because this is a Demonstration Project, the Commission placed a strong emphasis on developing a strong evaluation plan to assess the effects of the project on children and families as well as documenting best practices and lessons learned. It is hoped that by doing so, SDCOE will be able to use these findings to strengthen the existing preschool delivery model and eventually bring it to scale on a countywide basis once additional, non-First 5 funding is secured. Furthermore, First 5 San Diego's Demonstration project is one of 10 "Power of Preschool" projects funded by the State's First 5 California. Each of these 10 sites is developing new service delivery models and learning from their activities, evaluations, and one another. Thus, the First 5 San Diego PFA evaluation plan weaves together three, interconnected components:

- First 5 California Statewide Power of Preschool (PoP) Evaluation: Funded by California First 5, this effort provides a broad evaluation structure for the 10 PoP sites to examine the impact of PFA statewide. Only one of the six San Diego PFA communities (National City) is a PoP site.
- First 5 San Diego Evaluation Efforts: Funded by the First 5 Commission of San Diego County, this evaluation seeks to learn about the impact of the First 5 San Diego Preschool for All Demonstration Project on the six San Diego Communities (summative evaluation) and evaluate how the implementation of PFA programs across San Diego County impact existing preschool delivery models (formative evaluation).

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[186] Lynch, Robert. Enriching Children, Enriching the Nation: Public Investment in High-Quality Prekindergarten. Economic Policy Institute, 2007. Accessed 31 August 2007 <http://www.epi.org/content.cfm/book_enriching>

[187] The San Diego County Preschool for All Master Plan was the result of a community processes funded by First 5 to develop a vision and roadmap for implementing universal, voluntary preschool for all children in San Diego County. The County-wide vision of the Master Plan necessitates that funding sources, in addition to First 5 San Diego, be identified to support the project to scale. San Diego County Office of Education. San Diego County Preschool For All Master Plan. December 5, 2005. Accessed 4 September, 2007 <http://www.sdcoe.net/student/eeps/pfa/pdf/mplan_12-05.pdf>

[188] Note: As this was the first year of this demonstration project, SDCOE as the prime contractor was provided an opportunity to review an early draft of this document for technical accuracy.

- PFA Master Plan Evaluation: Funded by seed money from the Packard Foundation and First 5 San Diego, this evaluation is to inform the update and expansion of the PFA Master Plan to improve the delivery of PFA once it is ready to be expanded and go to scale throughout the County (a future project).

Key Elements

The mission of the First 5 San Diego's Preschool for All (PFA) Demonstration Project is to design, develop, and subsequently establish a multi-tiered service delivery model for preschool that will support the implementation of quality PFA programs at the local, regional, and countywide levels. PFA was designed to:

- Increase access to high-quality preschool in San Diego County so that children can acquire the skills they need to be successful when they enter kindergarten.
- Encourage the active involvement of family/parents through classes, parent/teacher meetings and opportunities to volunteer in the classroom.
- Encourage workforce/professional development of PFA provider staff with higher education, trainings, and workshops.

The San Diego County Office of Education (SDCOE) is the lead contractor for providing PFA services and has subcontracted with preschool providers in six communities throughout San Diego County – Escondido, Valley Center/Pauma, Lemon Grove, National City, South Bay, and San Ysidro. There are also two providers located in Chula Vista, which is not one of the six designated PFA regions, but serves children who live in National City and South Bay. Within these communities, there were a total of 16 PFA sites participating in the Demonstration Project in Year 1, including school-based, community-based, and family child care as listed in Exhibit 5.1.

Exhibit 5.1 Preschool For All Demonstration Project Sites by Region		
Region	**School/Center/Home**	**Setting**
Escondido	Escondido Unified School District	School-Based
	North County Serenity House	Center-Based
	Paredes Family Day Care	Family Child Care
Valley Center	MAAC Project	Center-Based
	Ridgeview Preschool	Center-Based
Lemon Grove	Lemon Grove School District	School-Based
National City	Carillo's Family Child Care	Family Child Care
	Child Development Associates (CDA)	Center-Based
	National School District	School-Based
Other*	A+ Family Day Care	Family Child Care
	The Children's Company	Center-Based
South Bay	Camacho/Ramirez's Family Day Care	Family Child Care
	South Bay Union School District - VIP Village	School-Based
	Southwestern College CDC	Center-Based
San Ysidro	Fuentes Day Care	Family Child Care
	San Ysidro School District	School-Based

**Located in Chula Vista, these sites serve both the National City and South Bay communities*

The overall goal of the PFA is to successfully enroll and serve 70% of four-year-olds located in all target communities by FY 2010-11. In year one, it was expected that 60% of four-year-olds would be enrolled in PFA quality preschool programs.

All providers participating in PFA are designated a "Tier level" based on quality criteria. Each provider is classified as either: PFA Entry (Tier 1), PFA Advancing (Tier 2), PFA Quality (Tier 3), or determined to be not yet eligible to be a PFA site. Tier ratings are based on: 1) ECERS/FDCRS score (*see Making a Difference: PFA in Action*) and 2) teacher qualifications. SDCOE provides support and training to enhance the quality of sites and their Tier rating, over time. Tiers are used to determine reimbursement rates for the providers— the higher the Tier, the higher the PFA slot reimbursement.

The following chapter utilizes findings from a variety of data sources to evaluate classroom outcomes, parent outcomes, and workforce outcomes. These sources included ECERS and FDCRS scores, DRDP-R scores, surveys with parents and teachers, and interviews with site directors. Additionally, interviews with members of stakeholders from the education community were conducted.

Summing it Up: Number of Children and Families Reached

In FY 2006-07, PFA funded a total of 16 sites – five school-based, five family child care, and six community-based (Exhibit 5.2). Overall, these sites held 103 sessions and served 1,662 children, with an average of 21 children in each session.[189] Actual enrollment was 69.4% of the target enrollment for Year 1 of 2,394 children. In retrospect, this target and was too ambitious for the start-up year of a demonstration project. The majority of sessions (78.8%) were held at school-based sites, where 85.0% of all students participating in PFA were served. Nearly one-fifth (23.0%) of all PFA student slots were fully-funded, with sites using PFA funds to create new slots for children, while the remaining 77.0% of student slots were enhanced, meaning that PFA funding was used to increase the quality of services for existing student slots. With the exception of family child care providers, all of the sites had more enhanced slots than fully funded slots. Family child care providers, on the other hand, had only fully-funded slots and tended to be smaller (serve fewer children) than the other sites.

Exhibit 5.2 Preschool For All Demonstration Project Process Numbers

Setting	Number of sites	Number of sessions	Fully-funded slots	Enhanced/subsidized slots	Total Slots
School-based	5	82	318	1,174	1492
Family child care	5	7	33	8	41
Community-based	6	14	32	97	129
Total	**16**	**109**	**383**	**1,279**	**1,662**

Making a Difference: PFA in Action

PFA outcomes were measured for the classroom, children, parents, and teachers. The following section presents findings related to each of these domains.

Ensuring Quality Classrooms

To measure the quality of PFA classrooms, the Demonstration Project uses the Early Childhood Environment Rating Scale-Revised Edition (ECERS-R) for classrooms and Family Day Care Rating Scale (FDCRS) for family care sites. These tools are among the nationally recognized instruments designed to measure various aspects of classroom and childcare site quality.[190] The overall ECERS-R and FDCRS score is one of three components that determines a session's Tier rating.

- PFA Entry (Tier 1), all seven subscale scores must meet or exceed 4.0
- PFA Advancing (Tier 2), all seven subscale scores must be 4.5 or above
- PFA Quality (Tier 3), all seven subscale scores must meet or exceed 5.5.

[189] Each three hour class is one session. Each classroom may accommodate both a morning and an afternoon session.

[190] ECERS-R is reliable at the indicator and item level; the percent of agreement across the scale is 86.1%. There is a high level of inter-rater reliability (.921 Pearson correlation). Harms, Thelma, Richard M. Clifford, and Debby Cryer. Early Childhood Environment Rating Scale: Revised Edition. Frank Porter Graham Child Development Institute, The University of North Carolina at Chapel Hill, 2005.

The ECERS-R and FDCRS were administered by an External Review Team at all sites. Both tools have subscales with roughly comparable categories and include scales from one (inadequate) to seven (excellent). See Exhibit 5.3 for the comparison of scales.

In Year 1, the overall ECERS-R and FDCRS average mean scores for each subscale were fairly high – at a rating of "Good" or better for each subscale (Exhibit 5.4).[191] The school/center's ECERS-R subscales with the highest mean scores were in the categories of Parents and Staff, and Interaction. The family child care (FCC) FDCRS subscales with the highest average mean scores were for Social Development and Adult Needs (see the Data Compendium for full description of subscale categories and scores). FCCs scored lowest on Space/Furnishing and schools/centers ranked lowest in the area of Program Structure, which includes scheduling, time for free play and group interaction, and provisions for children with disabilities. These initial scores serve as a baseline for classroom quality in Year 1 of the Demonstration Project and can be compared to subsequent assessments to analyze how quality has been enhanced over time.

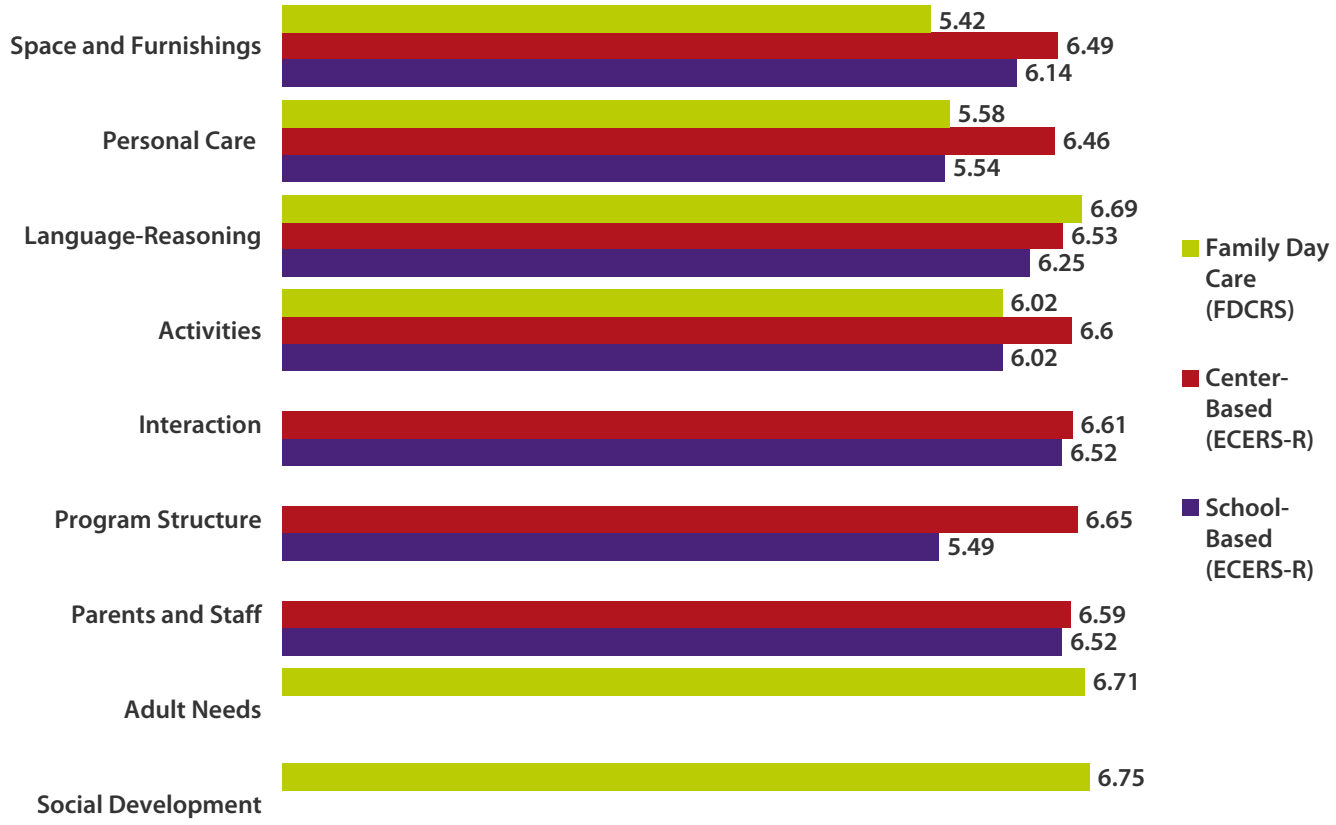
Exhibit 5.3 ECERS-R and FDCRS Subscale Comparison *

ECERS-R (school/center sites)	FDCRS (family child care sites)
space and furnishings	space and furnishings for care and learning
personal care routines	basic care
activities	learning activities
language-reasoning	language and reasoning
interaction	n/a
program structure	n/a
parents and staff	n/a
n/a	social development
n/a	adult needs
n/a	Providers for Exception Children (not measured by PFA in Year 1)

** The ECERS-R and FDCRS share similar subscales. For the purposes of presentation, similar scales are grouped as outlined in the table.*

[191] An average mean score is calculated by taking the average of all mean scores in any subscale.

Exhibit 5.4 ECERS-R (n=95) and FDCRS (n=8): Average of Subscale Mean Scores by Site Type[192]



Developmental Gains for Children

The Desired Results Developmental Profile (DRDP-R) measures a child's development in four domains – personal and social competence, effective learning, physical and motor competence, and safety and health. The DRDP-R data comes from 96 PFA sessions and represent matched fall and spring scores. (n=1,366).[193]

Developmental Scores in Fall and Spring

The DRDP-R has 39 questions and asks teachers to rate children as "exploring," "developing," "building," or "integrating." There is also a category for children "emerging" from one category to another. Numerical scores were assigned to each of the four categories, from a 0= not yet to 4= integrating. Thus, the higher the score, the more mastery a child exhibits. Teachers administered the tool twice during the school year, once in the Fall and then again in the Spring, in order to measure a child's progress.[194] As Exhibit 5.5 illustrates, mean scores in each category increased from the Fall to the Spring, with all of the increases being statistically significant ($p<.001$). The mean increases are high (See Exhibit 5.6) – ranging from 1.01 to 1.23 – which suggests that

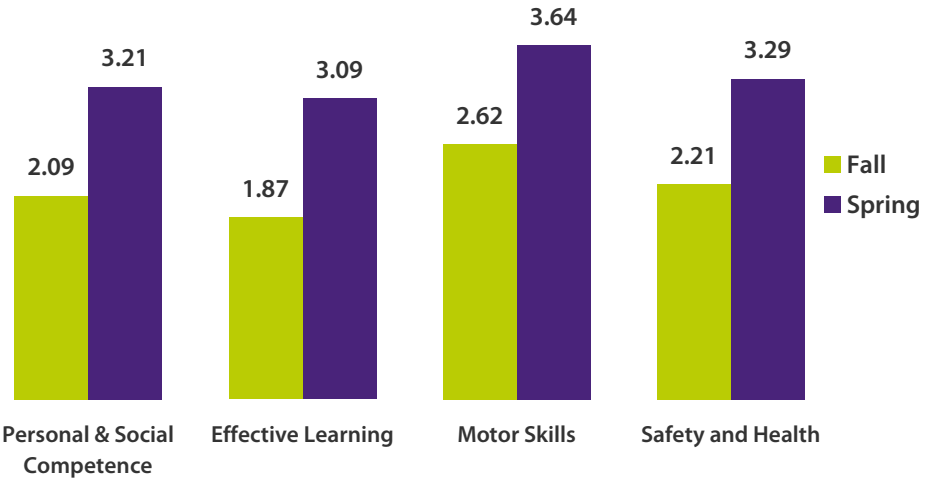
[192] The ECERS-R and FDCRS are different tools with some overlap in subscale content. Similar subscales are shown under one category to allow for comparison.

[193] Only matched scores were included in analysis. (Children with only a pre or post score were excluded). The total number of matched assessment scores represents 94.2% of all sessions and 82.2% of the children who could be assessed.

[194] Most surveys measuring baseline scores were administered in November while most spring surveys were administered six months later in May. Two limitations of this instrument are that increases may be due to normal child development of the course of the school year and that schools/teachers may have collected the data differently.

children in PFA programs quickly improved a variety of skills and abilities. More detailed outcomes can be found in the Data Compendium.

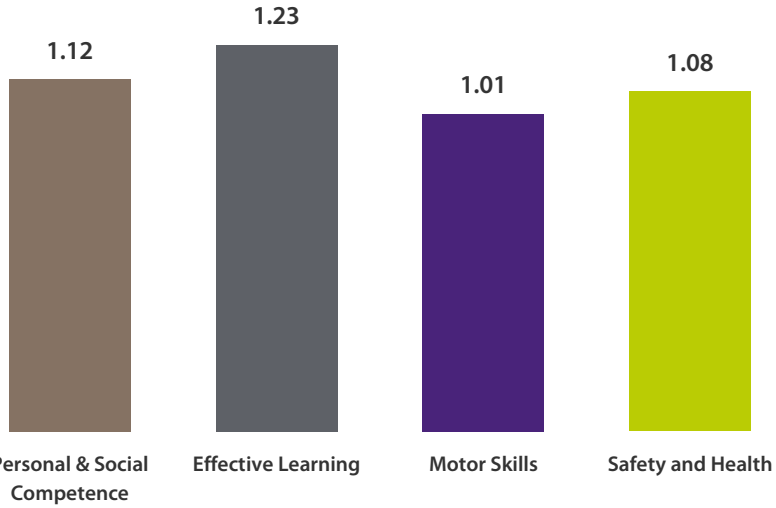
Exhibit 5.5 Mean DRDP Scores by Domain*



**Changes in scores were statistically significant (p<.001) for every domain*

Although score increases were similar across domains (See Exhibit 5.6), the changes in *Effective Learning* were the largest. Scores for *Effective Learning* were the lowest at baseline compared to the other areas, and while the magnitude of the change was the greatest, these scores were also the lowest of all categories in the Spring. By contrast, motor skill development, the area with the least amount of change, had the highest mean score both in Fall and Spring. Future evaluations will include parent interviews, which may elucidate why these trends occur.

Exhibit 5.6 Mean Changes in DRDP Scores by Domain*

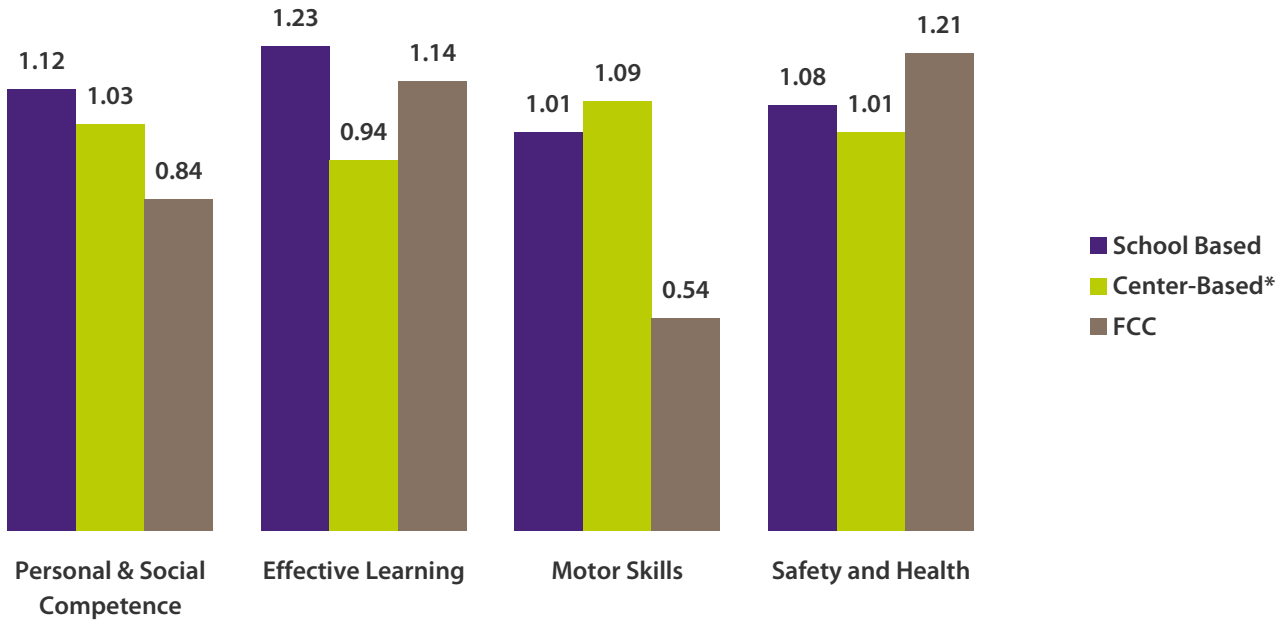


**Changes in scores were statistically significant (p<.001) for every domain*

Differences in Scores by Site Type

Exhibit 5.7 shows mean changes across domains by the type of setting: FCC, school-based, or center-based.[195] Children in school-based programs had the largest increase in scores for *Effective Learning* and the least amount of change for *Motor Skills.* Children in center-based programs had opposite results, with their scores for *Motor Skills* increasing the most and the scores for *Effective Learning* increasing the least. Children in FCC programs had the largest increase in scores for *Safety and Health* and the smallest changes in *Motor Skills.* Some of these differences may be due to differences in the way the tool is interpreted and administered by teachers. See the Data Compendium for more detailed results.

Exhibit 5.7 Mean Changes in DRDP Scores by Domain and Setting



**This includes faith-based, for profit, not-for-profit, and Head Start settings.*

Screening for Developmental Delays and other Special Needs

Early identification and intervention of developmental delays is a key goal of all First 5 projects.[196] Early identification and intervention can dramatically improve a child's health, learning, and social and emotional development in ways that become more challenging and less effective just a few years later. In order to facilitate early identification of delays, First 5 San Diego requires that all children attending a PFA program receive a developmental screening with a normed and validated instrument. The PFA evaluation included tracking the number of developmental screenings as well as the number of children who are referred for an IEP (Individualized Education Plan) or further assessment as a result of the screenings. The hope is that universal screenings will identify children with "mild" to "moderate" delays that often go undetected and/or unaddressed

[195] The majority of children (91.7%) with submitted DRDP-R scores are enrolled in school-based programs. Therefore, the mean changes by domain for this setting are similar to the overall mean changes shown in Exhibit 5.6. In addition, differences in mean changes by site type were not tested for statistical significance.

[196] The American Academy of Pediatrics recommends developmental screenings for children at 9, 18, 24 or 30 months; prior to entry in preschool or kindergarten; and whenever a parent or provider concern is expressed. See Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening PEDIATRICS Vol. 118 No. 1 July 2006, pp. 405-420

by existing identification protocols and programs.[197] Indeed, the American Academy of Pediatrics cites studies indicating that intervention prior to kindergarten has enormous academic, social, and economic benefits, including savings to society of $30,000 to $100,000 per child.[198]

During Year 1 of the Demonstration Project, the challenge was to identify an agreed-upon universal screening tool. California First 5's PFA committee identified the ASQ as the recommended tool for screenings, but many of the school districts had different identification processes. After much discussion among SDCOE, First 5 San Diego, the providers, and other key experts, two normed and validated tools were agreed upon for the universal screening: the Ages and Stages Questionnaire (ASQ) (currently utilized by other initiatives and widely used across the State by other First 5 funded programs) and the Parent Evaluation of Developmental Status (PEDS). By using these tools, children enrolled in PFA with mild to moderate delays may be identified and provided with additional support, either from the school or outside services , such as those provided by the First 5 funded Health and Developmental Services Project (see Chapter 2).

Although the goal of PFA is that all children will be screened, in year one only 16.7% of children received either an ASQ or a PEDS. Of the 392 parents who were invited to complete a PEDS, 271 were returned (a 69.1% response rate). Thirty parents were asked to complete an ASQ, and seven were returned (23.3% response rate). A total of two children were referred on for further assessment as a result of the ASQ;[199] however, none subsequently received services. Exhibit 5.8 provides additional information about screening by site type. In order to improve screening rates, SDCOE has clarified expectations and created a training module for staff and parents on the PEDS and ASQ that will be implemented in the beginning of FY 2007-08.

At the end of the year, of the 1,662 children served by PFA, only eleven children were identified as having a developmental concern -- less than 1% of the children served by PFA. Nine of these children were given Individual Education Plans, meaning that these children were identified under State guidelines to have special needs warranting additional assistance. Two children were identified as having "mild" to "moderate" developmental concerns. In light of the fact that studies have shown that 9% to 20% of all children will have a developmental issue, it appears that children in PFA may have been under-identified for special needs. The quality and quantity of screenings and assessments is an area for improvement in Year 2.

San Diego PFA Screening Tools

The PEDS (Parents Evaluation of Developmental Status) and ASQ (Ages and Stages Questionnaire) are screening tools that can be completed by parents and are recognized by the American Academy of Pediatrics as reliable and valid tools for children ages 0-5.

At first, the ASQ was the required screening tool for PFA. However, accommodations were made in year one to allow sites to conduct a PEDS as a preliminary screenings for all children. The ASQ is used as a secondary screening if the PEDS results indicate that there is a concern.

[197] School based providers are mandated to serve children identified as having special needs through Section 619 of the Individuals with Disabilities Education Improvement Act (IDEA). The IDEA does not generally required services for children with "mild" to "moderate" delays.

[198] American Academy of Pediatrics: Developmental and Behavioral Pediatrics Online. High Quality Developmental Screening. Accessed 12 September, 2007. < http://www.dbpeds.org/articles/detail.cfm?TextID=373>.

[199] Specific information on where children are referred is not tracked.

Exhibit 5.8 Preschool For All Year 1 Developmental Screening Results							
Provider Type	Total slots	Parents invited to complete PEDS	PEDS returned	Parents invited to complete ASQ	ASQ returned	Children with ASQ results suggesting referral for further assessment	Children who subsequently received services
School-based*	1,492	168	73	4	0	0	0
Family child care	41	43	27	7	5	2	0
Community-based	129	155	145	15	2	0	0
Total	**1,662**	**392**	**271**	**30**	**7**	**2**	**0**

**Only one school-based site provided screening data.*

Assessing Parent Involvement and Satisfaction

Parental involvement and satisfaction with their children's classrooms is a key goal of PFA and a priority for the First 5 Commission.[200] The First 5 San Diego Strategic Plan seeks to provide families with the skills, comprehensive support, and resources they need to promote their children's optimal development and school readiness.[201] Parent involvement in a child's preschool builds trusting relationships with families and allows parents and teachers to exchange information about the child's progress. It also supports the First 5 principle of a parent as a child's first and best teacher. Preschool California views family involvement as one of the components of an effective pre-kindergarten program.[202]

Parent Involvement

During the school year, parents are given an opportunity to participate in various activities. Overall, sites offered a total of 279 parent involvement activities, and these included parent education classes, board meetings, and opportunities for volunteering either at events or in the classroom (see the Data Compendium for more details).

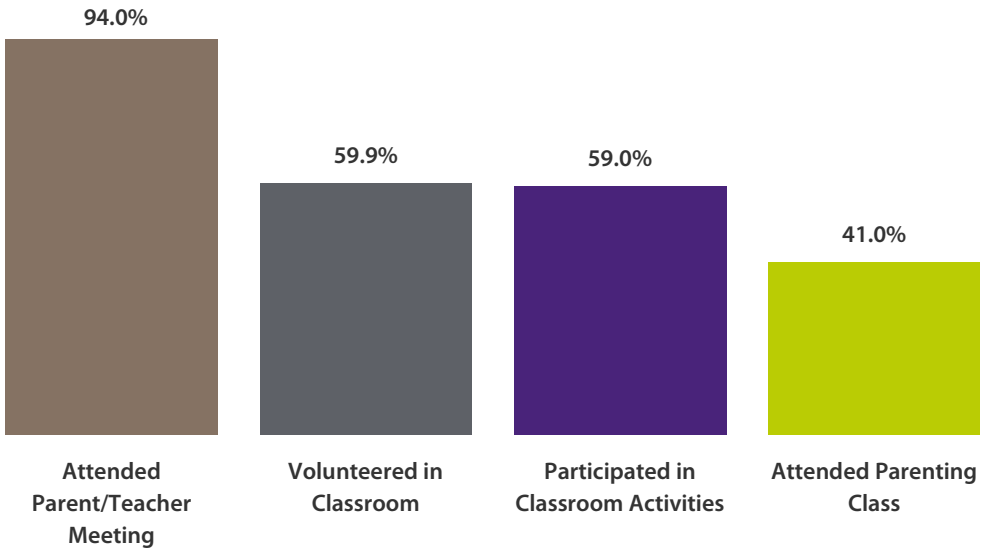
Over half of all parents who responded to the parenting survey (54.8%) reported participation in at least one parenting activity. Most parents (94.0%) reported participating in parent/teacher meetings, which is the least intensive parenting activity measured (see Exhibit 5.9). Approximately the same number of parents volunteered in the classroom as participated in classroom activities, 59.9% and 59.0% of parents, respectively, while 41.0% of parents attended parent education classes.

[200] State Evaluation Question 6.

[201] Issue Area 3.1: Parent and Family Development and Resources.

[202] Preschool California. "What is Effective Pre-Kindergarten." Accessed 10 September 2007. <http://www.preschoolcalifornia.org/for-policymakers/fact-sheets.htm>

Exhibit 5.9 Number of Parents Attending Parenting Activities (n=461)*



**Counts are not mutually exclusive*

Parent Development

To assess parental development, each site utilized a Parenting Survey, an instrument modified from the "Survey of Parenting Practice" developed by the University of Idaho. This tool measures parents' knowledge, confidence, ability, and behaviors around parenting before they participated in the PFA Demonstration Project ("then") and after participating ("now"). Ratings range from zero to six— the higher the rating, the more knowledge, confidence, ability or frequent the behavior. Eight hundred and forty-one surveys were returned, roughly a 50% response rate.[203] Although not a key implementation area during the startup year, Parent Development will be an area of focus in Year 2 of the Demonstration Project.

After being involved in the PFA, parents rated themselves higher on all 12 items on the Parenting Survey, with the increases being statistically significant for all items ($p<.001$). Exhibit 5.10 shows the mean "then" and "now" outcomes for all twelve survey items, as well as the mean difference between the two. The largest increase was in knowledge and the smallest increase was behavior. Consider the following findings:

- *Knowledge:* Parents noted the most improvement in the knowledge statement: "My knowledge of how my child is growing and developing."
- *Confidence:* This referred to a parent's confidence in their parenting skills, setting appropriate limits, and helping their child learn. Overall, this group of statements had higher ratings at both "then" and "now".
- *Ability:* This referred to a parent's ability to identify and respond to their children's needs (which showed the most improvement), as well as their ability to attend to their children's health and safety (which showed the smallest improvement.)
- *Behavior:* This was measured by responses to statements concerning increases in activities, such as reading, parents engaging with their children, and connecting with other families that have children. The statement where parents showed the most improvement was "The amount I read to my child."

[203] Parenting surveys are intended to be distributed to all parents; however, the total number distributed was not provided, preventing the calculation of a response rate.

Overall, mean differences were small but statistically significant, indicating that parents reported some positive change in their knowledge, confidence, ability, or behaviors as a result of PFA participation. One explanation for the small changes is that parents had relatively high "then" scores – over four (on a scale of one to six) for almost every statement – and did not feel they had as much to learn. "Now" scores are over 4.5 for every statement and over five for most statements. However, those who attended parenting classes reported the largest increases in scores for every statement except one, which suggested that parents might benefit from more intensive involvement in preschool activities (see the Data Compendium for more detailed information).

Exhibit 5.10 Outcomes for Parenting Survey

Survey Item	Mean "Then" (Before PFA)	Mean "Now" (After PFA)	Mean Difference	Number*
My knowledge of how my child is growing and developing.	4.25	5.20	0.96*	778
My knowledge of what behavior is typical at this age.	4.15	5.02	0.87*	770
My knowledge of how my child's brain is growing and developing.	4.15	5.06	0.91*	767
My confidence in myself as a parent.	4.54	5.26	0.72*	769
My confidence in setting limits for my child.	4.37	5.15	0.78*	761
My confidence that I can help my child learn at this age.	4.51	5.36	0.85*	772
My ability to identify what my child needs.	4.46	5.30	0.84*	772
My ability to respond effective when my child is upset.	4.40	5.12	0.72*	769
My ability to keep my child safe and healthy	5.04	5.63	0.59*	773
The amount of activities my child and I do together.	4.39	5.05	0.66*	767
The amount I read to my child.	3.94	4.74	0.80*	770
My connection with other families with children.	4.07	4.75	0.68*	771

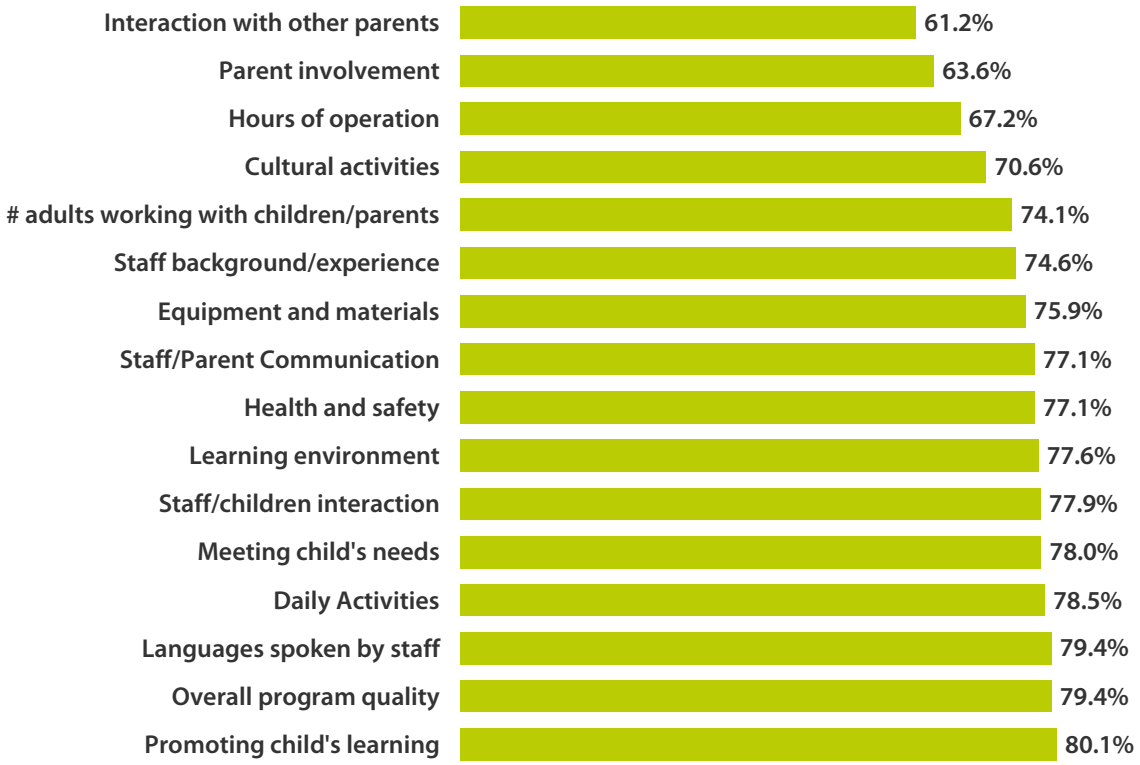
**Statistically significant at p < .001 with alpha set at .05 and .004 (Bonferroni's Correction).*

Parent Satisfaction

Parent satisfaction was another critical element identified by First 5, and also in the PFA Master Plan. To measure this, the PFA providers used the "DRDP Parent Satisfaction Survey", a survey developed by the California Department of Education that many school based sites already utilize. The survey is a series of satisfaction questions about components typically included in early care and education programs. Key findings include:

- Program satisfaction was high across all components (Exhibit 5.11), and 79.4% were very satisfied with the *overall quality of the program*. In one parent's words: "It's perfect. I couldn't ask for more."
- The component that the most parents (80.1%) felt very satisfied with was *promoting their child's learning and development*.
- The area the fewest parents (61.2%) felt very satisfied with was *interaction with other parents*. This finding is interesting when taking into account the low level of parental involvement in PFA early education settings (see Exhibit 5.11). The reasons for the relatively low percentage of parents participating in PFA activities require additional research.
- For each component of the parent survey, less than 3% of parents said they were "not satisfied" (more detailed results can be found in the Data Compendium).
- With regard to hours of operations, an area which received one of the lower satisfaction ratings, one parent said: "I think the hours should be longer. Three hours is not long enough for the teachers and students to teach and learn."

Exhibit 5.11 Percentage of Parents Who Were "Very Satisfied" by Component



Understanding Teacher Perspectives

The final area measured by the evaluation was that of teacher perspectives and professional development. The PFA Preschool Teacher Survey is an instrument that gathers information about lead teacher professional development, interaction with parents, and interaction with kindergartens, kindergarten transition, and school readiness awareness. In all, 74 PFA teachers completed the survey, a 74% response rate.[204] (Detailed survey results can be found in the Data Compendium).

"This year I enrolled in a program to get my bachelors degree. PFA was the main reason I decided to continue my education."

- PFA Teacher

According to these teachers' self reports:

- Teachers strengths are in education, experience, and parent involvement.
- Teachers' self-identified area of weakness is in fully preparing their students for the transition to kindergarten. This may in part be due to limited access to kindergarten teachers. While most teachers talked to the parents about the transition to kindergarten and prepared kindergarten transition files, they were not able to directly communicate with kindergarten teachers, which may have better facilitated the transition for some children.
- Most teachers have at least five years of preschool experience in addition to an Associate's degree, and all but one of the teachers made efforts to involve parents in some type of activity.

Education and Experience

PFA lead teachers were experienced; 63% had taught preschool for over five years and 48.6% had taught at their current preschool for over five years.[205] Most of the teachers (83.6%) were educated at or above the Associates level, as Exhibit 5.12. shows. In addition to their completed education, 60.3% of teachers were enrolled in a degree program at a university or community college, and of these, 29.2% were pursuing their Bachelors and 7.3% were pursuing their Masters degrees. To supplement their experience and formal education, most teachers also participated in additional professional development activities, such as training on using the DRDP-R or on working with children with special needs. Survey participants noted that they attended an annual average of 5.9 activities, some of which were sponsored by PFA. Many teachers felt that their attendance at these training opportunities was helpful. In one teacher's words: "It [PFA] has given me new techniques and strategies to use on my ELL (English Language Learner) students." Overall, the cohort of PFA teachers in Year 1 is well educated and has remained in their positions longer than their peers within the State.[206] [207]

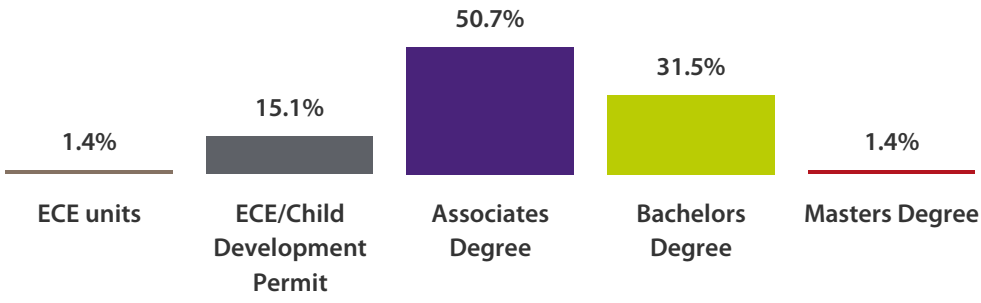
[204] Although all 100 lead teachers should have received the survey. However, the number of teachers who received the survey was not provided, therefore the response rate may not be accurate.

[205] Percentages reported are valid percentages based on the number of valid responses to each survey item

[206] Only 30% of Head Start teachers have Bachelor's Degrees. (National Institute for Early Education Research. "Preschool Policy Matters: Investing in Head Start Teachers." August 2003. Accessed 7 September 2007. http://nieer.org/resources/policybriefs/4.pdf).

[207] According to the California Early Care and Education Workforce Study (July 2006) the turnover rate for early education teachers in California is 22%. Only 39% of center based providers in Southern California have been employed in their current setting over five years. The turnover rate for this cohort of PFA teachers is under 7.5%.

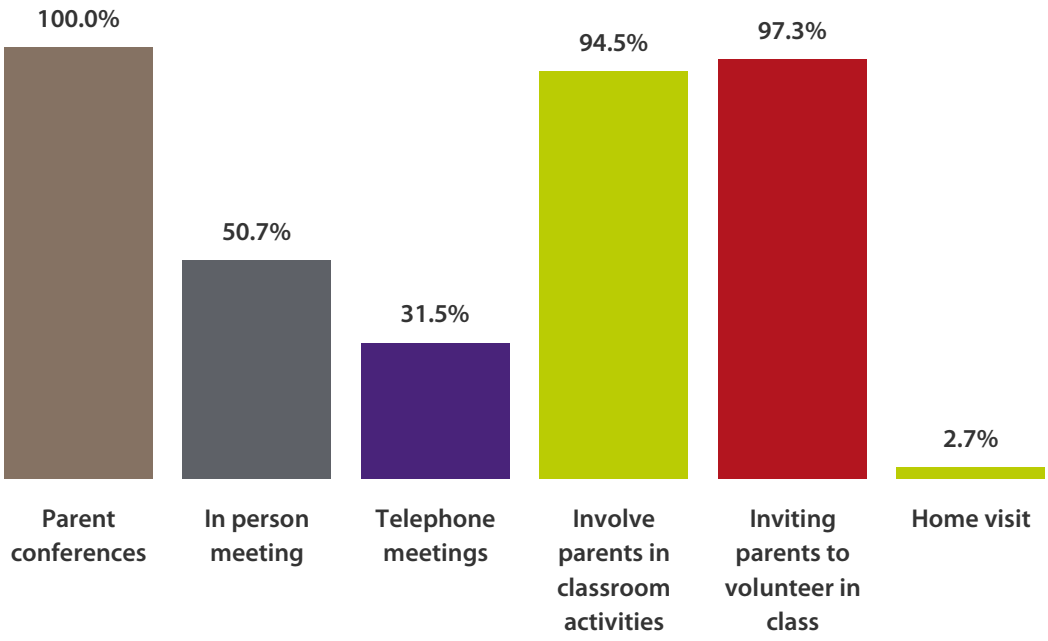
Exhibit 5.12 Level of Teacher Education (n=73)



Interaction with Parents

Overall the data show that teachers are involved with their students' parents. As Exhibit 5.13 shows, the most common parent involvement activities reported on the Teacher Survey were periodic activities such as parent conferences (100%) and inviting parents to volunteer in the classroom (97.3%), as well as more in-depth activities such as involving the parents in classroom learning/play activities (94.5%). The least common parent involvement activities were home visits (2.7%). These findings are consistent with the results of the parent survey (discussed in the previous section).

Exhibit 5.13 Activities Involving Parents (n=73)*



**Categories are not mutually exclusive*

Interaction with Kindergartens

The majority of PFA teachers do not have extensive interaction with kindergarten teachers. Most PFA teachers (86.1%) had met with parents to prepare them for the transition (90.9%) and had created transition files for students going to kindergarten. For the most part, the preschool teachers were not in direct communication with kindergarten teachers. Over one-third (36.1%) met with kindergarten teachers to discuss their students' transition. Only 37.5% said they attended meetings with kindergarten teachers, and even fewer (20.3%) said they attended trainings with kindergarten teachers.

Making the Connection

One of the intentions of all of First 5 San Diego's initiatives is to strengthen the systems of care that support young children. System-level evaluation for PFA Year 1 included observational and secondary data gathered from the PFA leadership team meetings as well as interviews with PFA site directors and key education experts in the San Diego area to document initial successes and challenges of the project.

"I totally believe in the idea of [PFA]. I know the benefits of preschool first hand and I see how the educational system is changing."

-PFA Director

Strengths

The first year of the PFA Demonstration Project has seen successful identification and inclusion of quality preschool programs in six designated areas of San Diego County. Specific achievements include improved access to quality preschool, increased education of teachers, a new commitment to collaboration, and parent involvement.

- **Improved access to quality Preschool**. Most PFA Directors viewed PFA as an opportunity to expand quality services to children in need, especially since the State preschool income requirements excluded a high number of families. In addition, family day care providers shared that their involvement in PFA has led to better quality services. Before PFA, they simply provided day care and now they have a curriculum and improved access to resources for children with special needs. As one Family Child Care Director stated, "Because I didn't have this curriculum in mind before, the children would play, we would watch movies. Now since PFA – our mindset, everything has changed."
- **Increased professionalism of teachers**. At least five Directors reported that participation in PFA has encouraged teachers to pursue B.A. degrees and look more objectively at their classrooms: "When we went through the ECERS-R review process…it made us kind of look at it through different eyes and I think it was helpful. It kind of became a road map for further improvement." Providers, especially family child care providers, felt that the recognition and validation teachers received due to PFA participation encouraged them. As one Director stated, "They are actually respected for what they do…I think that it's really raised their professionalism and their professional standards."

"A lot of people's mentality with family child care homes is not positive…I think this is the beginning of saying 'Hey, we are just as good as any certified preschool'."

- FCC Director

- **Developing collaboration and partnerships.** PFA preschools tended to have a number of partnerships, both with community agencies and local businesses, to increase the resources available to families. The most common partnership named by PFA Directors were with the YMCA (conducts special needs assessments

for a number of PFA sites), local health clinics that conduct physicals and other relevant screenings, and local family resource centers that help support families with a variety of needs. The larger, school-based programs tended to retain partnerships that existed before their PFA participation. In particular, they had previously cultivated private partnerships with companies that donate food, money, books, computers, glasses, and other supplies. Smaller community-based and Family Child Care (FCC) sites, on the other hand, had fewer partners but were interested in identifying new partners. In one director's words, "We want to make families feel better about themselves. We have a garden; I would love to have families begin to do gardening together and maybe look at organizations and groups who can support that."

One barrier many of the smaller sites faced was that they were not as familiar with the services offered in their area and were unsure of how to develop these partnerships. Some of the sites partner with other First 5 Initiatives – usually School Readiness or the Oral Health Initiative – but most sites did not know if their partners were First 5 funded or not, indicating a need for increased education about First 5 partners.

- **Involving Parents.** All of the sites seek and value the participation, advice, and suggestions of parents. While a few PFA Directors shared that their schools have mandatory parental volunteer time, most simply encourage it. Parents help in a variety of ways – participating in classroom activities, taking materials home, providing feedback and suggestions, or volunteering at events such as field trips or parties. For example, one site had parent interns, which enabled some parents to receive stipends for their contributions, and five of the providers (school-based, community-based, and for-profit sites) have parent advisory boards or committees where parents provide feedback in a formal forum.

Challenges

As with any large-scale project, the first year of PFA has met some challenges. First 5 San Diego is learning from these challenges and working with SDCOE to adapt the program accordingly. Some key challenges include:

- **Administrative Requirements.** As a demonstration project that is part of a state network of programs, PFA has specific data and reporting requirements. The focus of some requirements in accountability. The purpose of others is to track outcomes to make a case for funding quality preschool. Most of the Directors felt the administrative requirements associated with PFA were overwhelming at times. This included the requirements of conducting developmental screenings and classroom evaluations, as well as administering the parent and teacher surveys. The larger, school-based sites found some requirements to be burdensome because they have existing systems in place and other funders' reporting requirements to fulfill (i.e. state preschool requirements). However, it should be noted that a number of PFA's requirements, such as the DRDP-R and the DRDP parent survey, are already required of State Preschools. Smaller sites, meanwhile, found the requirements challenging because they did not have the staff and technology in place to respond to the reporting requirements.

  Most of the sites are optimistic about the future, believing that the first year of any new project is difficult, but others are more concerned about the documentation and reporting required and feel there are two systems that are not compatible. SDCOE and First 5 need to continue to work together to present unified goals to PFA providers, as well as the community as a whole. One PFA Director from a small community-based site commented that PFA requirements have already helped to improve their program, "It has been really good to learn different ways of documenting information about the kids so that it can carry forward with them. We have not done that in the past."

- **Workforce Quality.** Although PFA lead teachers have high qualifications, it is difficult for sites to find qualified instructional assistants. The shortage of qualified instructional assistants affects the instruction children receive as well as reimbursement rates because assistant qualifications are one of three critical elements that help determine Tier level. To address this, SDCOE made modifications to existing requirements and designed a "ramp up" for entry and advancing sites so that Year 1 qualifications of the

instructional aid would not impact the Tier level of a session. By Year 3 it is anticipated that the required qualifications for assistants will match the original Tier level requirements.

Additionally, it is challenging for lead teachers to reach the qualifications required for PFA Quality (Tier 3). At all Tier levels, lead teachers must hold at least a Child Development Teacher Permit (which includes 24 Early Childhood Education units), but the expense and time commitment needed to obtain a higher degree (A.A. or B.A.) make it challenging for lead teachers to pursue. Many sites expressed that the larger stipend received by higher qualified teachers is unfair and can create resentment among teachers who lack the education required for the stipend, but work as hard as those with higher qualifications. However, as the CARES program has shown (see Chapter 8), the stipend program is designed to act as a motivator to encourage teachers to expand their education. It is hoped that as sites continue to receive support from SDCOE, teacher participation in professional development opportunities will increase.

- **Participation.** In Year 1, PFA recruited diverse providers. SDCOE conducted two rounds of applications and specifically reached out to family day care providers, creating a "FCC think tank" to identify ways to cultivate FCC participation. Despite these efforts, there is still limited FCC participation in PFA. In year 1, 2.5% of PFA children attended Family Day Care sites. Although three of the PFA regions – Escondido, National City, and South Bay – have providers from the three different site types (school-based, community-based, and family child care providers) the other regions do not offer the same variety of options.

  Currently there are numerous providers who submitted letters of intent to participate in PFA but are not yet qualified. In total, there are 78 providers who expressed interest in participating – 29 in Escondido, 12 in Lemon Grove, 12 in National City, 18 in San Ysidro, five in South Bay, and two located in areas outside the six identified PFA communities. First 5 San Diego and SDCOE are working together to include a diverse range of preschool providers who will participate in the PFA Demonstration Project.

  "Parents love it. [They] love seeing their kids learning."

  – PFA Director

- **Startup.** As might be anticipated in the first year of a demonstration project, there were delays in start up. One of the delays was in implementing full ECERS-R reviews. A partial ECERS-R review was initially administered and used to establish Tier levels and reimbursement rates for providers. It took several months for the full ECERS-R results to be returned to the sites. Once the full ECERS-R was completed and results returned, the scores indicated that the Tier level of many sites should be reduced. Instead of reducing their Tier level and reimbursement rate mid-year, SDCOE worked with agencies to develop an improvement plan so that necessary changes could be made to improve their ECERS-R ratings and get them to the level of quality of the originally assigned Tier level.

  In addition to full ECERS-R review delays, there was some confusion regarding evaluation and data collection requirements. This was in part due to the delay in articulating the specific data collection requirements to PFA Directors, which in turn led to some confusion and/or resistance to implementing the evaluation. Although most PFA sites were successful in submitting the required elements of the evaluation (DRDP-R scores, child demographic data), there continues to be concern about data sharing and analysis as well as questions about the project's required data collection activities.

Recommendations

The following recommendations were developed based on the first full year of PFA implementation. As with any new initiative, it is anticipated that there will be challenges to address.

- **First 5 San Diego and SDCOE should work together to coordinate administrative requirements.** Many sites felt overwhelmed by the new administrative and reporting requirements of the PFA Demonstration Project. First 5 San Diego and SDCOE should clearly communicate with as many stakeholders as possible, such as the PFA Leadership Team Preschool Directors and School Superintendents, to eliminate confusion and delays regarding evaluation and data collection requirements. The formation of the Provider Evaluation Group in Year 2 and the recently published PFA Operating Guidelines will clarify requirements at the beginning of the school term, provide a regular forum for communication and feedback, and ensure that the provider voice is heard.
- **Continue to improve classroom quality.** The ECERS-R results indicated two areas for classroom improvement (i.e., personal care routines and program structure) while the FDCRS scores revealed two different areas for family child care improvement (i.e., space and furnishings and basic care). The ECERS-R personal care and the FDCRS basic care are similar enough that joint technical assistance could be provided. The professional development plans being implemented in Year 2 will target specific areas (i.e., Program Structure, Personal Care Routines) needing improvement.
- **Encourage collaboration between PFA providers and First 5 Initiatives.** Many PFA providers are interested in collaborating with First 5 partners. Although there was some collaboration between PFA and other First 5 initiatives in Year 1, many of the providers do not know about services First 5 offers in their regions. First 5 has a role to educate providers and facilitate collaboration between PFA and other initiatives. One key area for collaboration is with the Health and Developmental Services Project (HDS) to coordinate referral for assessment and treatment of developmental delays, especially for children with mild to moderate delays but do not qualify for services under the IDEA.
- **Improve screening and referral processes.** Just 16.7% of children in PFA programs were screened for developmental delays using either the PEDS and/or the ASQ. Of these, the few children who were referred on for further assessment did not receive services. SDCOE can work with PFA providers to ensure all children are screened in Year 2 and encourage teachers to work with parents to complete screenings. In addition, systems need to be improved to better track referrals for further assessment and treatment. Steps have already been taken to address this. During Year 2, program requirements for use of PEDS and ASQ were incorporated into the PFA Demonstration Project Operating Guidelines and data collection templates were distributed to providers at the beginning of the school year, to ensure that children receive screenings and that screening and referral activities are documented more accurately and consistently.
- **Continue to provide families with choices.** PFA should continue to recruit diverse providers to offer families choices in the type of preschool their children attend. One way to accomplish this is to assist sites that have submitted letters of intent with meeting PFA quality standards. For example, if teacher qualifications are too low, SDCOE can refer teachers to the CARES program so teachers can receive stipends as incentives to improve their education.

A Final Word on the Preschool for All Demonstration Project

During the first year of the Preschool for All Demonstration Project, 1,662 slots were provided for children in the six targeted communities to receive a quality preschool experience. The San Diego County Office of Education worked closely with School-Based, Community-Based and Family Day Care providers to integrate the various elements of the Demonstration Project. Classroom quality was enhanced by encouraging teachers to increase their educational level and attend trainings. In addition, parents were offered numerous opportunities to participate in their child's education through classroom volunteering, parent/teacher meetings, and parent education classes. Because this was the first year of the project there were some challenges, such as a limited number of providers in each region and a low number of completed developmental screenings. However, the first year of PFA also resulted in many achievements such as a significant increase in mean DRDP-R scores from Fall to Spring, a high level of parent satisfaction, and an expansion of quality preschool throughout San Diego County.

CHAPTER 6

Intergenerational Initiative

"One generation plants the trees; another gets the shade."

—Chinese proverb

Key Results

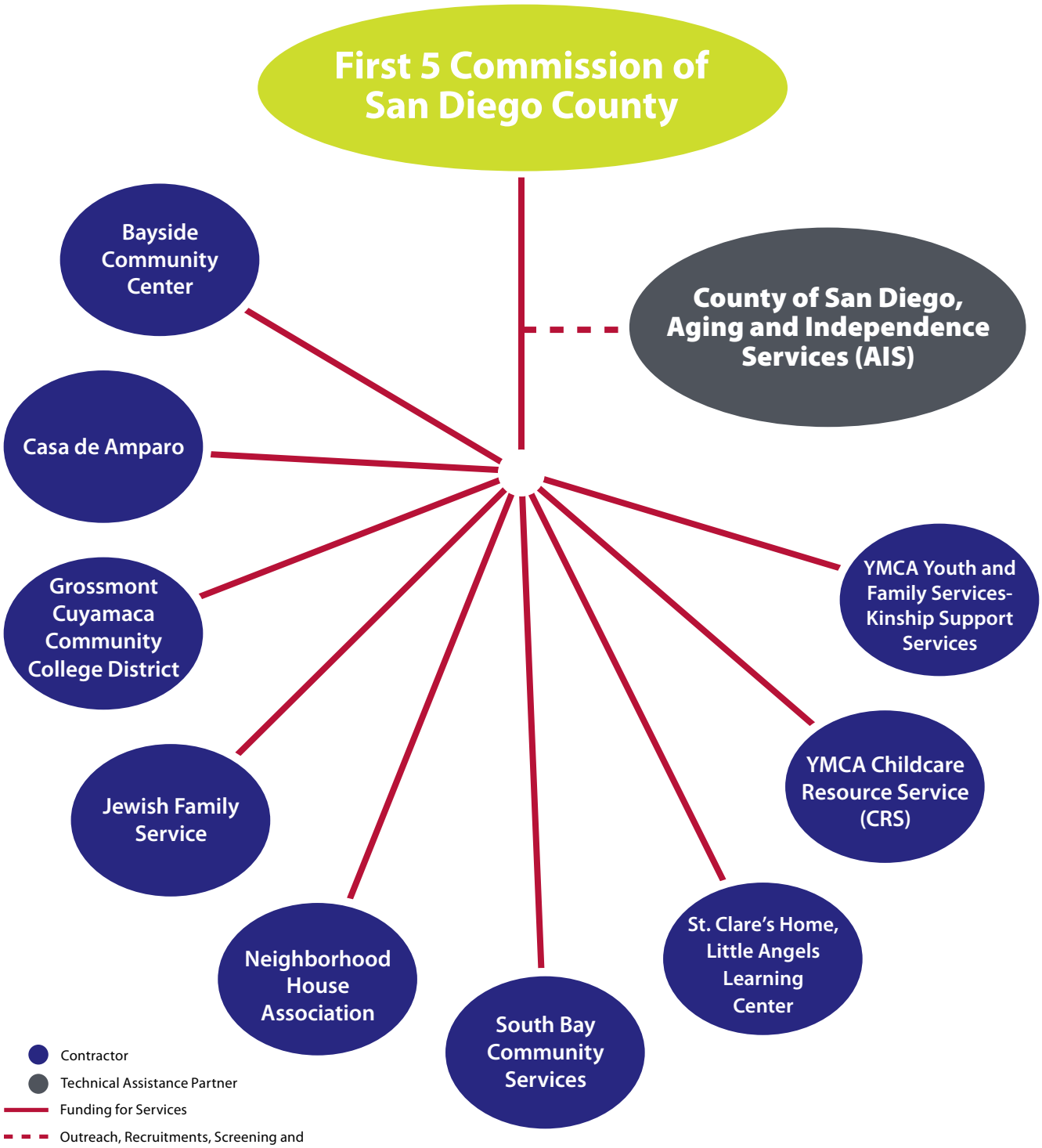
Over the last three years of this program (FY 04-07), providers and parents responding to surveys reported that Senior Mentors provided the following benefits:

+ Increased teachers' capacity to give extra attention to new children.
+ Increased teachers' capacity to create a positive learning environment in the classroom, including managing and calming the classroom.
+ Improved children's language, communication, and early learning skills.
+ Increased children's interaction with adults and peers.
+ Improved children's positive attitude toward learning.
+ Supported parents' opportunities for child to play.
+ Enhanced parents' knowledge of child development.

Summing It Up

+ Approximately 12,864 children were served through the Intergenerational Initiative over the last three years, including over 4,000 children during FY 2006-07.
+ Senior Mentors volunteered for more than 25,000 hours during FY 2006-07, for a total of over 77,000 hours during the course of the Initiative.

Intergenerational Initiative Structure*



* Includes First 5 funded Lead Agencies and Partners.

Introduction

The First 5 San Diego Intergenerational (IG) Initiative began in February of 2004 to bring together older adult volunteers (known as "Senior Mentors") to assist in programs serving children ages 0-5. The IG Initiative consisted of nine contractors who incorporated Senior Mentors into their existing programs to build capacity, assist program staff, and/or directly serve children and their families through a variety of activities.
[208] Approximately $4 million was allocated to the IG Initiative during the three year project. While the IG Initiative funding was slated to end on January 31, 2007, six of the nine contractors were provided optional no-cost extensions, allowing them to use unspent dollars to continue their programs in full or reduced capacity for an additional two to five months. All contracts were completed by June 30, 2007, and the Initiative has now officially ended at the time of this writing.

The IG Initiative had two primary goals:

- Tapping into San Diego County's senior population to help expand the capacity of programs that are preparing children for school
- Assessing the effectiveness of using intergenerational approaches in serving young children

In general, these two goals have been met with success, and where appropriate, the Commission now supports efforts to incorporate intergenerational strategies into its other initiatives.

Key Elements

Throughout the 3+ years of this Initiative, the IG programs have included a number of key elements:

- **Support for Diverse Services:** Senior Mentors assisted with different types of activities, including supporting teachers in child care and preschool settings, reading and interacting with children in waiting rooms, conducting home visits to children and their families, and facilitating kinship caregiver support groups.
- **Support for Diverse Providers & Clients:** Senior Mentors were trained to work with diverse groups of providers and their clients, including children in day care and Head Start programs, children and families in homeless and domestic violence shelters, and children being raised by grandparents or other relatives.
- **Interagency Collaboration:** On a regular basis, IG contractors worked together with the County of San Diego's Aging and Independence Services (AIS) to develop strategies and troubleshoot challenges related to program outreach, recruitment and training of interested senior volunteers, as well as retention of existing Senior Mentors.
- **Building of Intergenerational Bonds:** As children and Senior Mentors spent time together in these programs, they often developed special bonds and relationships similar to those shared between grandparents and grandchildren.

[208] For more information about the IG Initiative's history and purpose, see First 5 San Diego's 2004-05 and 2005-06 Annual Evaluation Reports.

Summing it Up

Although the IG Initiative was operational in a decreased capacity during spring 2007, IG contractors continued to serve many new children throughout FY 2006-07 (n=4,470; see Exhibit 6.1). And though the average number of Senior Mentors decreased this past year, Senior Mentors still volunteered over 25,000 hours.

Exhibit 6.1 IG Initiative: Numbers At-a-Glance

	FY 04-05	FY 05-06	FY 06-07	TOTAL FY 04-07
Children 0-5 (unduplicated) served	4,765	3,629	4,470	12,864
Average number of children served per month	1,737	2,082	1,369	1,729
Senior Mentor hours	23,165	28,722	25,521	77,408
Average number of Senior Mentors per month	97	113	96	102

The table above also indicates that, over the life of the Initiative, approximately 12,864 children ages 0-5 were served in programs where Senior Mentors volunteered over 77,000 hours to the benefit of program staff and young children and their families.

Making a Difference

The primary focus of the IG Initiative was to enhance services being provided to young children and their families by utilizing the skills and experiences of Senior Mentors. To evaluate the impact of the intergenerational strategy, the IG Initiative set out to measure three main outcomes attributable to the Senior Mentors:

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

"Our mentor is the person that was missing in my family – the grandparent - patient, loving, playful, and [with the] knowledge of how to help shape a person."

– First 5 Parent

In order to assess these outcome areas, two surveys were created in FY 2004-05 and were distributed in spring of each of the three fiscal years (FY 2004-05, 2005-06, 2006-07).[209] The two surveys included:

- **Provider Survey:** This survey was completed by program staff that worked directly with the Senior Mentors and had knowledge of the senior-child interaction and relationships, as well as knowledge of the Senior Mentors' effect on the program. This survey collected provider and child outcomes.

[209] For more information on the development of the Parent and Provider Surveys, see Appendix B.

- **Parent Survey:** This survey was completed by parents of children who were participating in an IG program and who had direct interaction with and/or knowledge of the Senior Mentors. This survey collected parent and child outcomes.

Limitations of the Data

During FY 2006-07, just five of the original nine contractors collected outcome surveys, as the others were either not operational during the full year or a particular survey was not applicable to their program.[210] A total of 43 Provider Surveys were completed (a 68% decline from the previous year). Only 50 Parent Surveys were returned (a 62% decline over the previous year.) Because of the limited number of participating contractors and the smaller number of completed surveys, no statistical testing comparing FY 2006-07 data with previous years' data was conducted.[211] Due to the small number of respondents and limited program participation, it is important to note that the data for FY 2006-07 are not representative of overall outcomes or trends for this initiative and should be regarded as largely informational.

Provider Outcomes

The presence of a Senior Mentor at the program site and/or in the classroom provided opportunities for the teachers and staff to devote more time to enhancing their program. Specifically, the Provider Survey focused on four areas – whether providers felt that the presence of Senior Mentors:

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

"The mentors are a great help when it comes to the children. The children learn as if the mentors are the teachers."

– First 5 Parent

The findings for FY 2006-07 were consistent with those of the previous year: the five programs responding noted that the presence of a Senior Mentor assisted in these four areas. Providers generally had the highest frequency of positive responses when asked to rate the degree to which the Senior Mentors had increased their capacity to give extra attention to new children, create a positive learning environment in the classroom and provide more language and learning activities. This trend of positive response percentages for each of the reporting periods can be seen in Exhibit 6.3. Provider responses from FY 2006-07 and the previous fiscal years signify that the IG Initiative consistently met its goal of increasing provider capacity among programs.

Child Outcomes

In addition to assisting providers, some Senior Mentors had direct contact with children through assisting in the classroom, conducting home visits, reading as part of literacy programs and supporting special needs children. In both the Provider and Parent Survey, respondents were asked how Senior Mentors contributed in the following areas:

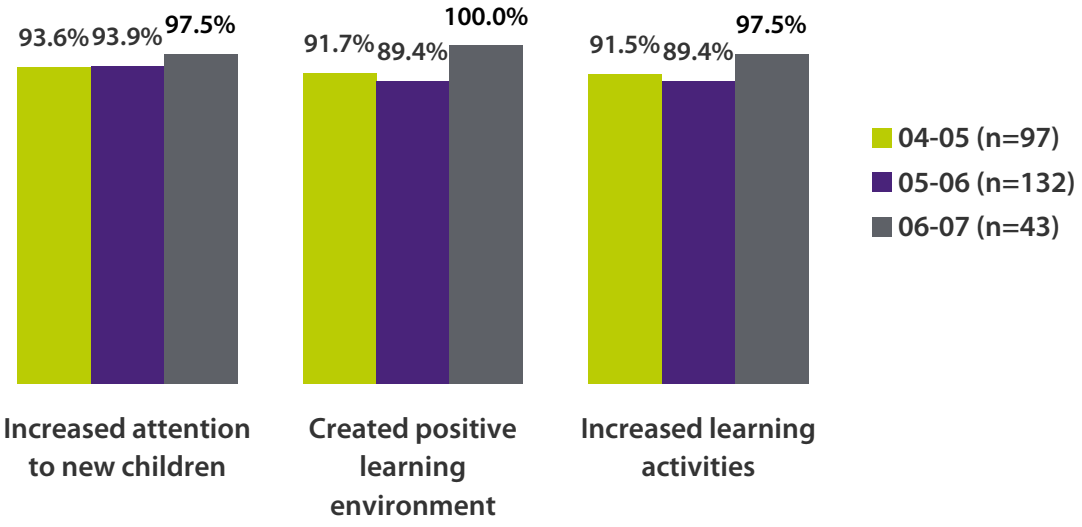
- Increased early learning skills;

[210] Three programs ended and one contractor, YMCA Kinship Support Services Program, had a unique program model and the surveys were not applicable to their participants or service delivery.

[211] For more specific information on the survey results, see the data tables in the Data Compendium. Also see the 2004-05 and 2005-06 Annual Evaluation Reports for outcome information specific to those fiscal years.

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

Exhibit 6.2 IG provider outcome highlights from FY 04-07



Overall, provider responses to the FY 2006-07 child outcome questions were high (with 10 out of 11 survey items having a 90%+ positive response rate). Due to the low response rate and limited program participation, this data cannot appropriately be compared to previous years to indicate any trends. Similar to previous years results, providers had higher responses in these areas than did parents. See the Data Compendium for more details.

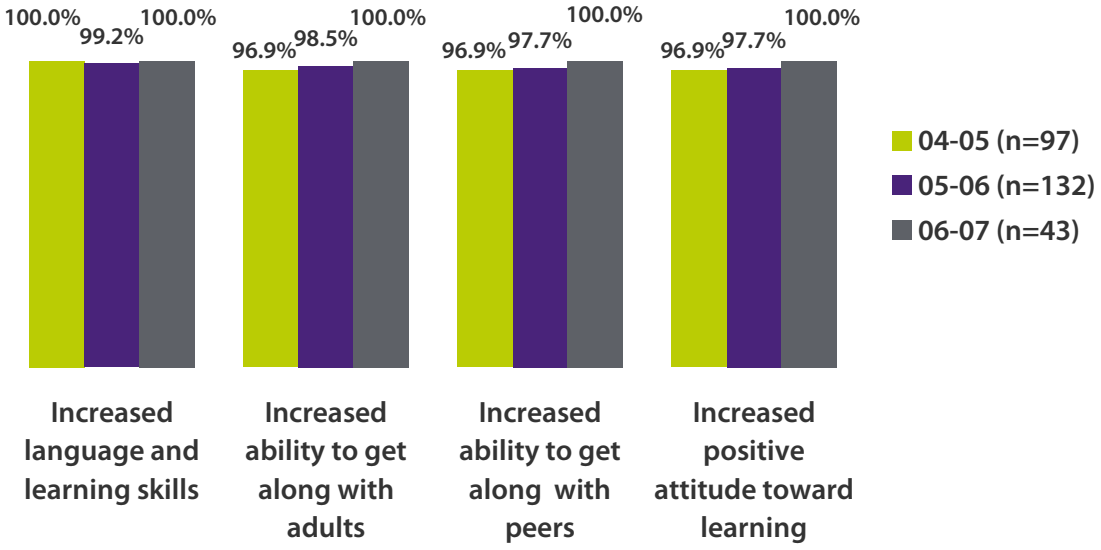
Nearly all staff completing the Provider Survey agreed that the Senior Mentors contributed to the development of children in the following manner:

- Language, communication, and early learning skills;
- Ability to interact with adults, including speaking up and seeking adult help;
- Ability to get along with their peers, including sharing and other pro-social behaviors;
- Positive attitude toward learning, including behaviors such as listening and following directions.

These outcomes can be seen in Exhibit 6.3.

Over the course of the Initiative's three years, the majority of survey respondents consistently reported that the presence of Senior Mentors promoted the cognitive and social well-being of children.

Exhibit 6.3 IG child Outcome Highlights from FY 04-07



Parent Outcomes

The third goal of the IG Initiative was to increase parents' knowledge and skills related to optimizing children's school readiness through the use of intergenerational approaches. To assess this goal, the Parent Survey included questions about the following parent outcomes:

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

"The mentor has brought a creative and fresh approach to playtime, making it more enjoyable for all."

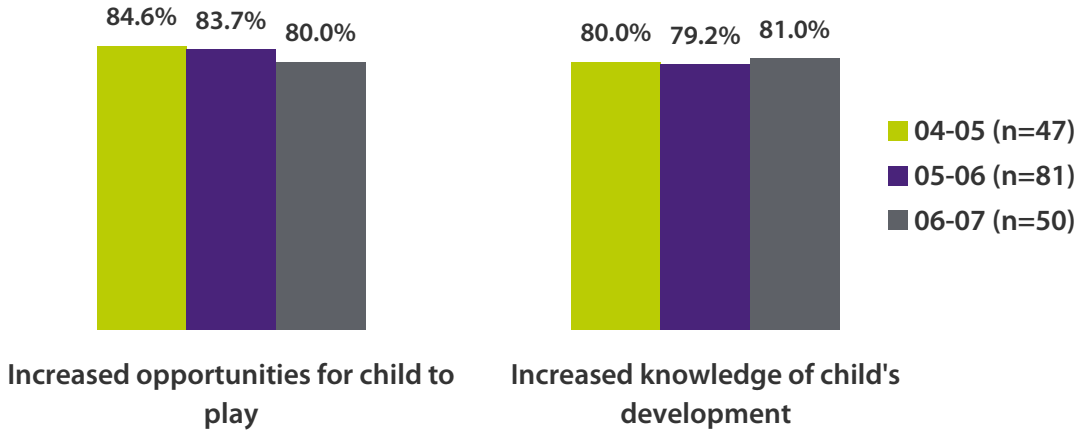
– First 5 Parent

The involvement of parents in the IG programs varied tremendously, from being direct recipients of Senior Mentor services to only having scarce knowledge of the seniors' presence at their child's program. Because of this variability, there have also been more inconsistencies in the parent responses to the Parent Survey questions for all three reporting periods. In FY 2006-07, responses concerning parent outcomes were slightly higher than in previous years, though still considerably lower than provider responses addressing child and provider outcomes.[212]

Over all three years, parent responses were consistently higher in areas addressing the role of Senior Mentors in: increasing the number of opportunities that parents provide for their child to play; and increasing a parent's knowledge of child development. These findings can be seen in Exhibit 6.4.

[212] Ibid

Exhibit 6.4 IG parent outcome highlights from FY 04-07



Responses addressing the effect of Senior Mentors on parent outcomes declined or increased slightly though – due to the limited number of responses – this may not reflect a trend.

Making the Connection: A Lasting Legacy

Throughout the life of the IG Initiative, evidence has shown that Senior Mentors can build capacity in First 5 programs, as well as have an impact on the children and families they serve. As a result, the Commission is now incorporating intergenerational strategies, where appropriate, into its new initiatives. This first occurred in 2006 with the First 5 for Parents Project. (See text box for more information). This is a testament to the success of the IG Initiative and the Commission's commitment to broadening the use of intergenerational approaches as an integral part of its programs and creating a "lasting legacy" for San Diego's children ages 0-5.

Integration of Intergenerational Approaches

The First 5 for Parents Project* started in 2006 and consists of 10 contractors who provide a variety of parent education and family support throughout the county. Four of the 10 programs incorporate intergenerational approaches into their service delivery.

During FY 2006-07, approximately **34 seniors volunteered over 9,000 hours** at First 5 for Parents programs. The seniors support the programs by reading and playing with children, facilitating home visits, and supporting foster caregivers and their children.

**For more information about First 5 for Parents , see Chapter 7.*

CHAPTER 7

First 5 for Parents Project

"[The program] helped me discover my child's abilities…they taught things I would have never done with my child. My child was very shy and timid; now he is more open."

—First 5 Parent

Key Results

+ **First 5 for Parents Project was launched:** The First 5 for Parents Project is the centerpiece of the Commission's Parent Development Initiative. FY 2006-07 marked the first year of this new project with a specific focus on parents as the first teachers of their children. By focusing on primary caregivers who shape children's early experiences, First 5 for Parents seeks to strengthen parents' knowledge and encourage positive behavior change in their children.

+ **A common evaluation design was piloted in this first year of the project:** FY 2006-07 was a pilot year for the evaluation. Some outcomes were measured consistently across contractors and some were measured with contractor-specific questions.

+ **Initial findings indicate relatively high levels of parental knowledge on most commonly measured indicators:** At the initial assessment, most parents reported very high levels of knowledge about the importance of: consistent communication with their children; peer socialization for young children; ways to promote a child's cognitive development and early learning; and the benefits of exercise and nutrition.

+ **Initial findings indicate relatively high levels of parental behaviors on most commonly measured indicators, with some areas where providers could target improvement:** At the initial assessment, most parents reported relatively high levels of behaviors related to spending quality time with their child, providing opportunities for the child to play with others outside the family, reading to their child three or more days per week and eating meals together as a family three or more times per week. Behaviors that show significant room for positive change include exercise frequency and time spent watching television.

Summing It Up

First 5 for Parents providers served thousands of children, parents and caregivers through a variety of service modalities, delivering parent education curricula on parenting skills, promoting children's early learning and cognitive development, and fostering healthy behaviors. During FY 2006-07:

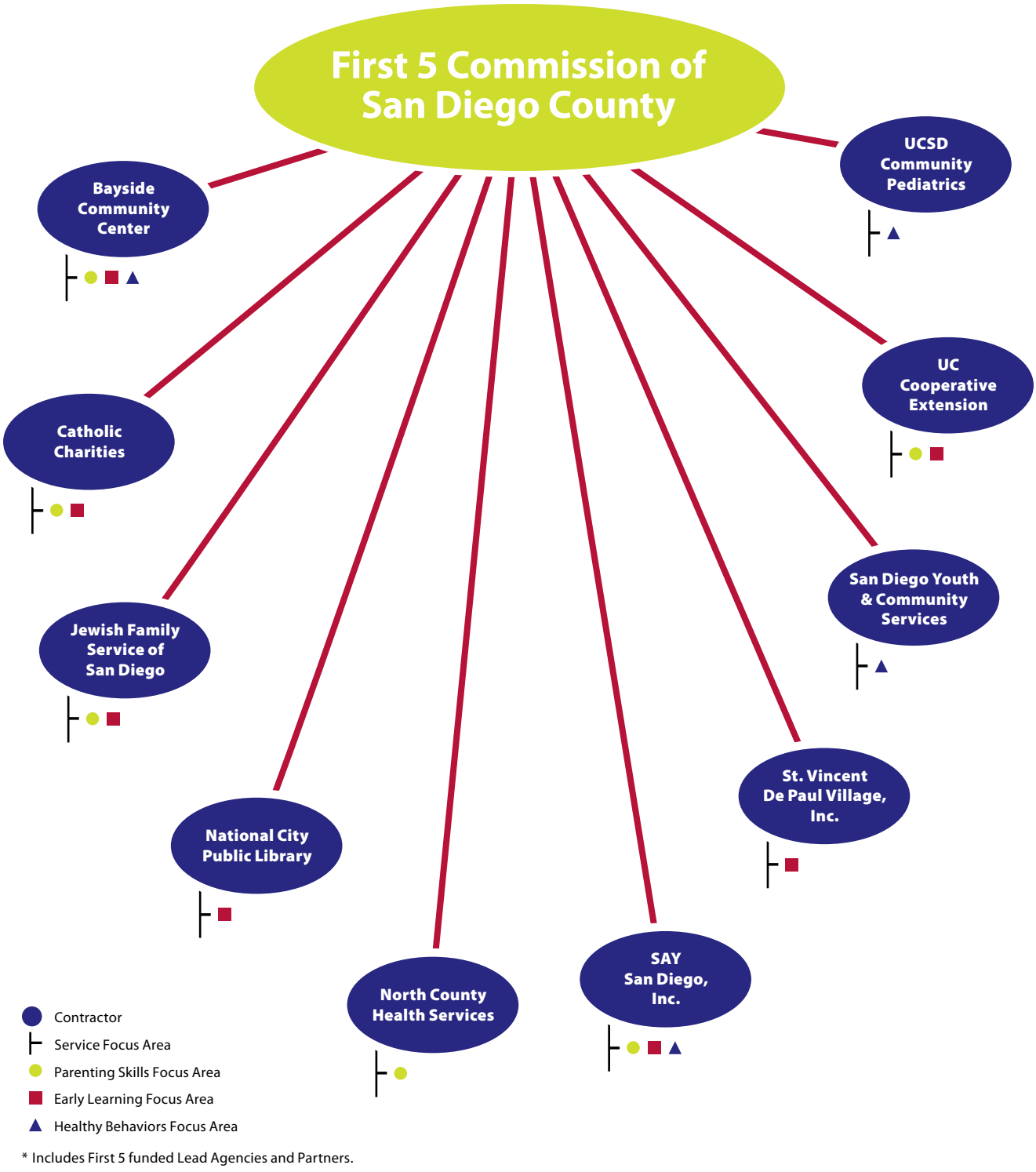
+ 9,890 children 0-5 and 3,381 parents and caregivers were served.

+ 2,367 home visits were made.

+ 2,055 classes were held.

+ 638 workshops were offered.

First 5 for Parents Project Structure*



* Includes First 5 funded Lead Agencies and Partners.

Introduction

Parents and caregivers are a child's first, and most important, teachers. Research has shown that "the environment provided by the child's first caregivers has profound effects on virtually every facet of early development, ranging from the health and well-being of the baby at birth to the child's readiness to start school at age five."[213] Parent activities such as showing children how to write words, using complex sentences and exposing a child to a rich vocabulary produce better outcomes for children in their ability to identify letters, connect letters to speech and sounds, and the use of richer expressive language in kindergarten.[214]

The importance of parents as role models and in creating supportive environments extends beyond traditional school readiness activities to include children's health. The Centers for Disease Control and Prevention's Healthy Schools Healthy Youth! website states: "The prevalence of overweight among children aged six to 11 more than doubled in the past 20 years, going from 7% in 1980 to 18.8% in 2004."[215] This alarming trend highlights the importance of supporting parents as they influence their child's health in providing proper nutrition and exercise. In all areas of their development, children are first exposed to language, attitudes, behaviors, and socialization in the home.

Locally, the 2005 Family Survey Report found that 96.9% (n=1,162) of parents and caregivers surveyed in San Diego County strongly or somewhat agreed with the statement: "I am this child's first and most important teacher." However, it was found that there were regional variations in family activities such as parents singing songs to children, reading or showing books, and telling stories.[216] There were also differences in these activities between English and Spanish-speaking households, and between families with different household incomes. [217]

The Bigger Picture: First 5's Parent Development Initiative

First 5 for Parents is the Commission's strategy to provide direct services under the larger Parent Development Initiative, which aims to educate and support parents to assist them in promoting their children's development and school readiness. In addition to $7.63 million to support direct services to parents, the Commission has also set aside $2 million for additional parent development strategies, including:

- Community strengthening and awareness
- Provider training and capacity building
- Systems change and development

In March 2007, First 5 San Diego commissioned a study to plan and develop these additional strategies for parent development. Key stakeholders are providing valued input as to how parents and First 5 can best address these needs. Results of this study will be reviewed at the end of 2007.

[213] National Research Council and Institute of Medicine. Committee on Integrating the Science of Early Childhood Development. From Neurons to Neighborhoods: The Science of Early Childhood Development. Ed. Jack P. Shonkoff and Deborah A. Phillips. Washington, D.C.: National Academy Press, 2000.

[214] Weiss, Heather, Margaret Caspe, and M. Elena Lopez. Family Involvement in Early Childhood Education. Cambridge: Harvard Family Research Project, 2006.

[215] "Healthy Youth!," 2007, Centers for Disease Control and Prevention, 9 September 2007 <http://www.cdc.gov/HealthyYouth/overweight/index.htm>.

[216] First 5 Commission of San Diego County. 2005 Family Survey Report (San Diego: First 5 Commission of San Diego County, 2005) 41-43.

[217] Ibid, 45.

First 5 San Diego developed the Parent Development Initiative (see textbox on previous page) and launched the "First 5 for Parents" Project in March 2006, allocating up to $7.63 million dollars over a three-year period. The Project supports the Commission's vision that every child enter school ready to learn by equipping parents and primary caregivers with the knowledge, skills, and resources they need to be their children's first and most effective teachers.[218]

Key Elements

The First 5 for Parents Project is the centerpiece of the Commission's Parent Development Initiative. FY 2006-07 marked the first year of this new project with a specific focus on parents as the first teachers of their children. Parents are their children's primary role models. Parents shape their child's early learning environment and make decisions about their families' exercise and nutrition. In focusing on these primary caregivers who shape children's early experiences, First 5 for Parents seeks to strengthen parents' knowledge and encourage behavior change in three Service Focus Areas:

1. Developing more effective parenting skills
2. Promoting children's early learning and early literacy development
3. Fostering healthier behaviors with proper nutrition and exercise

To this end, 10 contractors were selected to provide parent education services in a variety of communities across San Diego County. Contractors are connected by a shared goal to educate parents, but they address this goal in many ways. Consider the following:

- ***Different Service Focus Areas:*** Contractors chose to address the Service Focus Area(s) in which they felt they could make the most impact in their community. Some programs address a single area and others address multiple areas (see Exhibit 7.1).
- ***Different audiences:*** In launching First 5 for Parents, the Commission asked potential contractors to consider the needs of single parents, fathers, and parents in immigrant families; parents with lower literacy levels, pregnant and parenting teens, among others. In choosing the programs to fund, special consideration was given to programs that incorporate intergenerational approaches and early intervention for families with children under age three.
- ***Different curricula:*** The Commission requires contractors to employ curricula that are evidenced-based or are promising practices to meet the needs of the parents/participants with whom contractors work.[219] However, since programs address different Service Focus Areas and different audiences, they do not use the same, or even similar, curricula.

[218] First 5 for Parents falls under the Commission's Strategic Plan Issues Area 3 Parent and Family Development & 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.

[219] In the RFP an "Evidence-Based Practice" was defined as "a program, activity or strategy that has been shown to work effectively and produce successful outcomes, and is supported by research and evaluation." A "promising practice" was defined as "a program, activity or strategy that has achieved successful results in one organization and shows promise during its early stages for becoming an evidence-based practice with long-term sustainable impact. A promising practice must have some objective basis for claiming effectiveness and must have the potential for replication among other organizations."

- ***Different service modalities:*** Contractors offer many different service modalities including classes, workshops, and home visits (see Exhibit 7.1).[220] A parent may participate in a drop-in workshop for a total of less than an hour, or he or she might take part in a class that meets for 90 minutes a week for three months and that offers follow-up home visits for six months after completing the class.

Creating a Cohesive Evaluation Plan Across Diverse Programs

The variety of focus areas addressed, audiences, curricula, and modalities, it was challenging to develop and implement an evaluation to address Project level outcomes, which are also sensitive enough to capture changes among the wide variety of programs. Acknowledging this, FY 2006-07 was seen as a "pilot year" for the evaluation. The Commission designated knowledge and behavior outcomes to be monitored for evaluation purposes. Some of these outcomes were measured consistently across contractors (common survey questions) and some of these outcomes were measured with contractor-specific questions (individual survey questions). During this pilot year, Harder+Company Community Research facilitated a consensus-building process for contractors to select questions that would be measured consistently and used collaboratively. The common survey instrument was ready for implementation in mid-January 2007. For comparability across contractors, only results for common survey questions are presented here. Additionally, as most contractors had not reached their proposed follow-up periods at the end of the fiscal year, only baseline results are available for analysis and are included in this chapter (see Appendix B for additional notes on the development of the Project evaluation).

Exhibit 7.1
First 5 for Parents Programs by Service Focus Areas and Service Modalities

Contractors and Programs	Service Focus Areas			Service Modalities		
	1: Parenting Skills	*2: Early Learning*	*3: Healthy Behaviors*	*Classes*	*Workshops*	*Home Visits*
Bayside Community Center "Ready, Set, Go"	X	X	X	X	X	X
Catholic Charities "Parents As Teachers"	X	X			X	X
Jewish Family Service of San Diego "Peaceful Parenting"	X	X		X		X
National City Public Library "WOW Mobile"		X			X	
North County Health Services "Project Parenting"	X			X	X	
SAY San Diego, Inc. "Start Smart" & "Our Kids Count"	X	X	X	X	X	X
St. Vincent De Paul Village, Inc. " Project LEAP"		X		X		X
San Diego Youth & Community Services "Options for Health"			X	X	X	
UC Cooperative Extension "Off To A Good Start"	X	X			X	
UCSD Community Pediatrics "NEAT AT 2"			X	X		X

[220] Definitions: Classes are a series with definitive first and last sessions. Workshops are less formal, perhaps meeting just one time or meeting over a period of time with no explicit expectation of attendance; participants may or may not sign-up in advance and may or may not attend consistently or sequentially.

Summing It Up

This first year of First 5 for Parents marked the start up of services. As would be expected, programs took time to hire staff, train them in the curricula, develop outreach and recruitment materials, build relationships with partner agencies, and take the overall steps needed to effectively launch their parent education services.

- ***Thousands of individuals participated:*** Perhaps because providers have previous experience serving families of children ages 0-5, thousands of parents and caregivers participated in the programs during FY 2006-07 (see Exhibit 7.2). In turn, nearly three children ages 0-5 were reached for every parent that participated. The number of seniors refers to volunteers, not program participants, and represents participation in intergenerational service-delivery models (see Chapter 6: Intergenerational Initiative for more details on the utilization of Senior Mentors in First 5 funded programs).
- ***Contractors offered thousands of home visits, classes and workshops:*** As Exhibit 7.3 indicates, contractors offered numerous opportunities for parents to participate in parent education services. Some programs offer intense services, for example, weekly classes over several months. Others offer light touch services, such as drop-in workshops. Still others offer both light touch and intensive services (see Exhibit 7.1).
- ***English language learners predominate:*** As Exhibit 7.4 depicts, the majority of participants speak a language other than English at home.

Exhibit 7.2
Number of Participants

Total children 0-5	9,890
Children 0-2	*5,170*
Children 3-5	*4,720*
Parents	3,381
Senior Volunteers**	36

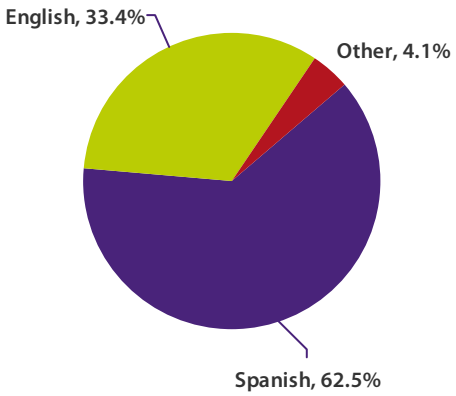
***Four contractors' programs use intergenerational service delivery models*

Exhibit 7.3
Number of Service Units by Type of Service

Home visits *	2,367
Classes **	2,055
Workshops ***	638

** Five of 10 contractors offer home visits*
*** Seven of 10 contractors offer classes*
**** Seven of 10 contractors offer workshops*

Exhibit 7.4 Primary Languages of Parent/Participants



** Other languages include: Arabic, Chinese, English and Spanish spoken with equal frequency, Japanese, Kirundi, Somali, Swahili and Vietnamese*

Making a Difference

As this was the first year of the First 5 for Parents Project, a portion of the year was spent in preparation to rollout services. As such, there are not sufficient pre and post data available from projects to measure results. There are limited initial evaluation results which provide initial baseline data worth examining to learn about the population of parents served and to suggest adjustments to the Project. The data in this chapter cannot be considered conclusive or representative of First 5 for Parents' real impact due to several limitations noted below.

Limitations of Pilot Year Data

- ***Follow-up data is not available for this fiscal year:*** The Common Survey was launched in mid-January 2007 and data collection for FY 06-07 ended on June 30, 2007. As a result, there is less than six months of survey data available for the present report. Participants that enrolled prior to January 2007 did not complete an initial survey. Additionally, several contractors had not reached the appropriate follow-up period prior to the close of the fiscal year.
- ***Only results for outcomes measured by common survey questions are presented for comparability:*** The results in this chapter reflect only the results of the common survey questions and do not capture a complete picture of First 5 for Parents (see Appendix B for a discussion of which outcomes are measured by the Common Survey and which are measured by contractors' individual instruments).
- ***Contractors select questions relevant to their programs:*** Not all contractors address all three Service Focus Areas, so not all outcomes are relevant to all programs (see Appendix B for more details).
- ***Participants may not choose to answer every question:*** The data presented reflect the responses of participants who replied to a question (referred to as valid percents). As a result, the total number of respondents varies by question.
- ***There are a limited number of duplicated cases in the analysis:*** Some contractors run multiple programs. If a parent participated in more than one of a contractor's programs, he or she may have completed more than one initial or follow-up survey.

Common Survey Results

The Commission is not only interested in determining whether parents gain knowledge, they also want to understand if parents are demonstrating this knowledge with appropriate behavior. Thus, the First 5 for Parents evaluation includes knowledge/behavior outcome pairs. To the extent possible, results for knowledge and behavior outcome pairs are presented together below, unless only the knowledge or behavior outcome was measured. To create a common evaluation for a diverse group of programs, Harder+Company Community Research facilitated a consensus process in which contractors selected questions that would be the basis of a

Common Survey (given pre and post) that measure changes in both knowledge and behavior. While individual programs also measured results for components unique to the parent curricula used, only the results of these common survey questions are presented in this chapter. [221]

[221] Please see Appendix B for a description of the Common Survey and a complete summary of the First 5 for Parents Project's evaluation design.

Several organizations were funded to address both parenting skills and early learning and literacy. (Service Focus Areas 1 and 2) and there are outcomes that are common to both these Areas. For clarity, the results for outcomes specific to Service Focus Areas 1 and 2, respectively, are presented separately followed by those outcomes common to both focus areas. Service Focus Area 3 (health behaviors) is distinct in its purpose and outcome measures are presented separately.

The presentation of initial survey results is organized as follows:

- Developing More Effective Parenting Skills (Service Focus Area 1 only)
- Promoting Children's Early Learning and Literacy Development (Service Focus Area 2)
- Supporting Parental Advocacy for Children's Needs (Service Focus Areas 1 and 2)
- Fostering Healthy Behaviors with Proper Nutrition and Exercise (Service Focus Area 3)

Only select findings are presented here. See the Data Compendium for a complete breakdown of the data.

Social Desirability

Across Service Focus Areas, many survey respondents indicated high levels of knowledge and frequent instances of desired behaviors.

These results may indicate the following: 1) a social desirability bias in responding to questions about parenting (i.e. wanting to give the "right" answer even if it is not true for the respondent), 2) a need for better targeting if programs are not reaching families with the highest levels of need, or 3) that using common survey questions across all contractors does not adequately measure the outcomes specific to each particular program.

Wherever possible, relevant comparison data from the general population (County-, State- and/or National-level) is presented alongside the survey findings. In most cases, the First 5 for Parents survey findings are

Parental Communication & Quality Time Spent with Child (Service Focus Area 1)

- ***Knowledge of the importance of consistent communication with child:*** Approximately 90% of respondents correctly identified two benefits of communicating in a consistent manner with their children (increase child's self-esteem, increase child feeling safe). A much lower percentage (60-70%) correctly identified false statements about consistent communication (increase behavior problems, decrease child's understanding of boundaries). The different rates of correct responses for reverse coded questions may indicate that the wording confused some parents or that parents were giving socially desirable responses to questions about parenting. (See "Social Desirability" textbox.)
- ***Quality time spent with child:*** Approximately 75% of respondents reported engaging in the following behaviors seven days a week: talking to their children (77.1%), holding/cuddling their children (76.9%) and putting their children to bed (74.0%). 62.3% eat with their children every day, while 37.9% play with their children daily. 21.3% tell stories or sing songs to their children every day.[222]

Peer Socialization (Service Focus Area 1)

- ***Knowledge about the importance of peer socialization:*** In the initial survey, about 90% of respondents correctly identified the benefits of play with other children their child's age (teaches the child to share, helps the child get along with others, as well as helps the child feel good about him/herself). Again, a much

[222] For those who reported never doing an activity with their child, it is possible that the person interviewed is a non-custodial parent, however this level of detail is not available at this time.

smaller proportion (65.4%) answered a reverse-coded question incorrectly, indicating possible confusion due to reverse coding or parents giving socially desirable responses.

- ***Opportunities for child interaction with others outside the family:*** Roughly half of the respondents (48.6%) to the initial survey reported that their children played with other children five days per week or more: 33.7% indicated their child plays with others five to six days a week and 14.9% indicated their child plays with others seven days a week. A small percentage (9.4%) reported that their child never plays with children his or her age other than a brother or a sister.[223] This finding suggests that most children whose parents participate in First 5 for Parents already receive peer socialization opportunities.

"If I would have never come to the program, I don't think I would have ever taken the time to go and buy my child materials to paint. The idea never crossed my mind. They have to do some kind of art daily. I've bought paints, crayons, and colored pencils. I never thought my child would be that into coloring. I would have only entertained him by buying him toys."

– First 5 Parent

Promoting Child's Cognitive Development (Service Focus Area 2)

- ***Knowledge about how to promote child's cognitive development and early learning:*** Over 90% (93.0%) identified that preschool is important in preparing young children to learn better in school. Over 75% of respondents correctly identified activities that would assist with cognitive development and early learning (playing is the way a child learns; it is important to talk to babies). For comparison, among the general population nationally, one study found that 71% of adults are aware of a child's brain development at a very young age and 76% of adults are conscious that early experiences in life will affect children in the future.[224] These high percentage results are in line with the results found among First 5 for Parents participants.

Promoting Early Learning (Service Focus Area 2)

- ***Knowledge about how to change everyday activities into learning opportunities:*** In the initial survey, respondents indicated a high level of knowledge about the types of everyday activities they could do with their children to help their children do better in school (give the child paper and crayons, sort clothes together for laundry, or read aloud for 15 minutes per day).
- ***Time spent reading to child:*** About two-thirds of respondents (67.6%) reported reading to their children three or more days per week.[225] This is significantly less frequent compared to the results of the San Diego County Family Survey in which 87.7% of respondents indicated reading to their child three or more days per week.[226]

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[223] Of those who reported that their child never played with other children their own age other than brothers or sisters, a small number of these children were under the age of one.

[224] Zero To Three: National Center For Infants, Toddlers and Families. What Grown-ups Understand About Child Development: A National Benchmark Survey. 2000. Accessed 26 September 2006. <www.zertothree.org>

[225] One contractor used a modified response set that was converted to the common response set for comparability. See the Data Compendium for a complete breakdown of the data.

[226] First 5 Commission of San Diego County. 2005 Family Survey Report (San Diego: First 5 Commission of San Diego County, 2005) 42.

Listening to Parent Voices

SAY San Diego's Start Smart program addresses all three of the First 5 for Parent Project's Service Focus Areas. The parent focus group research team focused only on the results related to Service Focus Area 1: Developing More Effective Parenting Skills. Start Smart targets high need families including those comprised of refugees and immigrants, English language learners, and kinship caregivers (individuals raising a child on behalf of a relative). Smart Start includes parent-child classes and off-site playgroups, which reinforce topics covered in class. Parents from Start Smart participated in two focus groups (one in English, one in Spanish) to share how the program has affected their parenting skills.

Practicing Positive Parenting Techniques

Parents were excited to have a place were they could learn and practice new parenting techniques -- specifically citing lessons addressing how to effectively handle a temper tantrum. One parent outlined the steps she had learned, and stated her amazement in how effective the technique had been with her child. First she would ask her son if he needed a hug. If that did not work, she would ignore him for a short time, after which she would tell him that if he settled down and wanted a hug, he could have one when he was ready.

Increased Quality Time Spent with Child

Another common theme in both the English- and Spanish-speaking groups was how parents have increased the amount of quality time spent with their children. They reported realizing through Start Smart that every moment is an opportunity to teach their children, and that they now use a simple trip to the grocery store as a learning experience. Parents also learned about low-cost resources for early earning exist in their neighborhoods, reporting that they have begun to take their children to the zoo and to parks.
All focus group participants stated that they read more to their children since joining Start Smart.

Increased Opportunities for Children to Interact with Others

Parents stated that one of the reasons they chose to join Start Smart was because they realized it would be a place where their children could interact with other children their age. Additionally, most participants report that they have limited play space in their apartment complexes and/or they feel unsafe in their neighborhoods leading to isolation for both children and parents.

> *"Where I live there are not too many places my child could play. I wanted him to play with other children so he could learn how to share. Since he is my only child, whenever we had other kids come over he had a hard time sharing but now he gets along with them and shares."*

"I am always more happy when I leave Start Smart; more happy with my child every time!" - First 5 Parent

Parental Advocacy for Child's Needs (Service Focus Areas 1 & 2)

- ***Knowledge about how to advocate for child's needs and negotiate systems serving young children and parental ability to advocate for child:*** Several survey questions addressed parents' ability to advocate for their children. Less than half of respondents (42.3%) indicated that they usually feel comfortable asking questions of professionals who care for their children; however 94.8% said they would express their concerns if their child was not receiving good quality services. When asked what action they would take if their children were not receiving good quality services, approximately half of respondents (52.0%) indicated they would wait and see if the problem improved. Approximately 70% of respondents indicated they are usually able to make good decisions about the services their children need.
- ***Ability to advocate for child:*** Almost a fifth of respondents (18.9%) who have a child in preschool or daycare had not gone to talk with the teacher or daycare provider about how the child was doing within the last month.
- ***Confidence in ability as a parent:*** Parents assessed their level of confidence in four parenting skills on a scale from "0" (low) to "6" (high). About half to two-thirds of respondents rated their skills between 5 and 6: knowing what is right for their child (64.9%); feeling able to handle day-to-day challenges of raising their child (55.4%); feeling able to discipline their child (52.9%); and feeling able to help their child (63.0%). Approximately 90% rated their confidence as a "3" or higher on each of these measures. As comparison, the 2005 San Diego Family Survey
- [227] found somewhat higher levels of confidence among the general population of parents with children ages 0-5: 98.6% of respondents agreed or strongly agreed with the following statement: "I feel confident as a caregiver about how to help this child grow and learn to the best of their ability."[228] These data may indicate a need to explore why parents participating in First 5 for Parents programs rate their confidence lower than San Diego Family Survey respondents.
- ***Connection with school:*** About half of the respondents had children under the age of four. Of those with children age four or older, most knew which school their child was going to attend for kindergarten.[229]

Exercise (Service Focus Area 3)

- ***Knowledge of the benefits of regular exercise, including lifelong benefits:*** Approximately 80-90% of respondents correctly identified positive effects of exercise, including that exercise promotes stronger muscles and bones (92.4%) and improves self-image (91.1%), sleep (87.1%), mood (89.1%), as well as increases energy (89.1%) and lowers the risk of Type 2 diabetes (82.1%). Approximately two-thirds of respondents (63.6%) correctly identified an untrue statement about exercise (that exercise raises the risk of high blood pressure), again indicating that the reverse coded question may have generated some confusion.
- ***Children exercise more often than their parents do:*** Almost two-thirds of respondents (61.3%) reported that their children participated in physical activity for at least 10 minutes at a time five to seven days per week. In contrast, only about one-quarter of parents (27.4%) reported participating in physical activity for at least 20 minutes.

[227] The Family Survey was a random-digit-dialed telephone of 1202 parents and caregivers of children 0-5.

[228] First 5 Commission of San Diego County. 2005 Family Survey Report (San Diego: First 5 Commission of San Diego County, 2005).

[229] Only three contractors asked this question.

- ***Parents indicated a large amount of time watching television:*** Nearly all respondents (92.9%) reported that they and their children watch television on a typical weekday (including playing video games and spending time on the computer). For children ages 0-5 who watch television on a typical weekday, 3% watch less than one hour; 31.5% watch one or more, but less than two hours; 29.5% watch two or more but less than three hours; and 36.0% watch 3 or more hours. Similarly, parents reported watching a comparable amount of television as their children. Nearly 80% reported that the television is on and in view at least some of the time during mealtimes. For comparison, the 2005 California Health Interview Survey (CHIS) found that 50.4% of children ages 0-5 in San Diego County watched zero to less than one hour per day of television in 2005, while 33.9% watched two hours a day and 15.8% watched three hours a day or more.[230] CHIS also found that 83.2% of children ages 0-5 spend zero to less than one hour on the computer per day, while 5.4% spent between two and three hours and only 1.1% spent between six and 20 hours on the computer (results for two hours and over are statistically unstable).[231]

Nutrition (Service Focus Area 3)

- ***Knowledge of the benefits of healthy dietary habits, including lifelong benefits:*** More than 80% of respondents answered that what a person eats can lower his or her chances of getting a disease like heart disease or cancer.
- ***Fast food consumption:*** Approximately one-third to one-half of parents reported that their families eat meals out one or more times per week at fast food restaurants. This is notably higher than the findings from the 2005 CHIS Survey which found that 20.5% of San Diego County children ages 0-5 consumed one fast food meal on the previous day.[232] Moreover, 35.2% of parents in the First 5 healthy behaviors programs reported that their families eat fast food for breakfast one or more times per week; 56.2% of families eat fast food for lunch one or more times per week; and 55.5% eat fast food for dinner one or more times per week.
- ***Meals eaten together as a family:*** About half of respondents reported eating breakfast (52.6%) and lunch (56.9%) together three to seven times per week, while nearly two-thirds (62.6%) reported eating dinner together five to seven times per week. This is better than statewide data that indicates 58.3% of families with children ages 0-5 ate a meal together every day with all of the family members in the household present.[233]

Family Involvement in Nutrition and Exercise (Service Focus Area 3)

- ***Understanding the importance of family participation and involvement in nutrition and exercise activities:*** Nearly all respondents identified the importance of positive role modeling and the importance of knowing what their child is eating and doing at child care or preschool. Approximately 90% of respondents recognized that if they exercise and eat nutritious food, their children are more likely to do so as well.

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[230] University of California, Los Angeles. California Health Interview Survey. 2005. Retrieved on 9/26/2007 from www.chis.ucla.edu

[231] Ibid.

[232] University of California, Los Angeles. California Health Interview Survey. 2005. Retrieved on 9/26/2007 from www.chis.ucla.edu

[233] Child and Adolescent Health Measurement Initiative. National Survey of Children's Health, Data Resource Center on Child and Adolescent Health website. 2005. Retrieved on 9/26/2007 from www.nschdata.org

Learning What's Best for Baby

Meet Tamara

Tamara is 16 years old. Her pink T-shirt almost, but not quite, disguises that she is expecting her first child (a girl) in two months. Tamara came to Teen Options, a drug rehabilitation day program of San Diego Youth and Community Services, about three months ago on the order of her parole officer.

"I had to come [because my Parole Officer told me to]. I was really upset because I already knew what to expect. I thought it was going to be like 'rehab'… boring! But then I got here and it was fun. It's exciting. I enjoy coming here," said Tamara. "I was in a rehabilitation facility before. I had got, what's it called – incarcerated? I thought it was going to be another rehab…nothing like this. [Teen Options] is a place for teen moms in recovery, a place to go that can help when you need support, in case you get off track. It's a good experience because you learn a lot."

"A lot of [what Options for Health teaches about exercise and nutrition] I hadn't heard before…I learned a lot of things. I'm really glad that I started going to the program, even though I have to come."

- Tamara, First 5 Parent

While at Teen Options, Tamara completed the eight-week course, *Options for Health*, which addresses First 5 for Parents' Service Focus Area 3: Fostering Healthy Behaviors. In the course, young mothers from Teen Options and teens learn about fitness and nutrition for pregnancy and infants through classroom instruction and hands on experiences like cooking, dance, and yoga.

Learning for the Entire Family

In her class journal, Tamara lists things she learned at Options for Health. Among them are, "how to make lasagna and how to feed a baby what's recommended." As a teen parent, Tamara lives at home with her mother, so what she learns about nutrition will affect both her mother and her new daughter.

Tamara learned about breastfeeding and easily recites the order in which she learned to introduce solid foods to an infant. She emphasizes the importance of introducing a variety of vegetables and fruits and that "you should only introduce foods one food at a time because they [the baby] could be allergic." She also points out how "certain foods can't be given to them at certain ages, like you're not supposed to give them honey because it has botulism and you shouldn't give them popcorn or peanuts because they could choke." She states that all of this information was new to her. This new foundation of knowledge will be the basis for her daughter's nutrition in the coming years.

Though Tamara learned how to make lasagna and details on cooking safely and nutritiously, she does not cook at home – her mother does. Her mother once made vegetable soup from a recipe Tamara got at Options for Health. Jennifer Chandler, Health and Nutrition Coordinator at Teen Options, runs the Options for Health program and notes that most participants live with parents or grandparents. Often a participant's mother or grandmother plans meals, shops and cooks for the household. Tamara's experience confirms this and points to the need for healthy behavior programs to strategically include family members involved in meal planning and preparation in the future. Tamara may not cook *now* but she is learning the foundations of a necessary skill that will serve her and her child for many years to come.

Small Changes are Big News

Tamara also learned that "it's okay to exercise a little when pregnant." Now that she knows this and can attend fitness classes at Options for Health, Tamara gets more regular exercise by participating in belly dancing and hip hop classes. She does not exercise outside of class, but she was not exercising at all before Options for Health so this small change is a significant improvement.

It is also notable that Tamara now eats more frequent meals and snacks. "I eat at least a snack every hour and a bigger meal three times a day," she writes in her journal. According to Jennifer, Tamara was not eating enough to sustain her and her growing baby when she joined the class. Tamara set a goal in her journal to "eat less chips and candy and more vegetables." Two weeks later, she writes, "I made the change to eat more vegetables, but only the ones I like."

"I definitely see changes in participants' diets. It's sometimes very, very small but if somebody stops having Dr Pepper at nine o'clock every morning, I take that as a success."

– Jennifer, First 5 Provider

Connecting to Healthy Resources

In addition to what Tamara has learned at Options for Health, the program has been a gateway to community resources that will help her maintain a healthy lifestyle. When Tamara started the program, she was about four months pregnant and did not have a prenatal care provider. She reports that the program connected her to a doctor and she also found WIC and Narcotics Anonymous meetings through the program.[1, 2]

Creating Role Models

Both Tamara and Jennifer note how Options for Health shapes mothers into role models of healthy behaviors for their children. Tamara writes in her journal about how she wants to "start out teaching and encouraging [my daughter] to eat healthy at a young age, and set a good example by eating what I would want to see my daughter eat." Jennifer shares that vision for Tamara and the other participants' children. "I hope [participants] continue to leave out the soda until later in the day. It's that role model piece. I try to remind them that it's not just their health but they're showing their kids what's good and what's not," said Jennifer. Tamara wants what is best for her child and programs like Options for Health equip Tamara and other parents with the knowledge, skills, and resources necessary to be healthy parents of healthy kids.

[1]WIC stands for "Women, Infants, and Children". It is a government-funded supplemental food and nutrition program for low-income pregnant, breastfeeding, and postpartum women and children under age five who have a nutritional risk.
[2]Narcotics Anonymous is an international, community-based association of recovering drug addicts. Members meet regularly to support each other during recovery.

Making the Connection

In this first year, the focus was on establishing services and developing evaluation tools. In the coming years there will be more detailed results to report. However, there are two important system related components of establishing parent education services for which there are notable results: establishing curricula and orienting programs in First 5's larger context.

Establishing Curricula: The Sustainability of Adopting and Adapting

Interviews with First 5 for Parents contractors revealed that most programs have modified an existing curriculum that is evidence-based or a promising practice to suit their target population. Common modifications include restructuring activities to address different age ranges or to adapt to space constraints; making materials more culturally responsive such as altering recipes for a cooking class and translating materials; and shortening the length of a course in order to make it meet the time constraints of new parents. Most, if not all, programs that were initially categorized as utilizing a best practice curriculum found the need to modify the materials or approaches.

A Fork in the Road: Design Issues in Creating the Parent Education Project

The goal of the First 5 for Parents Project is to strengthen parents' role as their children's first, and most important teachers. The intent is for First 5 for Parents programs to focus on parenting skills, early learning, and exercise and nutrition promotion.

When the Commission staff designed the First 5 for Parents Project, it considered two options: 1) Identify a specific evidence-based parent education model (which would have an established evaluation design) and select contractors to implement it; or 2) Allow contractors to identify and implement a wider variety of curricula to address the specific needs of communities they target. First 5 San Diego would then work with contractors to develop a way to evaluate the collective impact of disparate programs. The Commission chose the second option, yet remained committed to measurable results. To this end, the First 5 for Parents Request for Proposals (RFP) laid out a series of knowledge and behavior outcomes for applicants to address. This attempt to overlay measurable results on dissimilar programs is not a perfect solution. Programs address the same outcomes in such different ways that measuring their collective impact is difficult.

As a result, First 5 for Parents includes a variety of programs with different audiences, curricula, service modalities and focus areas under the broad umbrella of parent education. This presents a unique challenge in telling a cohesive story while remaining true to individual program challenges and accomplishments.

In the future, the Commission may want to consider the challenges that this blending of strategic and responsive funding pose to their legislative mandate to conduct results based accountability.

First 5's Larger Context: The Need to Anchor First 5 for Parents

Interviews with key experts suggest that community leaders in early childhood sectors are not yet fully aware of First 5 for Parents. There are a number of opportunities First 5 for parent contractors could take to enhance participation in their programs. For example, contractors could partner with the YMCA and have their Childcare Resource Services hotline recommend that parents seeking information consider attending a First 5 parent development class. Similarly, teachers in School Readiness and Preschool for All programs could be contacted and encouraged to provide parents with information on First 5 for Parent classes. In the coming year, First 5 for Parents contractors are already planning to promote their programs to parents and other First 5 contractors. For example, a representative from First 5 for Parents plans to present at an upcoming meeting of Oral Health Initiative partners.

Recommendations

- **Link First 5 for Parents programs to other programs and initiatives**. Given that interviews with key experts suggest that community leaders in early childhood sectors are not yet fully aware of First 5 for Parents, there are opportunities to promote First 5 for Parents programs to parents and community leaders. One avenue for promotion is to cross-train providers from existing First 5 San Diego initiatives. This would give providers the necessary information about the First 5 for Parents to promote the Project among their clientele and expand the scope of available services to children and families.
- **Learn from the wide base of existing curricula and narrow the focus in the future.** Contractors currently use varied curricula and service modalities and address an array of topics. This variability poses a challenge for evaluating the individual and collective impact of the Project. This breadth, however, is also an opportunity to examine the curricula and methods used and create a learning community among First 5 for Parents providers. Individual and shared results can be used to identify one or more locally effective curricula that the Commission could support on a broader basis in the future.
- **Extend programming to a more ethnically and linguistically diverse audience.** One of the aims of the project at its start was to engage immigrant parents. Contractors have successfully engaged parents from Latino populations, but are serving other immigrants to a much lesser extent. There is an important opportunity to expand services to underserved immigrant populations, while maintaining services for Latino families.

A Final Word on the First 5 for Parents Project

The First 5 for Parents Project was launched this year and already 3,381 parents and 9,890 children ages 0-5 have received services across all regions of the County. Providers have selected parent education curricula that are evidence-based or promising practices and adapted them to meet the needs of the clients they serve. Additionally, the pilot evaluation has been created and implemented, providing the foundation for documenting common parental outcomes across disparate programs in subsequent years. The variety of curricula, service delivery methods and unique clientele offers an important learning opportunity that can inform delivery of these services in coming years.

CHAPTER 8

Non-Initiative Contractors and Activities

"Experience is the chief architect of the brain. Early childhood experiences are powerful enough to completely change the way a person turns out."

—Dr. Harry Chugani, M.D.

The primary efforts of the Commission are accomplished through its large-scale long term initiatives. However, the Commission also uses its Responsive Funds to invest in projects that target emerging needs in the community; funds Innovative Grants to support pilot projects and test emerging strategies; and supports long term investments in a targeted activity that builds infrastructure or supports the capacity of organizations serving children 0-5 and their families. This chapter reviews the contributions of First 5 grantees, contractors, and various Commission activities to enhance systems of care for young children and families and to increase community awareness of the critical importance of the early years.

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

The Kit for New Parents has been a flagship program of First 5 California since its launch in 2001. The Kit contains videos, books and other resources that provide information and tips on parenting and children's development. Since 2001, approximately 2.5 million Kits for New Parents have been distributed to parents and caregivers at no charge throughout California,[234] with over 208,000 distributed in San Diego County alone. Locally, the Kit is distributed by UCSD Regional Perinatal System, the Welcome Baby Program (WBP). WBP partners with over 800 local agencies, such as clinics, hospitals, and resource centers, that in turn issue the Kits to the parents they typically serve.

***Commissioner Ron Roberts along with other Commission staff, contractors, and members of the community unveiling the new Kit for New Parents**

In spring of 2007, a new Kit was launched, containing DVD's, a developmental guide book, the health book What to Do When Your Child Gets Sick, a developmental growth chart, local resources for parents and a board book for parent/child reading. Commission Chair Ron Roberts held a press conference in April to highlight the release of the new Kits in English and Spanish and WBP helped organize community awareness events at each of the six Health and Human Service Agency regions. The awareness campaigns and the new Kit may have had a positive impact, as the number of Kits

[234] First 5 California. "Kit for New Parents Q & A." Accessed 4 September 2007. <http://www.ccfc.ca.gov/kit/documents/QA.DOC>

distributed in FY 2006-07 (47,360) was the highest number ever distributed since the project's inception.

WBP convened eleven Creating Teachable Moments (CTM) trainings for community organizations to demonstrate how to fully utilize the Kit with parents. The goal of these sessions is to train staff distributing the Kit on its content and on strategies to increase hands-on discussion of the Kit with clients. Survey results from English and Spanish-speaking providers who attended CTM from 2004 to 2006[235] revealed that out of 283 participants, more than half (61.5%) rated their ability as "very high" and 28.5% "high" in terms of:

- Familiarity with the content of the Kit;
- Recognizing a teachable moment;
- Assessing parent's readiness to change and individualize parent education approaches;
- Ability to orient and train other staff members.

WBP evaluates its Creating Teachable Moments trainings annually and works to refine them to best fit their distribution partners.

The New Kit for New Parents

The new Kits are currently available in English and Spanish. The briefcase-style box contains an educational DVD, easy-to read parenting guides, a tactile story book, brochures on raising a healthy child, a poison control magnet, information on Healthy Families low-cost medical care, What to Do When Your Child Gets Sick and other supportive materials.

The new Kit is targeted for future release in Chinese-Mandarin, Korean, and Vietnamese.

YMCA Childcare Resource Service, San Diego CARES

The goal of the San Diego CARES (Comprehensive Approaches to Raising Educational Standards) program is 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. CARES is an inclusive program, available to family child care providers and early education/preschool teachers. Launched by First 5 California in FY 2001-02, CARES receives 80% of its funding from the First 5 Commission of San Diego County and 20% from the State Commission.

CARES provides stipends to teaching and administrative staff to reward and encourage educational attainment. As redesigned in 2005, CARES participants are assigned to one of the following five tracks in to work toward a CARES Stipend: [236]

- Family, Friend & Neighbor
- Entry Level (less than 6 units)
- Permit Level (6 units or more)
- Degree (B.A. and M.A.)
- Professional (CARES Advisor for lower track participants)

[235] UCSD Regional Perinatal System, Welcome Baby Program. Creating Teachable Moments with the Kit for New Parents English and Spanish Trainings, Evaluation Summary FY 2004/2005 & 2005/2006.

[236] First 5 California. CARES Training and Technical Assistance Project: About the Project. 2007. Accessed 14 September 2007. <http://cares.w4qcc.org>

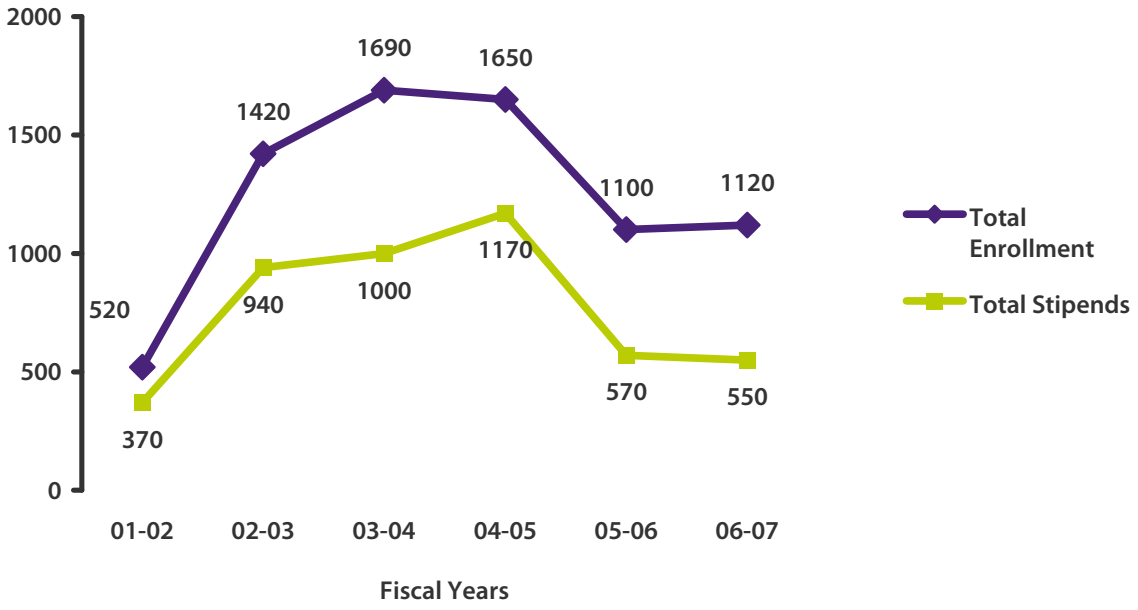
During FY 2006-07, there were approximately 1,120 participants enrolled in CARES. Of those who initially enrolled, 550 (49.1%) completed their coursework and received a stipend. As Exhibit 8.1 shows, in the first four years of the program, CARES enrollment increased dramatically. In its first year the program enrolled 520 participants, and at its peak in FY 2004-05 it had 1,650 participants, an increase of over 200%. The number of stipends paid also increased by over 200%, from 370 in FY 2001-02 to 1,170 in FY 2004-05. However, in FY 2005-06, the number of enrollments and stipends fell to 1,100 and 570, respectively.

The History of CARES

The California *Compensation and Retention Encourage Stability* (CARES) initiative originated in 1997 in response to a major child care crisis throughout the State. At that time, child care centers and family child care homes struggled with high turnover rates and under-qualified staff. The Center for the Child Care Workforce, along with a coalition of other service providers, developed an initiative which would increase highly skilled providers and staff retention with the use of rewards. This would be accomplished by compensating providers for their experience and providing payment of incentive stipends in support of ongoing education. Since its inception there has been an increase in professional development activities offered to child care workers, in community college enrollment, and in the number of new providers applying for child development permits. While the California Department of Education allocates stipends to state-subsidized child care providers, First 5 California and local First 5 Commissions provide incentives for non-subsidized child care workers. Most all of California's 58 counties have implemented the CARES program model and have modified it to best serve their communities. First 5 California renamed CARES as *Comprehensive Approaches to Raising Educational Standards*.

Source: First 5 California. CARES Training and Technical Assistance Project: CARES History. 2007. <http://cares.w4qcc.org>

Exhibit 8.1 San Diego CARES Participants: Total enrollment vs. total stipends by year



These changes in enrollment and stipend numbers are likely due to modifications in the CARES program model over time. In FY 2003-04, requirements for entry into the CARES program and stipend eligibility were restructured in an effort to increase enrollment numbers. For example, a pre-entry track was created to allow providers with less than 6 units of coursework to participate, and participants could receive stipends for attending professional trainings rather than completing college coursework. While this change increased enrollment numbers, it did not promote the key CARES goal of raising the education level of ECE teachers. In FY 2005-06, the CARES program model was again modified, creating five different tracks (listed above) and tightening eligibility requirements for reimbursement. Stipends are now paid for completion of coursework that helps ECE teachers move toward attaining a credential, or an AA or BA degree. Further modifications to the CARES model will continue with the intent of increasing program participation in the coming years.

"SD CARES has encouraged me to continue my education and in doing so I have improved on the quality of care and education that my students and parents receive. Thank you."

- First 5 San Diego CARES Participant

One goal of the CARES Initiative is to ensure the retention of child care providers. However, the San Diego CARES Year Five (i.e., 2005-06) Report notes that it has become increasingly difficult to retain ECE staff as they increase their level of professional development.[237] The report also states that a high level of turnover in the profession will continue as long as wages remain low in the early care and education field. As ECE teachers increase their education levels, they are more likely to leave their position for higher pay.

In a review of data through FY 2005-06, San Diego CARES reported a dramatic decline in teachers participating in CARES after four years, suggesting that participants change agencies, leave the childcare field or have completed or discontinued their educational goals.[238] And, while no additional retention survey has been conducted by San Diego CARES since FY 2004-05, the recently released California Early Care and Education Workforce Study found the average turnover rate across all counties in Southern California was 22%, the same rate calculated in the 2004-05 San Diego CARES evaluation.[239]

Participants continue to give San Diego CARES high ratings in terms of how the program has affected their ability to: provide quality childcare, effectively work with parents, learn new skills in working with children and stay motivated to continue their education (see Exhibit 8.2 for findings from FY 2004-05 and 2006-07). [240]

[237] Bassoff, Z.B., J. Tatlow. San Diego CARES Year Five Report Participant Experiences to Date and Year Five Survey on Retention and Impact on Child Care Practices. 2006. Evaluation Report to the YMCA Childcare Resource Service. San Diego, CA: Health and Human Services Consultants of Southern California, 2006.

[238] Ibid.

[239] Center for the Study of Childcare Employment, Institute of Industrial Relations, University of California at Berkeley. California Early Care and Education Workforce Study: Licensed Child Care Centers and Family Child Care Providers. Berkeley, CA: California Child Care Resource and Referral Network, July 2006.

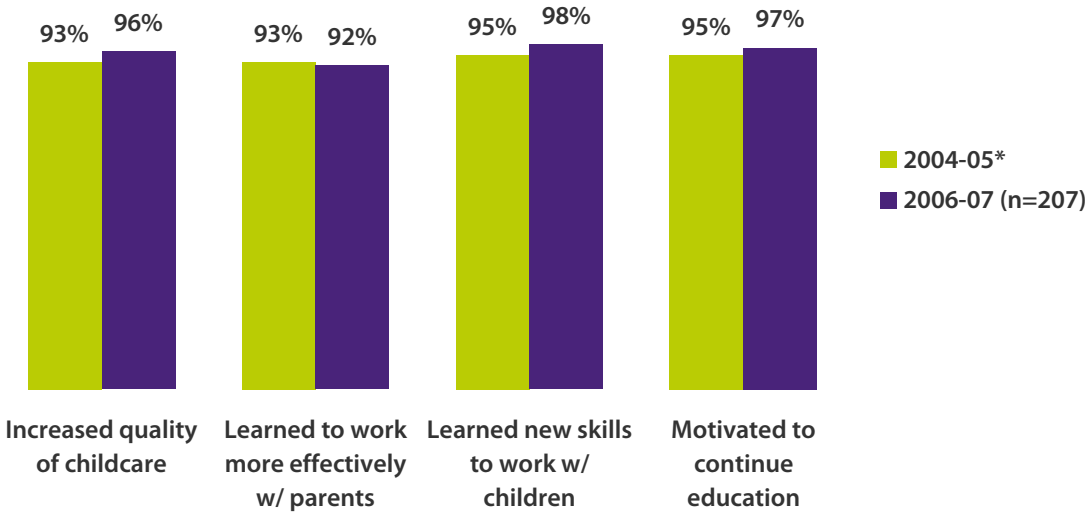
[240] YMCA Childcare Resource Service Participant Satisfaction Survey Results. San Diego CARES. 2006-2007.

Recent San Diego CARES participant satisfaction surveys also reveal that most participants favorably rate the service of CARES staff and the ability to receive information from them (90% and 89%, respectively). Although most opinions about the program remained positive, about 39% of respondents found completing the program requirements challenging for some of the following reasons:

- Conflicts with work hours and class schedules;
- Lack of class availability;
- Cost of registration and books.[241]

Even with these challenges, 80% of the respondents felt these difficulties would not impede them from completing the program requirements.[242] Participants suggested more weekend and evening classes at colleges near their residence, as well as assistance with the cost of child care while attending classes would be beneficial.

Exhibit 8.2 San Diego CARES participants' perceptions by year



**The total number of respondents was not available.*

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. Locally, 2-1-1 is available 24 hours per day, 7 days per week. San Diego County's 2-1-1 information and referral service has been supported by First 5 San Diego since 2003 and has received ongoing funding from First 5 to broaden community awareness of the service, increase call handling capacity and provide ease of access to First 5-funded service providers throughout the County. In FY 2006-07, First 5 San Diego provided 41.5% of the 2-1-1's operating expenditures.

During FY 2006-07, 2-1-1 assisted over 105,000 callers in finding needed health and social services. Approximately one in four of these callers (22% or 23,100 individuals) were from families with children ages 0-5. Callers received information and referrals to service providers, including First 5-funded providers. These

[241] The CARES stipend is issued to a participant after classes are completed. Participants must pay upfront costs.
[242] Ibid.

referrals address a variety of needs including child abuse prevention, basic needs (e.g., food and shelter), public assistance, drug treatment, financial assistance, legal services, physical and mental health services and parenting programs.

As of September 2006, 2-1-1 enhanced its database to begin tracking referrals to First 5-funded providers and document the extent to which 2-1-1 is used by San Diego County families to connect with First 5 services. Documented calls between October 2006 and June 2007 indicate that callers had been referred to services funded through each of First 5 San Diego's initiatives including Health and Developmental Services, Healthcare Access, Oral Health, School Readiness, Preschool for All and First 5 for Parents.[243] Among referrals for children 0-5 generally, callers requested information about a number of supportive services including Head Start, primary medical care, child welfare services, family planning, WIC, adult education, shelters, food assistance and legal services.

2-1-1 San Diego celebrated several milestones in FY 2006-07:

- Earned accreditation from the Alliance of Information and Referral Systems (AIRS) meeting the AIRS Standards for Professional Information and Referral;[244]
- Completed installation of an upgrade to the communications system, funded by a First 5 Capital grant[245] that is estimated to double call handling capacity;[246]
- Added key terms to identify First 5-funded contractors and initiatives to the 2-1-1 database to better track referrals made to First 5-funded agencies and added "First 5" to their program names in the 2-1-1 online Web Inform database available at http://www.informsandiego.org;[247]
- Partnered with HDS providers to respond to media coverage of the Newborn Medical Home Visitation programs and provide information to callers referred to 2-1-1 for information about Health and Oral Health via advertisements on KPBS and associated media sources;[248]Increased capacity to serve as a lead agency for emergency public health information and disaster response through participation in emergency drills, installation of an emergency power generator and upgrade of the telephone circuit to enable remote operations capability in the event of a disaster.

Numbers at-a-glance

2-1-1 San Diego assisted over 105,000 callers in finding needed health and social services during FY 2006-07, of which approximately one in four (22%) have children ages 0-5.

[243] At present, 2-1-1 does not directly track the number of callers with children 0-5 who are referred to First 5-funded services; 2-1-1 documents referrals to First 5-funded agencies, however these agencies have multiple projects that are not funded by First 5and would inflate the number of referrals to First 5-funded programs. Therefore, it is not possible to accurately count the number of referrals to First 5-funded programs in particular or the frequency of these requests relative to other needs.

[244] Alliance of Information and Referral Systems (AIRS) Accredited Agencies. Available at http://www.airs.org/aboutairs/about_accreditation.asp; Accessed September 24, 2007. AIRS and the United Way partner to promote the adoption of 2-1-1 referral services nationally. (See http://www.airs.org/lookingfor211.asp for more information about AIRS' 2-1-1 initiative.)

[245] 2-1-1 San Diego Quarterly Progress Report to the First 5 Commission of San Diego, submitted July 31, 2007.

[246] 2-1-1 San Diego Quarterly Progress Report to the First 5 Commission of San Diego, submitted April 30, 2007.

[247] The 2-1-1 database includes the key term "First 5" as part of the program name of First 5 contractors in the 2-1-1 resource directory. This identifier only identifies the agency as a First 5 contractor and does not differentiate between First 5 and non-First 5 services provided by these agencies, making tracking of referrals specifically to First 5 services difficult. In addition, 2-1-1 Inform San Diego online resource directory (http://www.informsandiego.org/WebInform/ResourceDatabase/RDMain.asp) does not allow searches by the key work "First 5".

[248] More information on the Health and Oral Health Media Campaign can be found on page 177.

To understand the quality of services provided, 2-1-1 internally conducted a Client Satisfaction Survey in August, November, January and April that included a convenience sample of 389 individuals who called 2-1-1 for services and were willing to take the survey. Of these respondents, approximately 32% of survey respondents were either pregnant or parents of children ages 0-5. Ninety-nine percent (99%) of respondents were satisfied with the 2-1-1 San Diego services and 98% indicated that 2-1-1 was helpful and that they would use the service again. Additionally, nearly all (98%) respondents said the 2-1-1 representative understood their needs either "very well" (88%) or "mostly" (10%). And nearly two-thirds (66%) indicated that they understand "much better" what help is available as a result of contact with 2-1-1, with 21% understanding "somewhat better."[249]

"A very useful service – somewhere to go when you don't know where to go."

– 2-1-1 caller

To determine whether callers of 2-1-1 utilized services as a result of calling 2-1-1, a small sample of those who completed the Client Satisfaction Survey agreed to participate in a 2-1-1-commissioned Client Follow-up Survey (n=95) conducted two to three weeks after the person's initial call. Of these respondents, nearly everyone remembered calling 2-1-1, with the majority reporting that they received a referral (98%) and tried to call or visit an agency they were referred to (92%). Of those who tried to access the service, 64% reported that the agency they called or visited met their needs. The most commonly reported reason for the service or agency not meeting their needs included incorrect or unanswered phone numbers.[250] Beginning in FY 2007-08 First 5 will initiate a "secret shopper" evaluation to assist 2-1-1 with improving the quality of service referrals.

Capital and Equipment Grants: Building Critical Infrastructure

There are limited funding sources for public and nonprofit agencies seeking to make infrastructure improvements. In response to a critical community need, the Commission approved the Capital and Equipment Campaign in FY 2004-05, which allotted a one-time expenditure of $60 million to invest in the physical infrastructure of programs that support children ages 0-5. The Commission approved the release of funds in three separate funding cycles. Exhibit 8.3 displays the projects that received funding for capital improvements during FY 2006-07.

Exhibit 8.3
Capital Project and Equipment Grants

Capital Improvements	Funds Used
Cal State University, San Marcos	Construct an Early Education Center, playground and parking area on the CSUSM campus.
Chula Vista Elementary School District	Purchase and install a modular classroom at Rice Elementary School to serve young children exposed to domestic violence and their families. Services will include: preschool, intake and assessment, children's group and individual counseling, parent and child play groups and parent education.

[249] The CAPSTONE Group. "2-1-1 San Diego Client Satisfaction Evaluation Report: FY0607." San Diego, CA: June 2007.
[250] Ibid

Exhibit 8.3 (continued) Capital Project and Equipment Grants	
Capital Improvements	**Funds Used**
Fallbrook Union Elementary School District	Construct and furnish an Early Childhood Learning Center, which will include two preschool classrooms, one special education classroom, two walk-in-and-play classrooms, a parent education room, a playground and support areas.
Family Health Centers of San Diego	Substantially expand health clinics located in North Park and Logan Heights to enhance services to children 0-5 and their mothers.
National School District	Purchase and install four portable preschool classrooms, three playground structures and renovate two existing preschool classrooms.
Neighborhood Healthcare	Purchase and renovate a building for prenatal programs and healthcare services.
San Diego Public Library	Designate special areas for preschoolers in four new libraries to promote school readiness and literacy.
Operation Samahan	Purchase screening and diagnostic equipment for fetal and pediatric diagnosis at the Perinatal and Pediatric Clinic, as well as office equipment and enhancements to the childcare reading room.
St. Vincent de Paul Villages	Construct a new facility to house St. Vincent de Paul Village's comprehensive therapeutic childcare services.
Santee School District	Purchase indoor and outdoor equipment that meet the standards of the National Association for the Education of Young Children.
San Ysidro Health Center	Construct a new health clinic to serve children 0-5 and their mothers.
San Ysidro School District	Construct a permanent preschool classroom, a resource room and a playground structure.
U.S Department of the Navy, Navy Region Southwest	Construct two new Child Development Centers at the Murphy Canyon and Coronado-Naval Air Station communities.
2-1-1 San Diego (INFO line of San Diego County)	Purchase 30 workstations and equipment for the resource and referral call center.

Innovative Grants: Responding to Emerging Needs and Strategies

The majority of the Commission's resources are devoted to multiyear initiatives that utilize evidence-based or proven practices. The Commission also recognizes its role in supporting innovative practices and supports these efforts by allocating monies to new projects that encourage the development and application of new service approaches or techniques that assist the overall development of children 0 to 5 and their families. Toward that goal, the Commission awards one-year Innovative Grants for up to $75,000 to enable organizations to pilot unique approaches or expand successful strategies in new ways or to new communities. Exhibit 8.4 showcases the 14 Innovative Grants approved during the FY 2006-07. Each program displayed provided direct services to young children and/or their families.

Exhibit 8.4
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.
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 *Healthy Preschoolers Program*	Combats childhood obesity at the preschool level by providing physical activity & nutritional education for children, parents and Healthy Start staff
Kids Included Together-San Diego Kit	Trains and supports early educators at six Navy child care facilities, to build inclusive environments that increase school readiness of children with special needs and disabilities.
La Cuna, Inc. *Individualized Therapy and Support Project*	Provides a therapist to work with foster children to ensure their emotional and social development is not harmed by their earlier childhood experiences. It also provides ongoing, intensive therapy to all its foster parents and children.
Palomar Family Counseling Service *Preschool Behavioral and Developmental Health*	Addresses behavioral and developmental disorders of children at preschool sites.
Rady Children's Hospital San Diego *Center for Healthier Communities*	Provides low-income women or parents of children ages 0-4 with necessary resources and skills to combat obesity.

Exhibit 8.4 (Continued) Innovative Grants	
Grantee/Program	**Description of Project/Services**
Ramona United Methodist Preschool *Gymnastic Camp*	Provides daily gymnastic classes for eight weeks throughout the summer for young children to combat childhood obesity at the preschool level.
Riding Emphasizing Individual Needs & Strengths (REINS) San Diego *Therapeutic Consulting Partnership*	Provides therapeutic riding lessons to children with a variety of severe disabilities.
SDSU Foundation Exceptional Family / Resource Center (EFRC) *Systematic Neonatal Intensive Care Unit Referral Project*	Works with the social work staff at 13 hospitals to develop and implement a common referral protocol for support services for families of infants in the NICU (Neonatal Intensive Care Unit).
Santee School District *Children & Families Ready 4 School PAL Innovative Project*	Provides on-site parent participation school readiness classes to families living in the subsidized housing projects.
Scripps Memorial Hospital La Jolla *The Parent Connection*	Conducts monthly parenting classes for groups of 12-15 fathers who have children ages 0-1 years.
Social Advocates for Youth (SAY) San Diego, Inc. *Stepping Up Start Smart*	Expands the Start Smart weekly parent/child interactive classes into four low income apartment communities; adds additional parent-managed playgroups; and expands the curriculum to reinforce parents' commitment to continue a positive learning environment at home.
UCSD School of Medicine *Substance Abuse Screening for Women*	Provides screenings and referrals to pregnant women at risk for substance abuse and assists in connecting women in need with treatment services.

American Academy of Pediatrics: Reach Out and Read

The concept for Reach Out and Read (ROR) was born from the desire of a group of pediatricians working in urban clinics to help improve the literacy levels and school success of children in low-income neighborhoods. In 1989, with the help of early childhood educators, pediatricians developed the ROR, a program which uses regular medical exams as a vehicle to develop parents' literacy skills and provides books to children of low-income families.[251] ROR trains physicians and nurses in three linked interventions: 1) promoting reading aloud as an integral part of well child visits; 2) providing developmentally and culturally appropriate picture books to families; and 3) engaging community volunteers to read to children in the waiting rooms while modeling developmentally appropriate techniques for the parents.[252]

Research has found that young children who grow up in literacy deprived homes show less interest in learning and do more poorly in school.[253] National studies of ROR found that between 10%-40% of its clients reported having no children's books at all until they received their first ROR book.[254] ROR research also found that parents in urban primary care clinics who had been given picture books were approximately four times more likely to report reading aloud as a favorite activity than parents who had not been given books.[255] Since its inception a decade ago, ROR has expanded to 3,289 hospitals and health centers in 50 states with 46,571 physicians and nurses trained in the ROR strategies. Doctors and nurses distribute more than 4.6 million new, developmentally appropriate books to families of more than 2.8 million children across the country annually.[256]

In FY 2006-07, First 5 San Diego recognized this model as an optimal, low cost, effective means to support the early literacy of the county's children. As part of its Responsive Grants program, the Commission approved $37,754 in funding over three years to strengthen and expand the existing Reach Out and Read program in San Diego County. This funding will enable ROR to expand the local program to 22 more sites; assist in developing more literacy rich waiting areas, as well as train medical staff and new volunteers. To date, 38 pediatric clinics in San Diego County utilize the ROR model and there are 34 active volunteers. Last year, 44,000 books were distributed to 33,000 children at doctors' offices participating in ROR. First 5 San Diego's investment in ROR assisted in building the program's capacity and infrastructure, which has been critical to ROR's overall success in San Diego.

SDSU Foundation/KPBS and First 5 San Diego

First 5 San Diego invested $4 million for a variety of media campaigns that were conducted by KPBS (the local public television and radio station) from 2001 through 2007. KPBS provided educational information to parents through various marketing and media activities.[257]

[251] reachoutandread.org. 2003-2006. 22 August 2007 < http://www.reachoutandread.org/about.html>.
[252] Needlman R, Klass P, Zuckerman B, "Reach out and get your patients to read," Contemporary Pediatrics (2002) 19:1
[253] reachoutandread.org. 2003-2006. 22 August 2007 < http://www.reachoutandread.org/about.html>.
http://www.reachoutandread.org/FileRepository/PolicyCaseForROR.pdf>.
[254] Needlman R, Klass P, Zuckerman B, "Reach out and get your patients to read," Contemporary Pediatrics (2002) 19:1
[255] Ibid.
[256] reachoutandread.org. 2003-2006. 22 August 2007 < http://www.reachoutandread.org/about.html>.
[257] All process and service delivery numbers originate from documents provided to Harder+Company by KPBS.

From May 2005 through June 2007, KPBS partnered with KGTV/Channel 10 and Univision (a Spanish language media outlet) to spearhead the Commission's Health and Oral Health Media Campaign. The campaign included four interstitials, news segments, a website, phone banks, community events and bus tails to provide information to parents and caregivers on health and oral health topics. Its targeted messages addressed: raising a healthy child, preventive health care, oral health, health insurance, and early screening for infant health and child developmental delays.[258] According to KPBS figures, these TV spots reached 85,000 households a week on Channel 10 and 12,000 households a week on Univision.[259] Two focus groups were conducted-- one for English-only speakers and the other for Spanish speakers – to test the effectiveness of the messages, the interstitials, the First 5 for Kids website and other resources that were part of the Health and Oral Health Media Campaign. Overall, focus group participants found that messages were useful in teaching them how to improve their child's overall development. The workshops, television and online resources helped participants become more aware of how to improve their child's physical and oral health.[260] The Commission has decided to cease launching discreetly focused media campaigns and engage the services of a public affairs and media consultant beginning in FY 2007-08 to better integrate its public communications with its initiatives and the priorities identified in its Strategic Plan.

"They put a couple of things that I don't think people know or realize. People like to kiss their babies on the mouth, put food in the baby's mouth out of theirs and most people don't know you should not do it […] A lot of people don't know that you have cavities and not taking care of your mouth while you are pregnant could very well affect your child…"

– Comment by parent about the KPBS interstitial on transmitting cavity-producing bacteria

[258] The Health and Oral Health Campaign ended in May 2007.

[259] KPBS FY2006-07 PowerPoint presentation entitled "Partnership Review": no date.

[260] KPBS contracted with C.L. Gailey Research to conduct the focus groups. Results were published in the report: First 5 for Kids: Health and Oral Health focus group. Encinitas, CA: C.L. Gailey Research. 2007.

Appendix A: Contractor Directory

1. Health Care Access Initiative

- *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. Health and Developmental Services Initiative

- *American Academy of Pediatrics, California Chapter 3 – Countywide Coordinator*
- *Family Health Centers of San Diego – Central Region*
- *Family Health Centers of San Diego – East Region*
- *Palomar Pomerado Health – North Inland Region*
- *Rady Children's Hospital – North Central Region*
- *Rady Children's Hospital – North Coastal Region*
- *South Bay Community Services – South Region*

3. Oral Health Initiative

- *Community Clinics Health Network*
- *Family Health Centers of San Diego*
- *Neighborhood Healthcare*

4. School Readiness Initiative

- *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*

5. Preschool For All Demonstration Project

- *San Diego County Office of Education*

6. Intergenerational Initiative

- *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*

7. First 5 for Parents Education Project

- *Bayside Community Center*
- *Catholic Charities*
- *Jewish Family Services of San Diego*
- *National City Public Library*
- *North County Health Services*
- *SAY San Diego*
- *St. Vincent de Paul Village, Inc.*
- *San Diego Youth & Community Services*
- *The Regents of University of California, San Diego/UCSD Community Pediatrics*
- *University of California-Cooperative Extension*

8. Non-initiative contractors and activities

- *Community Strengthening and Awareness*
- *Provider Capacity Building and Support*
- *Systems Change*
  - *Capital Campaign*
  - *Innovative Grants*
  - *2-1-1 San Diego*

1. Health Care Access Initiative

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.

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Neighborhood Healthcare
East Region
Neighborhood Healthcare provides education, outreach, retention, and healthcare application assistance for children and pregnant women in the East region in collaboration with Family Health Centers of San Diego, Home Start Inc., La Maestra, Mountain Health and Community Services, and San Diego Youth and Community Services.

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North County Health Services
North Inland Region
North County Health Services is the lead in a partnership with Neighborhood Healthcare and Fallbrook Family Health Center. These agencies work together to increase and sustain 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.

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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, Horn of Africa, O'Farrell Family Support Services, and Crawford Community Connection.

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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 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 Bayside Community Center, North Clairemont Healthy Start, and Operation Samahan.

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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. They work in collaboration with North County Health Services.

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2. Health and Developmental Services Initiative

American Academy of Pediatrics, California Chapter 3
Countywide Coordinator
Provides coordination of countywide approach to HDS vision and goals. AAP regularly convenes regional managers and lead staff to identify screening protocols and clinical pathways, develop referral guidelines, share best practices, create and implement standardized reporting and outreach strategies, and design quality improvement processes.

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Rady Children's Hospital
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. 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.

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Family Health Centers of San Diego
Central Region
Provides 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
- Palomar Pomerado Hospital- Welcome Home Baby
- Union of Pan Asian Communities (UPAC)
- Shiley Eye Mobile-UCSD
- YMCA Childcare Resource Service
- Home Start, Inc.
- San Diego Center for Children/ Therapeutic Services Inc.
- KIT Inc.

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Family Health Centers of San Diego
East Region

Provides 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
- Palomar Pomerado Hospital- Welcome Home Baby
- Shiley Eye Mobile-UCSD
- YMCA Childcare Resource Service
- Home Start, Inc.
- San Diego Center for Children/Therapeutic Services Inc.
- KIT Inc.

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Palomar Pomerado Health
North Inland Region

Provides a comprehensive continuum of health, developmental, behavioral, vision, hearing, speech screening, assessment treatment services to all newborns of first-time mothers and children ages 0-5 living in greatest poverty. Partners for this project include:
- Chadwick Center for Children & Families-RCHSD
- Children's Care Connection (C3)-RCHSD
- Exceptional Family Resource Center
- North County Health Services
- Palomar Pomerado Hospital- Welcome Home Baby
- Speech & Language Department-RCHSD
- YMCA Childcare Resource Service

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Rady Children's Hospital
North Coastal Region

Provides a comprehensive continuum of health, developmental, behavioral, vision, hearing, and speech screening, and treatment services to all newborns of first-time mothers and children ages 0-5 living in greatest poverty. Partners for this project include:
- Chadwick Center for Children & Families-RCHSD
- Children's Care Connection (C3)-RCHSD
- Exceptional Family Resource Center
- Home Start, Inc.
- North County Health Services
- Palomar Pomerado Hospital-Welcome Home Baby
- Speech & Language Department-RCHSD
- Vista Community Clinic
- YMCA Childcare Resource Service

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Rady Children's Hospital
North Central Region

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-RCHSD
- Children's Care Connection (C3)-RCHSD
- Developmental Screening and Enhancement Program-CAPF & RCHSD
- Exceptional Family Resource Center
- Home Start, Inc.
- Palomar Pomerado Hospital- Welcome Home Baby
- SAY San Diego Healthy Start Military Family Cluster
- Shiley Eye Mobile-UCSD
- Speech & Language Department-RCHSD
- Union of Pan Asian Communities (UPAC)
- YMCA Childcare Resource Service

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South Bay Community Services
South Region

Provides 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:

- Children's Care Connection (C3)-RCHSD
- Exceptional Family Resource Center
- Episcopal Community Services
- Home Care – RCHSD
- Paradise Valley Hospital
- Operation Samahan
- Imperial Beach Health Center
- Parents as Teachers
- American Lung Association
- YMCA Childcare Resource Service
- Shiley Eye Mobile - UCSD
- Speech & Language Department-RCHSD
- UCSD – Division of Community Pediatrics

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3. Oral Health Initiative

Community Clinics Health Network (Direct Services)
The purpose of the Oral Health Initiative (OHI) is to increase the number of children 0-5 and pregnant women 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:

- County Office of Ed., SMILES
- Rady Children's Hospital
- Share the Care
- Technical advisors and other professionals

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4. School Readiness Initiative

Cajon Valley Union School District
This program provides twice-weekly playgroups, available for two age groups at one school in the district. 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 homebased 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.

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Chula Vista Elementary School District

This program provides outreach to eight elementary schools with activities such as Kinder Camp, the Latino Family Literacy Project and Listos Para Leer. Intensive behavioral, speech, language, and other services are also available. Other programs and services include Family Readiness Advocates, and Early Intervention Mental Health Care. 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.

Kids on Track, a program for children and families with special needs provides outreach, screenings & referrals and case management to children from 0 to 5 with disabilities & other Special Needs or Mental Health Issues. The Special Needs Program (SNP) serves Harborside, Lauderbach, Montgomery & Otay elementary schools in the Chula Vista Elementary School District.

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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.

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National School District

Ready-Set-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.

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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.

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San Diego Unified School District
Early Link serves 26 elementary schools in 53 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. Developmental, 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.

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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:
stella@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 and playgroups for children 0-5. 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. Developmental, 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:** AnaliliaSanchez@vusd.k12.ca.us **Website Address:** www.vusd.k12.ca.us

5. Preschool For All Demonstration Project

San Diego County Office of Education The mission of the Preschool for All Demonstration Project (PFA) is to design, develop, and subsequently establish a multi-tiered service delivery model for preschool that will support the implementation of quality PFA programs at the local, regional, and countywide levels. The San Diego Office of Education is the lead contractor for providing PFA services and has subcontracted with the following preschool providers in the six target communities:	**Contact Name:** Lois Pastore **Phone:** (858) 292-3500 **Email Address:** lpastore@sdcoe.net **Website Address:** http://www.sdcoe.k12.ca.us/student/eeps/pfa/?loc=home
A+ Family Day Care	**Contact Name:** Veronica Schummer **Phone:** (619) 422-6584
Camacho/Ramirez Family Day Care	**Contact Name:** Raquel Ramirez **Phone:** (619) 424-7099
Carillo's Family Day Care	**Contact Name:** Maribel Carrillo **Phone:** (619) 527-8412

Child Development Association	**Contact Name:** Julia Childs **Phone:** (619) 477-9602
The Children's Company	**Contact Name:** Susan Holley **Phone:** (619) 421-9244
Escondido Unified School District	**Contact Name:** Jan Zelasko **Phone:** (760) 489-4131
Fuentes Day Care	**Contact Name:** Teresa Fuentes **Phone:** (619) 423-2066
Lemon Grove School District	**Contact Name:** Ollie Matos **Phone:** (619) 825-5727
MAAC Project	**Contact Name:** Edna Hollaway **Phone:** (760) 471-4210
National School District	**Contact Name:** Rita Palet **Phone:** (619) 336-8672
North County Serenity House	**Contact Name:** Dana Weevie **Phone:** (760) 746-5747

Paredes Family Day Care	**Contact Name:** Claudia Paredes **Phone:** (760) 480-0046
Ridgeview Preschool	**Contact Name:** Sarah Lopez **Phone:** (760) 751-9868
San Ysidro School District	**Contact Name:** Stella Ohnersorgen **Phone:** (619) 428-4476 Ext. 3583
South Bay Union School District-VIP Village	**Contact Name:** David Sheppard **Phone:** (619) 628-8690
Southwestern College CDC	**Contact Name:** Patie Bartow **Phone:** (619) 216-6695

6. Intergenerational Initiative

Bayside Community Center
Giant Steps – Generation to Generation
The Giant Steps program incorporated a senior mentor literacy component for children 0-5. The seniors read to children, and promoted 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.

Phone:
(858) 278-0771
Website Address:
www.baysidecc.org

Casa de Amparo
Take 5 for Tots
Casa de Amparo is an agency providing a continuum of services for abused and neglected children and their families in the North County area of San Diego County. The Senior Mentor Volunteer Program 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.)

Phone:
(760) 754-5500
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.

Phone:
(619) 644-7000
Website Address:
www.gcccd.edu

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.

Phone:
(858) 637-3000
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.

Phone:
(858) 715-2642
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 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.

Phone:
(619) 420-3620
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.

Phone:
(760) 741-0122
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.

Phone:
(619) 521-3055
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.

Phone:
(619) 543-9850
Website Address:
http://yfs.ymca.org/ymcasd_fscs.htm

7. First 5 for Parents Initiative

Bayside Community Center: Provide parent education, early literacy services and information supporting healthy behaviors using the Parent as Teachers model as well as the California 5-A Day plan for nutritional benefits.	**Contact Name:** Rose Ceballos **Phone:** (858)278-0771 **Email Address:** rose@baysidecc.org **Website Address:** www.baysidecc.org
Catholic Charities: Deliver a proven home-centered, age-specific curriculum. Staff shares knowledge and skills regarding early childhood development and literacy with CalWORKs and refugee families to demonstrate that "all parents will be their child's best first teacher".	**Contact Name:** Elizabeth (Liz) Kaye **Phone:** (619) 287-9454 Ext.167 **Email Address:** ekaye@ccdsd.org **Website Address:** www.ccdsd.org
Jewish Family Service of SD: Provide three different parent education components to support parents and their children: 1) Peaceful Parenting, gives parents the tools necessary to start early raising an emotionally healthy family; 2) Peace in the Home provides individual parent coaching for those families struggling with issues that need more focused attention; and 3) Intergenerational program supports early learning for families.	**Contact Name:** Alison Roland **Phone:** (760)944-7855 Ext. 139 **Email Address:** alisonr@jfssd.org **Website Address:** www.jfssd.org
National City Public Library: Provide accessible books and activities to children and their parents throughout National City via a book mobile.	**Contact Name:** Monica O'Hara **Phone:** (619) 470-5865 **Email Address:** monica.ohara@nationalcitylibrary.org **Website Address:** http://www.ci.national-city.ca.us
North County Health Services: Parenting classes are offered for caregivers of children ages 0-3 addressing issues related to behavior, stress, isolation, lack of parental support as well as improved relationship between child and caregiver. Childhood obesity and literacy are other areas that have been weaved into the curriculum. Specialty classes will also be offered for Fathers and Grandparents	**Contact Name:** Michelle D. Weedon **Phone:** (760)736-8661 **Email Address:** michelle.weedon@nchs-health.org **Website Address:** www.nchs-health.org

SAY San Diego, Inc.: Provide parent information & education through in-home and interactive, center-based activities. Includes weekly playgroups, parent education & support, home visiting & case management. Program incorporates NEAT (Nutrition Education Aimed at Toddlers). Provides developmental assessments where needed.	**Contact Name:** Bryan Jersky **Phone:** (619)582-9056 Ext. 233 **Email Address:** bjersky@saysandiego.org **Website Address:** www.saysandiego.org
St. Vincent de Paul Village, Inc.: Provide homeless parents, who are living at the Village's transitional housing facility for families and have at least one child age 0-5, with an array of opportunities to partner with their children, child care staff, and other parents to give their children the experiences and activities needed to prevent or mitigate low literacy. Services include home visits, "Parent and Child Together Time" and "Parent Participation in Childcare."	**Contact Name:** Angela Bull **Phone:** (619) 446-2124 **Email Address:** angela.bull@neighbor.org **Website Address:** www.svdpv.org
San Diego Youth & Community Services: Health and nutrition classes, healthy cooking classes, and exercise classes for young parents ages 12-25 and their children.	**Contact Name:** Jennifer Chandler **Phone:** (619)521-2250 Ext. 312 **Email Address:** jchandler@sdycs.org **Website Address:** www.sdycs.org
University of California – Cooperative Extension: Parent education workshops to assist parents of 0-5 in understanding developmental milestones, types of parent-child interactions that enhance development & promote social-emotional health & how to make home environments safe & nurturing.	**Contact Name:** Lori Renstrom **Phone:** (858)514-4976 **Email Address:** llrenstrom@ucdavis.edu
The Regents of University of California, San Diego/UCSD Community Pediatrics: Promote children's optimal physical health through coordination & oversight of nutrition & physical activity education services for caregivers of children ages 2-4.	**Contact Name:** Justine Kozo **Phone:** (619)681-0661 **Email Address:** jkozo@ucsd.edu

8. Non-initiative contractors and activities

UCSD Regional Perinatal System
Kit for New Parents: San Diego Welcome Baby Program
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 a parenting DVD, 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

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

Systems Change
Capital Campaigns

California State University San Marcos Foundation:
Cal State San Marcos Center for Children and Families
Grant Hubbard
(760) 750-4701

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

National School District:
Preschool/School Readiness Program
Rita Palet
(619) 336-8672

Neighborhood Health Care:
Neighborhood Healthcare Capital Project
DeWan Gibson
(619) 520-8313

Operation Samahan:
Samahan Clinic Perinatal and Pediatric Care Project
Fe Seligman
(619) 477-4451

San Diego Public Library:
Preschooler's Door to Learning Centers
Esther Siman
(619) 702-8702

Santee School District
Children & Families Ready 4 School
Hope Baker
(619) 956-5251

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

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

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
Healthy Preschoolers Program
Combats childhood obesity at the pre-school level by providing physical activity & nutritional education for children, parents, and Head Start staff.

Contact Name:
Molly Moran
Phone:
(619) 294-9585
Email Address:
molly@joyofsports.org

Kids Included Together-San Diego Kit
Inclusion Builds School Readiness
Trains and support early childhood educators in the system of six Navy Child Care Centers , serving 1063 children, to build inclusive environments that increase the school readiness of children with disabilities and other special needs.

Contact Name:
Sara Couron
Phone:
(858) 225-5680
Email Address:
sara@kitonline.com
Email Address:
www.kitonline.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
Palomar Family Counseling Services **Preschool Behavioral and Developmental Health** Support an on-site Preschool Behavioral and Developmental Health (PBDH) pilot project to address a growing list of behavioral and developmental disorders exhibited by the children they [child care providers] serve.	**Contact Name:** Irene Saper **Phone:** (760) 741-2660 **Email Address:** isaper@mdsn.com
Rady Children's Hospital San Diego **Center for Healthier Communities** Provides low income pregnant women or parents with children 0-4 years, visiting Family Resource Centers, with education, skills, and resources to initially "key" behaviors in their home environment aimed at preventing overweight.	**Contact Name:** Phyllis Hartigan **Phone:** (858) 566-7585 **Email Address:** phartigan@rchsd.org **Website Address:** www.rchsd.org
Ramona United Methodist Preschool **Gymnastic Camp** Provides daily gymnastic classes for eight weeks throughout the summer of 2007 for children 2.5 –5 years of age to combat childhood obesity at the preschool level.	**Contact Name:** Jill Bacorn **Phone:** (760) 789-3435 **Email Address:** jillbacorn@hotmail.com
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

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:
Diane Storman
Phone:
(619) 594-7405
Email Address:
dstorman@projects.sdsu.edu
Website Address:
www.EFRConline.org

Santee School District
Children & Families Ready 4 School PAL Innovative Project
Provide Parent Participation School Readiness classes to families living in the subsidized housing projects on site at their resource center.

Contact Name:
Hope Baker
Phone:
(619) 956-5251
Email Address:
hbaker@santee.k12.ca.us
Website Address:
www.santee.k12.ca.us

Scripps Memorial Hospital La Jolla
The Parent Connection
Conducts monthly parenting classes for groups of 12-15 fathers who have newborn to 1-year old babies.

Contact Name:
Daniel Singley
Phone:
(858) 344-4698
Email Address:
dsingley@dynamicbehaviorslutions.com
Website Address:
www.sbusd.k12.ca.us

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

UCSD, School of Medicine
Substance Abuse Screening for Women
Provides screenings and referrals for at-risk substance abusing pregnant women to assist them in seeking treatment and optimizing pregnancy outcomes.

Contact Name:
Francis Williams-Fant
Phone:
(858) 514-7545
Email Address:
frwilliamsfant@ucsd.edu

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

The First 5 San Diego local evaluation is designed to utilize a mixed methods approach, which combines quantitative (numbers) and qualitative (stories) methods. This approach 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 the voices of families served.

As in past years, the evaluation is guided by the Commission's Evaluation Framework, which provides a macro view of results to be achieved as defined by the strategic plan. 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 initiative and included in outgoing RFPs. 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 include parent surveys, child observation, and aggregated patient chart data. Additionally, the report includes quantitative data from subcontractor surveys, monthly or quarterly progress reports submitted to the Commission, 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 are complemented by qualitative methods to collect data from different vantage points and perspectives. Each initiative engaged parents and providers via qualitative methods such as case studies, focus groups, and key expert or "stakeholder" interviews to better understand the successes and challenges of initiative activities. 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.

Cross Initiative Methods

The following is detailed information about qualitative data collection that took place in multiple initiatives in order to obtain a cross project perspective of the impact of First 5 funded services.

Case Studies

The evaluation team conducted five case studies to understand in-depth the value of First 5 in parents and providers' lives. In addition, the case studies were designed to capture information detailing families' abilities to access multiple services, whether within a specific clinic or site, or across providers within a service network. 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. Families were selected from the following initiatives: one from Healthcare Access, two from Health and Developmental Services, one from School Readiness, and one from First 5 for Parents. Findings from each appear in their respective Initiative Chapter.

Focus Groups

A total of four focus groups with pregnant women (three in Spanish, one in English) were conducted in order to learn more about their health care access and oral health needs. In order to detect differences between

women already utilizing First 5 funded services and those not accessing these services, two focus groups with a total of 11 women were held at First 5 provider locations, while two with a total of 18 women were held at non-First 5 locations. The information from these groups was highlighted in the Healthcare Access Initiative and the Oral Health Initiative Chapters.

In addition, parents from SAY San Diego's Start Smart Parent Education Program participated in two focus groups (one in English, one in Spanish) to share how the program has affected their parenting skills. These results are provided in the First 5 for Parents Chapter.

For each focus group, the evaluation team contacted selected contractors and asked for their assistance in recruiting participants. The protocols were developed in collaboration with Commission staff. Participants were offered a $20 incentive, and food and childcare were provided. For each focus group, the evaluation team strove to have eight to 12 participants.

Subcontractor Survey

Many recent initiatives have included a lead-subcontractor structure that has changed how many key service providers interact with and perceive First 5. To understand the effect of this change in funding structure, Harder+Company distributed a survey to subcontractors under the Health & Developmental Services and Healthcare Access Initiatives. The survey was developed specifically to understand key areas of systems change, such as the leveraging of additional funds, and program's experiences working under a lead organization funded by First 5. All HDS subcontractors (n=24) were invited to complete the online survey. Agencies with subcontracts in multiple regions or across multiple service categories were instructed to complete the survey only once. A total of 16 responses were received, a response rate of 66.7%. The subcontractor survey was also received from ten out of eleven HCA subcontractors (90.9% response rate).

Key Expert ("Stakeholder") Interviews

Interviews with key experts were an opportunity to speak with influential members of the San Diego community who are outside of First 5 San Diego, but have insight about the system of care for young children and the Commission's work. The stakeholder interviews helped identify the successes and challenges of individual initiatives, as well as ways that 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.

Key experts were selected by initiative in collaboration with the First 5 Commission Staff. Harder+Company contacted the selected individuals from each entity five times before abandoning the interview effort. In total, 19 interviews were conducted.

Initiative-Specific Data Collection Strategies

Each initiative has its own evaluation design, derived from the key goal areas listed in the Commissions Request for Proposals (RFP). Each design contains both quantitative and qualitative methods to obtain in-depth information regarding each indicator. The following section provides an overview of each Initiative's data elements. Additional methodological details not provided in the Initiative chapter are also discussed. Qualitative analysis involved examination of trends and themes. Quantitative analysis typically included basic descriptive statistics and, as appropriate, chi-square and t-tests for statistical significance. Missing data (i.e., 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.

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.

Outcome Survey

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, each region utilizes an Excel spreadsheet tracking tool that is submitted 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.

In September 2006, the follow-up survey was modified to clarify items regarding health care utilization and to standardize the reasons for disenrollment across all follow-up periods. In addition, three questions were added to the survey:

- Reasons children visited the doctor, dentist, or emergency room
- Whether children visiting the doctor received immunizations

- Unique identifiers for each child were created so that next fiscal year the analysis will be able to follow individual children through their six, 12, and 18 month follow-ups, and determine more specifically when and how they become disenrolled.

Some of the changes make it difficult to compare FY 2006-07 to previous fiscal years: the previous survey asked whether or not children have utilized care *since being enrolled* and the new survey asks whether care has been utilized *in the past six months.* Thus, the survey analysis section in Chapter 1 incorporates the results of both the previous and new survey when possible.

Beginning in June 2007, survey administration procedures were also changed to match follow-up surveys over time. This will allow for individual-level analysis of program outcomes for families at 6, 12, and 18 months after enrollment, rather than examining trends at distinct periods of time. In addition, programs will institute a sampling plan in FY 2007-08 to reduce the number of follow-up surveys.

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 home	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, and 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	

Health and Developmental Services Initiative

During FY 2006-07, the HDS evaluation was completely operationalized to include outcomes measures, as well as the system level evaluation components. The evaluation relys upon Excel-based quarterly progress reports of HDS contractors for demographics and process data elements for each service category. Outcome data is reported twice a year, wherein contractors measure indicators and report via standardized Excel forms per indicator as appropriate to their programs. Outcomes forms were submitted to Harder+Company during February and July 2007. The systems-level evaluation examines the implementation and development of the HDS system of care and is primarily assessed via a subcontractor survey and qualitative measures, such as staff and stakeholder interviews.

Exhibit B.2
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	

Update to Outcomes Data Collection

Beginning in FY 2007-08, the outcome evaluation will be modified to improve data quality and to enhance to utilization of data. Previously, outcomes for all participants were reported in an aggregate form on a semi-annual basis. This method allowed for mid-course analysis of data; however, there were many cases where a follow-up measure had not yet been conducted, leaving many cases in a "pending" status and requiring

additional follow-up on an ongoing basis. To minimize this, outcome data will only be reported for cases where a disposition has been determined, meaning that pre- and post- measures have been conducted or that cases have become lost to follow-up. Although interim outcome data will still be reported at the mid-year point for quality checks, comprehensive outcome data reports will be provided at the end of the fiscal year for complete analysis.

Additionally, the breastfeeding and medical home outcome measures were modified so that individual outcomes can be tracked over time. Previously, data for these indicators were not matched, but rather collected on separate samples, which prevented the analysis from including a true comparison over time. In the new fiscal year, although data will still be collected in aggregate, service providers will report how specific clients changed from pre to post.

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.

OHI's six direct service goals are 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 received preventative and restorative dental care, and oral health education; and how many were connected to oral health services. In addition, the evaluation captures oral health provider education results.[294]

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.[295] All programs then report their aggregated monthly data in a customized, Excel-based tracking tool. In addition, qualitative methods complement numeric data in the evaluation design: four focus groups with pregnant women; and telephone interviews with three key experts in maternal and child oral health. The findings of all of these methods are interwoven throughout the chapter.

[294] "Providers" refers to prenatal care providers, general dentists, and other primary care providers.

[295] 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.

Exhibit B.3 Oral Health Initiative Evaluation Table		
Data Elements	**Related Goal(s)**	**Method of Collection**
Demographic data		
Children ages 0-5: ethnicity, language, age, special needs; Pregnant women: ethnicity, language	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 routine/specialty treatment	Goal 3	
Number of children ages 0-5 & pregnant women who receive care coordination services	Goal 4	
Number of children ages 0-5 & pregnant women who receive educational messages *	Goal 5	
Number of providers trained in relevant maternal & child oral health topics **	Goal 6	
Number & type of preventative services (sealants, fluoride varnishes, prophylaxis) delivered to children ages 0-5 & pregnant women	Goals 1-2	
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 with untreated dental decay	Goal 3	
Increase the proportion of children ages 0-5 & pregnant women who have visited a dentist in the past year	Goal 3	
Connect children ages 0-5 & pregnant women with needed oral health services (exams, treatment, etc.)	Goal 4	
Increase providers' knowledge of how to promote the oral health of children ages 0-5 **	Goal 6	

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 2006-07 evaluation report, the primary data drawn upon are the quarterly progress reports submitted to the Commission and child progress data. The quarterly progress reports provide process numbers according to State mandated categories and narratives. Child progress data includes the revised 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 quarterly progress reports to the Commission outlining numbers served, demographics, and narrative updates.

Exhibit B.4
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	Quarterly Progress Reports
Process measures data		
Number of parents taking classes focused on supporting child physical cognitive and socio-emotional development	RA1	Quarterly Progress Reports
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 Retrospective 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-R and ASQ*
Number of participants reporting satisfaction with the content, quality, and family centeredness of services	RA4	Parent Retrospective Survey

Updates to Analysis of Child Development Assessment Tools

This year marks a revision in the original DRDP instrument, including changes to each measure and response category. The types of analysis and developmental scales are congruent to previous years, but because of the change in the instrument, direct comparisons with previous program years cannot be made. In order to preserve connections to previous years and to the findings of the ASQ, the developmental domain categories from previous years were maintained: communication, gross motor, problem solving and personal-social. Therefore, general trends are suggested in the School Readiness chapter.

In FY2005-06, the Commission and Harder+Company sought recommendations from key developmental psychiatrists – Gary Resnick of Westat and Todd Sosona of the California Institute of Mental Health – for a tool appropriate for center-based interventions that could map to the DRDP. The Ages and Stages Questionnaire (ASQ) was suggested. The ASQ system is composed of 19 age-appropriate questionnaires and is designed to be completed by parents or primary caregivers.[296] The questionnaire for the age group closet to the child's age is used. Each questionnaire contains 30 developmental items that are divided into five domains: communication, gross motor, fine motor, problem solving, and personal-social.

This year, data was analyzed differently to reflect its intended use as a screener for developmental concerns at various ages.[297] Therefore, the analysis this year was enhanced in order to utilize the scientifically set cut-off scores for the ASQ's age-specific instrument, preserving the design of the tool while comparing children's status "above" or "below" the age-specified cut-off score at each point in time.

Parent Retrospective Survey[298]

In FY 2006-07, contractors administered the "Survey of Parenting Practice", a series of statements about knowledge, confidence, ability, and behaviors around parenting. When completing this section of the survey, parents responded to questions thinking about "now," after completing the parent education activity, and "then" before the activity. Ratings range from zero to six, with the higher the rating, the more knowledge, confidence, ability, or frequent behavior. This method of "retrospective" comparison allows for respondents to more accurately provide baseline data, compared to traditional pre/post methods, when participants tend to rate themselves higher before the intervention.

The post-test and retrospective pre-test responses to each of the 12 items were compared using a paired sample t-test, which compares the difference between the two mean ratings for each of the questions. Paired sample t-tests analyze the results when the same person reports at two different times or conditions. The advantage of the paired design is that it makes it easier to detect true differences when they exist.[299]

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[296] Brookes Publishing Co. Inc. Introduction to ASQ Second Edition. 2005. Accessed 10 October 2007. <http://www.brookespublishing.com/store/books/brider-asq/asq-introduction.pdf>

[297] The ASQ has two main purposes. First, the tool is used to screen large groups of infants and young children in order to early identify and accurately identify developmental delays and disorders in order to begin early intervention. The questionnaire also can be used to monitor the development that are at risk for developmental delays resulting from medical factors such as low birth weight, prematurity, or from environmental factors such as poverty, parents with mental impairments, history of abuse and/or neglect in home, or teenage parents (Squires, Jane, LaWanda Potter, and Diane Bricker. The ASQ User's Guide, 2nd ed, Baltimore, MD: Paul H. Brooks, 1995. 3-5) The ASQ intervals are 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54 and 60 months; each with age-appropriate questions and tailored cut-off scores.

[298] Methodology is the same for the Parenting Survey reported in the Preschool for All Demonstration Project.

[299] Shaklee, Harrie and Diane Demarest. Survey of Parenting Practice Tool Kit, 2nd Ed. University of Idaho. Boise, Idaho. 2005.

A Bonferroni adjustment is an analysis technique where the alpha level, or the chance of detecting a difference when one doesn't really exists, is decreased.[300] This is done to reduce the likelihood of getting a significant difference by chance alone (type 1 error). This technique was recommended by the authors of the survey tool in order to increase the validity of the findings. During analysis of the Parent Retrospective Survey, the alpha level was reduced from .05 to .004; statistical significance was reported at this reduced alpha level.

Preschool for All Demonstration Project

As stated in the PFA Chapter, the First 5 San Diego PFA evaluation plan weaves together three, interconnected components:

- First 5 California Statewide Power of Preschool (PoP) Evaluation to examine the impact of PFA statewide. Only one of the six San Diego PFA communities (National City) is also a PoP site.
- First 5 San Diego Evaluation Efforts to learn about the impact of the First 5 San Diego Preschool for All Demonstration Project at the six San Diego Communities (summative evaluation) and evaluate the how the implementation of PFA programs across San Diego impact existing preschool delivery models (formative evaluation).
- PFA Master Plan Evaluation to inform the update and expansion of the PFA Master Plan to improve the delivery of PFA once it is ready to be expanded and go to scale throughout the county (a future project).

Exhibit B.5 outlines the key data elements used for the PFA evaluation.

Exhibit B.5
Preschool for All Demonstration Project Evaluation Table

Data Elements	Method of Collection
Demographic data	
Children ages 0-5: ethnicity, language, special needs	Tracking Tool
Countywide Data	
Number of presentations inside/outside San Diego County	Tracking Tool
Number of meetings focused on the issues surrounding Work Force Development	
Number of stakeholders meetings held county-wide	
Community Data	
Number of Family Care Support Network Meetings	
Number of applicants (Letters of Intent)	
Number of PFA sessions/ Agencies who have a professional development plan in place	
Number of providers who submit a letter of intent who were not yet eligible to be selected as a	
Number of stakeholder events	
Session Data	
Number of sessions	
Number of fully funded and enhances slots	
Contacts from PFA support center/ HUB	
Number of parent involvement activities	
Number of early screening activities	

[300] "Bonferroni." Simply Interactive Statistical Analysis. Quantitative Skills Consultancy for Research and Skills. Accessed 6 August 2007. http://home.clara.net/sisa/bonhlp.htm

Exhibit B.5 (continued) Preschool for All Demonstration Project Evaluation Table	
Data Elements	**Method of Collection**
Outcome Data	
Number and percent of parents who demonstrate increased knowledge (confidence and competence) to promote child's optimal development and school readiness.	Parenting Survey
Number and percent of children making developmental progress in the areas of cognitive, social, emotional, language, approaches to learning and health/physical development	DRDP
Number of participants reporting satisfaction with the content, quality, and family centeredness of services	DRDP Parent Survey

In year one, all outcomes analysis mirrored the methodologies used in School Readiness. For more information on how the DRDP-R and Parenting Survey results were analyzed, please see the School Readiness section.

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. During FY 2006-07, five contractors participated in the provider (or "teacher") and the parent survey. 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 spring of the fiscal year. 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.6 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	Provider and Parent Survey Administered Annually
Increased knowledge of child's development	
Increased awareness of school readiness	
Increased early learning activities	

First 5 for Parents Project

The First 5 for Parents Project is the centerpiece of the Commission's Parent Development Initiative. FY 2006-07 marked the first year of this new initiative with a specific focus on parents as the first teachers of their children. In focusing on these primary caregivers who shape children's early experiences, First 5 for Parents seeks to strengthen parents' knowledge and encourage behavior change in three Service Focus Areas:

1. Developing more effective parenting skills
2. Promoting children's early learning and early literacy development
3. Fostering healthier behaviors with proper nutrition and exercise

To this end, 10 contractors were selected to provide parent education services in a variety of communities across San Diego County. Contractors are connected by a shared goal to educate parents, but they address this

goal in many ways. They have chosen to focus on different Service Focus Areas and audiences and implement a wide range of curricula and service modalities. Process and outcome data are measured through individual and common data collection tools in order to capture outcomes across the Project as well as provider-specific accomplishments and challenges.

Exhibit B.7
First 5 for Parents Evaluation Table

Data Elements*	Method of Collection
Demographic data	
Participant ethnicity and language	Monthly Progress Report
Process measures data	
Number of new parents	Monthly Progress Report
Number of new children ages 0-2 and ages 3-5	
Number of new families	
Number of seniors (for four intergenerational programs)	
Number of service units by type (classes, home visits, etc.)	
Other service count data available unique to individual programs (e.g.: number of books given out for National City Public Library	

*See tables in the following section for details on outcomes.

Outcomes Data Collection

Given the diversity of Service Focus Areas, audiences, curricula and service modalities, contractors collaborated during this first year to develop an evaluation plan for the First 5 for Parents Project that would measure common outcomes while accommodating the interests and needs of individual programs. The Commission designated knowledge and behavior outcomes to be monitored for evaluation purposes. Some of these outcomes were measured consistently across contractors (common survey questions) and some of these outcomes were measured with contractor-specific questions (individual survey questions). During this pilot year, Harder+Company Community Research facilitated a consensus process in which contractors selected questions that would be measured consistently and used collaboratively (see Exhibits B.8-B.10).

In order to achieve the goal of identifying consistent evaluation measures, Harder+Company facilitated a consensus process with contractors to develop a survey to measure many of the Project's knowledge and behavior outcomes. In this way, contractors were able to choose those survey questions they felt were best suited for their programs, while making it possible to analyze results across the entire Project. Developing the Common Survey took several months and had five key steps:

1. Contractors were offered a menu of questions for each outcome they are contracted to address. For each outcome, contractors chose the questions they felt most relevant to their respective curricula.
2. Harder+Company, First 5 San Diego and contractors worked to refine the chosen questions by agreeing upon common language and response categories.
3. Harder+Company translated the finalized Common Survey questions into Spanish with contractors' input and assembled a tailored list of questions for each contractor. The tailoring process is important to note because many questions address more than one outcome. For example, the outcome "increased confidence in ability as a parent" appears in both Service Focus Areas 1 and 2. In these

instances, contractors that chose the outcome in more than one Service Focus Area ask a single question (or set of questions) so as not to burden parents.

4. Contractors integrated Common Survey questions into their existing evaluation processes and pilot tested the Common Survey with their program's participants over several months. All contractors gathered baseline data and most had not gathered sufficient follow-up data for analysis by the end of the fiscal year. The ability to collect follow-up data depended on the length of the program and the date the contractor began enrolling participants. For some contractors it was not possible to collect follow-up data this fiscal year. For this reason, follow-up data is not presented here.

5. At the end of the fiscal year, contractors were invited to share their feedback on the Common Survey, and it was subsequently altered to address areas of concern. Data from the revised Common Survey will be presented in the FY 2007-08 Annual Evaluation Report.

It is important to note the following:

- ***The Common Survey is self-administered.*** Parents complete the surveys on their own much like a written exam. In cases where parents do not read and write in English or Spanish, program staff may verbally administer the survey or interpret it into another language.
- ***The Common Survey is administered at two points in time.*** Parents complete an initial survey at the start of services and a follow-up survey at a later point in time. The amount of time between baseline and follow-up surveys varies depending on the program length and design. For example, participants in one program take the follow-up survey on the last day of an 8-week series of weekly classes. In another program parents take it at their sixth monthly home visit. Contractors individually designated the time at which they expected to see change in participants, and the follow-up survey administration is implemented in accordance with the specified follow-up period.
- ***The Common Survey is case matched.*** Participants' pre- and post-surveys are matched to allow assessment of changes in knowledge and behavior at the individual participant level. For this first year, only baseline data is available. In future years it will be possible to look at change over time at the individual level. Some programs may have opted to collect the survey for a *sample* of participants.
- ***Several outcomes are captured by Individual Instruments that are contractor-specific.*** The Commission designated knowledge and behavior outcomes to be monitored for evaluation purposes. Some of these outcomes were measured consistently across contractors (common survey questions) and some of these outcomes were measured with contractor-specific questions (individual survey questions). There are outcomes unique to specific programs and curricula that are not included in the Common Survey and are not reported here. These data are used by individual programs for measuring results and guiding program improvement. Some of these results may be included in future First 5 San Diego reporting to the extent that they present opportunities to inform the field of parent education.

Exhibit B.8
First 5 for Parents Outcomes: Service Focus Areas 1, 2 & 3
How Each is Measured and Which Contractors Measure Each

Outcomes				How Measured		Contractors
				Common Survey	*Individual Instruments*	
Service Focus Area 1	*Knowledge Outcomes*	Increased knowledge about…	…age appropriate developmental milestones (also realistic expectations about these)		X	***Mandatory*** All six contractors that address Service Focus Area 1 must measure these outcomes: ▪ Bayside Community Center ▪ Catholic Charities ▪ Jewish Family Service ▪ North County Health Services ▪ SAY San Diego ▪ UC Cooperative Extension
			…types of parent-child interaction that enhance age-appropriate development		X	
			…how to promote child's social-emotional health		X	
			…different strategies for managing child behavior		X	
			…the importance of consistent communication with child	X		
			…bonding and attachment		X	
			…the importance of peer socialization	X		
			…specific ways to make the home environment a safe, healthy, nurturing place		X	
			…community resources for parents and children including basic health and other resources (also and exposure to these)	X		
			…how to advocate for child's needs and negotiate systems serving young children (e.g., healthcare, childcare, school system)	X		
			…how to access and assess quality childcare		X	***Optional:*** North County Health Services
	Behavior Outcomes	Families demonstrate improved skills to promote their children's social-emotional health			X	All Service Focus Area 1 contractors
		Increased use of positive parenting techniques to redirect behavior			X	
		Increased quality time spent with child		X		
		Improved relationships and attachment between parent and child			X	Jewish Family Service
		Increased opportunities for child interaction with others (outside of family)		X		All Service Focus Area 1 contractors
		Improvement in child's social skills			X	SAY San Diego
		Demonstrated improvements made to create a safe, healthy, nurturing home environment			X	All Service Focus Area 1 contractors
		Increased use of dentist and pediatric health services for checkups, immunizations, and other preventative / well-child healthcare		X		
		Reduced use of emergency room for primary care		X		None
		Increased confidence in ability as a parent		X		All Service Focus Area 1 contractors
		Parents' increased connection with school and community		X		Bayside & SAY San Diego
		Increased parental ability to advocate for child		X		
		Use of resource network and/or quality review tools to select childcare			X	North County Health Services

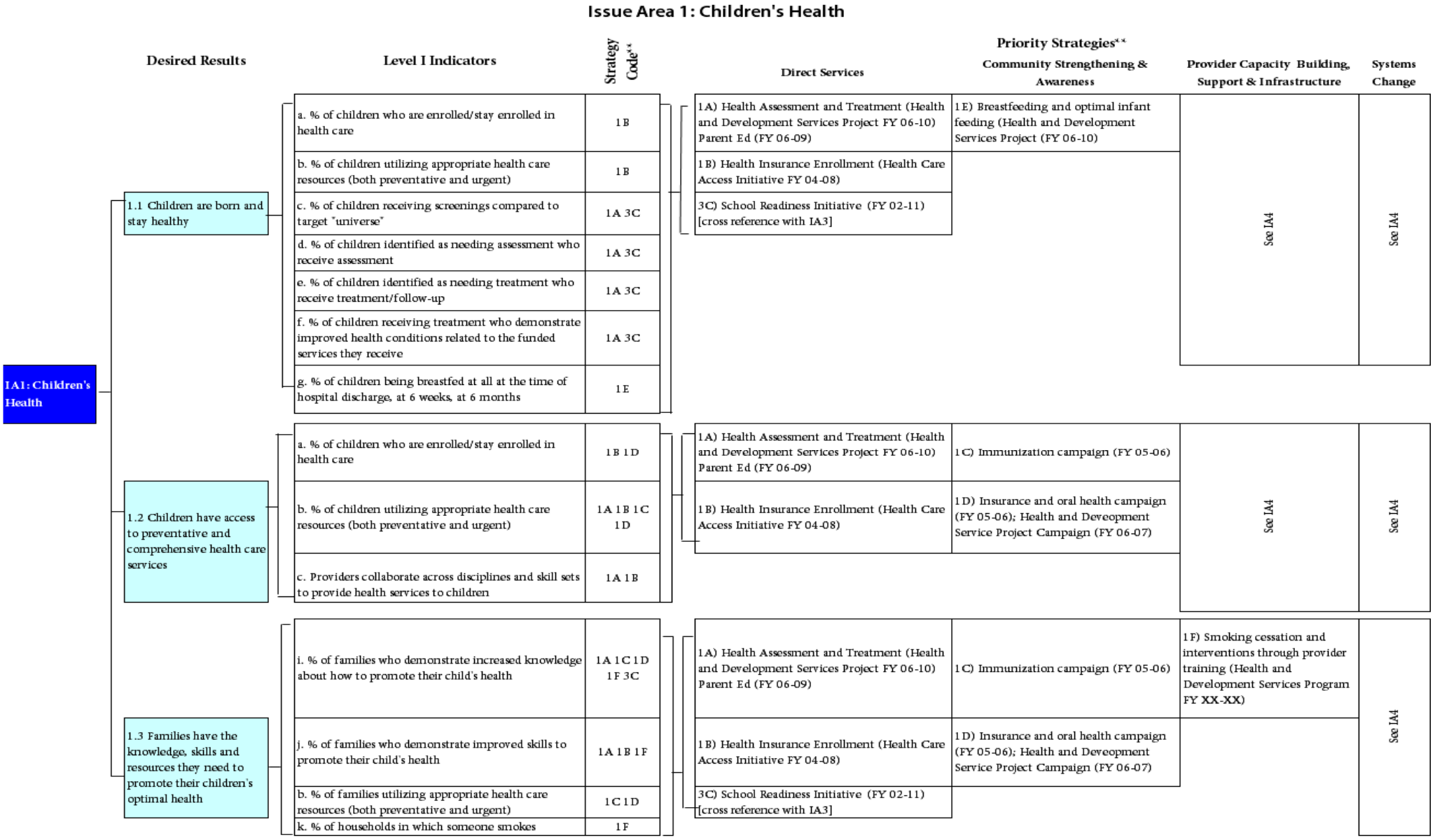
Exhibit B.9
First 5 for Parents Outcomes: Service Focus Area 2
How Each is Measured and Which Contractors Measure Each

Outcomes				How Measured		Contractors
				Common Survey	*Individual Instruments*	
Service Focus Area 2	*Knowledge Outcomes*	Increased knowledge about…	…how to promote child's cognitive development	X		***Mandatory*** All seven contractors that address Service Focus Area 2 must measure these outcomes: ▪ Bayside Community Center ▪ Catholic Charities ▪ Jewish Family Service ▪ National City Public Library ▪ SAY San Diego ▪ St. Vincent de Paul Villages ▪ UC Cooperative Extension
			…the importance of early learning activities	X		
			…how to change everyday activities into learning opportunities	X		
			…free/low-cost early learning and pre-literacy development community resources (e.g., healthcare, childcare, school system)	X		
			…how to advocate for child's needs and negotiate systems serving young children	X		
		Providers collaborate across disciplines and skill sets to provide early learning and pre-literacy services to children		X		***Optional:*** None
	Behavior Outcomes	Families demonstrate improved skills to promote their children's cognitive development			X	All Service Focus Area 2 contractors
		Increased time spent reading/telling stories to children		X		
		Increased use of library card / library		X		Bayside; Catholic Charities; Jewish Family Service; National City Public Library
		Increased opportunities to assist child in developing fine motor skills		X		Bayside; Catholic Charities; Jewish Family Service
		Demonstrated improvements made to create a stimulating and nurturing home environment			X	All Service Focus Area 2 contractors
		Families increase their access and use of free and low-cost community resources for early learning and pre-literacy development (e.g., libraries, free museum days, etc.)		X		Catholic Charities; Jewish Family Service; St. Vincent; SAY San Diego; UC Cooperative Extension
		Increased number of parents from diverse cultural and linguistic backgrounds who utilize pre-literacy services		X		Bayside; Catholic Charities; National City Public Library
		Increased confidence in ability as a parent		X		Bayside; Catholic Charities; Jewish Family Service; National City Public Library; SAY San Diego
		Parents' increased connection with school and community		X		St. Vincent; SAY San Diego; UC Cooperative Extension
		Increased parental ability to advocate for child		X		SAY San Diego
		Increased integration of pre-literacy services through multidisciplinary partnerships and collaborative long-range planning		X		None

Exhibit B.10
First 5 for Parents Outcomes: Service Focus Area 3
How Each is Measured and Which Contractors Measure Each

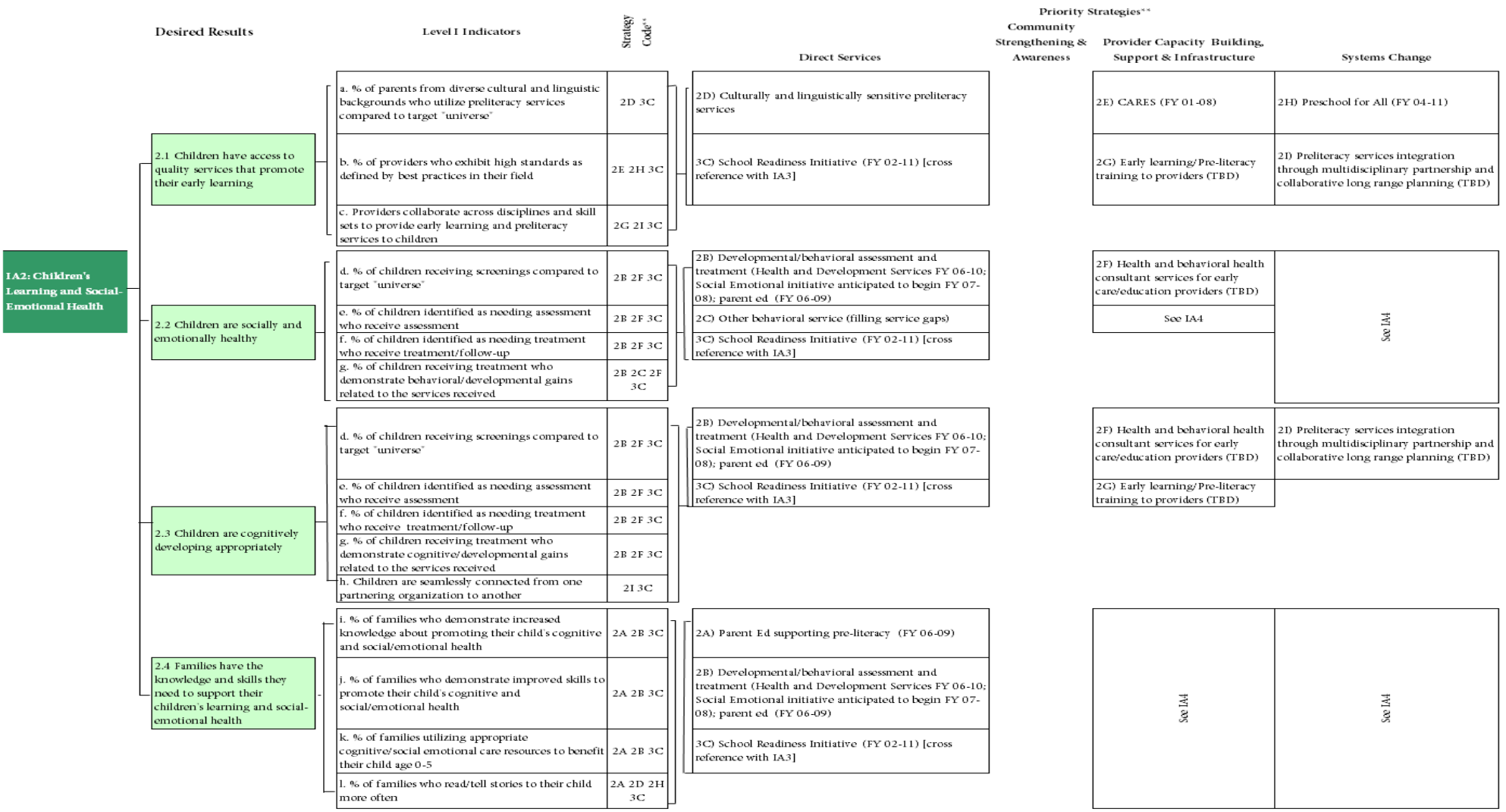
Outcomes				How Measured		Contractors
				Common Survey	*Individual Instruments*	
Service Focus Area 3	***Knowledge Outcomes***	Increased knowledge about…	…nutrition (balanced diet, serving size) and culturally-based healthy alternatives		X	***Mandatory*** All four contractors that address Service Focus Area 3 must measure these outcomes: ▪ Bayside Community Center ▪ San Diego Youth & Community Services ▪ SAY San Diego ▪ UCSD Community Pediatrics
			…the benefits of regular exercise for child and entire family	X		
			…the importance of family participation/ involvement in nutrition and exercise activities	X		
		Increased understanding of life-long benefits of exercise and healthy dietary habits		X		
	Behavior Outcomes	Decreased consumption of fast food and highly processed foods		X		All Service Focus Area 3 contractors
		Increase in healthy, balanced meals provided to the family			X	
		Increase in meals eaten together as a family		X		
		For child and entire family:	Increased levels of exercise	X		
			Decrease in sedentary behavior	X		Bayside; San Diego Youth & Community Services; UCSD Community Pediatrics
			Decrease in time spent watching television	X		All Service Focus Area 2 contractors

Appendix C: Evaluation Framework



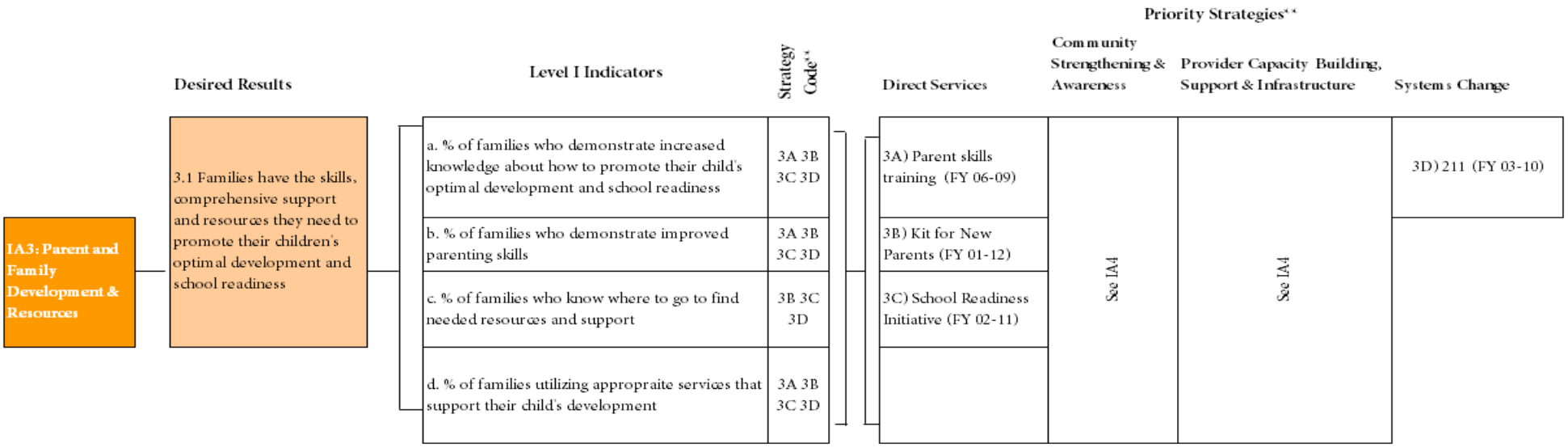
** Numbering matches that of the strategic plan. See plan for complete wording of strategy

Issue Area 2: Children's Learning and Social-Emotional Health



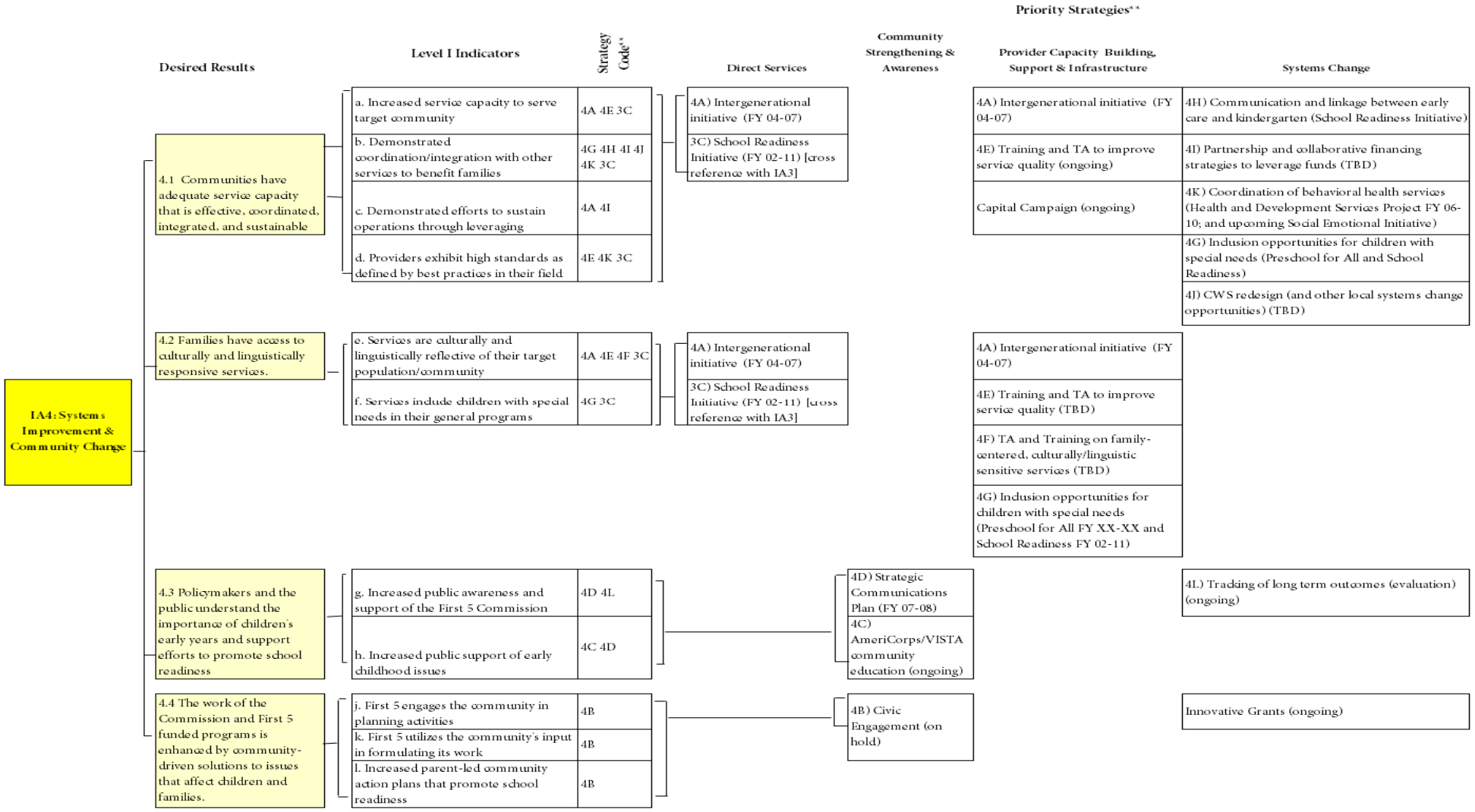
** Numbering matches that of the strategic plan. See plan for complete wording of strategy

Issue Area 3: Parent and Family Development and Resources



** Numbering matches that of the strategic plan. See plan for complete wording of strategy

Issue Area 4: Systems Improvement and Community Change



** Numbering matches that of the strategic plan. See plan for complete wording of strategy