First 5 San Diego

harder+company community research

Improving the Lives of Children 0-5

First 5 Commission of San Diego County

Annual Evaluation Report 2007-2008

October 2008

Acknowledgements

This report brought together the efforts of those touched by First 5 San Diego, such as its contractors, the families it serves and community stakeholders in a profoundly collaborative process. Contractors were often required to expand their view of evaluation from program-specific to initiative-level. The willingness of Commission 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 schedules to answer questions of themselves and their families, as well as reflected 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 years in this county: Ron Roberts (Chair 2007), Greg Cox (Chair 2008), Dr. Wilma J. Wooten, Jean Shepard (2007), Nick Macchione (2008), Carol Skiljan, and Charleen Tressler.
- The First 5 San Diego staff, who provided valuable insight and guidance to the evaluation team: Laura Spiegel (Executive Director), Dr. Lynn Eldred (Program and Evaluation Manager), Grace Young (Contracts and School Readiness Program Manager), Lauren Chin, Lisa Contreras, Martha Garcia, Charissa Hines, Phyllis House-Cepeda, Randall Marks, Tess Perez, Steven Smith, and the rest of the staff.
- Members of the First 5 San Diego Evaluation Leadership Team for their expertise, dedication and guidance: Dr. Lynn Eldred, Jeanne Gordon, M.A., Dr. Helen Hayden-Wade, Dr. Ruth Newton, Dr. Michael Peddecord, Melinda Redding, Dr. Alfonso Rodriguez, and Dr. Wilma J. Wooten.
- The First 5 contractors and subcontractors who identified families for primary data collection activities.
- Non-First 5 funded community members and policy makers who participated in confidential interviews to provide the "on the ground" perspectives of the Commission and its functions.
- Kate McCarthy at StudioM for graphic support.

Table of contents

Executive Summary

"Each of us must come to care about everyone else's children. We must recognize that the welfare of our children is intimately linked to the welfare of all other people's children."

—Lilian Katz, PhD.

In FY 2007-08, the First 5 Commission of San Diego County (First 5 San Diego) supported a network of six interconnected initiatives to address the needs of children ages 0-5 years and their families, and key identified contractors to address strategic areas of importance. A number of initiatives (i.e., Oral Health, Preschool for All and Healthy Development Services) enhanced their services through new approaches or established clear pathways and protocols that improved the system of service delivery. Other initiatives (i.e., School Readiness and Healthcare Access) continued to refine their existing model; yet others (i.e., First 5 For Parents), implemented their first full year of direct services.

This report contains an analysis and synthesis of the data collected during FY 2007-08. It is a macro analysis of initiative and program successes, as well as the areas for further study and/or needed improvement. This executive 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 Issue Area of Children's Health, Strategic Plan of First 5 San Diego targets the following Desired Results identified in the Commission's Strategic Plan:

- Children are born and stay healthy.
- Children have access to preventive and comprehensive health care 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, such as the appropriate use of health care resources, home visits to first time at-risk parents and families, and screenings, assessments and treatment for developmental speech, hearing, vision and behavioral services, as well as 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 in order for the Commission to fund 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 1,169 parents received education to support their child's health and promote healthy family behaviors.
- ***Healthy Development Services (HDS):*** Over one in seven children ages 0-5 years in San Diego County were served through HDS services. Some 32,912 individual children were served through the gateway services. The initiative provided over 8,000 newborn medical home visits, over 2,000 at-risk home visits, and over 13,000 developmental screenings. Over 16,000 hearing and vision screenings were performed. Additionally, a large component of this county-wide project includes screening, assessing, and treating children for developmental, and speech and language concerns. The initiative provided 16,032 screenings to identify developmental concerns and 8,926 screenings for speech and language delays. Approximately half of all children screened were identified as needing further assessment (47.3%).
- ***Healthcare Access Initiative (HCA):*** Contractors extended outreach to 130,426 families. Of the 13,366 children who received health insurance enrollment assistance, 70.0% were successfully enrolled.
- ***Oral Health Initiative (OHI):*** Contractors provided oral health screenings to 13,092 children ages 0-5 years and 1,935 pregnant women. In addition, 13,946 children ages 0-5 years and 1,878 pregnant women obtained routine dental treatment, and 680 children ages 0-5 years obtained specialty dental treatment.
- ***School Readiness Initiative (SR):*** This initiative pursues a "whole child" approach that includes certain health outcomes. As a part of these programs, School Readiness contractors provided 1,779 children with health screenings either by their own staff or by referring the child to other organizations for the screening.

Improving Children's Health	
Desired Results	**Highlights**
Children are born and stay healthy	■ The overall rates of breastfeeding at 6 weeks of age (76.7%) and 6 months of age (58.0%) 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 decreased by 11.6%, but exams and treatment increased (20.6% and 34.1% respectively) from last fiscal year.
Children have access to preventive and comprehensive health care services	■ Due to HCA's follow-up efforts, 94.7% of families were still enrolled in health insurance at 18 months, surpassing the state's Medi-Cal and Health Families retention rate (62%).
	■ In an attempt to ensure that the dental health system of care is seamless, OHI providers increased care coordination efforts by 24.1% for children and 77..5% for pregnant women.
	■ Over 90% of children utilizing HDS services were insured, and nearly 100% had an appropriate medical home and had received an annual well child visit.
	■ Just under half (48.5%) of children receiving core School Readiness early care and education services were screened for developmental delays, including fine motor and gross motor skills. This was a significant decrease from last fiscal year (70.6%).
	■ 75.4% of children participating in PFA were screened for developmental delays using the PEDS, a large increase from last fiscal year (15.9%).
	■ 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 (64.2% of children needing an assessment received services and 73.4% of children needing treatment received services).
	■ Over half of all children receiving HDS developmental and speech and language demonstrated gains as a result of services (57.1%). However, only a third (33.9%) of children receiving HDS behavioral services demonstrated gains as a result of the service, a dramatic decrease from last fiscal year (62.8%). The majority of children not showing gains in any service area remain in programs for further treatment or are being referred for additional services, either within HDS or to an outside agency.

Improving Children's Health (continued)	
Desired Results	**Highlights**
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. A total of over 99% of children visited the doctor within the year, a higher rate than County comparison data. In addition, 32.8% of children visited the dentist within the year, with 14.4% visiting the dentist in the past 6 months -- lower than county benchmark data 52.8% but similar to rates found in OHI.
	▪ Most referrals within HDS Regional Networks (75.6%) resulted in successful initiation of additional services. In addition, 1,787 referrals were provided by HDS partners to other First 5 funded initiatives.
	▪ Families accessing HCA services exhibited consistently lower usage of emergency room services (less than 7% at 12 months and 18 months) than county benchmark comparison data (21.8%).
	▪ OHI provided pediatric dentistry education to 23,280 primary caregivers of children (parents, pregnant women, and child care providers) and 428 dental and health care providers.
	▪ 211 San Diego, a resource and referral hotline, provided information on community health resources to approximately 39,000 parents of children ages 0-5 years.
	▪ 65,207 Kits for New Parents containing valuable information about child health, development, well being and safety, and as well as how to access local resources were distributed to parents. This was the highest number ever distributed in San Diego County since the program's inception in 2001. The Kits (in English and Spanish) were revamped and updated by First 5 California in FY 2007-08.

Children's Learning and Social-Emotional Health

In the second Issue Area, Children's Learning and Social-Emotional Health, the Commission's Strategic Plan 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 a variety of programs that promote children's early learning and social-emotional health including early care and education, parent development, 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, 5,052 children, including 663 children with disabilities or other special needs received services. Further, 3,277 children participated in activities to ease their transition into kindergarten (also an increase from last fiscal year). Finally, 2,217 parents and caregivers participated in parenting activities to facilitate their child's learning and social-emotional health (all increases from last fiscal year).
- ***Preschool for All (PFA):*** The initiative provided 142 sessions in the six targeted communities, providing quality preschool experiences to 2,153 children.
- ***Parent Education Initiative (PE):*** An estimated 4,662 parents received education to support their child's early learning (an increase from last fiscal year).
- ***Healthy Development Services (HDS***): The initiative provided 2,860 behavioral screenings. Approximately half of all children screened were identified as needing further assessment (47.3%).

Improving Children's Learning and Social-Emotional Health	
Desired Results	**Highlights**
Children have access to quality services to promote their early learning	■ This year more PFA teachers were educated at or above the Bachelor's level than last year (40.3% this fiscal year compared to last year's 32.9%)
	■ The CARES program provides stipends to early education providers so they can further their education and ultimately improve the quality of early care environments. This fiscal year, 534 early care educators completed coursework and received a stipend from San Diego CARES (a decrease from last fiscal year).
	■ The majority of SR preschool teachers (88.0%) were educated at or past the Associate's degree level (an increase from last fiscal year).
Children are socially and emotionally healthy	■ Children in both PFA and SR programs exhibited statistically significant improvement in the "personal and social competence" domain of the DRDP-R.
	■ Children enrolled in school readiness programs exhibited gains overall in social and emotional competencies, with those enrolled in full time programs exhibiting higher developmental gains than those in part time programs.
Children are cognitively developing appropriately	■ Children in both PFA and SR programs exhibited statistically significant improvement in the "effective learning" domain of the DRDP-R.
	■ Children enrolled in school readiness programs exhibited gains overall in cognitive competencies, with those enrolled in full time programs exhibiting higher developmental gains than those in part time programs.
Families have the knowledge and skills they need to support their children's learning and social-emotional health	■ 65,207 Kits for New Parents were distributed to parents of children ages 0-5 years 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, primarily due to updates to the Kit.
	■ Parents participating in School Readiness parenting classes showed increases in each of the parenting practices areas (knowledge, confidence, ability and connection to their child and other families).
	■ After being involved in the PFA, parents rated themselves higher on all 12 items on the Parenting Survey. Parents who did not participate in parenting activities throughout the school year only showed improvement on five of the twelve items, suggesting that parental engagement in preschool activities may help parents become more effective in their role as parents

Parent and Family Development and Resources

In the Issue Area of Parent and Family Development and Resources, the Commission's Strategic Plan 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, 4,662 parents participated in parent education classes and workshops built on best or promising practices. In turn, nearly two children ages 0-5 years were reached for every parent that participated.
- ***School Readiness:*** SR provides a variety of parent and caregiver education courses, including single session, sequential session and Parent and Child Together (PACT) opportunities. Overall, 6,642 parents attended these types of programs.
- ***Preschool for All:*** PFA offers parents a number of engagement activities. During this fiscal year, 632 parents participated in engagement opportunities.

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.
	▪ Parents served by HCA programs are more likely than those in county comparison studies to keep their children enrolled in public insurance programs, to have a medical home and to take their children to the doctor annually, and less likely to use the emergency room. 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 increased knowledge (98.4%), enhanced skills (98.5%), and becoming empowered to address the health and developmental needs of their children (98.5%).
	▪ OHI contractors provided care coordination to 8,987 children (a 24.1% increase) and 2,665 pregnant women (a 77.5% increase) to ensure that the dental health system of care is seamless for children and pregnant women.

Improving Parent and Family Development and Resources (continued)	
Desired Results	**Highlights**
Families have the skills, comprehensive support and resources they need to promote their children's optimal development and school readiness.	▪ 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 a statically significant increase in each parenting practice area (knowledge, confidence, ability and connection at $p<0.001$). 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 years have access to a 24/7 information and referral line (211) to support their knowledge of, and access to, community health and human services.
	▪ The Commission provided fiscal resources for fluoridating the water in the City of San Diego, providing a valuable health resource for the community.
	▪ 47,360 Kits for New Parents were provided to families of children ages 0-5 years 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 by changing the large systems that serve families of young children. The Desired Results identified in the Strategic Plan 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; improved awareness and cooperation across local health, education and community service systems; coordinated systems of care, sustainable funding; responsive services; creation of public policies that support 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, Healthy Development 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.
Families have access to culturally and linguistically responsive services.	▪ The majority of families served were identified as Latino/Hispanic. For example, 85.0% of SR children accessing early care and education services and approximately 56.0% of HDS's service contacts were Latino.
	▪ Overall parent satisfaction with key initiatives is high. For example, 84.0% of School Readiness Initiative parents and 82.4% Preschool for All parents were "very satisfied" with the quality of the program. This includes both English and Spanish speaking parents.

Systems Improvement and Community Change (continued)	
Desired Results	**Highlights**
Families have access to culturally and linguistically responsive services.	▪ Key stakeholders interviewed for this evaluation generally 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.
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 developed a communication plan focused on increasing public awareness of the Commission's programs, appropriate child development practices and the importance of the first five years of life.
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. Many stakeholders desired the Commission to be more involved with other funders and service provider collaboratives. They also suggested that the Commission engage more parents and communities in planning activities. If additional staffing resources were added, the Commission could pursue additional community planning and input strategies.

Conclusion

The First 5 Commission of San Diego has developed interlinking initiatives that address the needs of the whole child. This strategy is built upon a commitment to making multiyear investments in deep community change that produce measurable results for young children and their families. 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. As a result, the Commission has the information and the systems level perspective to 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.

Introduction

"Free the child's potential, and you will transform him into the world."

—Maria Montessori

In 1998, the passage of Proposition 10 authorized the use of a tobacco tax to fund services for children ages 0-5 years 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, a decade later, the Commission has developed as an organization, a key funder of services, and an agent of change. As San Diego County grows, the First 5 Commission of San Diego will continue to play a vital role. 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 ages 0-5 years 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 public report on the results of its funded projects in order to ensure these public investments in the youngest members of our community are producing the desired results, examine the challenges encountered, and recommend improvements or new directions. In addition, the Commission uses these results for future planning and to determine new strategic investments. The Commission is committed to using data to continuously improve the systems and services it supports to benefit the young children and their families it serves.

The purpose of this report is to document the overall impact of First 5 San Diego's work from July 2007 through June 2008 (FY 2007-08). 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 Community Research evaluation team. When appropriate, it includes benchmark data and research to contextualize the results of funded initiatives. This report is both a public accountability requirement to State and local First 5 Commissions and the San Diego County community concerning the public investments 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

First 5 San Diego, as well as an analysis of how the results of the Commission's projects can contribute to best and promising practices in the fields serving young children and their families. It also provides information to inform the future decision making of First 5 San Diego.

Data gathered through the Commission's evaluation can provide valuable information concerning the condition of young children and families, community needs, and gaps in services. Persons requesting different, or more specific, data or information than is included in this report should contact the First 5 Commission of San Diego County at 616-230-6460 to make a data request.

Improving Outcomes and Strengthening Systems: First 5 San Diego's Evaluation Design for FY2007-08

First 5 San Diego generally funds 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 produce common outcomes for young children and their families by pursuing similar activities and approaches. For example, the Healthy 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, the Commission's strategic concentration of funding has allowed it 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, its contractors, and an advisory body, as well as the Commission's evaluation contractor, Harder+Company Community Research. This approach is depicted in Exhibit A.

Key Components of the First 5 2007-08 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.

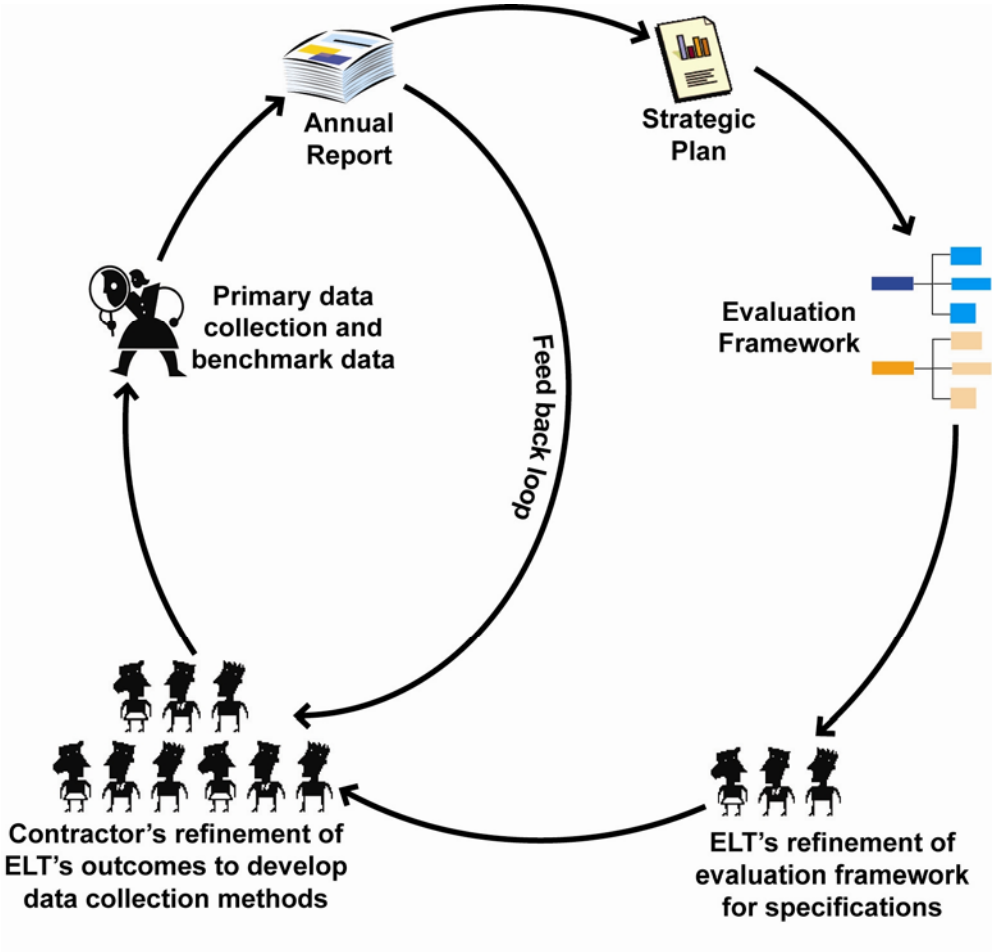
The evaluation begins with the Evaluation Framework, which is part of the Commission's Strategic Plan. (see Appendix C). This framework was developed by Harder+Company and the Commission's Evaluation Leadership Team (ELT), an advisory body of local evaluation and program experts, to broadly define objectives 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 result of this profoundly collaborative process, the Commission has an understanding of the impact of its

[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 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.

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, and stakeholder interviews. Specific details of the designs are included in each initiative's chapter and in Appendix B.

Exhibit A: Commission Approach to Evaluation



CHAPTER 2

Oral Health Initiative

"[My children have] gained weight since they had their teeth fixed. They're growing up well."

—OHI Parent

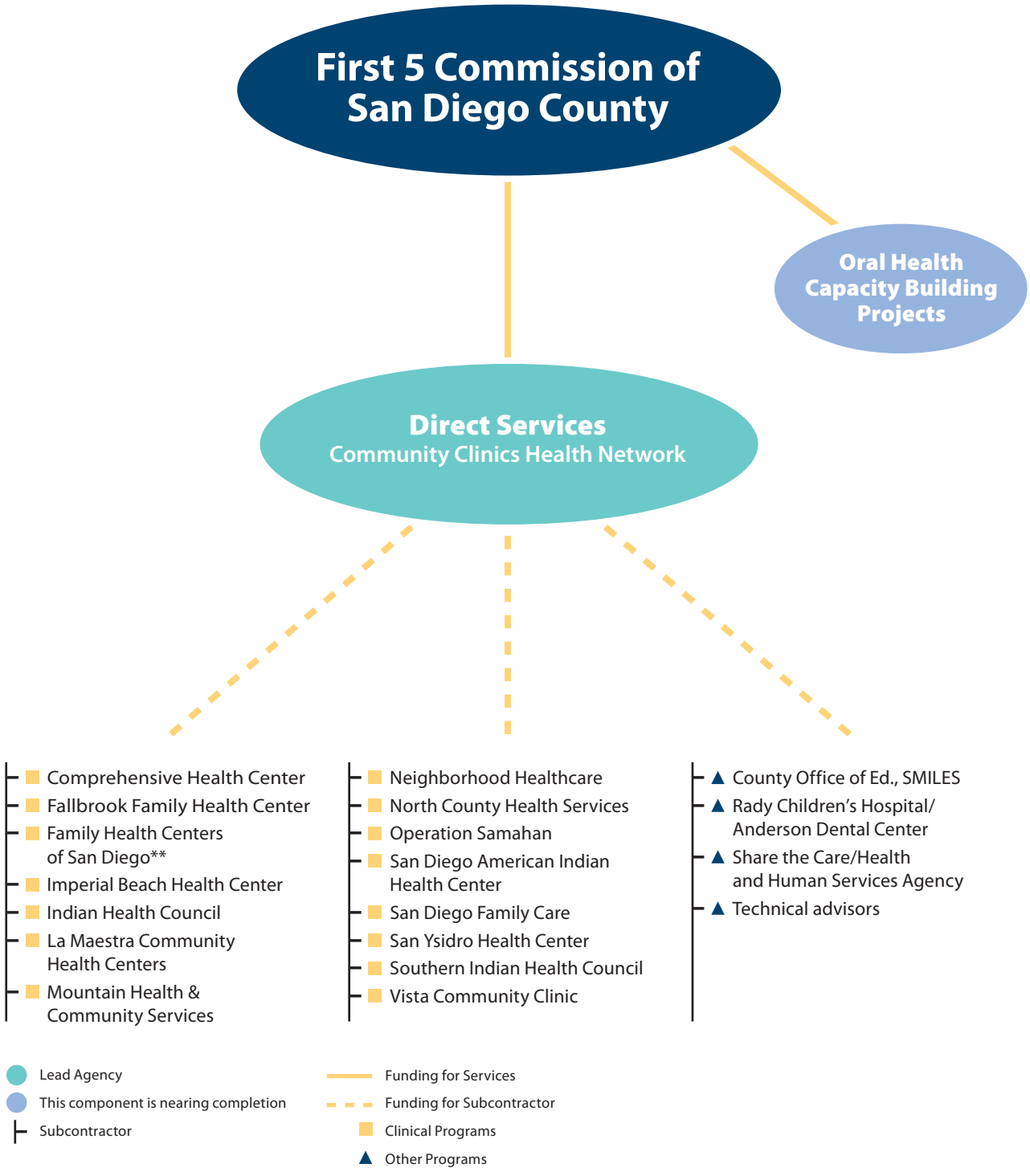
Key Results

- **Increased specialty treatment for children ages 0-5 years**. From last fiscal year, the number of children ages 0-5 years who received specialty treatment increased by 18.1%.
- **Care coordination increased.** In an attempt to ensure that the dental health system of care is seamless for children and pregnant women, OHI providers increased care coordination efforts for children ages 0-5 by 24.1% and pregnant women by 77.5%.
- **Increased efforts to educate primary care and prenatal providers.** From last fiscal year, the number of primary care and prenatal care providers who received training about oral health issues increased by 620.0% and 485.7% respectively.
- **Increased efforts to educate primary caregivers of children.** OHI also made a concerted outreach effort to educate parents, pregnant women, and child care providers.

Summing It Up

- 13,092 children ages 0-5 years and 1,935 pregnant women participated in oral health screenings.
- 11,525 children ages 0-5 years and 1,808 pregnant women received dental exams.
- 13,946 children ages 0-5 years and 1,878 pregnant women obtained routine dental treatment. Additionally, 680 children ages 0-5 years obtained specialty dental treatment. These data reflect an increase from last fiscal year.
- 8,987 children ages 0-5 years and 2,665 pregnant women participated in care coordination. These data reflect an increase from last fiscal year.
- 23,280 parents, caregivers, pregnant women and child care providers received oral health education. These data reflect an increase from last fiscal year.
- 428 dental and health care providers were trained about oral health issues. Primary care providers accounted for the majority of those trained.

Oral Health Initiative Structure*



* Includes First 5 funded Lead Agencies and Partners.
** This partner has an Oral Health Capacity Building Contract directly with First 5 San Diego.

Introduction

Early childhood caries and dental decay captured national attention in 2000 when the U.S Surgeon General published a report declaring dental diseases a "silent epidemic" among children, especially low income children. According to the Surgeon General's report, tooth decay is "the single most common chronic childhood disease – five times more common than asthma." [23] 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.[24, 25]

Untreated dental disease may: cause pain, affect a child's nutritional status, sleep patterns, or appearance; impair psychological status and social interaction; and cause problems with speech and language development.[26,27, 28] The pain of untreated tooth decay can also cause children to miss school.[29] In short, poor oral health negatively affects children's ability to function in school.[30] Addressing children's oral health before they enter school helps to ensure that they arrive to kindergarten ready to learn. For pregnant women, the mother's oral health has a direct relation to her unborn child's health. Studies have demonstrated an association between gum disease and poor birth outcomes including preterm delivery and low birth weight babies.[31, 32]

Ultimately, it is more economical to provide parents with comprehensive oral health education and children with preventive services than to treat a child with dental decay with painful and costly treatments. "Policy makers should consider subsidizing and promoting preventive interventions for early childhood caries for two reasons. First, the interventions will have a substantial impact of the oral health of a particularly vulnerable population of children, reducing early childhood caries by 40 to 80 percent. Second, part of the costs will be offset by savings in treatment costs."[33] Due to the highly preventable nature of the disease, national, state and

[23] Satcher, D. Oral Health in America: A Report of the Surgeon General. Washington, DC: U.S. Department of Health and Human Services, 2000.
[24] Centers for Disease Control and Prevention. Oral Health: Preventing Cavities, Gum Disease and Tooth Loss. At a Glance2008. Accessed 23 August 2008. < http://www.cdc.gov/nccdphp/publications/factsheets/Prevention/oh.htm>
[25] 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.
[26] Centers for Disease Control and Prevention. Oral Health: Preventing Cavities, Gum Disease and Tooth Loss. At a Glance2008. Accessed 23 August 2008. < http://www.cdc.gov/nccdphp/publications/factsheets/Prevention/oh.htm>
[27] Satcher, D. Oral Health in America: A Report of the Surgeon General. Washington, DC: U.S. Department of Health and Human Services, 2000.
[28] 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>
[29] Ibid.
[30] Satcher, D. Oral Health in America: A Report of the Surgeon General. Washington, DC: U.S. Department of Health and Human Services, 2000.
[31] 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.
[32] 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.
[33] Gomez-Ramos, F.J. "Cost Effectiveness Model for the Prevention of Early Childhood Caries." Journal of the California Dental Association. (1999)

county level oral health groups have strongly advocated for dental coverage for all children, strategic education to the public focusing on the most vulnerable populations, and preventive dental services.

In 2005, The First 5 Commission of San Diego launched the Oral Health Initiative (OHI) to address oral health. In total, the Commission has dedicated up to $5.1 million for OHI from its launch through FY 2009-10.[34] In FY 2007-08, the Oral Health Initiative expended $1.4 million on a comprehensive, countywide approach to address the dental health prevention and treatment needs of young children and pregnant women.

Key Elements

The intent of OHI is to provide a network of care that meets the 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 years and pregnant women free from oral health disease. As the leads agency, the Council of Community Clinics (the Council) oversees the project and supports 15 community clinics as well as Rady Children's Hospital/Anderson Center for Dental Care, the County of San Diego Share the Care program, the County Office of Education SMILES program and private dental providers (referred to as "OHI partners") across the County. Some partners operate at more than one site, creating an expansive network of care and providing services in six areas:[35]

1. **Oral health screenings for children ages 0-5 years and pregnant women:** Oral health screenings may be conducted in clinics as well as out in the community (i.e., at health fairs). Those screened may receive fluoride varnishes and/or sealants. Oral health education also occurs at screenings.
2. **Dental examinations for children ages 0-5 years and pregnant women:** Dental examinations are conducted by a dental practitioner and may include teeth cleaning, x-rays, fluoride treatments, sealants, and instruction on brushing and flossing teeth.
3. **Treatment services and follow-up for children ages 0-5 years and pregnant women:** Treatment services include routine treatment for both children and pregnant women in addition to specialty treatment for children (see textbox on the OHI Specialty Treatment Pool).
4. **Care coordination services for children ages 0-5 years and pregnant women:** Care coordination is the core of OHI. Dental Care Coordinators are employed at all 15 OHI clinic partners. The Dental Care Coordinators help families navigate the system; providing assistance with accessing dental

The OHI Specialty Treatment Pool

The specialty treatment pool was established in September 2006 and serves children who have severe dental needs. From September 2006 through July 18, 2008, the specialty treatment pool has:

- Paid out a total of $277,473
- Treated 107 children
- Conducted 2,726 procedures

Even with the pool, there are waiting lists for children who need oral surgery or need procedures which require anesthesia.

[34] In addition to OHI, the Commission funded a health and oral health media campaign in FY 2005-06 and also funded oral health projects through its Capital Projects Initiative. This helped build oral health capacity in the County.
[35] Not all OHI providers address all six areas. Some focus on one or two goals, while others offer a broader range of services, depending upon their capacity and expertise.

services and educating them about oral health issues and treatment recommendations. Dental Care Coordinators also conduct community outreach activities such as community screenings and education.

5. **Oral health education for parents and caregivers of children ages 0-5 years, pregnant women, child care providers and staff at community-based organizations (CBOs):** Dental Care Coordinators and other OHI partners provide education throughout the County at both the individual and community levels.

6. **Training for prenatal care providers, general dentists and primary care providers:** OHI provides training and education to health care providers and works to connect the medical and dental fields in order to improve oral health for young children and pregnant women.

Summing It Up

As Exhibits 3.1, 3.2 and 3.3 illustrate, OHI reached thousands of children ages 0-5 years, pregnant women, caregivers and providers across the County in FY 2007-08.[36] Overall, there were increases in exams, routine treatment, specialty treatments and care coordination. Additionally, there was a relatively large increase in training provided to primary care and prenatal care providers and a decrease in training provided to general dentists. Screenings for children and pregnant women decreased since FY 2006-07. See the textbox below for specific data.

Notable Numbers

Notable increases from FY 2006-07 to FY 2007-08 included:

- Specialty treatment for children ages 0-5 years increased 18.1%.
- Routine treatment increased for both children ages 0-5 years (11.9%) and pregnant women (34.1%).
- Care coordination services increased for both children ages 0-5 years (24.1%) and pregnant women (77.5%).
- Caregiver education increased for all target audiences: parents of children ages 0-5 years (17.1%), pregnant women (8.7%) and child care providers and staff of community organizations (50.6%).
- Training for primary care and prenatal care providers increased by 620.0% and 485.7%, respectively.

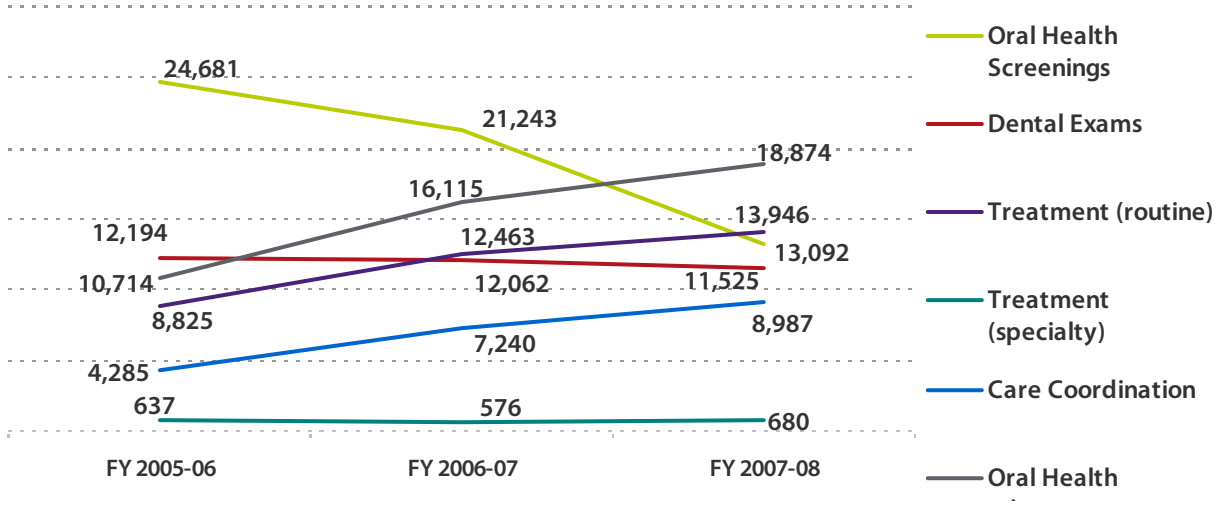
Notable decreases from FY 2006-07 to FY 2007-08 included:

- Oral health screenings decreased for both children ages 0-5 (38.4%) and pregnant women (11.6%)
- Training for general dentists decreased by 48.2% from FY 2006-07 to FY 2007-08.

[36] OHI programs collect and report monthly unduplicated counts of the number of individuals served for each type of service under each goal area. The total number of individuals served may include duplicate counts if an individual accessed services in more than one goal area and/or month.

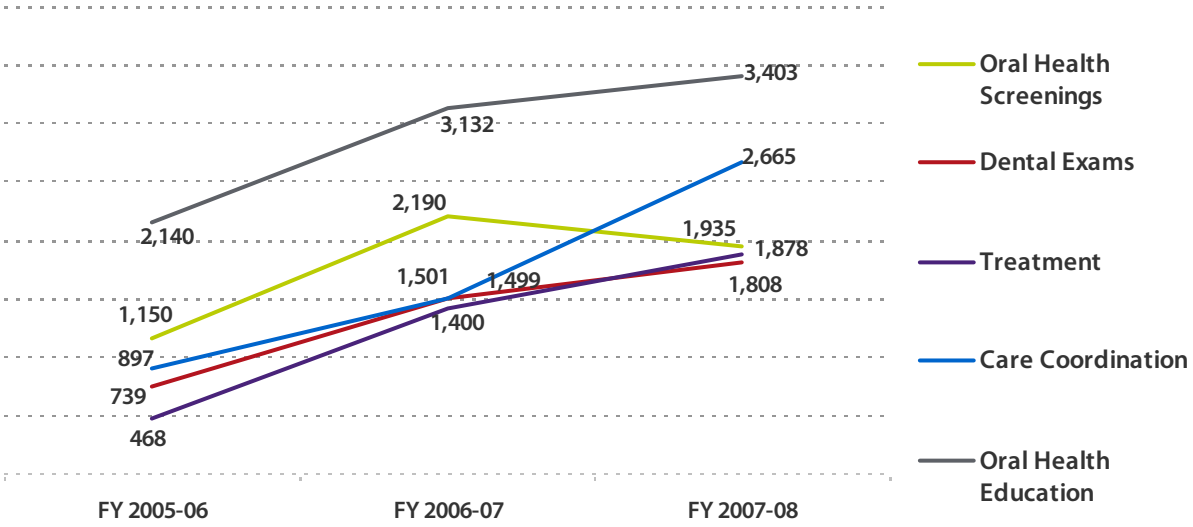
It is important to note that service totals from FY 2005-06 and FY 2006-07 data have been updated since the previous annual report[37]. This report includes updated figures for those years.

Exhibit 2.1 Number of Children ages 0-5 Receiving Oral Health Services
FY 2005-06, FY 2006-07, and FY 2007-08



*Children are indirectly served as oral health education is directed at the parent or caregiver

Exhibit 2.2 Number of Pregnant Women Receiving Oral Health Services
FY 2005-06, FY 2006-07, and FY 2007-08



[37] Updates are due to data discrepancies identified by OHI partners and resubmitted to First 5 after the publication of last year's report.

A comparison of the data from FY 2006-07 and FY 2007-08 illustrates that the number of services for children ages 0-5 years and pregnant women continues to increase for the majority of services, with a notable decrease in oral health screenings for both children ages 0-5 years and pregnant women. The reason for this drop may be due to administrative processes. Providers had a 15-month contract period that included 15 month targets. While providers exceeded all service targets, many screenings for this 15-month period were performed and recorded during the last fiscal year. This demonstrates that there is a need for services beyond what OHI is budgeted to perform. In addition, providers far exceeded previous performance in two areas key to building service capacity and strengthening prevention:

- Provider training: 428 dental and health care providers were trained about oral health issues compared to 131 trained in FY 2006-07.
- Caregiver education: 23,280 caregivers (parents of children ages 0-5 years, pregnant women and child care providers and community based organization) educated about oral health issues compared to 19,657 educated in FY 2006-07.

Exhibit 2.3 Overview of OHI Results, Comparing FY 2006-07 to FY 2007-08

Results	Increase (+) or Decrease (-) in numbers served from FY 2006-07 and FY 2007-08		
	Children ages 0-5 years	Pregnant Women	Providers
Oral health screening of children ages 0-5 years coupled with parent education	- 38.4%	- 11.6%	n/a
Children ages 0-5 years and pregnant women who received dental exams	- 4.5%	+ 20.6%	n/a
Children ages 0-5 years and pregnant women with identified oral health issues receive appropriate treatment services/follow-up	+ 11.9% (routine treatment)	+ 34.1%	n/a
	+ 18.1% (specialty treatment)		
Oral health care coordination services to children ages 0-5 years and pregnant women	+ 24.1%	+ 77.5%	n/a
Caregiver education	+ 17.1%	+ 8.7%	+ 50.6%
Provider training	n/a	n/a	- 48.2% (general dentists)
			+ 485.7% (prenatal providers)
			+ 620.0% (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 6 months of age.[38, 39, 40] Similarly, the American Academy of Pediatric Dentistry's guidelines specify that children

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

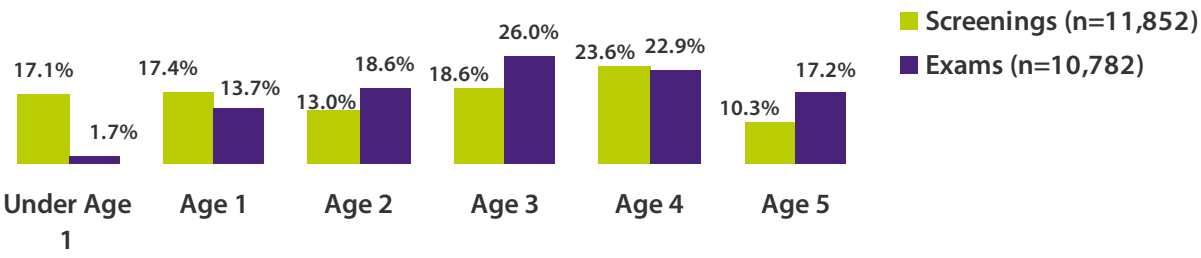
[39] American Academy of Pediatric Dentistry. "Guideline on Infant Oral Health Care." Clinical Guidelines. Chicago, IL: Author, 2004. 68-71.

should visit a dentist for an exam no later than 1 year of age, and routine exams should be repeated every 6 months.[41] Dental exams are a particularly important oral health service since these visits are the foundation of a child's dental home.

> **"When I called for my youngest daughter, they gave me an appointment for the next day."**
>
> – OHI parent

Prior to OHI, the standard practice among OHI partners throughout the County was to initiate dental exams at 3 years of age. OHI has changed that practice within the community clinic system and among private providers as well. OHI also increased training of primary care and prenatal care providers to standardize the practice of initiating exams at 1 year of age. Yet, only 17.1% of children screened in FY 2007-08, whose ages were reported, were under 1 year of age (Exhibit 3.4) – a decrease of nearly 14% from the last fiscal year.[42, 43] One reason for this large decrease in screenings of children under 1 year of age may be due to Assembly Bill 1433.[44] AB 1433 requires oral health assessments for children entering public school for the first time, typically children ages 4-5 years of age. There was an increase of 6.5% of children age 4 screened from last fiscal year.[45] This increase demonstrates OHI partners' response to assisting families with the State requirement and indicates that the demand for screenings may be beyond what OHI is budgeted to perform. In contrast, the number of exams peak at 3 years of age. This peak is consistent with last fiscal year (24.3% at age 3). This is the age that providers and parents have generally considered to be the appropriate time to initiate dental exams. It may be that more parent education about the importance of a dental exam beginning at 1 year of age is needed.

Exhibit 2.4 Ages of Children Screened and Examined, FY 2007-08



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

[41] 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

[42] OHI programs reported age data for 90.5% of children ages 0-5 years screened and 93.6% of children ages 0-5 years examined. The number of children who were less than 6 months of age at the time of screening was not reported.

[43] In FY 2006-07, 30.7% of children screened were under age one.

[44] Assembly Bill 1433 (effective September, 2006) requires oral health assessments for all children entering public school for the first time (kindergarten or first grade), with a goal of decreasing the number of children with dental disease through early intervention.

[45] In FY 2006-07, 17.1% of children screened were age 4.

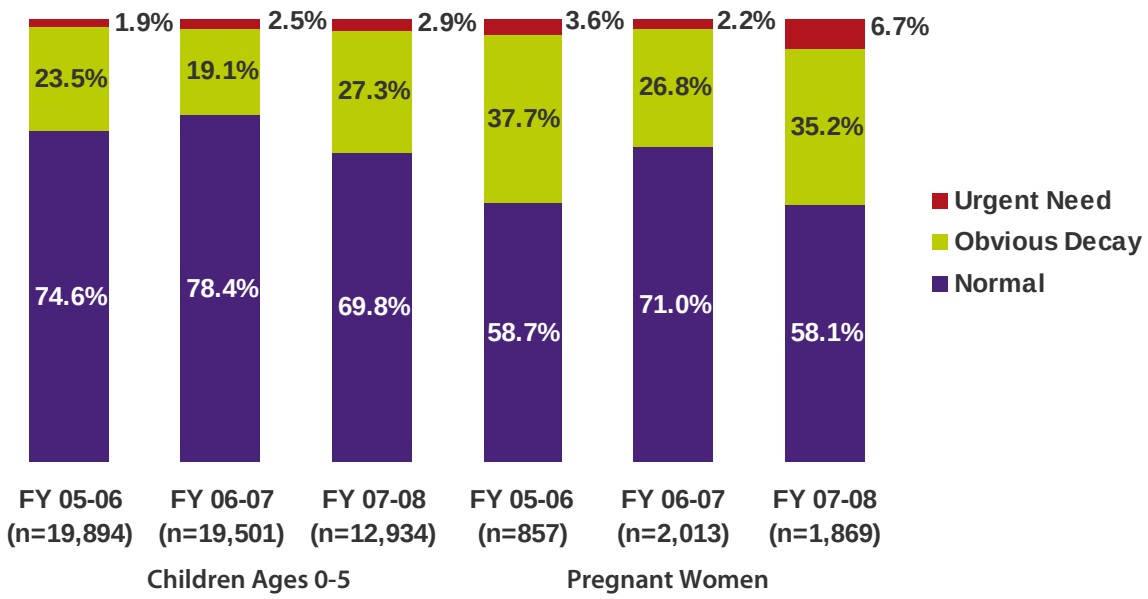
Detecting Previously Undetected Oral Health Concerns

Good oral health is vital for overall health and contributes to an individual's quality of life at any age. Early identification of oral health concerns through screenings and exams, coupled with early intervention is critical since dental decay can be reversed if detected and treated at an early age. Furthermore, providing education about the appropriate preventive and routine oral health care is key to reducing the risk of preventable dental/oral disease.[46]

Results of oral health screenings

Oral health concerns were identified in thousands of children ages 0-5 years and pregnant women through the screenings OHI partners provided during FY 2007-08. OHI partners found obvious decay or urgent dental needs in 30.2% of children ages 0-5 years (an increase of 8.6% from FY 2006-07) and 41.9% of pregnant women (an increase of 12.9% from FY 2006-07) for whom OHI partners reported screening results (Exhibit 3.5).[47, 48, 49,50]

Exhibit 2.5 Results of Oral Health Screenings
FY 2005-06, FY 2006-07, and FY 2007-08



Results of dental exams

[46] American Academy of Pediatric Dentistry. Policy on the Dental Home. 2004. Accessed 30 June 2008. <http://www.aapd.org/media/policies_guidelines/p_dentalhome.pdf>

[47] No population-based comparison data are available for pregnant women or for children ages 0-5 years at the County-level.

[48] 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.

[49] 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.

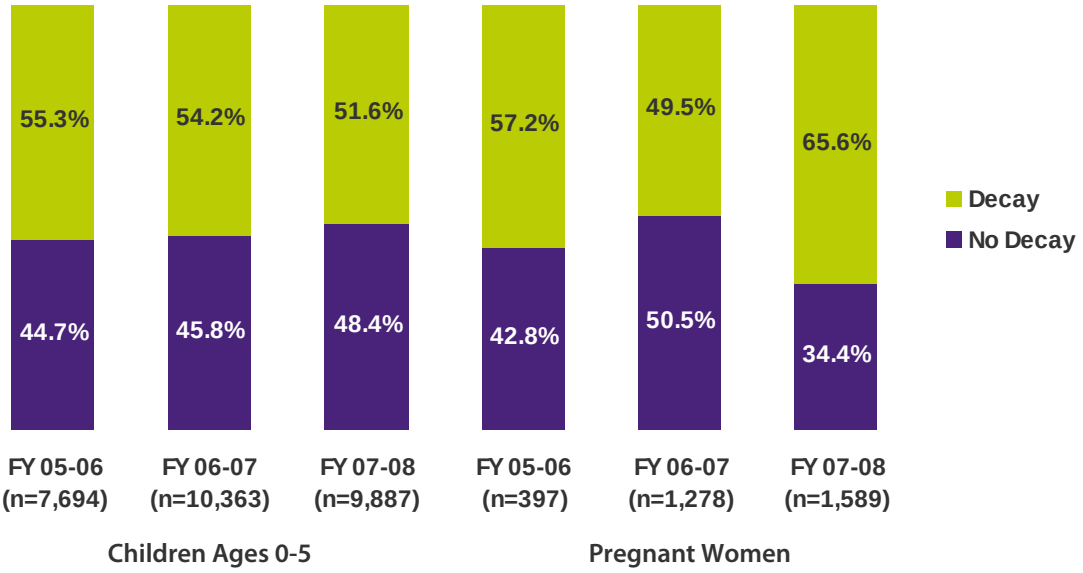
[50] In FY 2005-06 OHI programs reported age data for 80.6% of children ages 0-5 years and 74.5% of pregnant women screened. In FY 2006-07, OHI programs reported age data for 91.8% of children ages 0-5 years and 91.9% of pregnant women screened. In FY 2007-08 OHI programs reported age data for 98.8% of children ages 0-5 years and 96.6% of pregnant women screened.

Dental exams confirmed decay in a little more than half of children ages 0-5 years and a little less than two-thirds of pregnant women for whom OHI partners reported exam results.[51] The number of children ages 0-5 years confirmed to have decay has declined over the last 3 years, while the number of pregnant women confirmed to have decay declined in FY 2006-07, but then increased in FY 2007-08.[52] 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. This may be an area for further study for this initiative.

OHI Specialty Treatment Pool

Two providers currently perform the treatment for the OHI specialty treatment pool and treated 63 unduplicated clients in FY 2007-08.

Exhibit 2.6 Results of Dental Exams
FY 2005-06, FY 2006-07and FY 2007-08



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 6 months, Healthy People 2010 sets the more modest goal of annual dental visits, aiming for 57% of children and adolescents to have visited the dentist within the past year.[53, 54] To simplify data collection, OHI partners reported the length

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

[52] In FY 2005-06 OHI programs reported age data for 63.1% of children ages 0-5 years and 53.7% of pregnant women examined, in FY 2006-07, OHI programs submitted results for 85.9% of children ages 0-5 years and 85.3% of pregnant women examined, and in FY 2007-08, OHI programs submitted results for 85.8% of children ages 0-5 years and 87.9% of pregnant women examined.

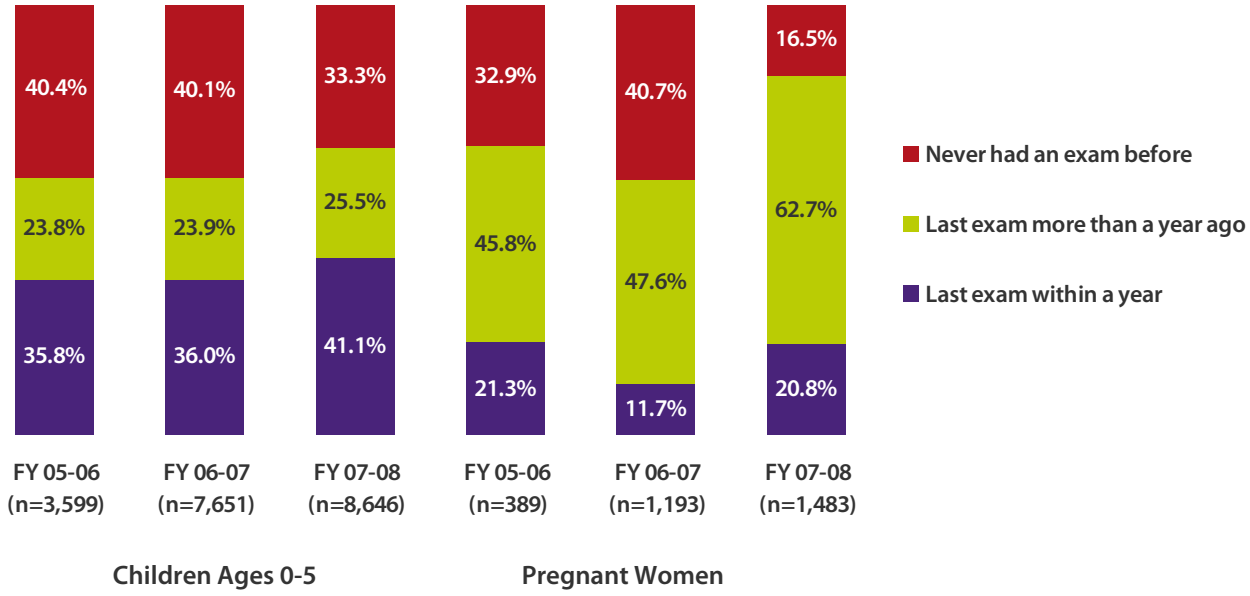
[53] Healthy People Objective 21-10 includes children over age two. Both the American Academy of Pediatric Dentistry and the American Academy of Pediatrics recommend children begin annual dental exams by their first birthday. Therefore, by age two, a child should have had an exam within the past year. For this reason, OHI programs do not report last dental exam data for children under age two.

of time since patients' last dental exams in the following three categories: (1) never visited the dentist; (2) last visited the dentist more than one year ago; (3) last visited the dentist within the past year. The findings presented below indicate that OHI 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 an increase for the second year among children ages 2-5 years who had an exam within the last year. This increase may indicate that OHI partners are having more success with recall visits. Additionally, for the second year, there was a decrease in the number of children ages 2-5 years who had never received an exam (Exhibit 3.7). These findings for children ages 2-5 are lower than figures for the county and state. In San Diego County, 60.5% of children ages 2-5 years had visited the dentist within the past year, according to the 2005 First 5 Family Survey.[55] 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.[56]

There has been an increase in the number of pregnant women reported having an exam more that a year ago for the second year; however, those reported to have never had an exam before decreased substantially from 40.7% in FY 2006-07 to 16.5% in FY 2007-08. Additionally, pregnant women reported having an exam within the last year increased from 11.7% from FY 2006-07 to 20.8% in FY 2007-08. This increase may be attributed to the concerted outreach efforts to pregnant women and prenatal care providers.

Exhibit 2.7 Lapse of Time Since Last Dental Exam,



[54] 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>

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

[56] 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.

Making the Connection

Providing dental services is core to the design of the Commission oral health efforts. Significantly, OHI has also been the catalyst for important system-wide changes that have the potential to affect the oral health of entire populations in San Diego County. While the local oral health community has pressed for these changes for many years, OHI has helped spark the system-wide collaboration needed to affect these changes.

The Context: OHI's Systems-Level Impact

OHI's six areas are interrelated – activities in one area can strengthen outcomes in other areas. OHI is notable in that it has both breadth and depth. With these advantages, OHI reaches thousands of individuals each year and addresses oral health issues at many levels – in prevention and treatment, as well as improving the platform for oral health services. It is useful to look at OHI in terms of a model called the "Spectrum of Prevention" (Exhibit 3.8). The Spectrum is a framework for discussing the multiple components necessary for 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."[57] The Spectrum asserts that activities at one level will lead to interrelated actions and outcomes at other levels. 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 necessitates policies and legislation to fund low-cost services (level 6).The table demonstrates how the Commission's oral health projects align with the Spectrum model for a comprehensive prevention system.[58]

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. In FY 2007-08, the Commission and OHI have taken steps, on a systems level, towards strengthening the existing framework of care, particularly in the areas of community water fluoridation, implementation of a Caries Risk Assessment (CRA), implementation of the Contract Monitoring and Evaluation Data System (CMEDS) database, and training to general dentists as well as primary care and prenatal care providers, all of which increases the clinics capacity to provide a dental safety net for young children and pregnant women. The below section highlights what strides have been made in these areas.

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

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

Exhibit 2.8 The Spectrum of Prevention

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	→	Implementation of a Caries Risk Assessment at dental exams; Implementation of the CMEDS database for individual client level data collection; Dentists providing exams at age one; Pediatricians providing dental screenings and referrals beginning at age 1; OB/GYNs providing dental screenings and referrals to pregnant women
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	→	Training for prenatal and primary care providers, general dentists
2. Promoting Community Education: Reaching groups of people with information and resources to promote health	→	Education for parents/caregivers of children ages 0-5 years, pregnant women, and child care providers
1. Strengthening Individual Knowledge and Skills: Enhancing an individual's capability of preventing Illness	→	Education for parents/caregivers of children ages 0-5 years, pregnant women, and child care providers

Community Water Fluoridation

Many studies have established that fluoridating public water supplies is the most effective way to prevent and reduce tooth decay at the community level.[59] In 1999, the Surgeon General listed fluoridation as one of the 10 greatest public health successes of the 20th century.[60] 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.[61, 62, 63]

Members of the local oral health community have advocated for decades to implement community water fluoridation to the San Diego area. With its commitment to children's oral health, the Commission allocated a $5.4 million investment in community water fluoridation, and was supported by an additional $1 million grant from The California Endowment.

[59] American Dental Association. Fluoridation Facts: Celebrating 60 Years of Water Fluoridation. 2005.
[60] American Dental Hygienists' Association. CDC Releases Guidelines on Fluoride Use to Prevent Tooth Decay. 2005. http://www.adha.org/profissues/cdc_fluoride_guidelines.htm
[61] Most populous state & least populous state. People. Populations Estimates and Projections. 2005. https://ask.census.gov
[62] Centers For Disease Control. Fluoridation Statistics 2002: Status of Water Fluoridation by State. <www.cdc.gov/fluoridation/fact_sheets/states_stats2002.htm>
[63] 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

Key to the timing of this project is the fluoridation of the drinking supply treated by the Metropolitan Water District (MWD). As a result of the complex water supply system of this area, San Diego County was to become a patchwork of fluoridated communities, with varying fluoride levels from water district to water district and resulting in communities with suboptimal, unregulated levels of fluoride.[64]

This fluoridation effort will begin in the City of San Diego which would benefit the greatest number of children 0-5 years in the County (approximately 112,210 children 0-5 years or 41.2% of total 0-5 population in the County).[65] The effort will then move to other areas of the county, as funds are available.

"We have so many water districts and it's only the main district [that is fluoridating]. I am thinking a lot of our patients are not getting it [fluoridated water]. [In] most of the areas we serve, there is no fluoridated water."

–OHI Dental Director

While most dental directors interviewed were familiar with the fluoridation efforts by MWD and augmented by First 5 San Diego, some expressed concern and some frustration about the areas being fluoridated, especially concerning the unmet needs. As one OHI Dental Director stated, "I don't think South Bay or parts of Chula Vista are ever going to have fluoridated water at this time. The push is out there, but I don't think that our areas are being addressed appropriately."

Exhibit 3.9 illustrates the Commission's history of involvement in regards to community water fluoridation in San Diego County.

[64] First 5 San Diego. Community Water Fluoridation. San Diego, CA: Author, 2007.
[65] San Diego Association of Governments. Accessed 27 August 2008. <http://www.sandag.org/index.asp?fuseaction=home.home>

Exhibit 2.9 Community Water Fluoridation Timeline

*The committee includes 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

Caries Risk Assessment: a New Tool for Care Coordination

Dental caries is an infectious disease in which acid-forming bacteria (found in dental plaque) damage teeth. If treated, dental caries can be reversed before a cavity forms on the tooth.[66] One way to ensure early identification of dental caries risk is to implement a Caries Risk Assessment (CRA), a process recognized by the American Academy of Pediatric Dentistry (AAPD) as an essential element of contemporary clinical care for infants, children, and adolescents.[67] The concept of caries risk assessment as a strategy for managing dental caries has evolved over the past 20 years and implementation of a CRA will provide OHI clinics with a standard risk tracking mechanism for children ages 0-5 years and pregnant women. Ultimately, preventing caries through risk assessment is a more efficient method to address the issue of dental disease than having to provide children with painful and costly treatments.

The advent of the CMEDS data system was the perfect opportunity to implement the CRA because the database will allow for tracking of individual client level data. Beginning in FY 2008-09, OHI partners will implement a standard CRA protocol modeled after existing processes.[68] The CRA will be administered at all dental exams and clients will be classified as having a low, moderate, or high risk. Those identified as high risk will be referred to the OHI Dental Care Coordinators for intensive care coordination and tracked in the CMEDS database.

The CRA will enable OHI to focus on and take a deep look at the population with the most significant costs to the oral health care system. Through the care coordinator network, trends and best practices will be identified and discussed. OHI is a national leader in implementing the Caries Risk Assessment to manage oral health care and improve outcomes for children and pregnant women most affected by dental disease.

"I am excited that our Evidence-Based work on the Caries Management by Risk Assessment [CAMBRA]* is trickling down to the safety net of providers. CAMBRA is a timely and innovative model in Oral Health across the country and I am pleased about the direction of San Diego County's [First 5] Oral Health Initiative. It's definitely headed down the right path of disease prevention management model by including an individual risk tracking mechanism for the patients in their clinics."

– Dr. Francisco Ramos-Gomez,
Professor, Section of Pediatric Dentistry,
UCLA School of Dentistry and Researcher for the UCSF/UCLA
Center to Address Disparities in Children's Oral Health,
Diplomat of the American Board of Pediatric Dentistry,
President Elect Hispanic Dental Association

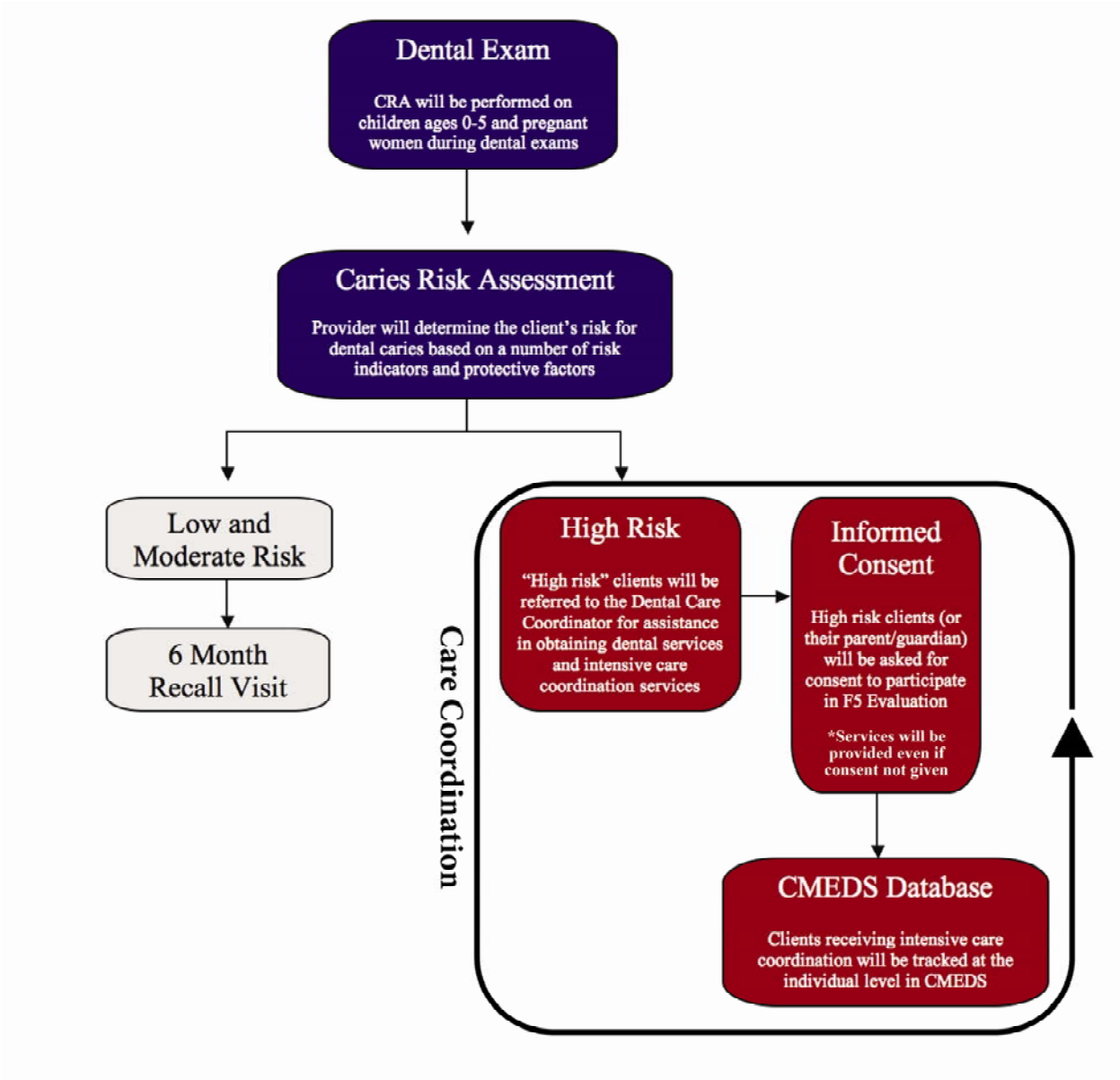
***The CRA is based on the CAMBRA model**

[66] Pediatric Dental Health. "Management and Prevention of Dental Caries in Children," 2004. Accessed 30 June 2008. <http://dentalresource.org/topic54denatlcaries.html>

[67] American Academy of Pediatric Dentistry. Policy Statement on the use of a Caries-Risk-Assessment Tool, 2002. Accessed 30 June 2008. <http://www.aapd.org/pdf/policycariesriskassessmenttool.pdf>

[68] Existing tools and processes include those developed by: Francisco Ramos-Gomez, DDS, MS, MPH; James Crall, DDS, SCD; First Smiles Program; and Pacific School of Dentistry.

Exhibit 2.10 Caries Risk Assessment & Focused Care Coordination: The Intensive Care Coordination Model



The Care Coordination model was created by OHI Dental Care Coordinators in collaboration with the Council and First 5

Connecting the Specialties: Increasing the Capacity to Treat Young Children and Pregnant Women

As part of its role, OHI sponsors an annual conference for oral health professionals. This year, a special outreach was done to include medical providers, including physicians and nurses. Ensuring a clear connection between medical and dental providers is critical for early prevention as medical doctors often see clients more regularly at well-child and maternity visits. Physicians and nurses can reinforce the importance of early dental care to their patients, while dental providers can provide critical preventive care services for the medical establishment.

In all, more than 100 professionals participated.[69] Conference topics included dental emergencies, pregnant women treatment myths and considerations, prenatal oral health and behavior management techniques. 19.6% of conference survey participants were from the medical field. Participant evaluations revealed: (n=84)[70],[71]

- ***Building a foundation to treat children ages 0-5 and pregnant women:*** 66.0% gained knowledge about providing treatment to pregnant women, 92.6% gained knowledge about providing infant/child oral health education to parents and caregivers, 94.0% of medical providers gained knowledge about when to refer children ages 0-5 years and 93.9% of dental providers gained knowledge about when to treat children ages 0-5 years.

Reflecting on Results

Over a quarter of survey respondents from the April 2008 training also attended the February 2007 OHI-sponsored provider training. These repeat attendees commented about how they and their practices have changed since attending the first training a year ago:

- "[I] changed [the method] of treatment planning [for] prenatal patients"
- "[I know] how to motivate parents to listen"
- "[I] am more comfortable treating children"
- "I just feel more confident giving advice and attending to pregnant women"
- "I provided better treatment to the kids 0-5 and the pregnant women"
- "I see more kids in the clinic"
- "[I] spend more time about patient education and improved my management behaviors for kids"

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

"Medical and dental need to practice teaching patient information from both fields."

– OHI Provider Training Attendee

[69] Additional dental, primary care and prenatal providers participated in smaller training events during the fiscal year.
[70] Participants 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 the survey during the training.
[71] Valid percents are reported. 'Not applicable' responses were coded as invalid and not reported. Additionally, some questions were only asked on dental providers.

- ***Planning to increase services to children ages 0-5 years and pregnant women:*** 92.5% of dental providers indicated they were more likely to encourage treatment in pregnant women and 92.9% of dental providers indicated they were more likely to treat children ages 0-5 years.

Providing a dental safety net for San Diego County's children and pregnant women

"[Specialty treatment] is a necessity for people with low incomes. [My daughter's] work would have cost me thousands of dollars!"

–OHI Parent

The majority of OHI clinics are Federally Qualified Health Centers (FQHCs), also referred to as Community Health Centers, which serve the underinsured and uninsured populations in San Diego County. OHI clinics rely on funding sources such as Denti-Cal and First 5 in order to provide a dental safety net for young children and pregnant women.

According to the California HealthCare Foundation, "California's reimbursement rates for publicly funded dental care are among the lowest in the nation, which is well below the fees charged by most dentists. As a result, less than half of dental practices accept Denti-Cal patients, and access to specialty care, such as pediatric dentistry and orthodontics, is very limited."[72] These low reimbursement rates coupled with the immediate threat of cuts to adult Denti-Cal discourage dentists in private practice from treating Denti-Cal enrollees.[73]

These low reimbursement rates and threats of cuts impact OHI partners and the populations they serve in many ways:

- OHI partners rely on income from Denti-Cal (in addition to funding from other sources such as First 5) to sustain clinic operations (i.e., staffing and office hours).
- Patients currently being treated by private dentists (who accept Denti-Cal) will likely turn to OHI partners for their care as more private dentists stop accepting Denti-Cal. Interviews with OHI Dental Directors revealed how OHI clinics are affected by the shortage of dentists who accept Denti-Cal and serve young children within San Diego County:
    - There are few pediatric dentists and specialists who will accept referrals of Denti-Cal clients.
    - There are limited numbers of clinics in San Diego that accept Denti-Cal and many are not conveniently located requiring patients to travel. This increases waiting periods.
    - Two Dental Directors stated that they often need to refer Denti-Cal clients to practices in other counties.

"We don't have a pediatric dentist [on staff]. Our general dentists have experience with children. When we have to refer out, there are very few that will take our patients and most of them are down South. Our patients don't have transportation to the more extensive treatment that they need."

–Health Center Administrator

[72] California HealthCare Foundation. Denti-Cal Facts and Figures: A Look at California's Medicaid Dental Program. 2007. Accessed 30 June 2008. <http://www.chcf.org/topics/medi-cal/index.cfm?itemID=131431>

[73] California HealthCare Foundation. Expanding Access to Dental Care Through California's Community Health Centers. 2008. Accessed 20 August 2008. <http://www.chcf.org/topics/view.cfm?itemID=133725>

OHI funding benefits clinic operations (see textbox) and also allows clinics to increase their capacity as a dental safety net in their role of providing an integrated model for the oral health care of children ages 0-5 years and pregnant women.

Reflecting on Results
How OHI Benefits Clinics

When asked how participating in OHI has benefited their clinic, Dental Directors' responses included:

- "[OHI has] benefitted the clinic a lot. It is an integrated model – patients are receiving comprehensive health care. We find that they are taking care of themselves overall."
- "We give free screenings and that draws patients in. And we do community events, and this offers the opportunity to get this population into the clinic.
- "The tertiary funds to help kids where there was never a funding source [before]."
- "OHI has helped by bounding other community health centers to each other. It's helpful to know what works for them and what doesn't."
- "Children have more access to dental care. [There is more] dental education to the children and the parents. [We have] increased our visits, which increase our financial ability. [OHI] has been an excellent thing – I believe a very positive thing."
- "I think it's benefitted the community. I think it's a great program."

A recent study conducted by the California HealthCare Foundation with six community health centers in California revealed that, although these clinics have the potential to expand dental care for low income Californians, they do not have the capacity to meet the dental care needs of their populations. Barriers ranged from insufficient capital resources to difficulties hiring high quality professional staff and a patient-payer mix that does not allow for adequate reimbursement. The study specified six recommendations for overcoming these barriers (exhibit 3.11).[74] Significantly, the OHI system currently addresses five out the six recommendations, which helps strengthen the safety net for oral health services in San Diego County.

[74] California HealthCare Foundation. Expanding Access to Dental Care Through California's Community Health Centers, 2008. Accessed 20 August 2008. <http://www.chcf.org/topics/view.cfm?itemID=133725>

Exhibit 2.11 OHI's Alignment to Dental Safety Net Recommendations	
CHF Recommendation	**The OHI System**
Creation of a peer networking program that would allow clinic dental directors and executives to discuss clinical, operational, administrative, financial, and policy issues.	The OHI lead agency (the Council) fosters peer networks by conducting meetings with OHI Dental Directors, OHI Dental Care Coordinators and clinic administrators.
Wider dissemination of "best practices" for clinic efficiency and cost saving, such as bulk purchasing of supplies and services.	The OHI lead agency maintains a group purchasing program, which allows OHI clinics to purchase supplies at a discounted rate.
Clarifications of reimbursement policies for FQHCs on allowable services, billing rules and procedures, and location of services.	The OHI lead agency holds trainings for community health center staff to address billing issues with the State of California Denti-Cal program.
Greater funding for capital funds and start up costs.	OHI's Oral Health Capacity Building Projects has provided capital funding for OHI clinics.
Support for programs which encourage dental student professionals to practice in a clinical setting, such as externships, residencies, and loan repayment.	One OHI partner has collaborated with other oral health agencies to establish a Pediatric Residency Program.
Further research on the ability of health centers to provide inducement to attract qualified dentist through partnerships with other oral health centers, use expanded–scope dental professionals, and streamline licensing and regulatory requirements for expanding or opening new clinics.	No action currently planned.

Update on Recommendations from FY 2006-07

The following actions were recommended in the Commission's Annual Evaluation Report for FY 2006-07. As described below, OHI has taken strides to address many of these areas.

Recommendation 1: Play a lead role in organizing key players to respond to AB 1433 requirements.

Update: AB 1433[1] has benefited OHI partners. Interviews with OHI Dental Directors revealed that AB 1433 has affected many of the clinics in a positive way. It brings more children into the clinics, helping to establish a dental home and getting children into the system. Outreach was conducted in FY 2007-08 to help with the completion of the required form. Although there has been challenges working with the school districts, OHI clinics have created partnerships with some schools and agencies (i.e., Head Start) to provide the required screening. However, AB 133 is an unfunded mandate, and OHI services have been critical in helping families meet this requirement.

Recommendation 2: Sustain and expand provider capacity building efforts.

Update: In FY 2007-08, OHI provided a number of professional development opportunities including a conference and numerous training programs provided by the Council, including training sessions on the California State Denti-Cal program to address billing issues and sealant trainings for Registered Dental Assistants. The Dental Director and Care Coordinator meetings are forums for sharing best practices and improving care in a collaborative fashion.

Recommendation 3: Maximize the potential benefits of community water fluoridation and expand the circle of local support for oral health services.[1]

Update: The Commission has allocated $6.4 million toward this effort, and completed a technical study of all water districts needing fluoridation. The Commission authorized funds for the capital costs of water fluoridation and 2 years of operations and maintenance funds for the City of San Diego. It will be crucial to secure a commitment from the City of San Diego to fund ongoing operations and maintenance for up to 20 years.

Recommendation 4: Explore how to offer pregnant women more individualized, one-on-one education about the importance of oral health and low-cost dental services.

Update: In FY 2007-08, OHI increased outreach to primary and prenatal care providers to better serve this population, and the annual OHI conference also invited OBGYN's to attend. Additionally, OHI Dental Care Coordinators partnered with prenatal education providers to provide oral health education to expecting parents.

Recommendation 5: Consider a treatment pool or other funding mechanism for pregnant women. Update: Due to limited funding, a treatment pool for pregnant women was not established in FY 2007-08 and will continue to be explored by OHI.

Recommendations

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

- **Continue to consider a treatment pool or other funding mechanism for pregnant women.** Even when they know the benefits and where to go for dental health care, many pregnant women are unable to access dental treatment because they cannot afford the costs of treatment, or the scope of services for pregnant women covered by Medi-Cal is too limited. First 5 San Diego may continue to explore how Medi-Cal funds dental care for pregnant women and identify how to align its funds to maximize pregnant women's access to dental care. 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.
- **Expand the pool of specialty providers that contract with the treatment pool for children ages 0-5 years.** OHI Dental Directors and Dental Care Coordinators expressed the need for an expanded pool of specialty providers for referrals to the OHI treatment pool. This is of particular concern for clinics located in North San Diego County where distance is the largest barrier to treatment.
- **Investigate strategies to recruit and retain dentists or other dental professionals in Community Health Centers.** Staff turnover and the shortage of dentists impact OHI clinics and the patients they serve. It would be beneficial for OHI to investigate ways of recruiting and retaining dental professionals to practice in community health centers, such as partnering with dental schools or providing externships and loan repayments.
- **Finalize the caries risk assessment tool and intensive care coordination model and provide ongoing training and technical assistance for CMEDS to maximize the capability of the database.** To successfully implement this groundbreaking practice at OHI clinics countywide, it will involve a pilot phase, ongoing feedback, training, and improvement.
- **Connect Dental Care Coordinators to other First 5 programs.** Interviews with OHI Dental Directors revealed the majority were either not aware of, or not certain if, their clinic receives funding for, or works with, other First 5 initiatives. The Dental Care Coordinators are well positioned to share information about other First 5 initiatives with their clients and with other professionals in the clinic. At minimum, Care Coordinators should utilize the First 5 warmline at 211 San Diego for referring families of these high risk children who may benefit from other important health or early education services funded by First 5.
- **Continue to foster partnerships with the medical community.** In FY 2007-08, OHI made strides in connecting with the medical community. The medical community has been responsive to OHI's outreach and partnerships between the medical and dental community should continue to be explored and strengthened. "The medical-dental partnership is crucial because when physicians recommend a dental visit, patients are more likely to follow up." [75]
- **Implement a social marketing campaign to change community norms around oral health.** In FY 2007-08, OHI continued to provide oral health education and training. Education on community water fluoridation is of particular importance at this time as the City of San Diego moves forward with its water fluoridation efforts. Many families, particularly members of various immigrant communities, will need information concerning the safety benefits of community drinking water. Continued education efforts coupled with a social marketing campaign will help change community norms around oral health.

[75] California HealthCare Foundation. The Good Practice: Treating Underserved Dental Patients While Staying Afloat, 2008. Accessed 20 August 2008. < http://www.chcf.org/topics/view.cfm?itemid=133706>

- **Explore the possibility of tracking and reporting recall exams.** It is difficult to draw conclusions about why results of dental exam figures have changed from year to year without knowing how many individuals are returning patients (recalls). It would be beneficial to explore tracking these returning patients as well as the reason for the return visit. CMEDS may begin to explore this possibility for high risk patients.

A Final Word about the Oral Health Initiative

In FY 2007-08, OHI programs delivered crucial preventive and restorative dental services to over 10,000 children ages 0-5 years and thousands of pregnant women. One of OHI's greatest accomplishments this fiscal year is the increase of care coordination services particularly for pregnant women. OHI providers increased care coordination efforts for children ages 0-5 years by 24.1% and pregnant women by 77.5%. Direct services, remained central in FY 2007-08 and there was a focus on increasing outreach to the medical community.

OHI partners also provide a dental safety net for young children and pregnant women in San Diego County and their scope extends far beyond the provision of direct services (i.e., screenings, exams and treatment). As the Initiative moves into its fourth year, it is notable that OHI's system level improvements have raised community knowledge about oral health. These improvements include care coordination, parent and caregiver education, provider education, capacity building efforts, capital projects, and a specialty treatment pool for children. San Diego County's First 5 Oral Health Initiative offers 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.

Case Study 2
Learning the Importance of Oral Health*

Rosario's Family

Rosario is a grandmother in her sixties and has raised seven children of her own. They have all grown into adults and lead their own lives, living in either San Diego or Mexico. Rosario thought she was finished raising children until her daughter was deported to Mexico and she took in three of her sixteen grandchildren ages 4, 5, and 11. Soon after Rosario received the children, she attempted to enroll the younger children, Lola and Oscar, into Head Start. It was here that she faced some unexpected health barriers and turned to First 5 San Diego funded services for help.

Oral Health Prerequisites

To be enrolled in Head Start, a physical exam is required for the children. To obtain this physical exam, Head Start referred Rosario to La Maestra, a First 5 San Diego funded clinic, for a routine physical. The results showed that both children had poor dental health. Lola had nine cavities, while Oscar had six. Oscar's cavities were easy for the dental health provider to fix because he was relaxed during the procedures. Rosario enrolled him in Head Start shortly thereafter. However, Lola, the younger of the two, was so tense that the health providers tried unsuccessfully three different times to fix her cavities. After these fruitless attempts to treat Lola, La Maestra staff coordinated a meeting between Rosario and the clinic's dental coordinator, Selma. Shortly thereafter, Rosario learned of the First 5 funded Oral Health Initiative (OHI) specialty treatment pool that could assist Lola.

"What a problem that a child has his teeth bad…And people with low resources, we need. Because it wasn't $500. It was thousands."

- Rosario, First 5 Parent

Hospitality at the Hospital

When Rosario voiced to Selma, "I don't know what I am going to do because I don't have insurance or anything and the girl is not well." Selma began the process of enrolling Lola into the (OHI) specialty treatment pool. Rosario recalls that Selma "...did all my paperwork" and was able to get Lola transferred to a specialist at a hospital. At the hospital, Rosario received an appointment for Lola very quickly. "…They attended [to] me quickly because to be able to go into Head Start she had to have a clean health record," Rosario said. With First 5 funding, Lola received sedation and the specialists were able to complete all of the work she needed without having to remove any of her teeth.

Rosario was so grateful for Selma's help:

"Thank God Selma contacted me and that's it. They can help her and, yes, thank God, they could. The girl is doing very well...What a great heart Selma has because she worried about [the] kids! ...she's the one who helped me a lot to get into that program."

After Lola completed the procedure at the hospital, Rosario received additional health information for the children on behalf of First 5 from the La Maestra clinic. The information taught the children how to brush their teeth in the morning and at night, and they also provided them with tooth brushes.

Moving Forward

Rosario noted that an ongoing concern for her is the lack of dental insurance for her grandchildren. This is primarily a result of the legal barriers she faces to enrolling the children in Medi-Cal, since she does not have legal custody, coupled with a low-income that restricts her from purchasing health insurance for all three children. Rosario intends to schedule a follow-up appointment for Lola. She feels very comfortable at the clinic because there are no language barriers. Overall, Rosario has had a positive experience at La Maestra. She finds them to be "very humane," providing services for her when she had no other options.

"Those people in those clinics help people very much. . Just like us with low-resources that…any little thing, any doctor…one makes the sacrifice and with little payments, one can pay. . But they have been able to help me"

- Rosario, First 5 Parent

**All names were changed to protect confidentiality*

CHAPTER 3

Healthy Development Services Initiative

"[HDS gave us] very good information about things that are important to us as teen parents…we learned how to take care of our kids, what to expect from them, and how to be better parents."

—HDS Parent

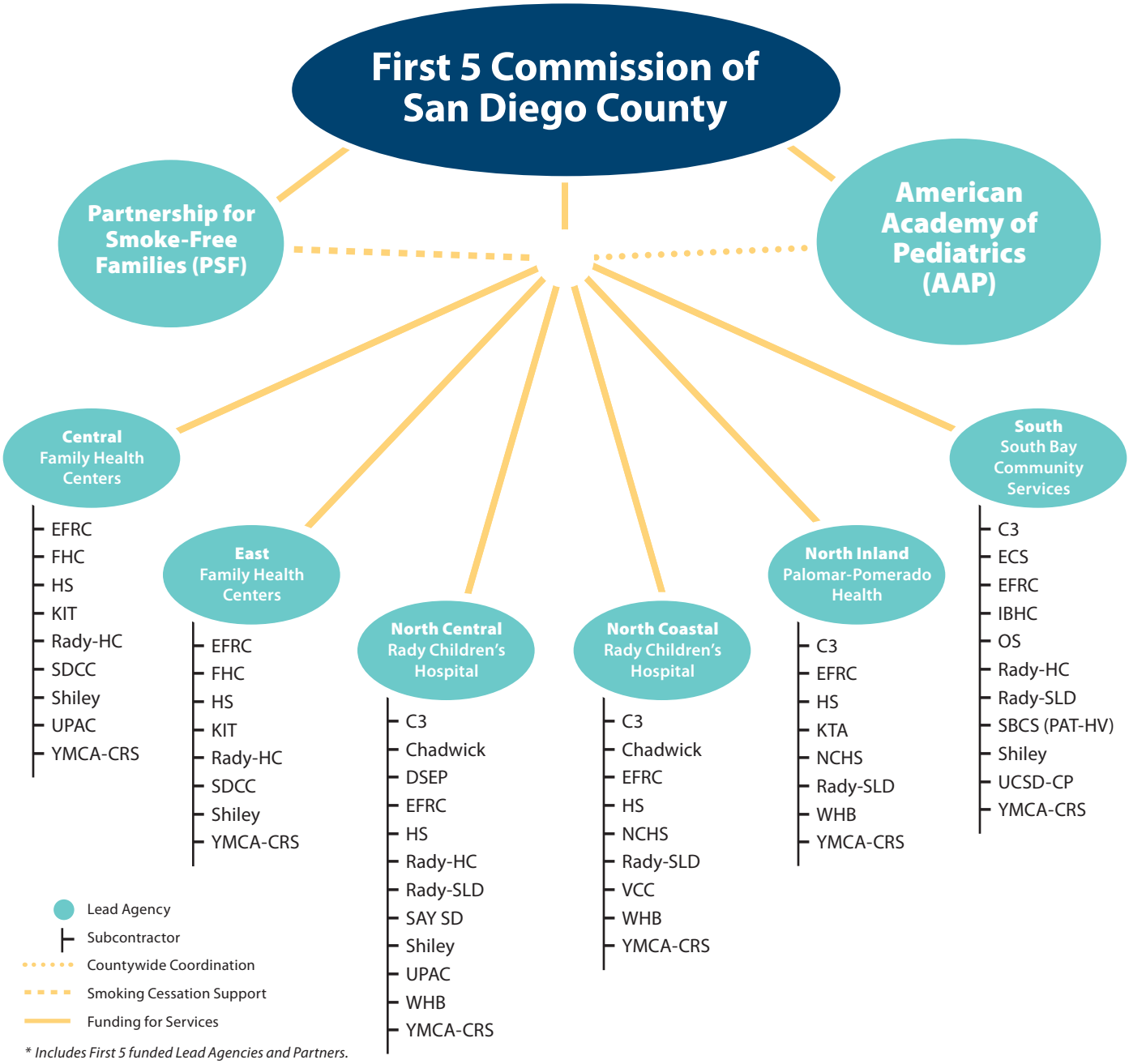
Key Results

- **Over 1 in 7 children age 0 to 5 years in San Diego County were served through HDS services.** Some 32,912 individual children were served through the gateway services.
- **Children received needed services.** Approximately 64.2% of all children needing assessments and 73.4% of children needing treatment received services this year.
- **Children exhibited health and developmental gains.** Across the project, over half (57.1%) of all children tracked during FY 2007-08 showed gains based on treatment received through HDS. Many of those children who did not show gains continued in the program or were referred to specialists for additional assistance.
- **Children had access to and used appropriate health care resources.** Over 95% of children were insured, and nearly 100% had an appropriate medical home and had received an annual well child visit.
- **HDS providers increased collaboration and service coordination.** A total of 10,883 children/families being served in HDS received a referral to another HDS service, for a total of 11,071 referrals. Three quarters (75.6%) of those referrals resulted in a successful initiation of services. Also, a total of 21,865 referrals were given to HDS clients for non-HDS services during FY 2007-08.
- **The HDS system of care approach continued to strengthen.** Regional leads and AAP continued to meet to standardize approaches to service delivery through clinical pathways, referral networks and data collection.

Summing It Up

- Nearly 33,000 children were served by four HDS gateway services in FY 2007-08, an increase of 4,000 from the previous fiscal year. Children served among all service areas equaled 68,733, though children may have received services across multiple areas and may be duplicative.
- Developmental screenings were the most provided service, 16,032 screenings were provided to 13,624 children.
- Over 7,000 children received a screening for speech and language delays (for a total of 8,926 screenings). In addition, a total of 2,860 behavioral screenings were provided to 2,553 children, a tremendous increase from the previous fiscal year.
- Over 8,000 newborns received at least one newborn medical home visit, for a total of 13,442 visits.
- Nearly 9,000 vision and hearing screenings were performed this year.
- Over 25,000 families received tobacco use screenings this year; 5.5% of screenings indicated a smoker in the household and were referred to the Smoker's Helpline.

Healthy Development Services Initiative*



** Includes First 5 funded Lead Agencies and Partners.*

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.
KTA=Kids Therapy Associates, Inc.
NCHS=North County Health Services
OS=Operation Samahan Clinic
PAT-HV=Parents as Teachers Home Visiting
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

Over the last decade, research studies have increasingly demonstrated the role and importance of healthy development in assuring school readiness and lifelong learning capacity. 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 years 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.[76] Furthermore, there may be significant costs ($30,000 to $100,000 per child) resulting from the failure to identify and address developmental problems in the early years. Much of this cost is ultimately born by the education system when children with preventable delays enter school.[77]

In response to this need, the First 5 Commission of San Diego County funded the Healthy Development 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. The initiative follows the research recommendations of developing systems that reduce gaps and improve the coordination of early childhood services.[78] First 5 San Diego has allocated $51.6 million over four and a half years for this project. In FY 2007-08, HDS worked to provide services to thousands of children throughout San Diego County and continued to work on system-level efforts to improve the delivery of those services, creating a system of care that is more responsive and more effective.

Key Elements

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

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

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,

[76] 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>
[77] Halfon, N., Uyeda, K., Inkelas, M., Rice, T. "Building Bridges: A Comprehensive System for Healthy Development and School Readiness." National Center for Infant and Early Childhood Health Policy, 2004.
[78] Ibid.

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 San Diego County's six Health and Human Services Agency (HHSA) regions, 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 years and their families:[79]
  - ***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.
  - ***At-Risk Home Visitation (ARHV)*** or ongoing home visiting for families considered "at-risk" 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.
  - ***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 for pregnant woman and new parents to reduce children's exposure to tobacco in the home.
- **Countywide Support and Capacity Building:** The American Academy of Pediatrics (AAP), California Chapter 3, is contracted to oversee and coordinate HDS' countywide implementation. AAP identifies screening protocols and clinical pathways, develops referral guidelines, organizes uniform and standardized reporting, shares best practices and designs quality improvement resources and support. Additionally, AAP coordinates needed training, develops and utilizes an advisory committee, creates linkages with key health care and community-based organizations, and promotes fiscal leveraging.

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

Summing It Up

During FY 2007-08, HDS served 68,733 children ages 0-5 years among the many HDS service areas (Exhibit 2.1).[80] However, a more conservative measurement estimates that 32,912 unduplicated children received HDS services.[81] This represents one in seven children aged 0 to 5 years in San Diego County.[82] The introduction of a Commission data system in FY 2008-09 will allow for the collection of an unduplicated count of children served by HDS. FY 2007-08 marks the second year of HDS and provides a year of comparison data that provides a sense of how services have grown. Eight of the 11 service areas increased the number of children served in FY 2007-08. There were significant increases in the number of developmental screenings, speech and language services, behavioral services, newborn home visits, and behavioral consultation services. Seven out of nine service areas that had established target numbers met those targets (See Exhibit 3.1).[83] Three service areas had a decrease in the number of children served from FY 2006-07 to FY 2007-08, though still met their target numbers.

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 at 9, 18, and 24 or 30 months and whenever a parent or provider concern is expressed. Despite this national recommendation, previous data indicated that only approximately 65.0% of San Diego parents reported that their child received some type of developmental screening or assessment.[84] Consequently, First 5 San Diego determined developmental screening to be a top priority for HDS and a primary gateway for most other HDS services.

[80] This number is a combination of all children served in the categories listed and includes a duplicated count of children who may have received services in multiple categories. These process numbers originate from contractors' quarterly reports to the Commission, which are produced by each region. It is not possible to determine a true unduplicated count of all children served for the entire project.

[81] AAP calculates this number by designating four service components as primary "gateway" services in which children are likely to enter into the HDS system: NMHV; Developmental screening; Vision screening; PS&E (indirectly served children). Children are not directly served by PS&E, as parents are the primary clients. Therefore, the number of children for this category is based on each parent served having at least one child under the age of 6 years of age.

[82] This ratio was calculated by dividing the unduplicated count by an estimated 273,588 children ages 0-5 years in San Diego County. Accessed through the California Department of Finance website <http://www.dof.ca.gov/HTML/DEMOGRAP/ReportsPapers/Projections/Births/birth_projections>

[83] In FY 2007-08, AAP and First 5 established a more standardized approach to developing targets with the regional leads allowing for comparison of service numbers to target numbers.

[84] First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005. 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?" This question was used as a proxy, because many parents are unfamiliar with the term "developmental assessment."

Exhibit 3.1 Total Children Served by Service Category*				
Service Area	**Total New Children Served in FY 2006-07**	**Total New Children Served in FY 2007-08**	**Increase (+) or Decrease (-) in New Children Served from FY 2006-07 to FY 2007-08**	**FY 2007-08 Target Number Met**
Developmental Screening	11,622	13,624	+	✓
Developmental Assessment/Treatment***	5,801	6,605	+	✓
Speech and Language Services***	8,771	11,423	+	No target
Behavioral Services***	1,209	4,384	+	No target
Newborn Medical Home Visitation	6,396	8,331	+	✓
At-Risk Home Visitation	3,187	2,157	-	✓
Vision Screening	8,921	8,590	-	✓
Vision Assessment/Treatment***	959	1,135	+	
Hearing Screening	8,952	8,639	-	✓
Parent Support and Empowerment**	1,999	2,367	+	✓
Behavioral Consultation****	90	1,478	n/a****	
Total Maximum Children Served***	**57,907**	**68,733**	**+**	
Total Minimum Children Served***	**28,938**	**32,912**	**+**	

**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. It was assumed that each parent served had at least one child under the age of 6.*
****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.*
*****In FY 2006-07, the number of children who received behavioral assessments through consultation services was counted here, however in 2007-08, the collection was modified to include the number of clients who required a consultation (typically a parent or provider). It was assumed that each client requiring a consultation represented a child. Because of the change In data collection, the two fiscal years cannot be compared.*
******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.*

Exhibit 3.2 shows the number of screenings, assessments, and treatment units provided, as well as the number of children receiving those development, speech, and behavioral services during FY 2007-08 compared to the previous fiscal year.[85] All services and children served increased from FY 2006-07.

Exhibit 3.2 Developmental, Speech/Language and Behavioral Services

	Developmental		Speech & Language		Behavioral	
	FY 2006-07	FY 2007-08	FY 2006-07	FY 2007-08	FY 2006-07	FY 2007-08
Screenings	13,275	16,032	7,774	8,926	645	2,860
Children Screened	11,622	13,624	6,442	7,087	466	2,553
Assessments	3,371	4,589	972	1,974	460	1,364
Children Assessed	3,045	3,786	931	1,866	203	508
Treatment Units*	11,329	13,969	9,532	11,275	2,858	7,507
Children Treated	2,756	2,819	1,398	2,470	540	1,323

**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 and language and Parent-Child Interaction Therapy (PCIT) for behavioral services.*

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 16,032 developmental screenings were provided to 13,624 children. Approximately 45.6% of children screened were determined to need some follow-up after screening, an increase from last fiscal year (40.3%).[86] Developmental assessment and treatment contractors conducted 3,786 assessments and provided 13,969 treatment units. The average treatment unit per child increased from four units per child served in FY 2006-07 to five treatment units per child served in FY 2007-08.

Speech and Language Services. Although it is not a gateway to other HDS services, speech/language service contractors continued to serve a relatively high number of children. Over 7,000 children received screenings for speech and language delays (for a total of 8,926 screenings). Of the children screened, 29.7% screened were found to need further assessment, an increase from last fiscal year (27.3%).[87] Speech and language service contractors assessed 1,866 and treated 2,470 children, for a total of 11,275 treatment units. The average treatment unit per child decreased from 6.8 units per child in FY 2006-07 to an average of 4.6 units per child in FY 2007-08.

[85] It is important to note that these three service areas often overlap and during FY 2007-08, service providers were asked to more clearly collect each service as it occurred even if there was overlap. For instance, some developmental service providers screen for speech and behavioral delays during the developmental screen, as the issues are not always distinguishable. In these cases, providers should have documented all three screenings, rather than just one. This was not necessarily the case for FY 2006-07, and therefore increases in services may be reflective not only of program growth, but of more accurate counting.

[86] 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 for services from outside the HDS network. The percentage needing follow-up is based on all children receiving the service and is therefore an duplicated count of children served.

[87] Ibid.

Behavioral Services. Behavioral screenings (n= 2,860) were provided to 2,553 children during this fiscal year. Over a third of these children (36.9%) were identified as needing further assessment, which is a decrease from last fiscal year (50.8%).[88] Behavioral assessments (n=1,364) were given to 508 children, and 1,323 children were provided a total of 7,507 treatment units (average of 5.7 units of service per child). This was an increase from FY 2006-07 (average of 5.3 service units per child).

"Thank you for teaching us how to keep our children healthy and also how to and how not to discipline our children…I know I will be a better parent now."

– Teen Parent who received Behavioral Services

Home Visitation

Research has found home visiting models to be highly effective in providing services to hard-to-reach and at-risk populations, as well as improving family health and self-sufficiency.[89] HDS offers 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, as well as the mother's risk for postpartum depression. The nurse examines the child's feeding and assists with breastfeeding support as needed and provides brief parent education about child development, including distribution of the Kit for New Parents (See Chapter 7 for a discussion of the Kit for New Parents). The home visit also includes a general screening for home safety and smoking in the household, and identifies needs for referrals and resources.

In FY 2007-08, the RSNs and AAP continued to build relationships with local birthing centers to facilitate the referral of first-time mothers to NMHV. New mothers from 13 of 17 San Diego County birthing centers currently refer to HDS. As a result, during the 2007 calendar year, 61.4% of San Diego County's first time mothers were referred for a HDS newborn medical home visit, a 17.2% increase from 2006 calendar year.[90] As Exhibit 3.3 illustrates, there appears to be a gap between the number of referrals and the number of children being served by HDS.[91] Of those referred, 66.2% received a newborn medical home visit, which is an increase from last fiscal year (62.0%). In addition, the bar graph shows the gap between the number of referrals and the estimate of new mothers served by the birthing centers. Overall, 40.7% of first time mothers are receiving newborn medical home visits – a large increase from last fiscal year (27.4%). It is important to note that not all birthing centers are currently participating in the NMHV referral process and that parents can decline a visit.[92]

---

[88] Ibid.

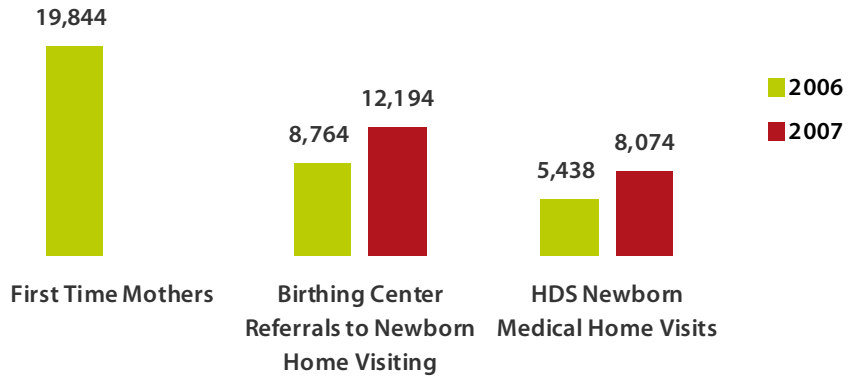
[89] A. Goodman. Grants Results Special Report. The Story of David Olds and the Nurse Home Visiting Program. July 2006. Robert Wood Johnson Foundation. <http://www.rwjf.org/files/publications/other/DavidOldsSpecialReport0606.pdf>

[90] 2007 calendar year data was used for referrals and NMHV. The number of first time mothers in 2006 is used as an estimate for 2007, as the number of new mothers in 2007 was not available.

[91] 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.

[92] 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.

Exhibit 3.3 2007 Newborn Medical Home Visiting Referrals and Visits Compared to Estimates from 2006 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)*

During FY 2007-08, the NMHV service providers conducted over 13,400 visits -- which included the initial visit, and any necessary follow-on visits or phone follow-up -- to over 8,300 infants and their families (refer to Exhibit 3.4). Of the children served, 7,125 (85.5%) were breastfeeding at the time of the visit, an increase from last fiscal year (83.7%).[93] However, more children were living in a household with a smoker than last fiscal year (7.6% in FY 2007-08 compared to 6.0% in FY 2006-07).

Exhibit 3.4 Home Visitation Services

	Newborn		At Risk	
	FY 2006-07	FY 2007-08	FY 2006-07	FY 2007-08
Visits*	8,037	13,442	7,098	8,087
Children Served	6,396	8,331	3,187	2,157

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

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 Exhibit 3.4 illustrates, 2,157 at-risk children and their families received 8,087 home visits. While the number of children and their families served decreased from last fiscal year, it is important to note that the average visits per child increased from an average of 2.2 visits in FY 2006-07 to an average of 3.7 visits in FY 2007-08. This increase in the average number of visits per child suggests that children and their families are being more intensively served through ARHV. For at-risk children and their families, more children seen at the first home visit were breastfeeding (49.1%) than last fiscal year (40.9%).[94] Additionally, 6.9% of the children considered at-risk were living in a household with someone who smokes, a considerable increase from FY 2006-07 (2.4%). The home visitors provide families with referrals to the California Smoker's Helpline as part of the connection to Partnership for Smoke-Free Families (see page 62).

[93] 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>

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

Hearing and Vision Services

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

During FY 2007-08, a total of 8,639 children received hearing screenings (see Exhibit 3.5). Of those children screened, 14.9% were found to need further assessment, which is an increase from last fiscal year (10.4%).[95] Hearing screening providers refer all children who need additional assessment or treatment outside of HDS to a primary physician for services.

Vision service providers also conducted screenings for 8,590 children during FY 2007-08. Of those children screened, 20.5% were noted as needing additional services which decreased from FY 2006-07 (25.4%).[96] Vision service contractors also assessed 696 children and treated 439 children, averaging one treatment unit per child.

Exhibit 3.5 Hearing and Vision Services

	Hearing		Vision	
	FY 2006-07	FY 2007-08	FY 2006-07	FY 2007-08
Screenings	8,953	8,705	9,130	8,697
Children Screened	8,952	8,639	8,921	8,590
Assessments	-	-	797	763
Children Assessed	-	-	794	696
Treatment Units	-	-	162	439
Children Treated	-	-	83	439

Parent Support and Empowerment

The primary focus of HDS is to ensure early identification and treatment of children's delays. Key to this project is assisting parents, who 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 child development, available resources and the skills needed to support their children.

Exhibit 3.6 Parent Support & Empowerment Services

	FY 06-07	FY 07-08
Sessions	3,079	3,188
Parents Served	2,109	2,367
Children Served Indirectly*	1,999	2,367

**For FY 2007-08, the actual number of children served indirectly was not collected, as parents are the primary clients. It was assumed that each parent served had at least one child less than 6 years of age; therefore the number of parents and number of children estimated to be served are identical.*

[95] 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 (i.e., families have private insurance or qualify for other publicly funded services. 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).

[96] Ibid.

In FY 2007-08, PS&E contractors provided approximately 3,188 sessions with 2,367 parents, including one on-one sessions and group workshops and classes. Over 2,300 children were beneficiaries of the PS&E services. (See Exhibit 3.6).

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 3.7 reports the types and numbers of services provided by the contracted consultation service providers during FY 2007-08. There was an increase in all types of consultation services, with the exception of a slight decrease in family consultation, when compared to FY 2006-07 results.

Exhibit 3.7 Consultation Services

	FY 2006-07	FY 2007-08
Family Consultations	921*	838
Provider Consultations	863	1,329
Workshops	217	966
Workshop Attendees**	2,521	4,141

**This number has been updated since last fiscal year report*

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

Tobacco Use Screening and Treatment Referral Services

Smoking during pregnancy can seriously slow fetal growth and nearly doubles a woman's risk of having a baby with low birth rate. The Surgeon General has stressed that secondhand smoke causes premature death and disease in children including asthma and other respiratory diseases.[97] 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. [98]

PSF trains clinicians across the childbirth continuum to implement evidence-based practices for treating tobacco use.[99] PSF's Quit Link program trains providers (obstetricians, home visitors, and pediatricians) to identify tobacco use among pregnant women, new parents, caregivers, and the at-risk families they see. Additionally, the program instructs providers to refer these families to the California Smoker's Helpline smoking cessation program.[100]

Exhibit 3.8 Tobacco Screenings

	FY 2006-07	FY 2007-08		
	Number of Screenings	Number of Screenings	Number of Smokers	% of Smokers Based on Screening
Prenatal	6,033	12,953	499	3.9%
Newborn Medical Home Visit	2,418	8,553	560*	6.6%
At-Risk Home Visit		1,394	129*	9.3%
Pediatric	1,917	2,539	212	8.4%
Total	**10,368**	**25,439**	**1,400**	**5.5%**

**Number of households*

During FY 2007-08, PSF exceeded all targeted tobacco screenings goals reaching a total of 25,439 women receiving prenatal care, a newborn medical home visit (NMHV), at risk home visits (ARHV) and at pediatric offices. This was a significant increase over the number of screenings documented in FY 2006-07. As Exhibit 3.8 illustrates, the greatest number of tobacco screenings this year were conducted in the prenatal period, with 50.9% (n = 12,953) of total screenings occurring in obstetric offices, followed by 33.6% (n=8,553) at NMHV.[101]

---

[97] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Children and Secondhand Smoke Exposure. 2007. Accessed 30 September 2008. <http://www.surgeongeneral.gov/library/smokeexposure/report/fullreport.pdf>

[98] PSF was developed through a collaborative between Rady Children's Hospital, Sharp Healthcare, and Scripps Health. In addition to other awards, PSF 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. Printed in 2004, the aforementioned manual is currently being distributed nationwide.

[99] 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.

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

[101] There are some differences in the number of smokers identified as reported by NMHV, ARHV and PSF. Reporting could be better coordinated in FY 2008-09 to address these small discrepancies.

Making a Difference: Outcomes

The Healthy Development Services Initiative tracks seven core outcomes through the evaluation. The following section outlines the results of these outcomes. Similar to FY 2006-07, there are limitations in data collection that will be resolved with the implementation of the Commission's data system. For a discussion of these limitations, please see Appendix B.

Breastfeeding

Research has shown that breastfeeding provides nutritional, health, immunological, developmental and psychological benefits for infants and children.[102, 103] The First 5 San Diego breastfeeding indicator aims to measure the percent of children who are breastfeeding at 6 weeks and 6 months of age. This indicator was collected by the NMHV and ARHV providers during FY 2007-08, as 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.[104]

Compared to FY 2006-07, the results for this fiscal year show that slightly fewer children served by NMHV were breastfeeding at 6 weeks of age (73.5% vs. 75.8%); however there were more children breastfeeding who were served by ARHV (88.0% vs. 81.1%; see Exhibit 3.9). Results for breastfeeding at 6 months of age were very similar to the previous year (Exhibit 3.10).

Overall, 76.7% of children were breastfeeding at 6 weeks of age, and 58.0% were breastfeeding at 6 months of age during FY 2007-08.

As expected, and similar to last year, the rate of breastfeeding decreased from the 6 weeks to the 6 months age time points. For the NMHV group in this fiscal year, 73.5% indicated some breastfeeding at 6 weeks of age and 55.5% were breastfeeding at 6 months of age. For ARHV, there was a higher rate of breastfeeding at 6 weeks and 6 months of age (88.0% and 68.4%, respectively).

Exhibit 3.9 and 3.10 also show the rates of breastfeeding from various secondary data sources. The bar graph in Exhibit 3.9 shows that during FY 2006-07 the rates of breastfeeding at 6 weeks of age for both NMHV and ARHV children met or surpassed the Healthy People 2010 goal, though the rate dropped slightly below the goal for NMHV children during FY 2007-08. Exhibit 3.10 indicates that the Healthy People 2010 goal of breastfeeding at 6 months of age was surpassed both this year and last. ARHV showed higher breastfeeding rates than NMHV, perhaps because families receiving ARHV are benefiting from the ongoing support of a home visitor, while NMHV services are typically only given once.

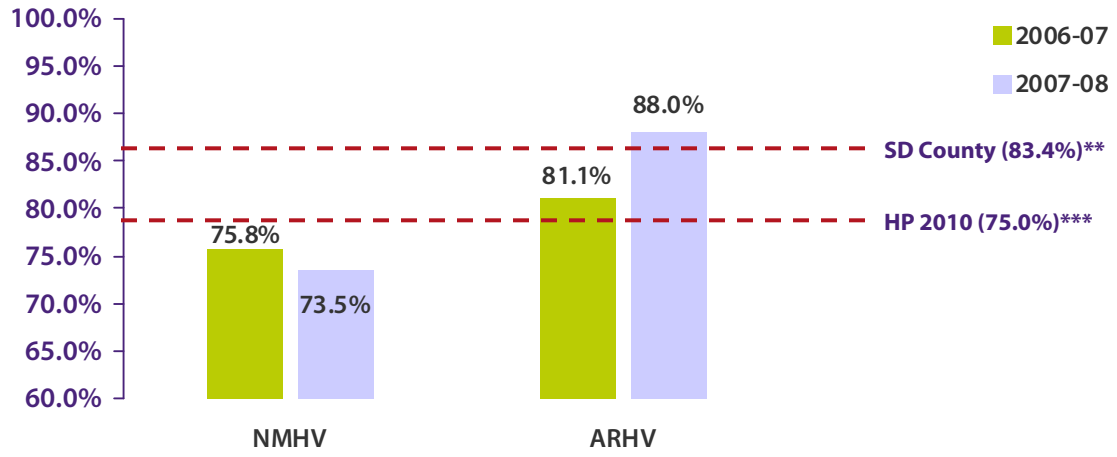
---

[102] Bright Futures Children's Health Charter. "Nutrition Issues and Concerns." Bright Futures in Practice: Nutrition. Washington, DC: Georgetown University, 2002.

[103] American Academy of Pediatrics Work Group on Breastfeeding. "Breastfeeding and the Use of Human Milk." Pediatrics, 100 (1997): 1035-39.

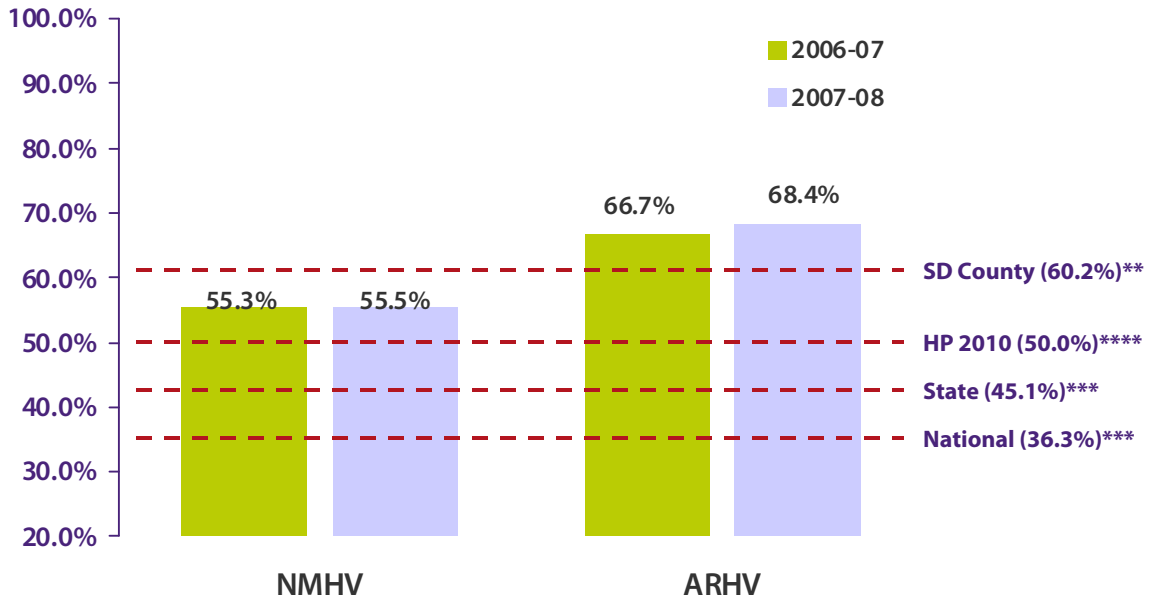
[104] Lactation support is not part of all at-risk home visitors' protocol therefore caution should be used when interpreting the long-term breastfeeding findings. These outcomes may not actually be a result of the service. ARHV providers will not collect this data beginning FY 2008-09.

Exhibit 3.9 Breastfeeding rates at 6 weeks of age by service*



*Includes the valid percent of children with breastfeeding status (does not include unknown or missing data).
**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>

Exhibit 3.10 Breastfeeding rates at 6 months of age by service*



*Includes the valid percent of children with breastfeeding status (does not include unknown or missing data).
**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>

In FY 2007-08, HDS home visitation providers began to report in aggregate the change in breastfeeding status over time. Specifically, they documented the number of children who were breastfeeding at the first visit and 6 weeks of age, and first visit, and 6 months of age. While the majority of reported children were breastfed at both time periods for both NMHV and ARHV, it is interesting to note that of children who were *not* breastfeeding at the first visit, approximately 4.0% of children were breastfeeding at 6 weeks of age and 3.0% of children were being breastfed at 6 months of age. These results may indicate that the breastfeeding support that NMHV and ARHV provide new mothers may help to initiate breastfeeding behavior after the first visit.

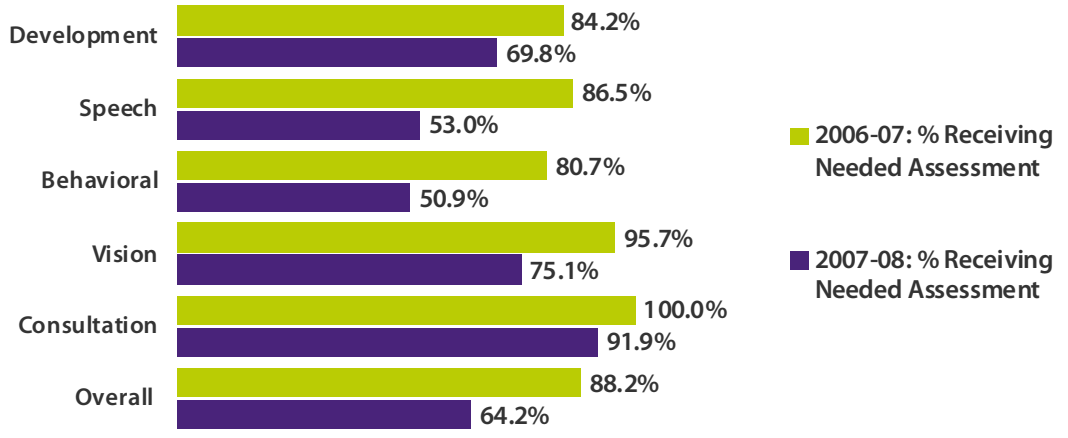
Assessment and Treatment

Because HDS is designed as a system of care, a critical measurement of the system's success is 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 and language, behavioral, behavioral consultation, and vision.

During FY 2007-08, approximately 64.2% of all children needing assessment and 73.4% of children needing treatment received services.

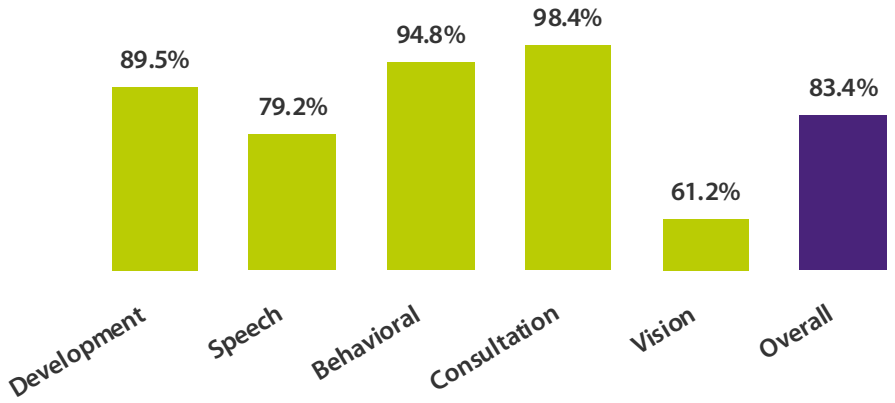
Assessment: Overall, the majority of those children needing assessments still received them (a combined 64.2% for all service areas). Completed assessments for all service areas decreased in FY 2007-08 compared to the previous fiscal year, with speech and behavioral services seeing the largest decrease in assessment completions (Exhibit 3.11). Additionally, a total of 83.4% who received an assessment were subsequently identified as needing treatment (an increase from last year's 67.1%), which indicates that the screening and referral process is increasingly more accurate, as there were more children assessed this year who were presenting with health and developmental delays (See Exhibit 3.12).

Exhibit 3.11 Children receiving assessment based on need by service*



**Includes the valid percent of children receiving services (pending services were not included).*

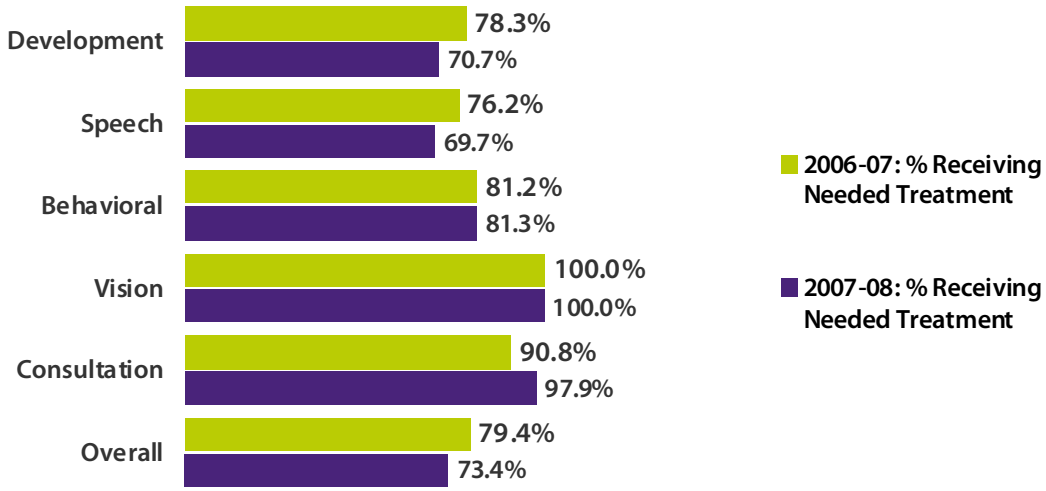
Exhibit 3.12 Assessments that indicated treatment need by service - FY 2007-08*



**Includes the valid percent of children whose assessment showed need (does not include missing data).*

Treatment: Overall, 73.4% of children needing treatment received services. Similar to the assessment data, there was a slight decrease compared to last fiscal year in children who received treatment based on those that needed it for both developmental and speech services. Other service areas had similar findings or improvements from last year. (See Exhibit 3.13.)

Exhibit 3.13 Children receiving treatment based on need by service*



**Includes the valid percent of children receiving services (pending services were not included).*

Attrition: The number of children not receiving the services they needed during FY 2007-08 was about one-third (35.8%) for assessments and one-quarter (26.6%) for treatment. The most common reasons for children not receiving needed services included that the family was lost to follow-up (47.2% for assessments and 50.5% for treatment across all service areas) and the family declined services (30.0% for assessments and 23.0% for treatment across all service areas). [105, 106] One reason for this may be that families do not understand the

[105] "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.

importance of early intervention services or are resistant to receiving services so they do not follow through on provider phone calls or appointments. In addition, families may more and do not provide forwarding information. More case management services are need to ensure that families are not lost when their children have health and developmental needs that can easily be met.

Wait time for services: Approximately 20% of children referred for either assessment or treatment had no reported outcome. It is likely that these children were put on waiting lists for services or were referred near the end of the reporting period when there was not enough time to receive the service. Similar to the previous fiscal year, there are wait times for some services. In the most impacted regions, wait times for speech services reached two months; wait times for behavioral services ranged between two weeks and up to six months for one provider. While regional leads are working with AAP to address these issues, these figures indicate a need for more resources at the assessment and treatment provider agencies. Some HDS-associated providers noted that the increase in screenings has, in turn, increased the number of children identified with delays. In general, the assessment and treatment components are more costly and require a greater number of qualified professionals than are currently available in San Diego County – particularly speech and language and behavioral therapists (see the systems evaluation component of this chapter for more information).

Across the project, over half (57.1%) of all children tracked during FY 2007-08 showed gains based on treatment received through HDS.

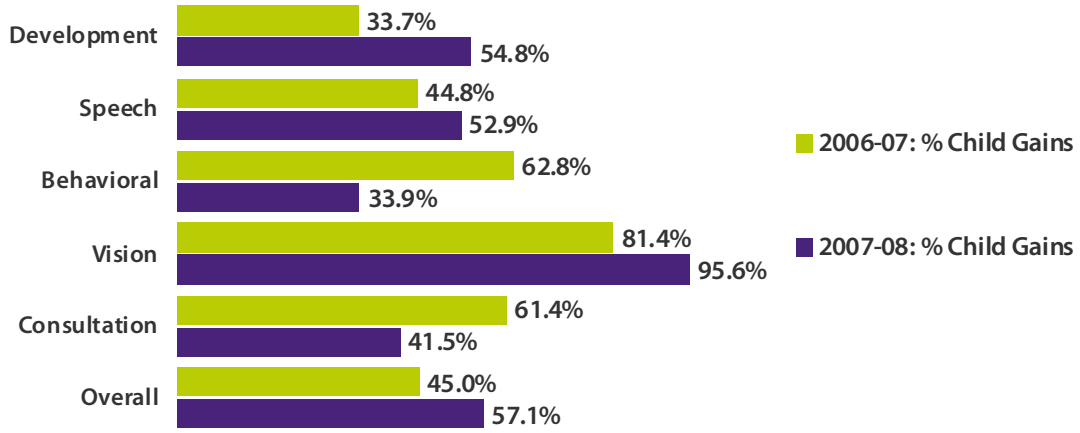
Child Health and Developmental Gains

One of the most important and challenging HDS outcomes to measure is a child's health and developmental gains as a result of treatment.[107] Exhibit 3.14 illustrates the combined percent of children with gains in each service area as a result of the treatment, comparing FY 2007-08 to the previous fiscal year. Across the project, over half (57.1%) of all children tracked showed gains (an increase from last year's 45.0%). FY 2007-08 data shows an increase in children showing gains after receiving developmental and vision services; however, children's gains in behavioral services decreased.

[106] These percentages are out of the total number of children who did not receive an assessment (n=3511 out of 9798); and those that did not receive treatment (n=1880 out of 7068).

[107] Please see Appendix B for information on the limitations of this indicator.

Exhibit 3.14 Child gains due to HDS treatment by service*



**Includes the valid percent of children reported as showing gains (pending outcomes were not included).*

It is important to note that some delays are more straightforward in their treatment and ability to exhibit gain than others, which accounts for some of the difference in child gain results. For example, the measurement of child gain for vision services is the use of corrective lenses, a relatively simple and low cost corrective action. It is expected that the percentage of gain be relatively high. By contrast, the other services show more modest gains, but these services have more complex measurements of gain. Behavioral treatment, in particular, may include a long period of treatment through classes or one-on-one sessions, and gains may be measured by multiple measurement tools. Children may be in services for a relatively long period of time before gains are realized. While behavioral service providers reported only 33.9% of their clients showed a gain, 30.9% of children not yet showing a gain will continue in their treatment services.

Specifically, when children did not demonstrate a gain, the following reasons were reported (percentages reported for all services in aggregate):

- Child was lost to follow-up or family refused measurement (58.7%)
- The measurement of the gain was unclear, which may point to additional needs (18.1%)
- Child continued in program (12.7%)
- Child was referred to another non-HDS provider for additional services (8.1%)
- Child was referred to another HDS provider for additional services (1.3%)

Parent Knowledge and Skill Increase

The PS&E subcontractors are charged with assisting parents in learning about children's health and developmental needs and how to navigate complex systems of care. Other 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. To measure the impact of these services, these parents completed a brief survey before and after receiving services to document changes in knowledge and skills. These surveys included

program-specific measures which are aggregated to show results across each service area.[108]

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

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

Results of the three general parent questions were aggregated across service areas and follow in Exhibit 3.15 showing comparisons between fiscal years. Not surprising, the numbers of parents who agreed with these statements continued to be high this fiscal year, though some of the results were slightly lower than those reported in FY 2006-07. Although these questions do not ask parents to specify what they have learned or increased as a result of the program, these responses indicate that, according to parents, they are generally benefiting from HDS programs.

Exhibit 3.15 Parent affirmative responses to general questions (aggregated across service areas)*

Valid percents (unknown or missing responses were not included)

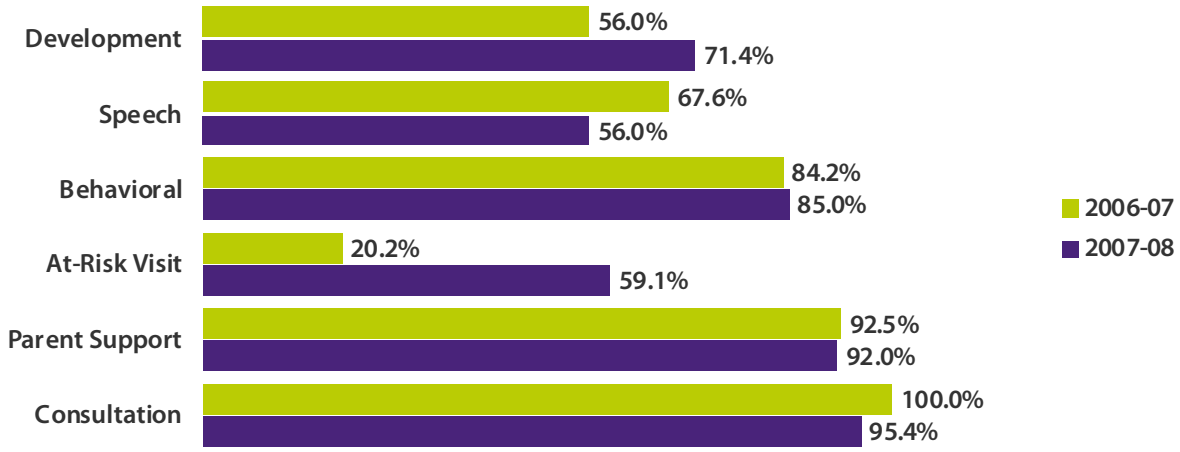
In addition to the three general questions, parents' knowledge and skills were also measured by service providers using program-specific tools as noted above. These results can be seen in Exhibits 3.16 and 3.17 by service area and fiscal year. Though many parents exhibited improvements in knowledge and skills, the results for FY 2007-08 were somewhat mixed, depending on the service area. Similar to FY 2006-07, over 80% of parents receiving services through PS&E, behavioral services, and behavioral consultations exhibited knowledge and skills gains. For increased knowledge specifically, parents showed far lower increases in the ARHV (59.1%), speech (56.0%) and developmental (71.4%) service areas. However, this fiscal year – in comparison to the previous fiscal year – ARHV possessed a much higher percentage of parents who

[108] Please see Appendix B for information on the limitations of this indicator.

demonstrated increased knowledge. Results pertaining to enhanced skills for FY 2007-08 are similar to the knowledge findings, though more parents had increased skills than knowledge for both developmental and speech service areas.

Reasons for minimal increases in knowledge and/or skills between pre- and post-test scores could be a result of the pretest score being high (indicating existing knowledge/skills)[109], a parent's lack of knowledge gain, and/or an unclear result or score (perhaps indicating additional needs). One service area that continued to have high pretest scores was ARHV, with 23.6% for knowledge and 35.1% for skills. Additionally, speech services reported that 30.6% of parents had a high pretest score on knowledge. These data suggest that parents may already be knowledgeable and skillful at some level when they begin services. Further assessment is needed to determine whether the appropriate populations are being served through ARHV and speech, or the measurement tools are not sufficiently sensitive to detect changes in parents' knowledge and skill level.

Exhibit 3.16 Parent increases in knowledge by service*



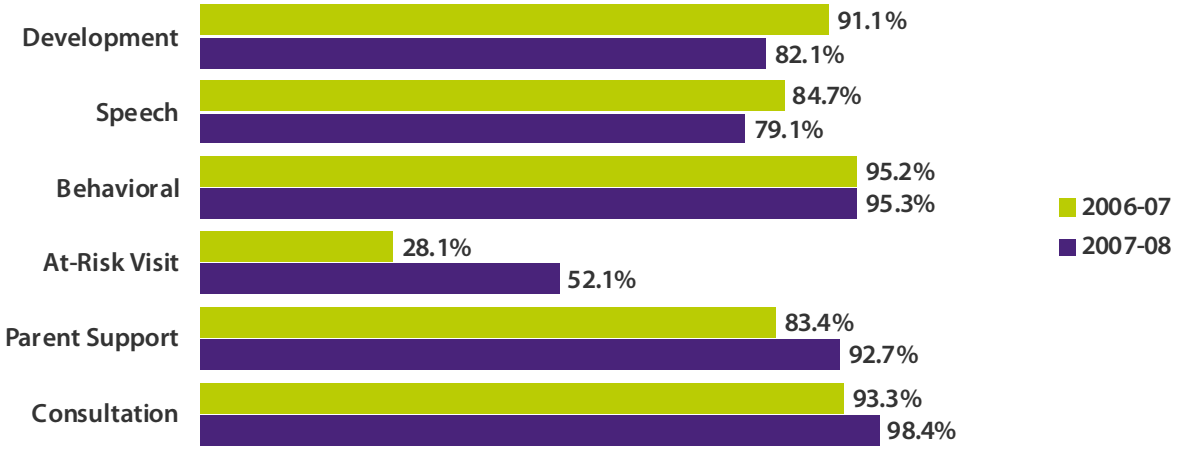
Valid percents (unknown or missing responses were not included)

"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

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

Exhibit 3.17 Parent increases in skills by service *



Valid percents (unknown or missing responses were not included)

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 components related to the children's use and access of health care, as well referral tracking and reporting to services both within and outside of the HDS network.

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, including the status of children having:

1) Health insurance
2) A primary medical provider (i.e., medical home)
3) An annual well child preventive exam
4) Up-to-date immunizations

All four of these items are important in terms of ensuring appropriate health care for children. Both home visitation service areas (NMHV and ARHV) collected this data during FY 2007-08, as these service providers connect clients to appropriate health care resources.[110] All home visitors were asked to collect this data at baseline (entry into services), and again at

2007-08 Overall Child Health Care Access/Use Results

- Health Insurance: 95.8%
- Medical Home: 98.2%
- Annual Child Exam: 98.0%
- Up-to-Date Immunizations: 84.5%

[110] In the previous FY, PS&E and Developmental service providers also collected this data; however it was determined that these providers did not consistently assess health care needs among clients, nor did they often refer families to resources as part of service delivery, and therefore these providers did not collect this data in FY 2007-08.

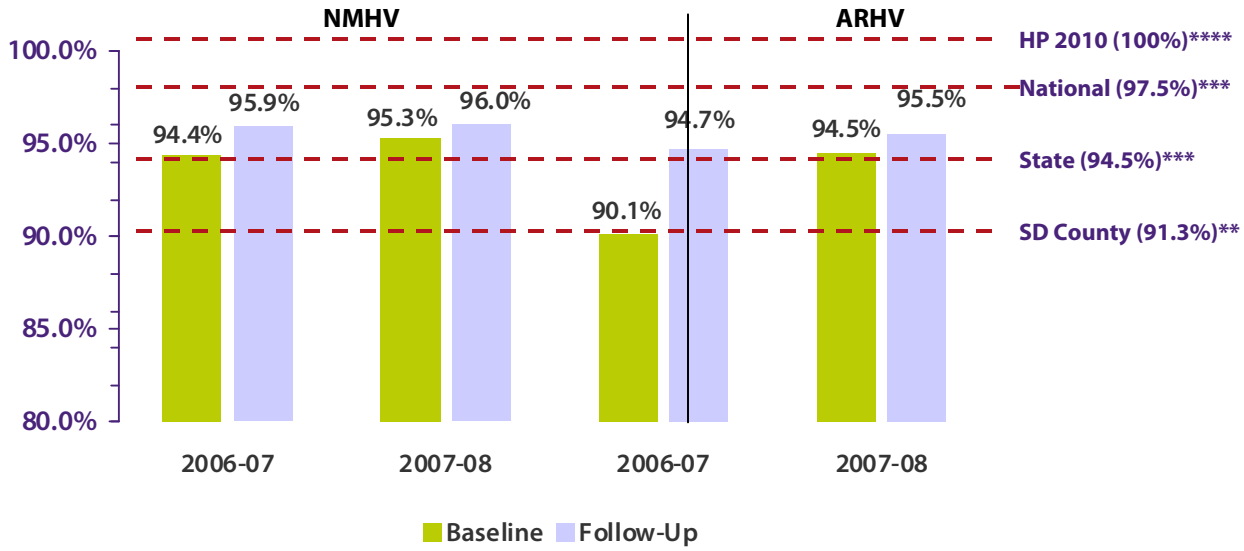
follow-up (i.e., at 6 months of child's age for NMHV; at case closure for ARHV).[111] The following subsections offer details of each of the four children's access and use of health care elements.

Health Insurance

During FY 2007-08, HDS children's health insurance rates at baseline and follow-up were at or above 90%, which generally coincides with other county, state, and national comparison and benchmark data (Exhibit 3.18). Notably, both types of home visitation providers' data present a higher rate of insured children at follow-up – a combined rate of 95.8% of children had insurance at NMHV and ARHV follow-up. Additionally, insured rates were slightly higher this fiscal year than last.

A large majority of children had insurance at both pre and post periods (NMHV = 91.5%; ARHV = 91.0%), with some becoming insured at post after not having insurance at the first visit (both NMHV and ARHV = 4.5%). There were a small portion of children who were insured at the first visit but were uninsured at post (NMHV = 3.8%; ARHV = 3.5%), and less than 1% did not have insurance at either time period (NMHV = 0.2%; ARHV = 1.0%).

Exhibit 3.18 Children with health insurance by service*



**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>*

[111]During FY 2007-08, this data was collected in aggregate; however, service providers reported how specific clients changed from pre to post. This is different method from how data was collected last year, and therefore this portion of the chapter includes tables that present the change from pre to post for this FY, as well as graphs that present comparisons of aggregated results at pre and post for this FY and last FY.

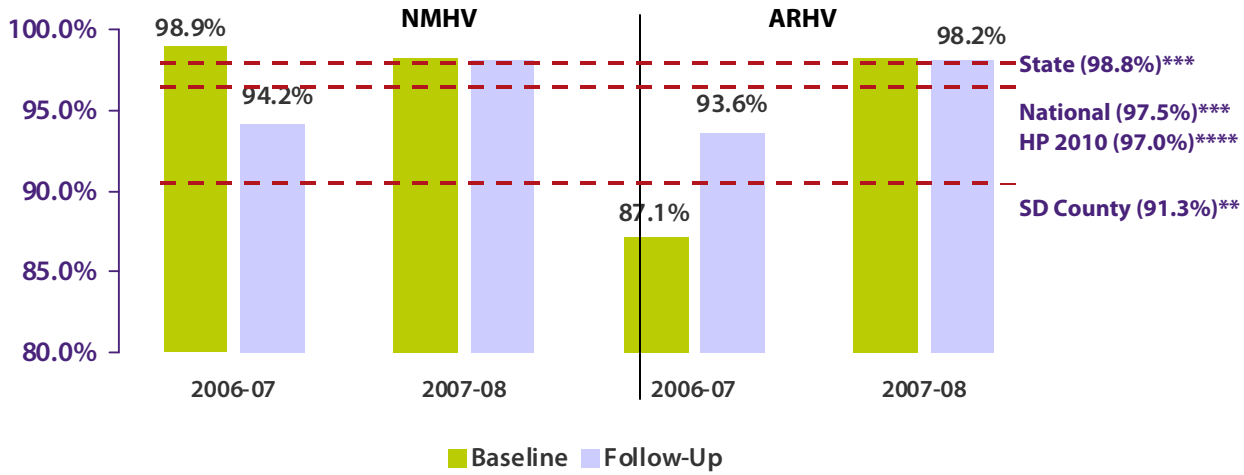
Medical Home

Children with a medical home are more likely to use appropriate preventive and urgent health resources, as well as have better health outcomes.[112] Medical home rates among children tracked during FY 2007-08 were high (between 98-99%), surpassing the Healthy People 2010 goal, as seen in Exhibit 3.19.[113] Additionally, the data show a larger percentage of children with a medical home for both NMHV and ARHV than last year. There were however, fewer children with a medical home at follow-up than baseline for both home visitation service areas. Overall, across both service areas at follow-up, approximately 98.2% of children served had an appropriate source of medical care at *both* baseline and follow-up (NMHV = 97.9%; ARHV = 98.2%). Less than 2% of children who had a medical home at baseline, but the follow-up measure indicated an inappropriate source of medical home – an urgent care facility, emergency room, a source outside of the United States or no facility (NMHV = 1.8%; ARHV = 1.6%).

[112] Institute of Medicine (U.S.). Health Insurance is a Family Matter. National Academies Press, 2002, 111.

[113] For this element, any parent's response that the child *normally* received care from a primary care physician/group, community clinic, or military medical facility was considered to be a medical home.

Exhibit 3.19 Children with a medical home by service*



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>*

Well Child Visits

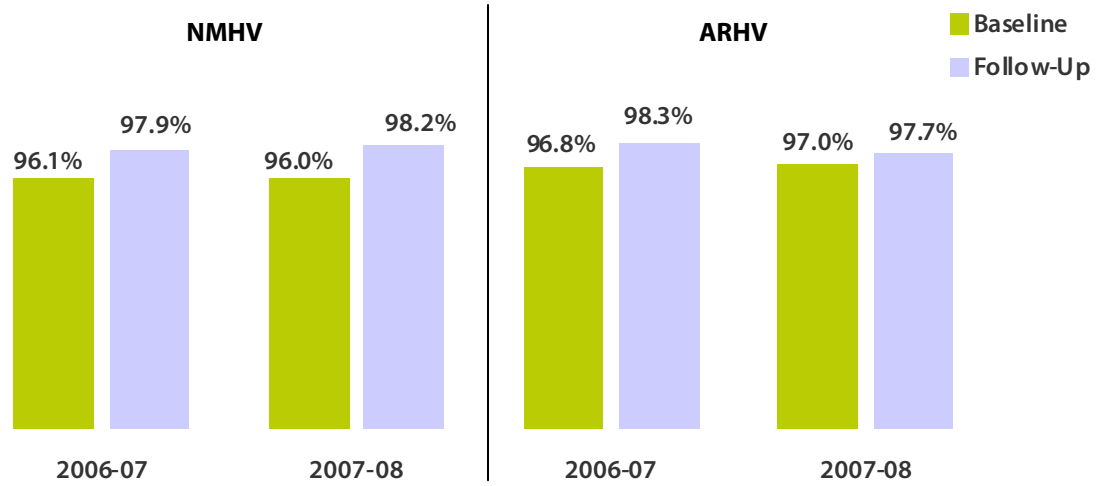
Well child check-ups are important for appropriate preventive care, allowing physicians to promote behaviors conducive to healthy development and give age–appropriate counseling.[114] HDS home visitation service providers asked parents if their child had received their initial medical visit (for children ages 2 months and under) or if their child had had any well-child check-ups within the last year (for children older than 2 months). There are no appropriate county, state, or national data for comparison.[115]

For both service areas and fiscal years, there was an increase in the percentage of children with an annual preventive visit at follow-up, with consistency across the two years (see Exhibit 3.20). When combining the number of children served by NMHV and ARHV, 98.0% of the children received an annual well child visit by follow-up. Similar to the other health care access measurements, most children received a well child exam at both pre and post. There were some children who had not visited their primary care at baseline, but successfully received that visit by post (3.7% for NMHV, 2.0% for ARHV).

[114] M. Regalado and N. Halfon, "Primary Care Services Promoting Optimal Child Development from Birth to Age Three Years: Review of the Literature," Archives *of Pediatrics and Adolescent Medicine* 155 (12,2001): 1311-1312. Available at http://www.cmwf.org/usr_doc/regalado_optimalchild_531.pdf.

[115] The only similar contextual data found includes the average number of general well child visits that children ages 0-2 have had within the past year. These data cannot be used for comparison to HDS results, however, because HDS does not ask how many visits the child has had throughout the previous 12 months.

Exhibit 3.20 Children with an annual well child visit by service*



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

Child Immunizations

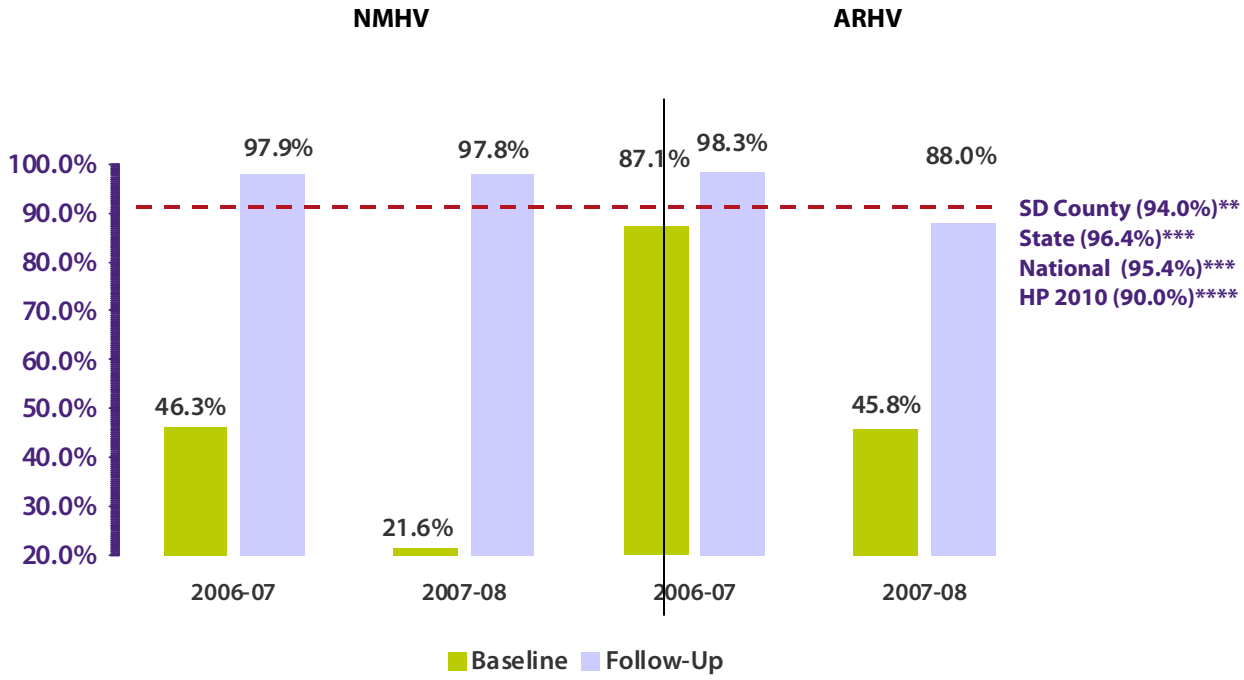
Children who have health insurance and who use appropriate preventive health care resources are more likely to have up-to-date immunizations.[116] For FY 2007-08, the rate of up-to-date immunizations at baseline was well below the Healthy People 2010 marker for both NMHV and ARHV. Importantly, nearly all NMHV children and most ARHV children tracked were current on their immunizations by the follow-up visit (exhibit 3.21).[117] When NMHV and ARHV results are combined at follow-up, 84.5% of the children had up-to-date immunizations. Interestingly, both NMHV and ARHV populations exhibited a lower rate of children with current immunizations at baseline in FY 2007-08 compared to FY 2006-07 (NMHV exhibited 21.6% vs. 46.3%, respectively and ARHV reported 45.8% vs. 87.1%), though there is no indication why this trend occurred.[118]

[116] Trust for America's Health/Every Child By Two. Closing the Vaccination Gap: A Shot in the Arm for Childhood Immunization Programs. August 2004. www.healthyamericans.org.

[117] HDS home visitation providers collected immunization status for children over 2 months old by either parent self-report or checking the child's immunization card. 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.

[118] Most NMHV first visits occur during the first 2 weeks of life, however this data was only collected on children whose first visits (i.e., baseline measurement) occurred when they were age 2 months and older, and therefore eligible for a vaccination.

Exhibit 3.21 Children with up-to-date immunization status by service*



**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>*

Use of Referrals

For the first time, this year HDS providers tracked and reported referrals for children from HDS providers to other HDS network services, as well as to agencies outside of the HDS network. HDS providers were required to track a sample of the completion of referrals within their HDS Regional Service Network during FY 2007-08. All referrals made outside of the HDS Regional Service network were also counted and reported by service category, but not tracked for successful linkage.

Referrals Internal to the HDS Network

One goal 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.[119] Below are the key findings related to HDS services that *provided* referrals to their clients during this fiscal year (see Exhibit 3.22 for details).

[119] 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. Following up with the family is conducted as a last resort if not other information is available. The sampling size for referral outcomes was a minimum of 25%.

- Of the 10,883 total children who received a referral, most of those children were being served by the two primary gateway service areas – NMHV (n=4,169) or developmental (n=3,902).
- Similar to last year, the majority of all NMHV referrals were to PS&E and ARHV, while most of developmental service referrals were to speech and language.
- ARHV and hearing service areas had the largest increases in referrals since FY 2006-07.
- Overall referral completion rate was 75.6%, with vision, hearing, and developmental providers reporting the highest percent of children receiving services at the referred-to agency.

During FY 2007-08, a total of 10,883 children/families being served in HDS received a referral to another HDS service, for a total of 11,071 referrals. Three quarters (75.6%) of those referrals resulted in a successful initiation of services.

- Most service areas reported that at least 60% of their clients received the referred-to service, though NMHV reported slightly lower numbers, with 57.6% of their children linking successfully.
- As stated previously, there are many reasons why a family may not receive services. For those clients that did not initiate services, the majority were lost to follow-up. Additionally, families may decline services or may not follow through with the appointment for new services, especially if they are uncomfortable or unclear about the purpose of the service.

Exhibit 3.22 Referrals within HDS Network by service and fiscal year: Services providing referrals

	FY 2006-07		FY 2007-08	
Service Area	Total Children Referred OUT n*	Initiated Services Valid %**	Total Children Referred OUT n*	Initiated Services Valid %**
Developmental Services	3,444	55.8%	3,902	76.0%
Speech / Language Services	318	71.1%	314	65.9%
Behavioral Services	46	80.6%	153	72.9%
Newborn Medical Home Visitation (NMHV)	5,210	86.9%	4,169	57.6%
At-Risk Home Visitation (ARHV)	47	72.2%	539	62.2%
Vision Services	0	-	1	100.0%
Hearing Services	0	-	1,560	99.9%
Parent Support and Empowerment (PS&E)	84	76.9%	70	71.0%
Health / Behavioral Consultation Services	76	86.6%	175	65.1%
Total	**9,225**	**71.5%**	**10,883**	**75.6%**

**Includes total number of children referred by HDS service areas to other HDS services. Children could have been referred to a service area more than once, but are counted here only once. The total number of referrals for FY 2007-08 was 11,071.*

***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.*

Below are the key referral process findings related to HDS services *receiving* the referrals (see Exhibit 3.23 for details).

- The HDS service areas receiving the most internal referrals in order are as follows: speech, ARHV, developmental, and PS&E.
- The developmental service area had the largest increase in receiving referrals during FY 2007-08.
- Clients referred to developmental and PS&E had the highest rates of referral completion (94.4% and 85.2%, respectively), while ARHV and behavioral services had the lowest completion rate (57.0% and 64.3%).

Exhibit 3.23 Referrals within HDS Network by service and fiscal year: Services receiving referrals

	FY 2006-07		FY 2007-08	
Service Area	**Total Children Referred IN n***	**Initiated Services Valid %****	**Total Children Referred IN n***	**Initiated Services Valid %****
Developmental Services	321	80.6%	2,064	94.4%
Speech / Language Services	2,596	51.4%	2,760	81.7%
Behavioral Services	298	71.0%	395	64.3%
Newborn Medical Home Visitation (NMHV)	1	100.0%	0	-
At-Risk Home Visitation (ARHV)	2,718	84.4%	2,564	57.0%
Vision Services	140	56.5%	428	69.9%
Hearing Services	152	53.2%	486	58.2%
Parent Support and Empowerment (PS&E)	2,913	97.0%	2,033	85.2%
Health / Behavioral Consultation Services	86	51.1%	153	67.1%
Total	**9,225**	**71.5%**	**10,883**	**75.6%**

**Includes total number of children referred by HDS service areas to other HDS services. Children could have been referred to a service area more than once, but are counted here only once. The total number of referrals for FY 2007-08 was 11,071.*

***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.*

From both referral provider and referral receiver perspectives, the most commonly noted reason for referrals not being successful was that many of the families were lost to follow-up (overall 16.4%), pointing to the need for more case management resources for families in the HDS system. Additional reasons for not linking to services included families refusing services (7.0%) and providers refusing the referral (1.0%).

Referrals External to 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 made to different health and social services.[120, 121] The list of outside referral services included six broad categories and specific service organizations or types of services within each category:

A total of 21,865 referrals were given to HDS clients for non-HDS services during FY 2007-08.

- **Health Care Services:** includes First 5 San Diego's Healthcare Access Initiative, primary care physician, 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.
- **Child Services:** includes First 5 San Diego's School Readiness Initiative, child care/day care, child education services, such as Head Start and preschool, as well as 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.

A look at what HDS services were referring out of the HDS network is useful to determine which needs could not be met within that particular service or the HDS system. This year, a total of 21,865 referrals were provided to clients for services outside of HDS, which is a 26.4% increase from last year (see Exhibit 3.24). Both NMHV and ARHV service providers reported the highest number of outgoing referrals to outside agencies (5,764 and 4,764, respectively), which would be expected as the home visitation providers do an overall assessment of families, which in turn, may lead to additional needs that are not provided by HDS. This year, NMHV had a tremendous increase in the number of referrals given to outside agencies – proportionally greater than the increase in NMHV. Most of the referrals given through NMHV were for breastfeeding support and parent support or parent education services. Families being visited by ARHV are typically in need of many services to help them meet more urgent needs; therefore, it is no surprise that the majority of ARHV referrals outside of HDS were classified as basic needs (e.g., housing, food, clothes) and parent support.

[120] 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.

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

Exhibit 3.25 presents the numbers of referrals that were made to services outside of HDS, quantified by six broad categories covering a variety of health and social services. Similar to FY 2006-07, the category receiving the most referrals this year is "Other," which includes a variety of service organizations and programs. Over a third (38.3%) 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 (24.0%), over half of which were to a primary medical provider (56.8%). Early intervention services were also important (12.1%), and referrals to California Early Start, School Districts and the Regional Center made up 5.1%, 3.5% and 2.8% of the total referrals. There was a large increase in the number of referrals to parent and family support services compared to last fiscal year (an increase of 140%); however dental care referrals saw a large decrease (a decrease of 81%).

Exhibit 3.24 Referrals to outside HDS Network: HDS services providing referrals

Service Area (HDS)	FY 2006-07 Referrals		FY 2007-08 Referrals	
	n	%	n	%
Developmental Services	1,657	9.6%	2,328	10.6%
Speech /Language Services	385	2.2%	472	2.2%
Behavioral Services	53	0.3%	202	0.9%
Newborn Medical Home Visitation	1,095	6.3%	5,764	26.4%
At-Risk Home Visitation	3,227	18.7%	4,764	21.8%
Vision Services	3,544	20.5%	1,051	4.8%
Hearing Services	5,226	30.2%	3,013	13.8%
Parent Support and Empowerment	1,979	11.4%	4,249	19.4%
Health / Behavioral Consultation Services	136	0.8%	22	0.1%
Total	**17,302**	**100.0%**	**21,865**	**100.0%**

Exhibit 3.25 Referrals outside HDS Network: Services receiving HDS referrals				
Service Category (non-HDS)	FY 2006-07 Referrals		FY 2007-08 Referrals	
	n	%	n	%
Health Care Services	3,530	20.4%	5,244	24.0%
Dental Care Services	1,126	6.5%	217	1.0%
Parent/Family Support Services*	1,829	10.6%	4,384	20.1%
Child Services**	1,631	9.4%	2,791	12.8%
Early Intervention Services	2,143	12.4%	2,652	12.1%
Other	7,043	40.7%	6,577	30.1%
Total	**17,302**	**100.0%**	**21,865**	**100.0%**

**These referrals can be for the Parent Education Initiative and other parent support education.*
***These referrals can be for child care/daycare, the School Readiness Initiative, child education such as Pre-K and Head Start and child development/behavior (non HDS).*

As part of the First 5 San Diego goal to create a more integrated system of services for young families, 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 1,800 referrals were provided by HDS to these other First 5 services, which was approximately 8.2% of all referrals to outside programs/services (Exhibit 3.26). The percentage of referrals to other First 5 initiatives and funded services decreased from last fiscal year (10.2%). Comparison of the two years shows a large increase in referrals to School Readiness and Health Care Access, but a large drop in referrals to the Oral Health Initiative and First 5 for Parents project.

Exhibit 3.26 HDS referrals to other First 5 funded initiatives/projects by fiscal year		
	FY 2006-07 Referrals	FY 2007-08 Referrals
First 5 Project	**n**	**n**
Healthcare Access Initiative	215	868
Oral Health Initiative	1,103	117
First 5 for Parents Project	474	228
School Readiness Initiative	27	574
Total	**1,819**	**1,787**

The reasons for fluctuations in referrals outside the HDS network and to other First 5 Initiatives are unknown. Trends may change due to changing needs of families served by HDS. Additionally, linkages to other F5 services or outside resources may change overtime, depending on the connection maintained between clinicians and other personnel. In areas where referral rates are low, new in-service presentations may be needed to remind HDS providers about the availability of additional services for their families.

Making the Connection

HDS is the most purposeful attempt of the San Diego Commission to create, from the ground up, a more integrated system of developmental services for young children and their families. The vision was to infuse child development into parenting and provider practices; fill the gap in services for children with mild to moderate delays in the early years, when intervention will make a lifelong difference; to create a seamless network of development services that serve all families in San Diego County and to create connections between the systems that service children with developmental delays – from mild to severe delays – so children are referred and receive appropriate and prompt services. By structuring the project with six Regional Service Networks (RSNs), which brought together formerly isolated services and obliged them to collaborate, the Commission deliberately attempted to stimulate systems integration and change.

Evaluating systems change is challenging, thus, the HDS evaluation includes a robust system-level evaluation to track if, and how, the system of care for young children is being strengthened as a result of this initiative. This evaluation is based on the Substance Abuse and Mental Health Services Administration's (SAMHSA) design for evaluating systems of care.[122] This approach examines the implementation and development of the HDS system of care and provides feedback for continuous improvement of the quality of each RSN and its countywide presence. 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 3.27).

Exhibit 3.27
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. Family Focused
4. Early Intervening
5. Responsive to Cultural, Linguistic, and Special Needs
6. Readily Accessible
7. Accountable
8. Sustainable

[122] 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>

The data presented in this section documents the evolution of HDS over time in each Core Principle and Domain of the Evaluation Framework. Data collection activities used this fiscal year included:[123]

- **Online Survey of Regional Leads:** Lead representatives from each RSN were invited to participate in an online survey to assess progress toward achieving the goals in each of the areas described in Exhibit 2.30. Five out of the six regional leads participated in the survey.
- **Subcontractor Survey:** This online survey provided feedback from several HDS service providers regarding the coordination efforts of regional leads, and current successes and challenges within HDS. One representative from all HDS subcontractors (n=27) were invited to complete the online survey. A total of 19 responses were received, a response rate of 70.1%.
- **Regional Coordination Focus Group:** 11 HDS providers including Regional Leads, Case Managers, a Social Worker, Assessment Specialist, Research Associate, Program Director, and Regional Service Manager participated in this group to provide feedback on how regional coordination across the HDS system works.
- **Regional Lead Quarterly Reports:** In FY 2007-08, regional leads began tracking issues of collaboration, community involvement and outreach and community partnerships, as well as providing narrative descriptions of activities, successes and challenges.
- **Countywide Coordination Quarterly Reports:** A review was conducted of AAP's quarterly reports reflecting on the work they accomplished throughout the year.
- **HDS Meeting Agendas and Minutes:** Meeting minutes were reviewed for key activities and process decisions.

The system-level data show that there has been much change in each of the RSNs across the core principles. Key findings for each core principle, along with definitions, are provided in the following section. Where possible, comparisons to findings from the previous fiscal year are made.

1. 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.

Building Relationships: The success of the HDS system of care depends to a large degree on the strength of the relationships between the lead contractors and their subcontractors that provide direct services, between the HDS lead (AAP) and local pediatricians, and between the HDS system and developmental services providers such as the Regional Center, California Early Start and the school systems.

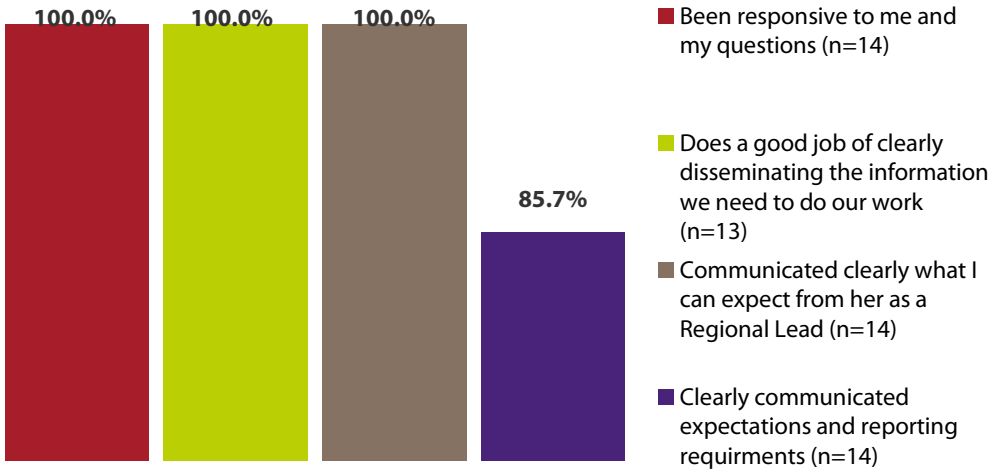
As the countywide coordinator, AAP conducted 45 visits with local pediatric offices to help standardize the practice of performing developmental screenings in accordance with national AAP guidelines. AAP and the other HDS providers have worked and successfully built relationships with the 13 birthing hospitals that now provide referrals to NMHV, the Regional Center, California Early Start, public health nursing, and local school districts. None of these relationships existed prior to HDS.

The regional leads also continued to successfully build relationships within their own networks, evidenced by

[123] Additional details on the data collection activities can be found in Appendix B.

subcontractors' reporting a high level of satisfaction with their regional leads. All respondents of the subcontractor survey (100%) agreed that their regional network coordinator has been responsive, clearly communicates what their agency can expect from the regional lead, and does a good job of disseminating the information needed to do their work. Fewer subcontractors (85.7%) responded that expectations and reporting requirements are clearly communicated (see Exhibit 3.28).

Exhibit 3.28 Subcontractors' Satisfaction with Regional Coordination*



** Valid percents are reported. 'Not applicable' responses were coded as invalid and not reported.*

Connecting Families to the Network: A key aspect to providing HDS's comprehensive services is the referral process. Prior to HDS, there was no coordinated referral system. Children needing a variety of services from multiple providers had to "find their own way" and children were often screened and rescreened by providers in different systems. In just over 2 years, four of the six regions have clearly defined and established protocols for how and when to provide referrals for additional HDS services to ensure children are able to receive the services the need throughout the HDS network. In addition, the regional leads worked together to establish a countywide form to use for all HDS referrals. These steps make services seamless for families who may be under stress with concern over their child's developmental progress. At this time, most but not yet all of the dozens of community partners and agencies use the HDS referral form.

Key Areas of Regional Coordination

- Leadership and coordination
- Evaluation management
- Case management
- Outreach and networking

Regional Coordination: One of the greatest aspects of regional coordination is the provision of referrals to families – both for HDS services and services outside the HDS network. In addition, regional coordination allows the sharing of best practices and for more standardization so families are served consistently throughout the county. To improve service delivery and integrate staff across HDS provider agencies, regular meetings, trainings and site visits are held throughout the regions. Regional staff also make efforts to distribute information to community based organizations and other ancillary support programs in their regions by participating in community collaborative meetings to market HDS services, attending regional events sponsored by other organizations, coordinating with local school districts to distribute information to parents, conducting presentations and engaging in community outreach activities such as health fairs.

This year, the regional leads began tracking some of their efforts to structure a comprehensive system of care on a quarterly basis. Exhibit 3.29 highlights key regional coordination activities conducted throughout the fiscal year.

Exhibit 3.29 Key Regional Coordination Activities

	FY 07-08
Referrals	
Referrals to network subcontractors (within region)	4,532
Referrals made to other regional leads	910
Training Opportunities	
Trainings for regional and subcontractor staff coordinated or led by the regional lead	43
Trainings and/or in-services for regional and subcontractor staff in other regions coordinated or led by the regional lead	30
In-services provided by other agencies (that the regional lead helped to arrange) for regional and subcontract staff	20
Community Involvement and Outreach	
Meetings, presentations and in-services provided by the regional lead to entities or providers outside of HDS	134
Health fairs and community events attended to promote HDS	73
Conferences attended to promote HDS	15
Community Partnerships	
Ongoing partnerships	143
New sites outreached to by the regional lead	22
New active partnerships	17

**This was optional to collect; however, all six regions reported data*

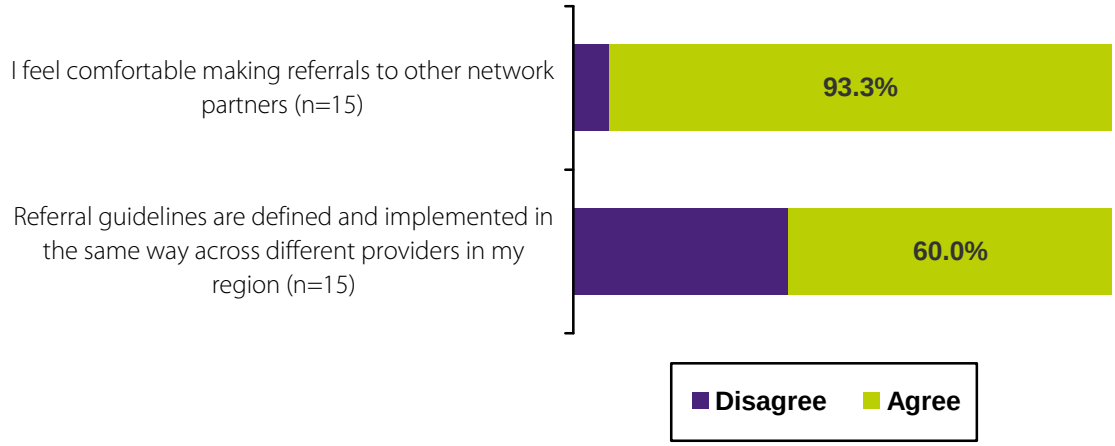
2. Coordinated and Integrated

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

The design of HDS requires that eleven categories of services are coordinated and integrated -- something that did not exist prior to HDS. To measure this factor, the evaluation asked questions directly of the providers who are part of the developing system and also tracked the structural changes that are being made to HDS to support system coordination and integration.

A view from the front lines: Responses from providers (Exhibit 3.30) indicate that more work can be done on implementing standardized referral guidelines across the different providers in a region (an activity already underway by AAP). Service providers also cited a number of ways how they share best practices and guidelines with their regional lead and other providers in their network, including case review and consultation, training, regular communication, as well as sharing of resources and quarterly reports.

Exhibit 3.30 Service Provider's Perspective: Coordinated & Integrated*



**Valid percents are reported. 'Not applicable' responses were coded as invalid and not reported.*

Subcontractors noted a variety of technical assistance that can be provided in FY 2008-09 to increase coordination and integration of services countywide. Recommendations included:

- Continued data collection support and clear evaluation/outcome criteria, especially in regards to the new database system
- Improving ease of receiving referrals
- Public promotion of HDS services to the community in all languages
- Continued outreach to physicians that developmental services are important
- Continued brainstorming about ways to serve children who do not qualify for First 5 or other funded services
- Regular site visits or conference calls by the evaluator and/or lead to review any concerns or questions

A view from the top: AAP works to enhance the coordination and integration of services at a structural level within the initiative. AAP meets regularly with the regional leads, both individually and in group operations and executive-level monthly meetings. The purpose of these meetings is to work with the regional leads to improve service coordination countywide. This fiscal year, AAP pursued the following avenues to strengthen the system that HDS is creating.

Standardizing service definitions: Although there is a focus on coordinating service delivery, there are often inconsistent definitions of services across providers, as well as a variety of service models, assessments used, and referral protocols. This fiscal year, AAP began working with Regional Leads and HDS service providers to identify common practices and establish consistent protocols. Some of these efforts include:

- Convening of service area workgroups. AAP convened meetings with providers from developmental services, at-risk home visitation and parent support & empowerment. Through the identification of common service elements, providers can ensure that HDS services are well coordinated and provided in a consistent manner countywide.

- Identification of minimum standards for case management. AAP worked with Regional Leads to identify the following areas where case management is most needed:

    1. Families receiving two HDS services need help coordinating these services
    2. Families needing multiple HDS services
    3. Coordination of HDS with outside agencies, such as Regional Center and the school districts
    4. Families needing HDS services but also exhibiting needs for services outside HDS (i.e., Regional Center).

  AAP is also planning to establish common countywide intake procedures for case management in the next fiscal year.

- Exploring changes to behavioral services. As demand for these services has increased, provider capacity is being stretched. Regional Leads are already maintaining waitlists for these services. AAP and the Regional Leads are working on how to improve provider capacity. Additionally, AAP and the Regional Leads have identified key priorities for behavioral services:

    1. Redefine behavioral services to be more comprehensive
    2. Establish a similar set of referral criteria
    3. Consider appropriate outcomes
    4. Evaluate the increase in expulsions in early care and preschool settings.

Streamlining interactions with common organizations: One way in which AAP worked with the Regional Leads was to identify ways to facilitate regional coordination. This included coordinating services and protocols with common subcontractors and coordinating outreach to common organizations, such as Public Health Nursing and California Early Start.

Exploring the role of case management: The Regional Leads have also focused on the role case management plays in the coordination of HDS services. To explore this topic, a "case management" focus group was conducted. Key findings included:

- Case management varies from in-person (particularly with ARHV) to over the phone.
- Some participants commented that case management is such an important part of HDS that it should be a stand-alone service area, rather than a piece of the existing early intervention services.
- It would be beneficial to have a dedicated person to work with families as they move through the HDS system.
- They recommended linking families to HDS services through a "gateway," such as newborn home visiting.

"I define case management as helping a family navigate the systems, referring, overcoming barriers to accessing referrals."

– Focus Group Participant

- There has been better coordination of referrals throughout HDS and an increase in communication between service providers to ensure that families are being tracked.
- Challenges include integrating referral tracking and management into their existing workload as well as difficulty following up on referrals outside of the HDS network.
- The implementation of electronic referral tracking through the Contract Monitoring and Evaluation Data System (CMEDS) will be of huge benefit to case management and care coordination, but only if there is a commitment from all HDS partners to utilize the system.

Promoting HDS: A priority of HDS this year has been communication and outreach. AAP and the Regional Leads worked together to identify a common message for HDS that can be used to promote HDS to pediatricians, other providers, and families. In addition, AAP worked very closely with First 5's Communications Contractor to develop the new communications plan, which focuses on the importance of early intervention and healthy development check-ups.

The HDS Message

- **Effective developmental screening requires using the right screening tool**
- **Early intervention can make a big difference in children's lives**
- **Once screening identifies a need, developmental services are available to help through HDS and other community resources**

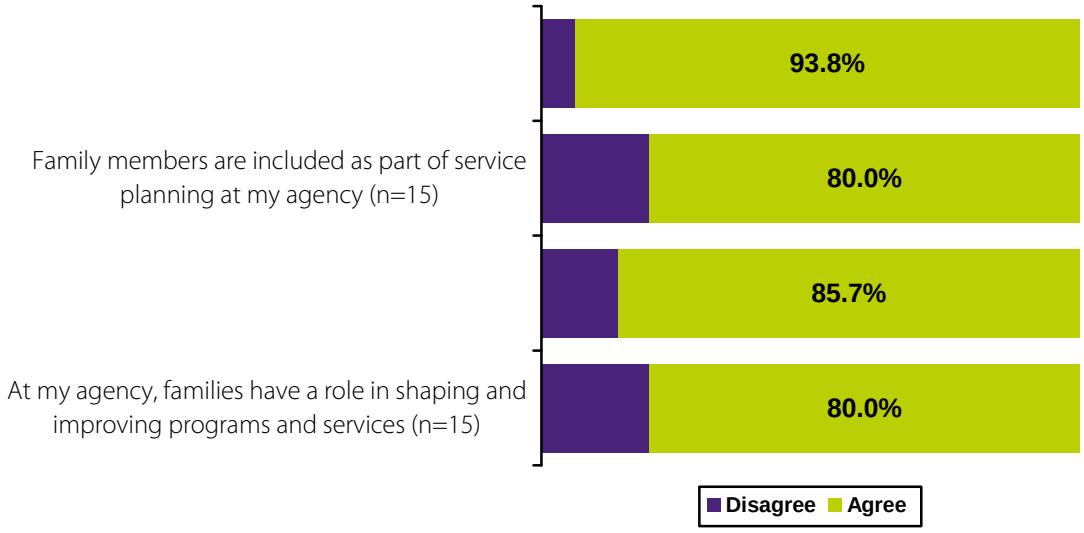
3. Family Focused

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

In a field that involves hospitals, public health, education, behavioral health and other government services, it is easy for the voices of families in need to be lost. Too often, systems are created that meet internal organizational needs rather than address the barriers that families face in accessing services. Lead and subcontractors were surveyed concerning how they incorporate the family perspective into the HDS service system. Three of the five respondents from the lead survey stated that they hold family/provider team

meetings, parent advisory groups, and include family's perspectives in intervention designs. Additionally, subcontractors reported strong integration of families into service delivery based on four core attributes of family focused service provisioning (Exhibit 3.31).

Exhibit 3.31 Service Provider's Perspective: Family Focused*



**Valid percents are reported. 'Not applicable' responses were coded as invalid and not reported.*

Participants in the subcontractor survey also reported many successes in working with families. These included:

- **Connecting Families to Services:** Providers reported success in helping families understand a complex service system and connecting families to services earlier, as well as connecting them to additional community resources.
- **Providing Education and Addressing Concerns:** Providers have developed tailored parent education for different groups (e.g., military fathers and new mothers) as well as focused on specific educational topics (e.g., Baby Basics, a class in development for new parents).
- **Improving Access to Services:** Bi-cultural (English and Spanish) staff make it easier to understand and serve families from both cultures. In addition, providers have created groups for the children who are on a waitlist for individual services, in order for them to receive some interim treatment.

Providing a family focused system of care is complicated by the larger structure and needs of the family that are outside of what First 5 funds. These include being able to serve families with severe needs or multiple psychosocial factors that require additional services outside of HDS, such as housing and employment assistance. Other challenges include gaps for services for children with special needs and the large geographical areas that providers cover throughout San Diego County.

On a structural level, AAP worked with providers in FY 2007-08 to identify family focused strategies. A standing agenda item at the monthly meetings with AAP and the Regional Leads is the identification and sharing of existing strategies for engaging and tracking families. These have included a "drop by" strategy for home visitors and placing family educators in Family Resource Centers to keep families connected.

4. 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.

Core to HDS is the principle that early intervention – particularly in the first 3 years of life – provides the greatest opportunity to bring about profound, lifelong benefits.[124] Within the HDS system, AAP conducts many outreach efforts with local service providers to ensure children can access HDS services as soon as possible. One such effort is the outreach to birthing hospitals to promote referrals to newborn home visiting (see page 59). Another is outreach to local pediatricians. As previously stated, AAP conducted 45 visits with local pediatric offices to discuss HDS services and promote the use of developmental screenings as part of the well child check-up. Regions also facilitate early intervention by promoting screening/assessment and entry into care by working collaboratively with clinics, medical providers and community agencies in their region, through community outreach/outreach specialists, as well as working with Child Welfare Services (CWS) and Public Health Nursing (PHN).

HDS Target Population

- Children with mild to moderate developmental delays rather than developmental disabilities
- Issues connected with home environment and lack of stimulation rather than genetically based developmental concerns
- Children who would benefit from short-term services (roughly less than three months duration)

5. Responsive to Cultural, Linguistic, and Special Needs

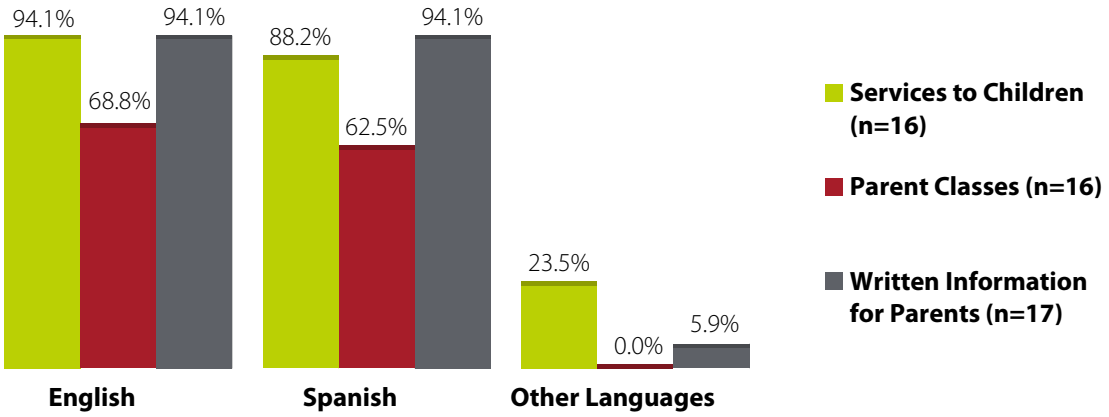
Definition: Agencies/providers are sensitive to differences in race/ethnicity, religion, language, gender, sexual orientation, abilities/disabilities, socioeconomic background, and other community-specific characteristics in order to maximize client participation and service quality.

With over 80 languages spoken regionally and with residents originating from over 100 nations, it is critical for services in San Diego County to be culturally and linguistically appropriate. Subcontractors were asked to respond to their ability to be responsive to the cultural, linguistic and special needs, through a variety of ways.

Cultural/Linguistic: The regions take different approaches to this area. All regions have bilingual and bicultural staff to meet the needs of Spanish speaking families. Many regions outsource services to reach additional populations. For example, two regions subcontract with the Union of Pan Asian Communities (UPAC) to help address the language needs of families who speak Chinese, Vietnamese as well as other Asian-Pacific languages. Three reported providing annual cultural competency training for HDS providers. Regions also address and review cultural competency issues at site visits with subcontractors. Subcontractors generally provide services and written materials in Spanish, and 62.5% of subcontractors provide parenting classes in Spanish (Exhibit 3.32). Services to children are also provided in Chinese, Tagalog and Vietnamese, with one respondent providing services for children in eight different languages and written information for parents included Vietnamese, Chinese and Japanese.

[124] Shronkoff, J.P., and Phillips, Deborah A. National Research Council, et al. From Neurons to Neighborhoods: The Science of Early Childhood Development. National Academy Press, (Washington D.C., 2000).

Exhibit 3.32 Service Provider's Perspective: Language Capacity*



** Categories are not mutually exclusive as respondents may have been from agencies that provide more than one service within HDS. Valid percents are reported. 'Not applicable' responses were coded as invalid and not reported.*

Children with Special Needs: AAP and the Regional Leads focused on identifying and promoting available training and professional development opportunities that would expand service providers' capacity to work with children with special needs. This can be especially challenging when doing assessment and treatment with these children. HDS providers with specific experience serving children with special needs also offered training and in-services to their HDS colleagues.

In addition, through building regional platforms focused on early identification of developmental delays, HDS has had an impact on the overall system that serves children with special needs. In particular, HDS referrals have dramatically increased the outcomes of the Child Find program at the Regional Center.

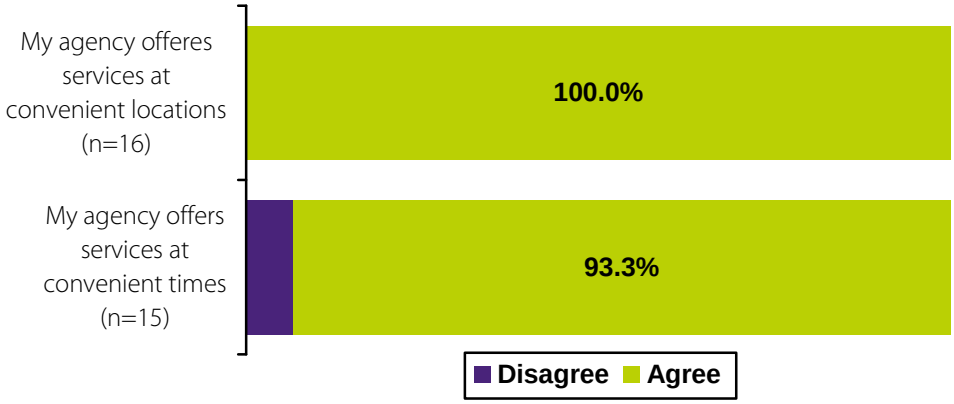
6. Readily Accessible

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.

Both the regional leads individually and AAP on behalf of the overall initiative have undertaken steps to enhance the accessibility of services.

Regional specific activities: Within the RSNs, Leads do much to ensure families have access to HDS services. Clients' financial barriers are addressed by linking families to community resources (such as Healthy Families, Medi-Cal and WIC) either through direct assistance or referrals. Transportation is a key barrier to accessing services. Leads provide transportation assistance and place services in convenient locations. Additionally, HDS subcontractors reported offering services at convenient times and locations (Exhibit 3.33).

Exhibit 3.33 Service Provider's Perspective: Readily Accessible*



**Valid percents are reported. 'Not applicable' responses were coded as invalid and not reported.*

Regional Leads reported that it is a challenge to hire and retain bilingual staff across the regions, but particularly in professional areas where there is a lack of professionals with early childhood specialties. Within HDS, there is a particularly high demand for speech and behavioral therapists who can serve young children and/or provide services in Spanish. There are also needs for more providers in vision screenings and developmental treatment. Additional clinician time is needed for occupational therapy, physical therapy and speech services. Subcontractors noted similar challenges. The majority of respondents (64.7%) reported that their agency was not staffed sufficiently to meet service needs due to a variety of operational reasons including high service demand, low caseloads required for intense services, lack of bilingual staff, and turnover. To assist with challenges in recruiting and retaining staff, First 5 San Diego has worked internally to change to multi-year budgeting for HDS, enabling providers to guarantee multiyear positions. This is especially beneficial for filling vacancies mid- and late-year.

These staffing challenges, coupled by the increase in demand as HDS services become more well-known, have resulted in wait lists for many of the service areas. One of the most affected areas is behavioral treatment, where wait times varied by provider and region. The longest wait times ranged from four to six months.

Cross-initiative activities. AAP has pursued a number of activities to facilitate the accessibility of HDS services. These include:

- Working with First 5's Communications Contractor to design the Public Service Announcements and other communications materials about the importance of a developmental screening.
- Meeting with other initiatives, including Preschool for All and Oral Health, to identify ways families can be linked to the variety of services First 5 funds.
- Working with Regional Leads to better define the HDS target population to promote more effective communication with community partners and appropriate referrals to HDS.
- Coordinating several trainings for HDS providers, including a 2-day ASQ/ASQ-SE train-the-trainers seminar, a workshop on autism, and a child development training that focused on administration of the Ages and Stages Questionnaire (ASQ) assessment tool.

AAP is currently investigating opportunities for telemedicine, which allows providers to interact with families via the telephone, Internet, other networks. Use of this technology would better connect families in remote

parts of the County to HDS services. While Regional Leads see the potential of this technology, they note that telemedicine may not be useful in all service areas, such as speech and language services and sessions with younger children with shorter attention spans. There may also be cultural and generational resistance to these services.

7. Accountable

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

Regional Leads are tasked with creating and overseeing regional networks for service providers. The leads continue to strive to better understand their subcontractors' service delivery systems and strengthen relationships. Leads are responsible for ensuring that all service providers are meeting their obligations to HDS. Regional leads share best practices and guidelines with other providers in their regions through meetings, conferences, trainings, email exchanges, reports, and site visits. Additionally, the executive meetings facilitated through AAP and quarterly subcontractor meetings help ensure that program goals and service outcomes are being carried out. As this complex system of services has now taken root, Leads can now set specific service targets and improve overall quality assurance. As the convener of provider meetings, AAP can continue to refine service content and protocols.

8. Sustainable

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

Sustainability is an important component to HDS as providers look past the current F5 funding of this initiative and into the future. As noted last year, to ensure that RSN Leads are contributing to the investment in HDS, lead contractors are required to provide a 20% match for the remaining 3 years of HDS.

Several leads noted in their quarterly report narratives that they, or their subcontractors, are actively seeking additional funding to expand or continue HDS services. Unique strategies include negotiating a royalty fee from a childhood development website and working to secure Medi-Cal Administrative Activities (MAA) reimbursement for outreach efforts to Medi-Cal eligible families supported by HDS.

AAP has convened an HDS redesign committee to examine the current structure of HDS and use recommendations from their quality assurance work evaluation data to improve services and better structure the HDS system to meet ongoing needs. The efforts of this committee will be shared in the coming fiscal year.

Update on Recommendations from FY 2006-07

The following actions were recommended in First 5 San Diego's Annual Evaluation Report. First 5, AAP and HDS providers made changes to address these recommendations, as is discussed below.

Recommendation 1: Continue collaboration and strengthen commitment to countywide vision.

Update: In FY 2007-08, HDS continued to collaborate between regions as well as with agencies and entities outside of the HDS network.

Recommendation 2: Support Coordination.

Update: The need for more support and resources for coordination continued to be a theme for FY 2007-08. Regional Leads and subcontractors continued to cite the need for case management in order to help families navigate the network of services within HDS and outside the realm of HDS. AAP has begun to work with Regional Leads to identify areas where case management is most needed.

Recommendation 3: Maximize Outreach.

Update: HDS partners continued to outreach and raise community awareness around the importance of early childhood health and developmental services available to families. In FY 2007-08, HDS regional leads outreached to new agencies to create new HDS partnerships. Additionally, Regional Leads held numerous meetings, presentations and in-services for entities and providers outside of HDS.

Recommendation 4: Examine opportunities for standardization.

Update: 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. In FY 2007-08, AAP convened service area workgroup meetings with At-Risk Home Visitation and began discussions with developmental and parent support and empowerment service providers to discuss ways to strengthen the delivery of care and identify consistent service definitions.

Recommendation 5: Strengthen capacity building activities.

Update: In FY 2007-08, Regional Leads conducted a number of collaboration activities including providing technical assistance, training, and in-services for subcontractors to build staff capacity. However, barriers to services that were reported during FY 2006-07, continued to be cited by HDS partners in FY 2007-08. These barriers include lack of trained specialists, as well as retaining bilingual and bicultural staff to adequately serve families.

Recommendations

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

- **Expand capacity to support prompt, professional treatment.** HDS service delivery grew in FY 2007-08 and HDS partners provided service to approximately 13% more children. Along with this growth, waiting lists for assessment and treatment services continue to grow in length. As more children are increasingly screened, more are identified as needing professional assessments and treatment. This is stretching the capacity of the existing system and resulting in longer wait times for families. Additional funding is needed for treatment, and the local system needs to be expanded to provide these services. In particular, there are shortages of bilingual staff in most areas.
- **Play a leadership role in increasing the numbers of early childhood development professionals in the San Diego area.** All HDS providers have noted the challenges of locating qualified professionals and a notable need for speech and language professionals and behavioral therapists. AAP and some of the regional leads are looking at working with the Commission staff and other area providers on innovative strategies to bringing more professionals to this area.
- **Address the need for case management.** Regional Leads and subcontractors continued to cite the need for case management in FY 2007-08. In addition to helping families coordinate and navigate services in a complex system, case management would be beneficial in ensuring:
    - Fewer families lost to follow-up;
    - An increase in the number of completed assessments for the developmental, speech and language, behavioral, consultation, and vision service areas;
    - An increase in the number of children and families that successfully connect to a referral within the HDS network; and
    - An increase in the number of referrals to other First 5 initiatives.

  AAP is interested in piloting the use of FANS – Family Assistance Navigation Specialists – to bolster case management. This would require either additional funding or reallocating resources from other HDS services.
- **Strengthen the HDS platform.** A broad based planning effort is underway to create a SART (Screening, Assessment, Referral and Treatment) program for children in San Diego County. Part of the planning process has included designing a system that will build upon the HDS platform. In addition, as ties are built and strengthened, HDS is part of referrals into, and from, the systems that support children with more severe developmental delays, including the Regional Center Child Find program and the school systems. As HDS becomes a platform that integrates with, and moves toward, a true continuum of services, it is critical that the HDS platform is strong enough to support and not be crushed by these other efforts. At minimum, this would include expanding case management and treatment.
- **Strengthen focus on accountability and sustainability:** As this complex system of services is strengthened, these are two important core principles to establishing a system of care. AAP, First 5 and the Regional Leads can collaborate to ensure more consistency in services and protocols across regions. Leads can also set specific service targets and improve overall quality assurance to improve accountability across the system. As HDS continues to grow and develop, it will be important for the regional networks to focus on leveraging funds to support the continuation and expansion of HDS.

- **Continue to examine opportunities for standardization.** HDS partners can now take the lessons of year one and two to better define more consistent service definition, delivery and targets across regions, as well as standardize assessment instruments and measurements.

A Final Word on the Healthy Development Services Project

In FY 2007-08, HDS partners increased service provision throughout San Diego County, serving over 32,000 children. HDS also began to address the need to reduce gaps and improve coordination of services as referral systems within regions were established. Through the creation of HDS, developmental services are now better coordinated within and across regions, as well as across systems. Deep partnerships have been created with the Regional Center, California Early Start, public health nurses, birthing hospitals and pediatricians' offices.

Before HDS, these system providers had little reason to work together but are now collaborating to build a true system of developmental services for children. In roughly two and a half years, HDS has built and connected regional systems that create a platform of developmental services and referrals for children with mild to moderate delays. This is a tremendous achievement. The intent is that – as a result of four and a half years of stable funding – this system will be well established and prove to be an integral part of a continuum of services for children with special needs that is committed to early identification and treatment providing lifelong benefits.

Through the leadership of the local AAP, HDS has raised considerable awareness of the need for young children to have regular developmental checkups. The goal is to change pediatric practice *and* to have parents embrace developmental checkups and become more knowledgeable and involved in promoting their child's optimum development.

Although work to improve standardization between service areas and regions remains, there is a strong commitment to the importance of this throughout the initiative and undoubtedly will continue to be a key element in the coming year.

Case Study 3
Fitting in With the Playgroup*

A Mother's Concern

Gwen lives in a neighborhood where she can walk outside and talk to other mothers. When her son Justin was 6 months old, Gwen, along with about 20 other mothers, decided to create a playgroup for their children. Now, two years later, Gwen noticed that Justin hesitated to assert himself with his peers. "…Other kids were taking toys away from him and he was pushed around easily, and he couldn't protect himself," Gwen said. "He wouldn't push back; he would stand back, which caused a lot of emotional stress for him." Also, although her husband speaks English, Gwen speaks Dutch and she noticed that Justin was having difficulties asserting himself in English. "And I was hoping to boost his language skills," she said, adding, "so he could start off saying to kids 'Don't push me' or 'My turn.'" Gwen's concerns were not just about Justin's self-defense abilities, she was also growing concerned that Justin was being pushed around so much that "he kind of lost his trust in people." Gwen found help for Justin through a variety of services offered by First 5's Healthy Development Services at Family Health Center (FHC).

Connecting to Services

On the advice of one of the playgroup mothers, Gwen connected to First 5 through a call to 211. Initially, Gwen recalled feeling a bit hesitant and uncomfortable because she "didn't know anything specific," she said. "I just knew that it was the program called First 5 for children…." However, Gwen decided to follow through with the call to 211, which referred her to Family Health Centers (FHC). At the beginning, Justin underwent several basic assessments. "They do cognitive; they do fine motor skills and gross motor skills. So, they do all kinds of tests," she said. Justin's assessments had a strong emphasis on his speech to determine if there were concerns or issues that might need additional focus. Gwen recalled that Justin did well on many of the tests, with the exception of the language test. "Maybe language-wise he should be more advanced," Gwen urged. In addition to receiving help with her son's speech, Gwen had also told FHC staff that Justin had an eating problem. "He is a picky eater, does not like to eat vegetables, and plays with his food," she said.

"…he was doing much better. He did stuff he would never do for me. He did it because he loved the Occupational Therapy."

- Gwen, First 5 Parent

In order to improve his speech, Justin attended one-on-one meetings with a speech therapist and then he progressed to small group sessions that included Gwen. To address Justin's eating problem, he began seeing an occupational therapist who helped him work on improving his food intake and sensory glands. Justin works well with the occupational therapist and enjoys spending time with her, which served as a good catalyst for making the therapy fun. "He was very happy to go. And then it became food oriented, which was the goal," Gwen recalled.

Progress Made

Gwen remembers that, in the beginning, Justin was scared to enter the First 5 Services at Family Health Centers because he was unfamiliar with the setting. But as time progressed, Gwen recalled that "he just learned to love it…" Gwen has watched Justin's fear diminish and his social initiative and assertiveness increase. Gwen recalled that, in the past, Justin did not defend himself in the playgroup but she now sees a positive change in his behavior since enrolling in First 5. "He stood up for himself in the play group," she said. "He would pull his toys back when somebody else would take [them] away." In addition to seeing improvement in Justin's language, Gwen has learned strategies from the occupational therapist to help improve Justin's poor eating

habits. "You cannot just [put] a food bowl in front of him and say 'eat' because he doesn't like it," Gwen said. "So, they warm up [and he will] eat it and then [they encourage him to] start eating. And, in the end, he's just eating."

Working Toward the Future

Gwen feels that Justin's speech challenges are due to him being bilingual, but she is more concerned about his "being shy and not being able to communicate the things that are… dangerous," she affirmed. Therefore, she would not only like Justin to be able to better communicate for conversational purposes, but also for his own safety. Justin has finished all the individual speech therapist sessions and will continue participating in the small group sessions. Gwen would also like to see Justin continue to improve his eating habits in the next couple of months. Justin is still refusing vegetables. Since they have completed the maximum allotted occupational therapy sessions at the FHC, she is working to convince her insurance to pay for additional occupational therapy sessions that she feels can continue to help Justin improve his eating habits.

"I'm very grateful to have this support network to use at First 5…being free and just the opportunity to know, yes, you have a problem, you should work on it, it makes things easier and try to work on it much earlier than later on."

- Gwen, First 5 Parent

**All names were changed to protect confidentiality*

CHAPTER 4

School Readiness Initiative

"[School Readiness] unites parents to their children and it makes a beautiful atmosphere in our home."

—School Readiness Parent

Key Results

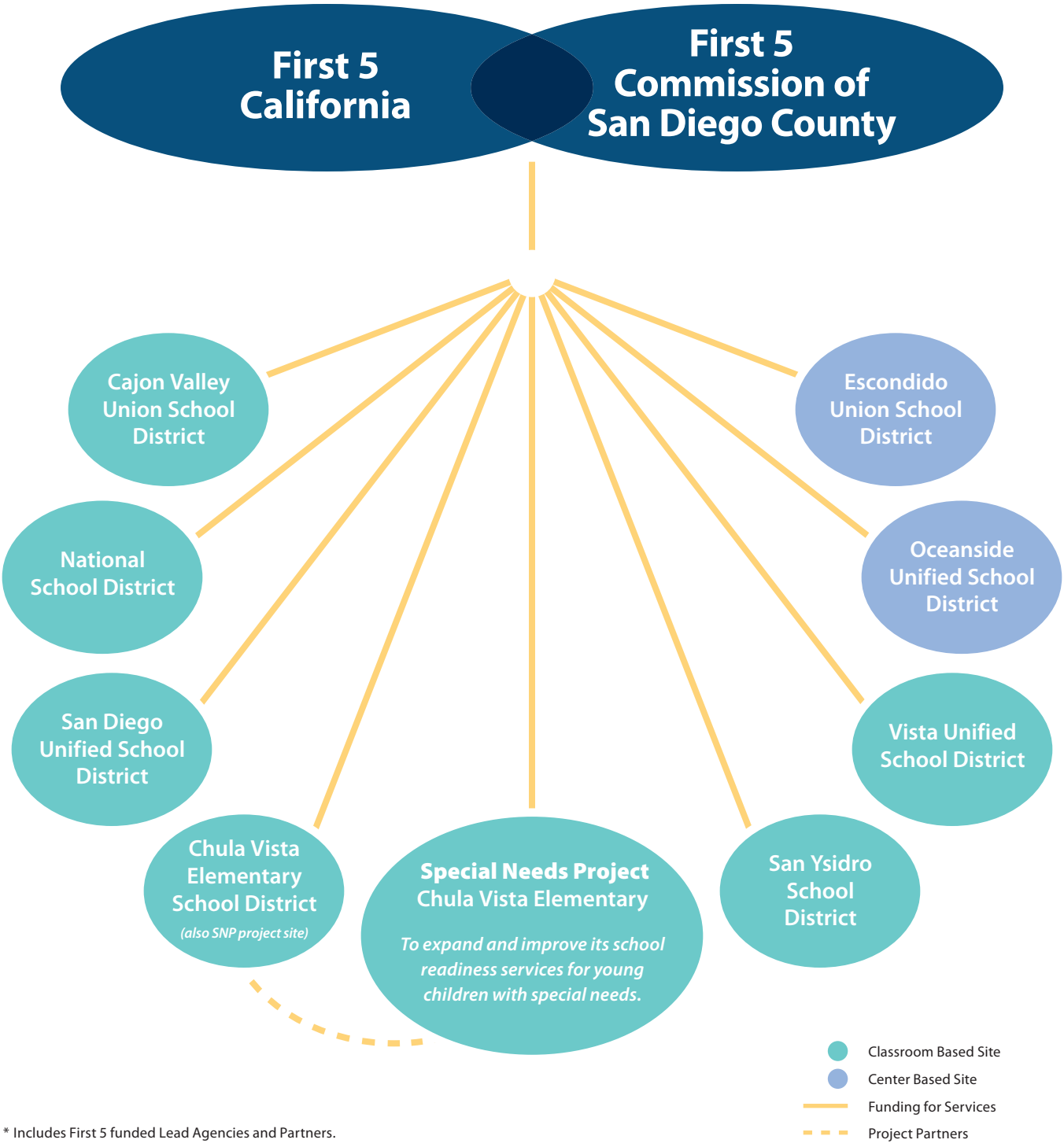
- **Children improved in each of the developmental domains.** Children enrolled in classroom-based early care and education services, both full- and part-time, improved in all four developmental domains of the DRDP-R. Children attending center-based services also improved in all five developmental domains of the ASQ.
- **Parents increased ratings in each of the four parenting practice areas.** Parents participating in parenting classes and workshops demonstrated increases in each of the parenting practices focus areas (knowledge, confidence, ability and connection) for the second consecutive year. Additionally, 99.7% of parents indicated overall program satisfaction with the School Readiness Initiative.
- **Children are receiving developmental screenings.** About half of children participating in early care and education services received developmental screenings. Almost all children identified with disabilities or special needs received services, treatment or supplemental intervention.
- **Staff are articulating with elementary schools and participating in professional development.** There was an increase in interactions between SR program staff and elementary staff this fiscal year. The majority of SR preschool teachers have formal kindergarten transition plans for children, and over half discuss these plans with kindergarten teachers. Further, there was an increase of SR staff with more than five years of experience in their field, and almost all participated in professional development activities this year.

Summing It Up

The School Readiness Initiative served 15,827 children 0-5, 7,239 parents/caregivers, and 1,076 staff and service providers during FY 2007-08:

- 5,052 children (including 663 children with disabilities or other special needs) and their parents and caregivers participated in early care and education activities, exceeding their goals by 18.9%.
- 6,642 parents and caregivers participated in parenting and family support services.
- 7,373 children received health screenings, including 2,618 developmental screenings.
- 3,277 children participated in kindergarten transition activities and 597 parents had transition meetings with teachers.
- 731 program and community service staff members attended professional development activities.
- 510 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

Almost a half million children enter kindergarten in California each year; about 8% of whom are in San Diego County.[125] While enrollment reaches record numbers, approximately 60% of these children perform at significantly lower levels than expected because they arrive without the necessary skills to learn.[126] Research has found that children's low performance during the early years can continue throughout their academic careers.[127] 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.[128] Employing such a comprehensive approach better prepares children to enter kindergarten ready to learn.[129]

To address this gap, the School Readiness Initiative was launched in 2002 as a joint project between First 5 California and local county Commissions. First 5 San Diego contracted with eight local school districts with low Academic Performance Index (API). Since its inception, the Commission has dedicated $14,458,450 to the Initiative, including $2,927,047.50 in FY 2007-08 with an equal match from First 5 California. The total investment in the School Readiness Initiative has been $28,916,890 since its inception. The School Readiness Initiative is based on the National Education Goals Panel's "Five Essential and Coordinated Essential Elements." [130, 131]

The Special Needs Demonstration Project (SNP) is a complementary component of the School Readiness Initiative. This pilot project was designed to enhance School Readiness services in a specific geographic area through early identification of children ages 0-5 years 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. The Chula Vista Elementary School District was one of ten sites across the state selected by First 5 California to implement the Demonstration Project. Both projects are discussed in this chapter.

Key Elements

School Readiness (SR) is the longest running Commission initiative. During its six years, SR has evolved from a series of discrete programs in school districts that broadly addressed similar objectives, to a more 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.

[125] California Department of Education. DataQuest. Accessed 11 September 2008. <http://dq.cde.ca.gov/dataquest/> [FORMAT]
[126] http://www.childtrendsdatabank.org/indicators/7EarlySchoolReadiness.cfm
[127] First 5 California "School Readiness 2001." 20 March 2001: 2 Accessed 17 August 2006. <http://www.ccfc.ca.gov/pdf/sr5.pdf >
[128] Ibid.
[129] Ibid.
[130] Early Connections: Technology in Early Child Development. Five Areas of Child Development. 2005. Accessed 17 August 2006. <http://www.netc.org./earlyconnections/index1.html>
[131] The NEGP "Five Essential and Coordinated Elements" include Parent and Family Support, Early Care and Education, Health and Social Services, Schools' Readiness for Children, and Program Infrastructure, Administration and Evaluation.

- ***A "whole child" approach:*** All SR program models across the state are based upon the First 5 California "Five Essential and Coordinated Elements" of school readiness,[132] adapted from the National Education Goals Panel (NEGP).[133]
- ***Multi-level***: SR programs focus on three target groups: the child, the family and the school. These programs support child development by fostering children's physical, social-emotional and cognitive development. These programs support 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 school systems through joint training and articulation planning meetings.
- ***Regular communication:*** School Readiness program coordinators meet monthly to discuss successes and challenges and collaborate with each other and Commission staff.

Summing It Up

In FY 2007-08, the School Readiness programs increased services to each core population compared to last fiscal year. They served 15,827 children ages 0-5 years (45.0% increase), 7,239 parents and caregivers (12.4% increase), and 1,076 staff and service providers (a 54.8% increase).[134, 135] Most children participating in SR activities were three years of age and older, of Hispanic/Latino descent, and primarily spoke Spanish in the home. The following section provides the results of services provided to children, parents and caregivers, as well as staff and service providers this fiscal year. For this section of the report, similar services across each SR program were aggregated to highlight the main services provided throughout the county. The number of children and parents served are organized by the three of the four result areas for children and parents, which include improved child development, improved child health, and improved family functioning. The final result area – improved systems of care – is found in the section, "Making the Connection" on page 118.

"It gives information about where the kids should be… [developmentally that] I would have never known about."

- School Readiness Parent

Improved Child Development

Early Care and Education (ECE) services include a variety of program components designed to increase the school readiness of children: full- and part-time preschool, parent and child activities in learning centers and service enhancements to programs funded through other sources.[136] Pre-kindergarten programs play a vital role in a child's social, emotional, and cognitive development.[137]

Exhibit 4.1 displays the number of unduplicated children served through ECE services. Over 5,000 children were served through the ECE activities, exceeding the projected goal of 4,250 (15.3% increase compared to FY

[132] http://www.ccfc.ca.gov/Help/api.asp

[133] National Education Goals Panel (1997), "Getting a Good Start in School," Washington, D.C. : National Education Goals Panel.

[134] May include duplicate counts within and between services. See each result area findings for more specific information.

[135] Children can receive multiple services so this is a duplicated count. In some cases, SR programs connect families with services and do not provide these services directly.

[136] Includes curriculum, behavioral and health enhancements provided to California Department of Education preschools, First 5 of San Diego Preschool for All Demonstration Project preschools, Head Start and some community and faith-based programs.

[137] "California Report Card 2008; The State of the State's Children." Children Now. 2008. 18 Aug. 2008 http://publications.childrennow.org/publications/invest/reportcard_2008.cfm

2006-07). Similar to last fiscal year, the number of children served through ECE activities exceeded their set goals, despite the fact that FY 2007-08 goals were increased from the previous fiscal year.

Exhibit 4.1 Children Served through Early Care and Education, FY 2006-07 and FY 2007-08*

Service	FY 2006-07			FY 2007-08		
	Number	Goal	% of Goal	Number	Goal	% of Goal
Full-Time Preschool	628	524	119.8%	588	524	112.2%
Part-Time Preschool	624	529	118.0%	367	328	111.9%
Parent & Child Activities	1,678**	1,600	105.9%	1,865***	1,583	117.8%
Service Enhancements****	1,451	1,173	123.7%	2,232	1,815	123.0%
Total	**4,381**	**3,826**	**114.5%**	**5,052**	**4,250**	**118.9%**

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

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

**** Includes 190 intensively served and 1,675 "light touch" children.*

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

This year, 13.1% of children served in all ECE activities had special needs,[138] compared to less than 10% in FY 2006-07 (9.5%; see Exhibit 4.2). Most notably was a dramatic increase in children with special needs enrolled in full-time preschool (1.6% to 20.2%). This increase was due to a more concerted effort by some contractors to include children with special needs. These findings suggest that the School Readiness programs are making progress towards serving the population of children ages 0-5 years with special needs, as it is estimated that between 8%-17% of children have special needs.[139, 140, 141] Children with special needs reported in the SR results are not duplicate children served by the Special Needs Project Demonstration Project.[142, 143]

"For a lot of these moms, [the SR program is] their only social time… They are very isolated so they come together and talk about parenting."

- Key Community Expert

[138] 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" (www.first5ca.org)

[139] HDS and PFA initiatives both use CDC statistics for benchmarking the number of children with developmental delays at 17%. However, the CDC's statistics encompass ages 0-17 years: Centers for Disease Control and Prevention. "Child Development: Developmental Screenings." Atlanta, GA. <http://www.cdc.gov/ncbddd/child/devtool.htm> Accessed September 12, 2008. [FORMAT]

[140] Note that the percent of children with special needs is quoted from a 2001 publication. Other initiatives in the Commission utilize the CDC percentage of 17%.

[141] Note that in the First 5 funded Healthy Development Services Initiative provides screening for children, which identifies mild to moderate delays in low-income areas. This Initiative has found that 20%-27% of children screened demonstrate some form of developmental delay, suggesting the high need in School Readiness populations.

[142] The Special Needs Project (SNP) reports child-level data through a state level database, so duplication is minimal.

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

Exhibit 4.2 Children with Special Needs Served through Early Care and Education, FY 2006-07 and FY 2007-08*				
Service	FY 2006-07		FY 2007-08	
	Number	% of Served	Number	% of Served
Full-Time Preschool	10	1.6%	119	20.2%
Part-Time Preschool	102	16.3%	65	17.7%
Parent & Child Activities	22	1.3%	122	6.5%
Service Enhancements**	283	19.5%	357	16.0%
Total	**417**	**9.5%**	**663**	**13.1%**

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

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

Results from the Parent Retrospective Survey were overwhelmingly positive about the SR early education programs (see the "Improved Family Functioning" subtitle later on in the "Making a Difference" section). In addition, parents also noticed a difference in their children's interest in learning and school. As one parent commented, "I think that programs like this will assist in allowing [the children] to feel more comfortable in the next grades. It helps them feel good about learning, trying to learn, and practicing skills."

Improved Child Health

SR programs provide a variety of health and social services to participating children and families, following a "whole child" approach to preparing children for kindergarten.[144] These services may be funded directly by First 5 School Readiness funds (i.e. the SR contract may fund 50% of a school nurse or a speech therapist) or SR programs may reach out to other available services (e.g., the First 5 San Diego Oral Health Initiative or Healthy Development Services programs). Services directly funded as part of a First 5 San Diego SR program or provided referrals to other providers (i.e. indirectly) were counted as part of their overall children's health service counts to demonstrate the whole child approach of SR.

Exhibit 4.3 displays the number of children receiving developmental, health and behavioral services, as well as referrals for further assessments or services and case management. This year, programs exceed their goal of 5,800 health and social services by 27.1%. This marks a 76.3% increase in services over last fiscal year.

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

Exhibit 4.3 Children Served through Health and Social Services, FY 2006-07 and FY 2007-08*						
Service	FY 2006-07			FY 2007-08		
	Number	Goal	% of Goal	Number	Goal	% of Goal
Developmental Screenings	1,634	2,485	65.8%	2,618**	2,968	88.2%
Health Screenings***	1,910	1,357	140.8%	2,489	1,779	139.9%
Behavioral Services	122	100	122.0%	160	125	128.0%
Referrals/Case Management****	515	432	119.2%	2,106	928	226.9%
Total	**4,181**	**4,374**	**95.6%**	**7,373**	**5,800**	**127.1%**

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

***Includes 840 developmental screenings conducted by HDS.*

**** Includes general health, dental, language/speech/hearing, and 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 SR programs noted the comprehensive nature of the program. Through feedback in a parent focus group and the Parent Retrospective Survey, parents expressed gratitude for the opportunity to access a variety of health and social services. As one parent shared, "It opened my eyes to recognize new things that help my daughter be healthy." And in the words of another parent, "It gave me a lot of information about my children's developmental stages." The programs also provided parents access to needed developmental screenings and intervention:

> *"If it hadn't been for this grand program, one of my children would not have received his intervention in time. He was diagnosed… because of the timely diagnosis, my son has a future where he will overcome for himself. He is now at the right educational level for his age. Thank you for his evaluations and recommendations."*

For more information on the universal SR screening protocol, see "Creating Systems Change for Navigating Referrals" and "SR Developmental Screening System: Parents' Perspective" later in this chapter.

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 visitation programs. Research has demonstrated that these types of parent services have a direct positive impact of the developmental progress of children.[145, 146, 147] Parent and Family Support services were delivered

[145] 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>

[146] 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.

in several formats this fiscal year. 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 behavior, general health and parent support.

"It helped me… be more patient with my kids and husband."

- School Readiness Parent

Overall, 6,642 parents and caregivers received services through Parent and Family Support, an increase of 14.4%, compared to FY 2006-07. All service types but two (sequential parent classes and single session PACT projects) exceeded their goals. Parents reported that they are now better prepared to recognize learning opportunities with their children, plan developmentally appropriate activities and better understand their children (see below for results of the Parent Retrospective Survey). Many parents shared the effect of the programs. As one parent said, "[the program] helps with their learning abilities, in their school and how we can help in their class and at home."

Exhibit 4.4 Parents and Caregivers Served through Parent and Family Support, FY 2006-07 and FY 2007-08*

Service	FY 2006-07			FY 2007-08		
	Number	Goal	% of Goal	Number	Goal	% of Goal
Sequential Parent Classes	1,580	3,158	50.0%	1,869	3,320	56.3%
Single Session Parent Classes	3,480**	1,669	208.5%	4,043***	1,939	208.5%
Sequential Parent & Child Together (PACT)	331	175	189.1%	274	175	156.6%
Single Session Parent & Child Together (PACT)	217	250	86.8%	107	100	107.0%
Home Programs	303	240	126.3%	349	242	144.2%
Total	**5,808**	**5,392**	**107.7%**	**6,642**	**5,776**	**115.0%**

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

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

**** These parents and caregivers participated in approximately 543 classes (217.2% of the goal of 250).*

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

Creating Systems Change for Navigating Referrals

As School Readiness continues its focus on universal screenings for children, understanding the assessment and referral system is vital for program improvement. During telephone interviews, School Readiness Coordinators were asked about their school district's screening procedures. All contractors conduct initial developmental screenings. If the screening identifies a need for further assessment, families are typically referred out.

Formal Plans for Tracking Children

Six of the nine programs* represented in the interviews identified formal plans for following-up on the status of the referral. These included using existing staff members to follow-up with the family. Many of the sites also reported that their in-house services provided needed interventions, reducing the need for communication with outside agencies. Three of the Coordinators specifically stated that, if necessary, staff attend IEP meetings with parents, sharing personal experiences with the challenges faced by the child and family. For those sites with no identified plan, there is little communication or feedback with parents regarding their follow-through or their experience with other services. Several of these sites reported frustration with lack of parent follow-through and the uncertainty of referrals.

Challenges in Communication

One challenge shared by several Coordinators is the difficulty they face receiving information from outside agencies regarding their referrals. One Coordinator stated that, "for confidential[ity] reasons, the teacher cannot get that information." Access to this information would assist SR staff in developing the best plan for the child. One site has overcome this barrier by using a psychologist or speech pathologist to conduct follow-up. These professionals can obtain the appropriate releases to ensure an ongoing exchange of information with the referred-to agency. Other sites reported that they continue to discuss this challenge and are working on improvements in information exchange. One of the challenges is that, while the school districts may refer screenings, assessments, and/or treatments to external agencies, they do not at this time have any formal data sharing agreements (either Business Services Agreements or MOAs) with community services providers. This is an area for future exploration.

Another barrier identified by Coordinators is parental follow-through. Often, children are referred to another site for follow-up or intervention services, but parents do not comply. Several Coordinators share that even when staff work with families, parents do not always obtain services needed by their child.

Solid Community Ties

Coordinators who identified a strong link with their local providers reported more success with follow-through from parents. Specifically, one Coordinator commented that because there are few providers in their region, they have been able to develop a strong relationship with service providers and these relationships often assist with linking parents: "We have a relationship with the referring agencies since most are to one local agency . . . also [we] have on-site services from the agency, so oftentimes it does not feel like an external referral."

SR programs have experienced varied success in screening and referring children for further assessments and/or interventions. From a systems standpoint, breaking down barriers to communication with referral agencies, and parents, is vital to ensure children receive the services they need. Continued improvement in protocols and partnerships may facilitate better success in the future.

---

* Includes eight SR program Coordinators and one Special Needs Demonstration Project coordinator

Making a Difference: School Readiness in Action

The overarching goal of SR 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, health and human services to children, parent and family support, and improving connections between early care educators, kindergarten staff and the elementary school systems. Programs utilized standardized tools to measure outcomes for children, families and SR staff. In addition to selected site visits, interviews with SR 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. For more information on the methods used, please see Appendix B. Child and parent outcomes are organized by the three of the four original result areas: improved child development, improved child health, and improved family functioning. The final result area, improved systems of care, is found in "Making the Connection" on page 118.

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

Improved Child Development

The centerpiece of SR is providing quality early education experiences to children. Classroom-based programs used the revised Desired Results Developmental Profile (DRDP-R), which is a teacher's observational assessment for children. The Ages and Stages Questionnaire (ASQ), completed by parents and/or SR staff, was used at parent-child activity centers. All data and findings are for children with both Fall ("pre") and Spring ("post") matched cases, for fiscal years 2006-07 and 2007-08. While both tools measure similar behaviors and skills, limitations in analysis and comparison exist 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.

"The children are gaining the skills that they need for school. We are really empowering these families."

- SR Coordinator

Child Outcomes: Classroom-based Programs

Classroom-based child outcomes are measured through DRDP-R from six School Readiness programs and represent matched scores for 1,075 children (34.1% of children enrolled in early learning activities). Last fiscal year, DRDP-R data represented matched scores for 1,312 children or 49.4% of children enrolled in early learning activities.[148, 149] This decrease in data could be due to the new First 5 San Diego consent form process,

[148] In FY 2004-05 and 2005-06 only four districts were required to complete the DRDP for their children enrolled in early learning activities. In FY 2006-07, 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.

which was integrated into School Readiness mid-year. In fiscal year 2008-09, consent forms are being included in enrollment packets; therefore, increased participation rates are expected.

This year's data was analyzed differently than previous years. The changes bring the analysis in line with the DRDP-R four domains of child development – personal and social competence, effective learning, physical and motor competence, as well as safety and health. The new analysis is also congruent of analysis conducted for the Preschool for All Demonstration (see Preschool for All, Chapter 5). Last year's data was reanalyzed to reflect these changes.[150]

Exhibit 4.5 displays the change in results of the DRDP-R from Fall to Spring assessments, by the instrument's four domains, and within each domain. Data are mixed, including children attending full-time and part-time programs (see Appendix B for further details of methods and findings.)[151]

Key findings of the DRDP-R include:

- Comparing this fiscal year to last, more children were enrolled in full-time early learning programs (88.2% compared to 53.7%) than part-time programs (11.8% compared to 46.3%).[152] As in last year, DRDP-R results suggest that students enrolled in full-time classroom-based services are increasing their developmental skills at a higher level than those in part-time services.
- 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 2007-08 domain scores increased from FY 2006-07, except for motor skills.
- The largest increase for all students was found in safety and health, followed by effective learning and personal and social competence. This finding is in contrast to FY 2006-07, where the smallest increase for all students was found in safety and health.
- In both fiscal years, children in a full time program experienced higher results in all four DRDP-R domains than those attending the program part-time, with the largest difference found in safety and health. This suggests that increased exposure to SR programs may increase the benefit to children.

Exhibit 4.5: DRDP-R Developmental Area Mean Score Change by Attendance Type and Fiscal Year

Domain	All	Full Time	Part Time
Personal and Social Competence			
FY 2006-07	+1.08*	+1.13*	+0.99*
FY 2007-08	+1.10*	+1.25*	+0.93*
Effective Learning			
FY 2006-07	+1.13*	+1.22*	+1.09*
FY 2007-08	+1.14*	+1.38*	+0.91*
Motor Skills			
FY 2006-07	+0.97*	+1.03*	+0.91*
FY 2007-08	+0.96*	+1.00*	+0.96*
Safety and Health			
FY 2006-07	+0.92*	+1.01*	+0.82*
FY 2007-08	+1.22*	+1.65*	+0.98*

**Changes are statistically significant (p<.001).*

[149] 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 3,150 children during FY 2007-08 and 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.

[150] Due to changes in instrument and analysis, comparisons with FY 2004-05 and FY 2005-06 are not available.

[151] See the Appendix B: Methods for an explanation of the DRDP-R and each of the domains.

[152] Children from one School Readiness program did not provide attendance data for their children in FY 2007-08 and have been excluded from analysis based on dosage this year (n=576).

Child Outcomes: Center Based Programs

ASQ data are reported for two center-based programs, totaling 240 matched cases, representing 74.8% of intensively served children at these sites (n=321).[153,154] The analysis used is in line with the intended use of the ASQ as a screener for developmental concerns at various ages. Therefore, the analysis is enhanced by utilizing the scientifically set boundaries, or "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 boundary score at each point in time.[155, 156] Most of the children screened were two or three years of age. The average age of children screened with the ASQ was 2.87 years, though ages ranged from two to 62 months.

"We are not just doing SR for kids, but for parents… We are prepping school to receive parents and children."

- Key Community Expert

Key findings of the ASQ include:

- The results suggest evidence of age-appropriate developmental progress for the majority of children. In both fiscal years, over half of all children had increased scores in all five developmental areas (55.0% in FY 2007-08 and 55.8% in FY 2006-07). One parent mentioned that by using the ASQ, "I am able to see how my son is developing."
- In both fiscal years, the majority of children were assessed at being above the cut-off point and continued to be above the cut-off point at retest for all five domains.
- In descending order, the three domains that had the highest percentage of increases were fine motor, problem-solving and personal-social. This is different from last fiscal year in which the three domains with the highest increases were personal-social, communication, and fine motor.
- In FY 2007-08, there were no decreases in percentages of children above the cut-off score in any domain. Last year, there was a decrease for

Exhibit 4.6: ASQ – Percent of Children At or Above Cut-off in Fall and Spring by Developmental Area, by Fiscal Year

Domain	Fall	Spring	Change
Communication			
FY 2006-07	83.4%	83.4%	0%
FY 2007-08	80.1%	88.2%	8.1%
Gross Motor			
FY 2006-07	90.0%	90.4%	0.4%
FY 2007-08	96.6%	98.3%	1.7%
Fine Motor			
FY 2006-07	87.7%	90.8%	3.1%
FY 2007-08	86.4%	97.0%	10.3%
Problem-Solving			
FY 2006-07	87.7%	84.7%	-3.0%
FY 2007-08	87.3%	97.0%	9.7%
Personal-Social			
FY 2006-07	88.3%	92.6%	4.3%
FY 2007-08	87.3%	96.2%	8.9%

[153] See the Appendix B: Methods for how the ASQ, developed as a screening instrument, was authenticated for use in this evaluation.

[154] In FY 2006-07, data included 163 matched cases from Escondido and Oceanside, representing 90.1% of intensively served children at these sites (n=181). Many of the ASQ's were completed by parents with the assistance of School Readiness staff.

[155] "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.

[156] The instruments 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.

problem-solving and communication was stagnant.

- In both fiscal years, communication skills exhibited the highest number of children remaining below the cut-off in Spring, suggesting they may be developmentally behind their peers in this area.

"Both my children and I learn at the same time."

- School Readiness Parent

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

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 and referrals in FY 2006-07.[157] Through various developmental screening tools, children enrolled in Early Care and Education 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 Healthy Development Services Initiative.[158] Almost half (48.5%) of children receiving early care and education services were screened, compared to 70.6% in FY 2006-07.[159] Exhibit 4.7 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.

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

Key findings of the SR Developmental Screening System include:

- There was a decrease in the number of screenings that identified children as needing further assessment this fiscal year – only 15.9% versus 30.4% last fiscal year.
- Almost two-thirds (64.2%) of those assessed were identified as having a disability, developmental delay or other special need – a 38.4% increase over last fiscal year. This could be a sign of more accurate assessment and identification processes.
- Approximately 10% of all children screened were identified as having a disability, developmental delay or other special needs (10.2%). These rates were similar to last fiscal year and are in line with national

[157] Developmental screening tools include the Ages and Stages Questionnaire (ASQ) and the Parents' Evaluation of Developmental Status (PEDS).

[158] One SR program subcontracted with a First 5 San Diego Healthy Development Services provider to conduct screenings for children enrolled. The screenings under this situation are included here as SR contract dollars funded these screenings.

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

statistics that assume between 8%-17% of children have special needs.[160] However, the percent of children identified is lower than what has been found locally in similar populations by HDS (20%-27% of children screened demonstrate some form of developmental delay).

- The percentage of children identified with disabilities or special needs who subsequently received services or treatment increased greatly this year. All but one child received services or treatment this year (99.4%), compared to about two-thirds last year (69.3%).

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 increased staffing in SR programs for case management or the partnership between SR and the First 5 San Diego Healthy Development Services Initiative. (See "SR Developmental Screening System: Parents' Perspective," for the experiences of families following the SR Developmental Screening System.)

Exhibit 4.7 Children Receiving Early and Comprehensive Developmental Screening and Intervention, by FY 2006-07 and FY 2007-08

	FY 2006-07 (n=2,485)		FY 2007-08 (n=3,555)	
Service	**N**	**Percent**	**N**	**Percent**
Children Enrolled in Early Care and Education Activities	2,485	100.0%	3,555	100.0%
Screenings Conducted	1,756	70.6%	1,724	48.5%
Of those Screened, Number Referred for Assessment	534	30.4%	274	15.9%
Of those Assessed, Number Identified with Disabilities or Special Needs	205	38.4%	176	64.2%
Of those Identified with Disabilities or Special Needs, Number Receiving Services or Treatment	142	69.3%	175	99.4%
Of those Identified with Disabilities or Special Needs, Number Receiving Supplemental Intervention[161]	236	115.1%	169	96.6%

As the number of children enrolled in SR Early Care and Education programs increases, so should the number of screenings. This fiscal year, there were fewer screenings, marking a drastic drop in the percentage of enrolled children receiving screenings.

While SR programs address barriers to screening children, the process of referring them and tracking the referal process also needs to be streamlined (see "Creating Systems Change for Navigating Referrals" section below). The current system is inadequate for referral tracking and each SR program works within the framework of their respective school districts. In addition, each have their own process for the assessment, referral and treatment processes, and their own definition of screening, assessment, treatment and

[160] 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 years: Centers for Disease Control and Prevention. "Child Development: Developmental Screenings." Atlanta, GA. <http://www.cdc.gov/ncbddd/child/devtool.htm> Accessed September 12, 2008. [FORMAT] Results from HDS have found that more than 20% of children in low income areas are identified with special needs.

[161] Supplemental intervention 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) and children with identified disabilities or special needs that did not need an assessment and continued directly to supplemental intervention.

intervention. Improvements in referral tracking for data reporting are planned for FY 2008-09 with the integration of First 5 San Diego CMEDS.

Improved Family Functioning

A cornerstone of First 5 is that parents are the first and best teachers and models for their children.[162, 163, 164] The School Readiness Program includes a Parent and Family Support Services element to improve parents' skills, literacy, and access to needed services. To measure these improvements, parents participating in SR parent education activities in all eight districts completed the Parent Retrospective Survey. The Survey is comprised of two components: a modified "Survey of Parenting Practice" developed by the University of Idaho[165] and a modified "Desired Results for Children and Families – Parent Survey" developed by the California Department of Education.[166]

Similar to last fiscal year, most surveys were administered in person at the completion of a parent education activity. Some surveys were given to parents at the end of the school year to complete at home and return through the mail – 34.2% of participating parents completed a survey.[167] In order to determine the difference in change and satisfaction, surveys were coded based on the type of parenting activity in which parents engaged (see Exhibit 4.8 for distribution by fiscal year).[168] The majority of adults participating in parenting activities were the mothers (87.8%).[169] Only 7.9% were fathers, and 2.5% were grandparents. Other (1.9%) adults participating included aunts, adoptive parents, foster parents, day care providers and stepparents.

Exhibit 4.8. Type of Parenting Activity, FY 2006-07 and FY 2007-08

Activity Type	FY 2006-07		FY 2007-08	
	Number	% of Total	Number	% of Total
Sequential Parent Classes	823	55.9%	714	31.4%
Single Session Parent Classes	170	11.6%	976	43.0%
Sequential Parent & Child Together Classes	174	11.8%	287	12.6%
Single Session Parent & Child Together Classes	162	11.0%	146	6.4%
Home Programs	143	9.7%	148	6.5%
TOTAL	1,472	100%	2,271	100%

[162] 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.

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

[164] 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>

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

[166] 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>

[167] This is the approximate ceiling response rate, as it is likely that parents completed surveys more than once.

[168] 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, 36.8% (n=476) reported that they participated in other parenting education classes prior to the parenting activity in which they were completing the survey (suggesting potential duplication).

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

The remainder of this section explores the results of the Parent Retrospective Survey from two perspectives: changes to parenting practices and parent satisfaction with the program.

Parenting Practices

The "Survey of Parenting Practice" is a tool which asks parents to rate their current level of knowledge, confidence, ability and behaviors ("now") to their levels before completing the parent education activity ("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.[170] In the course of a class, parents learn more about child development and often come to realize how much there is to know.

Mean parent scores on all items on the parenting practice survey increased significantly from "then" to "now." Exhibit 4.9 illustrates the mean "then" and "now" outcomes for all twelve survey items, the mean difference between the two, and a comparison between this and last fiscal year. Increases were statistically significant for all items ($p<.001$).[171] Below is a brief description of findings within the knowledge, confidence, ability, and behaviors scales.

- *Type of intervention:* While scores increased significantly among parents in all parenting activities, parents attending sequential parent and child together (PACT) classes and home visitation programs consistently demonstrated the greatest increases. This finding was true in FY 2006-07 as well.
- *Knowledge:* A parent's knowledge of child development is the basis for sound parenting practices.[172] In general, knowledge items showed the lowest mean "then" scores and the most improvement between "then" and "now" scores. Out of all twelve items on the survey, the statement, "My knowledge of how my child's brain is growing and developing," showed the greatest improvement.
- *Confidence*: Building on a foundation of child development knowledge, parenting confidence is formed by feedback and recognizing strengths in parenting.[173] Overall, items in the confidence category showed the second highest mean improvement from "then" to "now." Within this category, the most improvement was seen in the statement, "My confidence that I can help my child learn at this age."
- *Ability:* Parents bridge the gap between theory (knowledge and confidence) and practice through trainings in child development.[174] As a group, ability items showed the highest mean "then" and "now" scores. Out of all twelve items on the survey, "My ability to keep my child safe and healthy" had the highest mean "then" and "now" scores, and thus showed the least improvement (though still statistically significant).
- *Behavior*: Knowledge, confidence and abilities all add up to parental interaction with their children and other families.[175] Within the behavior category, the item that showed the most improvement was, "The amount of activities my child and I do together," and the item that showed the least improvement was,

[170] "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.

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

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

[173] Ibid.

[174] Ibid.

[175] Ibid.

"My connection with other families with children." As a group, behavior items showed the least mean improvement.

- *Differences between fiscal years:* This fiscal year, the mean differences between "then" and "now" were greater in classroom-based sites for most items, although these differences were only statistically significant for one of the items. Last fiscal year, the differences were similar between classroom-based sites and center-based sites. Another difference between the two fiscal years was an increase in mean "then" scores from FY 2006-07 to FY 2007-08 for every item. This suggests that parents who completed surveys this fiscal year had somewhat greater parenting knowledge, confidence, ability, and positive parenting behavior than parents who completed surveys last year. This may be attributed to the fact that this fiscal year, parents had somewhat older children (mean age of child: 4 years and 3 months) in the program than last (mean age of child: 3 years and 9 months). The age of the participating child was found to be positively correlated with "then" scores and negatively correlated with mean difference scores.[176]

Exhibit 4.9. Outcomes for Parenting Survey FY 2007-08

Survey Item	Mean "Then" (Before SR)	Mean "Now" (After SR)	Mean Difference	Mean Difference FY 2006-07
My knowledge of how my child is growing and developing. (n=1,819)	3.99	4.97	0.98*	1.20*
My knowledge of what behavior is typical at this age. (n=1,811)	3.91	4.87	0.96*	1.18*
My knowledge of how my child's brain is growing and developing. (n=1,804)	3.98	5.00	1.02*	1.21*
My confidence in myself as a parent. (n=-1,806)	4.28	5.18	0.90*	1.03*
My confidence in setting limits for my child. (n=1,800)	4.09	5.02	0.93*	1.14*
My confidence that I can help my child learn at this age. (n=1,813)	4.28	5.25	0.97*	1.16*
My ability to identify what my child needs. (n=1,811)	4.22	5.17	0.95*	1.12*
My ability to respond effective when my child is upset. (n=1,806)	4.11	5.00	0.89*	1.05*
My ability to keep my child safe and healthy. (n=1,806)	4.63	5.39	0.76*	0.82*
The amount of activities my child and I do together. (n=1,802)	4.18	5.06	0.88*	1.08*
The amount I read to my child. (n=1,811)	3.92	4.76	0.84*	1.06*
My connection with other families with children. (n=1,811)	3.96	4.78	0.82*	1.01*

Parent Satisfaction

Parent satisfaction is a core component for SR programs state wide. To measure this, SR providers implemented the "Desired Results for Children and Families – Parent Survey" - a survey developed by the California Department of Education already utilized by many school-based sites. The survey is a series of

[176] Significant positive correlations were found between child's age and all but one "then" score. A significant positive correlation was also found between child's age and the average of all "then" scores, $r = .12$, $p < .001$. Significant negative correlations were found between child's age and all mean difference scores. A significant negative correlation was also found between child's age and the average of all mean difference scores, $r = -.12$, $p < .001$.

satisfaction questions about components typically included in early care and education programs. Key findings from FY 2007-08 include (see Exhibit 4.10 for details):

- Of all program components, the highest percentage of parents indicated that they were "very satisfied" with the "overall program quality" (84.0%).
- For each program component, at least 95% of parents reported that they were "very satisfied" or "satisfied," regardless of the type of parenting activity they participated in.
- While parent satisfaction was high across parenting activities, sequential PACT classes had the highest percentage of parents reporting "very satisfied," while parents in single session PACT classes exhibited the lowest percentage of "very satisfied".
- For all program components, a higher percentage of parents in classroom-based programs were "very satisfied" than parents in center-based programs.[177]

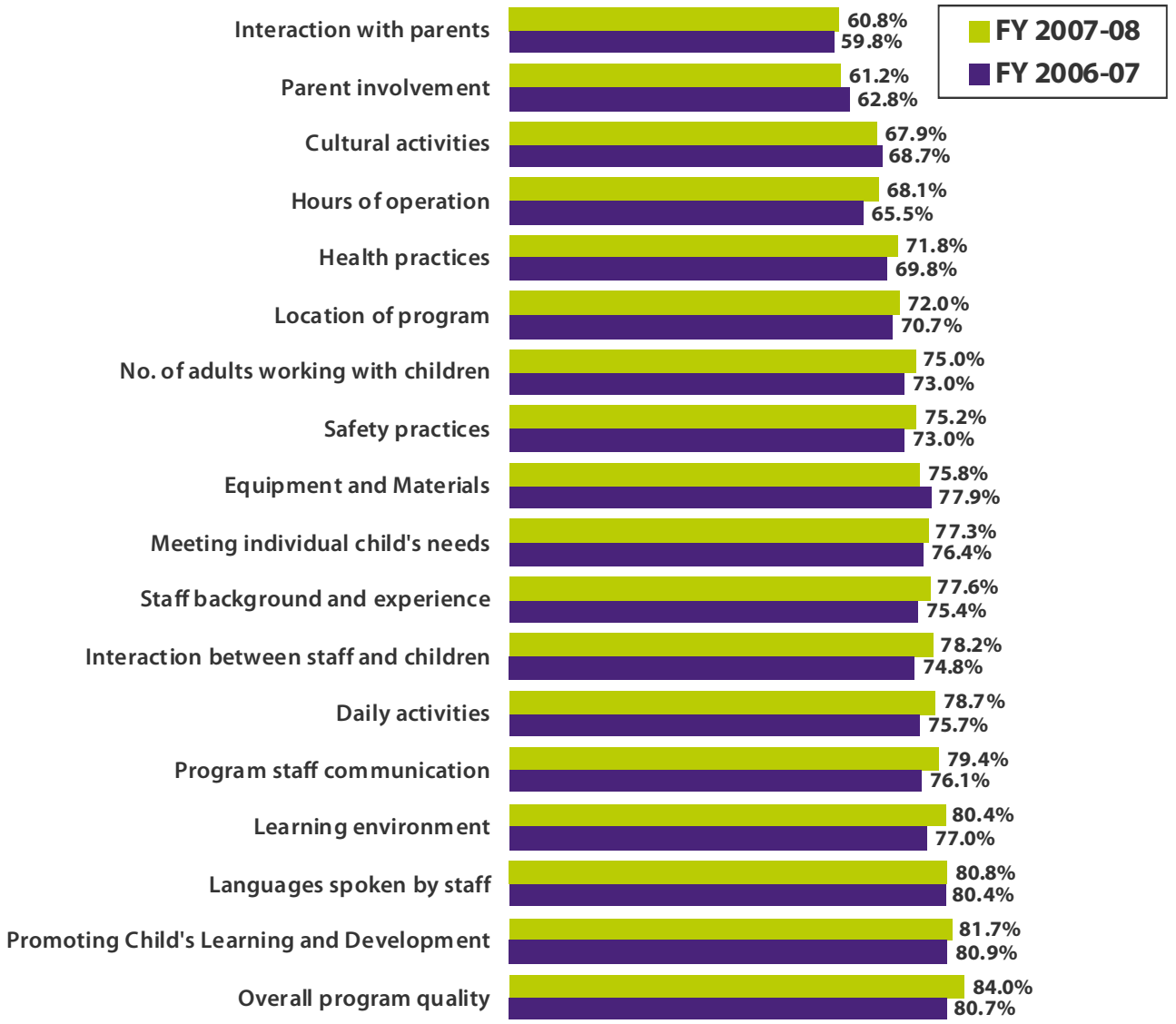
"I couldn't be happier with the program. The teachers are amazing and know how to make learning fun."

- School Readiness Parent

- Components that received the lowest satisfaction ratings were parent-centered (interaction with other parents, parent involvement) and programmatic (hours and cultural activities).
- Satisfaction ratings remained fairly similar between FY 2006-07 and FY 2007-08. Notably, the percentage of parents who were "very satisfied" increased for 15 of the 18 components from last year. The average increase among all 18 components was 1.6 percentage points, and the greatest increases were seen in "interaction between staff and children" and "learning environment" (3.4% increases for each).

[177] While these changes were significant in practice, they were not statistically significant.

Exhibit 4.10. Percentage of Parents Who Were "Very Satisfied" by Component and Fiscal Year



Making the Connection

Systems integration and improvement are core components of the School Readiness Initiative. This section explores improvements to the system of care through four core areas: connecting preschool and kindergarten teachers, experience level of the SR staff, parent interaction with staff, and enhancing sustainability and developing community partnerships.

Kindergarten Transition

Perhaps one of the most important components of SR systems improvement is enhancing communication between the SR programs, elementary schools, and parents. This communication is vital to ensuring that early childhood education programs support children as they development the skills critical for school readiness, and that schools support the transition needs of those children and families entering kindergarten.[178]

During FY 2007-08, there was a 65.2% percent increase in kindergarten transition activities. These activities involved working directly with children and parents/guardians, as well as meetings and information sharing between SR program staff and kindergarten teachers. Specifically, 3,277 children participated in kindergarten transition activities (110.2% of this fiscal year's goal), such as Kinder Camp (a two to four week intensive program for children with little to no preschool experience), kindergarten visitation and kinder-readiness assessments. Additionally, 597 preschool parents (131.8% of this fiscal year's goal) were included in school based activities, such as meeting with School Readiness ECE program staff to discuss the changes that lay ahead as their child enters kindergarten. As one parent shared, "My child learned a lot and it prepared him well for entering kindergarten." However, one parent expressed the desire to be more involved in the process, "I think the more participation they have from parents, it will improve the goal of this program to prepare the children for kindergarten."

"It has opened up the opportunity for all school district teachers to come together and deliver the same teaching across the district."

- School Readiness Preschool Teacher

The critical component of kindergarten transition activities is effective communication between ECE staff and kindergarten teachers. This activity is crucial to ensuring a smooth transition for children entering elementary school. This year, 170 School Readiness staff (151.8% of this fiscal year's goal) participated in kindergarten articulation meetings with elementary staff (including kindergarten teachers, administrative staff, and support teams), an increase compared to last year. Survey responses[179] from preschool teachers and specialty service providers[180] show that despite increases in the number of ECE to kindergarten articulation activities this fiscal year, the interaction rates between SR personnel and kindergarten teachers remained relatively limited for a number of key activities – mutual trainings and meetings – for both this and last fiscal year (see Exhibit 4.11 and 4.12). Preschool teachers'

[178] 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. Accessed 10 September 2007 <http://www.ccfc.ca.gov/PDF/SRI/stuart-reaching-back.pdf>

[179] These surveys were based on the NEGP "Ready Schools Checklist": 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>

[180] Specialty service providers are any staff funded by SR, but not a teacher. This includes school nurses, behavioral specialists, speech and language specialists, and administrative staff.

interaction with kindergarten teachers remained fairly the same this fiscal year compared to the previous fiscal year. Meanwhile, specialty service provider's interactions declined from last fiscal year.

Exhibit 4.11 Preschool Teachers Activities Involving Kindergartens, FY 2006-07 and FY 2007-08

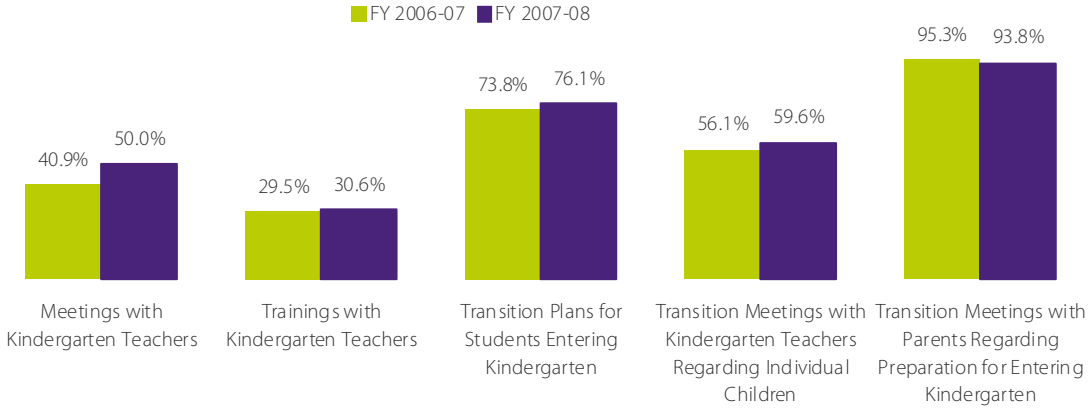
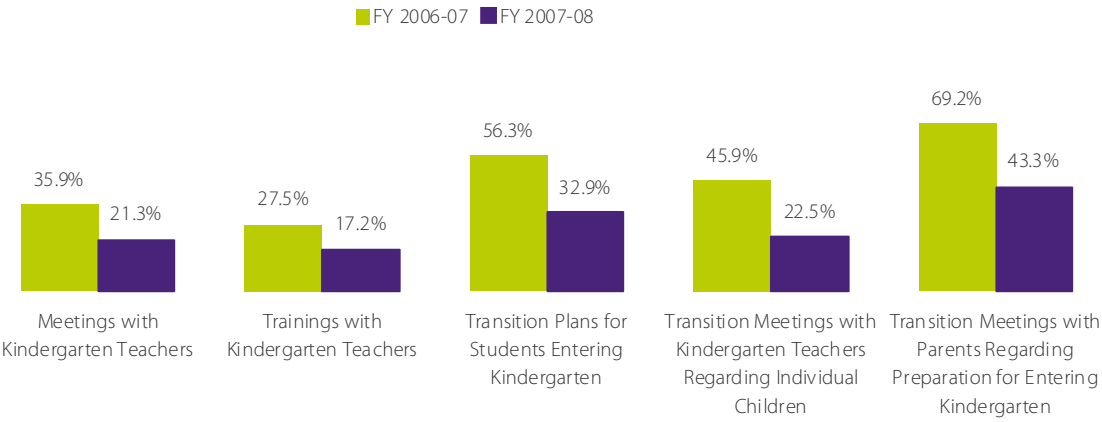


Exhibit 4.12 Specialty Service Providers Activities Involving Kindergartens, FY 2006-07 and FY 2007-08



Another critical step to ensuring that kindergarten teachers obtain preparatory information about children coming into their class is the contents of the transition files. Over three-fourths (76.1%) of preschool teachers and over one-quarter (32.9%) of specialty service providers have formal transition plans for students entering kindergarten. Exhibit 4.13 displays the increase across all types of transition documents inserted into transitional files in FY 2007-08 compared to last fiscal year, as reported by preschool teachers and specialty service providers whose sites have kindergarten transition plans. Notably, only approximately one-quarter of these files contain the DRDP-R results. These results would give kindergarten teachers important information about a child's developmental strengths and areas where a child might need more focused assistance and attention.

Exhibit 4.13. School Readiness Transition File Contents by FY 2006-07 and FY 2007-08

Transition Document	Preschool Teacher		Specialty Service Provider	
	2006-07 (n=44)	2007-08 (n=37)	2006-07 (n=40)	2007-08 (n=31)
	Percent	Percent	Percent	Percent
DRDP-R Data	70.5%	88.9%	22.5%	25.8%
Health Information	65.9%	86.5%	17.5%	51.6%
# of Years in Preschool	45.5%	56.8%	10.0%	35.5%
Parent-Teacher Conference Notes	63.6%	75.7%	12.5%	35.5%

Staff Education and Experience

Survey results showed that teachers and specialty service providers were more experienced in FY 2007-08 than last fiscal year – 68.1% of preschool teachers and 47.8% of specialty service providers had worked in their position for over five years. Exhibit 4.14 and 4.15 show that most of preschool teachers (88.0%) and specialty service providers (89.6%) were educated at or past the Associate's level, with the greatest increase in education level from the last fiscal year occurring among preschool teachers obtaining an Associate's degree. However, the number and percentage of SR staff pursuing degrees beyond the Associate's level decreased from FY 2006-07 to FY 2007-08. Notably, participation of ECE staff in AB212 and CARES (stipend programs to support continuing education) decreased in the same period.[181]

Exhibit 4.14 Preschool Teachers Level of Education

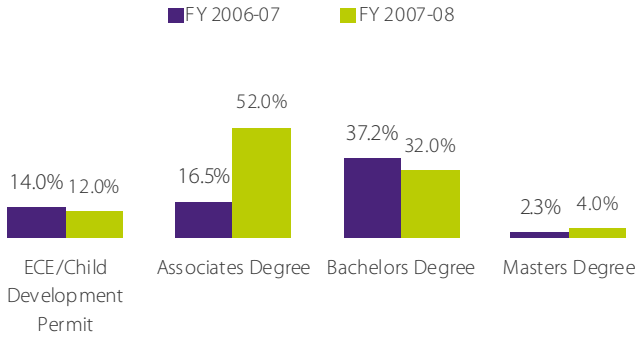
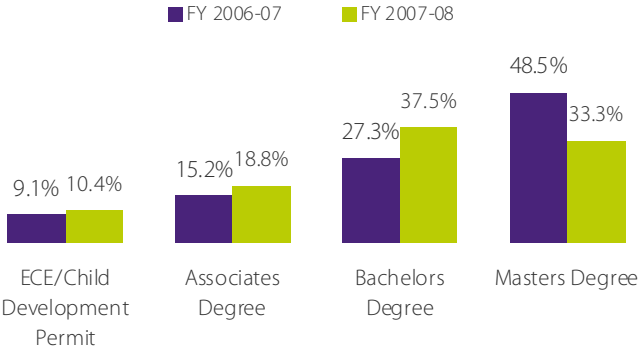


Exhibit 4.15 Speciality Service Providers Level of Education



SR programs also offer staff a variety of training opportunities. All preschool teachers were offered opportunities to attend professional development activities, while not all specialty service providers were offered that same opportunity. Most teachers participated in these (98.0%), while notably fewer specialty service providers (76.7%) participated. Those staff that participated attended an average of 5.3 activities throughout this fiscal year – compared to 7.8 last fiscal year. These trainings included such topics as

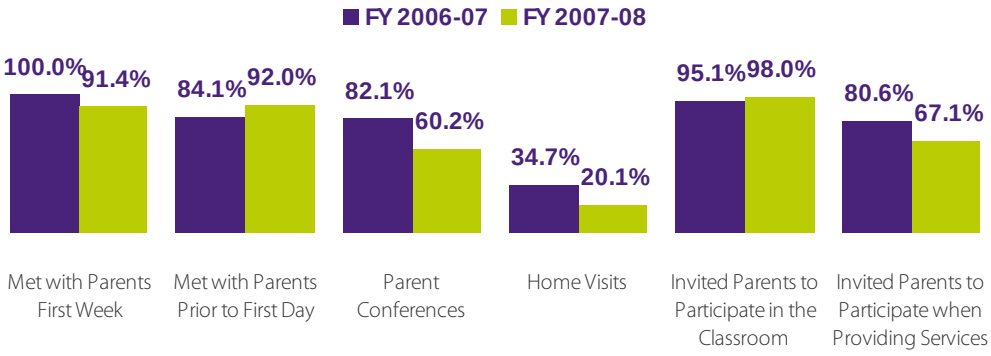
[181] For more information on AB212 and CARES, see Chapter 7.

"Early Literacy and the Learning Child," "High Quality Pre-K Classrooms," and "English Language Learners and Literacy in the Early Years." Some SR staff also worked with mentor teachers and behavioral specialists. This type of professional support is a best practice in promoting stability in the ECE workforce.[182] All teachers this year and almost all last year (97.6%) felt their professional development was applicable to their classrooms.

Parent Interaction with Staff

Parent involvement in the learning environment is vital to a student's success. In FY 2007-08, almost every SR preschool teacher responding to the Preschool Teacher survey indicated that they met with parents during the first week of school, (91.4%) and most met with parents prior to the first day of school (92%). The most common on-going parent involvement activity during the school year was to invite parents to participate in the classroom, followed by inviting parents to participate when ECE teachers and staff provide services to their child (see Exhibit 4.16). Interviews with Coordinators uncovered that SR programs sought to include parents in their administrative and planning activities. For example, five School Readiness programs have Parent Advisory Committees that provide parent and community input and leadership to these 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) remain connected to School Readiness over time by volunteering, participating in staff hiring processes and working for the program as paid employees. However, despite all of these efforts, it is of note that most parent involvement activities declined this fiscal year when compared to last fiscal year.

Exhibit 4.16 Activities Involving Parents



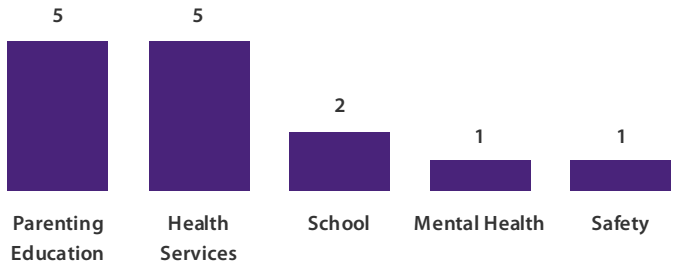
Sustainability and Community Partnerships

The SR programs utilize existing links with their district schools and relationships developed with other First 5 funded and non-First 5 funded community partners in an effort to enhance the system of care that supports young children. Interaction with, and support from, elementary schools are two important aspects of sustaining early care and education programs. School Readiness programs coordinators reported that they increased partnership efforts with schools districts in FY 2007-08 and continue to demonstrate success in maintaining relationships.

[182] 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. <http://www.ccfc.ca.gov/PDF/SRI/stuart-reaching-back.pdf> Accessed 10 September 2007

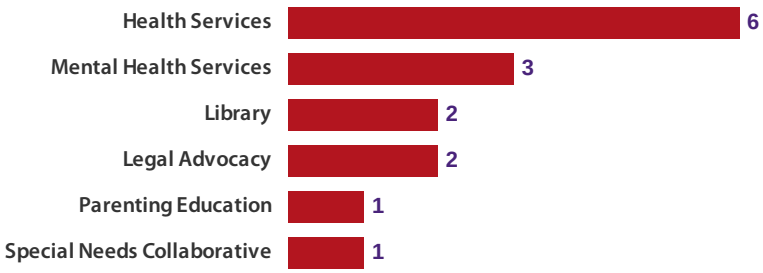
Most frequently, SR partnerships are with other First 5 funded programs, in particular, HDS that provides screenings and services for children with mild to moderate developmental delays and their parents and First 5 for Parents parenting education services (Exhibit 4.17). Partnerships with community agencies continue to expand. One Coordinator commented that one partner is now "offer[ing] more classes in the center… before maybe only one time a month but now we have parenting classes in the afternoon two times a week." Many families enter First 5 San Diego services (and those of other community agencies) through referrals from their child's SR program (for more details on families' experiences, see below "SR Developmental Screening System: Parents' Perspective").

Exhibit 4.17 Ongoing Community Partnerships by Service Category (n=14)



Six of nine SR Coordinators reported that they have developed new relationships with community organizations that support and expand services for children participating in SR programs.[183] These partners include health service delivery, parenting education, mental health services, and local libraries. Two Coordinators stated that they had each formed four new partnerships this fiscal year. One notable increase in partnerships indicates that the SR programs are becoming more interwoven into their community's service support fabric.

Exhibit 4.18 New Community Partnerships by Service Category (n=15)



The following strengths and challenges section outlines the key areas for either continuance or improvement for SR programs for the next fiscal year.

Strengths

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

- **Results continue to be sustained on many core outcomes.** Children exhibited improved outcomes in all developmental domains; parents exhibited improved outcomes on all four parenting practice topic areas; and staff participated in quality professional development activities that they found valuable.
- **Continued 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. For the second year Commission staff enhanced these meetings with guest speakers from various First 5 funded agencies. In addition, more SR

[183] Includes eight SR program Coordinators and one Special Needs Demonstration Project coordinator.

Coordinators participated in First 5 all contractor meetings and representatives from each SR program attended the State First 5 conference. These events provided opportunities for face-to-face interaction with other First 5 programs and to gain a broader perspective on school readiness issues.

- **Continued and additional community partnerships.** School Readiness programs successfully sustained existing relationships and built new ones with other First 5 funded projects and other community agencies, including parenting education, health and school-based service providers. Several have created new partnerships with mental health and legal advocacy agencies, as well as local libraries.

The successes listed for the School Readiness Initiative are not exhaustive, as many programs experience success with program participants every day. SR program staff and parents interviewed for this report recognized the important work accomplished by School Readiness and First 5 San Diego to prepare children and families for school. Parents are thankful for their SR programs. One parent shared, "Thanks to the program, I feel my child will like school," while another said, "Thank you for the support you give us parents so that we become better parents and we understand the needs of our children."

Challenges

Even as the Commission's longest running Initiative, School Readiness experienced 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:

- **Maintaining gains from previous years.** There were a few key outcome areas where the data show a decline. These areas should be examined more deeply to determine the cause and ensure improvement in the next year.
  - Fewer SR teachers are participating in CARES and AB212 – programs that offer stipends to encourage ECE teachers and staff to improve their education levels. As studies show a correlation between the teacher's education level and classroom quality, it is important to renew efforts to encourage continuing the formal education of ECE staff.
  - There were declines across all areas of activities involving parents. SR programs have the opportunity to encourage early parent involvement that is important to a child's ongoing school success.
  - There is a decline in the contact reported between specialty service providers and kindergarten teachers, especially in the area of kindergarten transition. The K-12 and pre-kindergarten environments are substantially different, highlighting the importance of information exchange between kindergarten teachers and specialty service providers. Providers working directly with children with special needs provide critical information to kindergarten teachers, which will assist children to succeed in the kindergarten environment.

    "I know teachers are in need of more funding for supplies and more study tools for children."

    – School Readiness Parent
  - The number of developmental screenings conducted dropped by 28% to only 48.5%. This is below the target of ensuring 100% of children in First 5 SR ECE programs receive developmental screenings. Further, of those screened, the number of children referred for assessments dropped from 30.4% the previous year to 15.9%, though an improvement in the accuracy in those identified as needing services.
- **Sustaining programs beyond the First 5 investment.** Since its inception in 2002, the First 5 School Readiness Initiative was designed to receive a flat amount of funding each year. The intention was to build effective programs that local school districts and other funded agencies would commit 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. First 5 California will be reducing the number of projects it funds. There is uncertainty whether, and to what extent, First 5 California will continue to fund School Readiness as a statewide Initiative. SR programs need to develop plans for sustainability and First 5 San Diego has plans to offer technical assistance to these school districts in FY 2008-09.

- **Inconsistency in SR Developmental Screening data.** In fiscal years 2006-07 and 2007-08, SR contractors reported the results of referrals from developmental screenings. Many SR staff expressed confusion around the definition of each step in the screening process, and also shared difficulty in following-up with families and service providers regarding the services. For FY 2008-09, changes have been made to the vocabulary and definitions of screening process steps, and child-level and referral data will be collected in the new CMEDS data system. Additional work needs to be done in improving coordination between health and school-based programs, including the establishment of formal agreements for referrals and data sharing.

- **Changes to data collection activities.** While data collection instruments and methods remained the same since FY 2006-07, the First 5 San Diego Consent Form and Process was introduced mid school year. SR programs had to incorporate school district guidelines, and meet with parents to explain and collect consent forms. This resulted in a decline in child-level data available for evaluation. In FY 2008-09, school districts will include the consent form in their enrollment packets, which should result in a consent rate. The CMEDS data system will streamline data tracking and allow a deeper analysis of results.

Update on Recommendations from FY 2006-07

The following actions were recommended in the Commission's Annual Evaluation Report for FY 2006-07. As described below, SR has taken strides to address many of these areas.

Recommendation 1: Encourage collaboration between SR providers and First 5 Initiatives.

Update: Although still in progress, great strides towards collaboration between First 5 Initiatives occurred throughout this fiscal year. Several First 5 San Diego funded programs, such as the American Academy of Pediatrics and Jewish Family Service, have made presentations at monthly SR meetings, making connections to improve partnerships between First 5 Initiatives.

Recommendation 2: First 5 and School Readiness programs should work together to coordinate administrative requirements.

Update: First 5 program staff and SR contractors have also worked together to coordinate administrative requirements. Fiscal reporting requirements have been streamlined this year, and contract renewal processes occurred earlier than in previous years.

Recommendation 3: Nurture mutual understanding.

Update: As exhibited by the results of SR Coordinator interviews, First 5 program staff has been available to contractors for all aspects of the contract. They have been flexible when working with contractors, and have been friendly, responsive and approachable. Further, they have clearly communicated their fiscal expectations of contractors, and shared what contractors can expect from them.

Recommendation 4: Sustaining programs over time.

Update: While advancements in the administration of School Readiness are evidenced throughout, program sustainability is the final recommendation yet to be addressed. Many SR programs have made steps towards securing their programs (see section "Sustainability and Community Partnerships" on page 122). Current SR contracts are scheduled to end in the next two fiscal years. Without arrangements to support programs fiscally, they could end by 2011. First 5 program staff has intentions to implement sustainability plans with SR contractors in FY 2008-09.

Recommendation 5: Continue to improve outcome measurement reporting.

Update: The only recommendation fully addressed was the continued improvement of outcome measurement reporting. All SR programs successfully collected and submitted child-level data. However, challenges in implementing the First 5 San Diego consent form the quantity of data available for evaluation. With the consent form fully implemented, the quantity outcome data in FY 2008-09 is expected to increase.

Recommendations

The following recommendations were developed based on FY 2007-08 data and evaluation findings.

- **Increase parent involvement in programs and kindergarten transition.** The involvement of parents in School Readiness services is of utmost importance for the success of the program and the children enrolled. The results of the satisfaction portion of the Parent Retrospective revealed that parent involvement in programs received the lowest ratings for two consecutive years. Parents also requested additional parent-teacher meetings, especially those focusing on kindergarten transition. Further, staff responding to the Preschool Teacher and Specialty Service Provider Surveys indicated a marked decrease in the number of parents volunteering in classrooms and during services last year. SR program staff should strategize to increase parent participation in activities and services.
- **Work with SR programs to retain past improvements.** Program results should be examined with the SR Coordinators as a group and with each individual program to determine what is causing declining trends: fewer teachers and staff participation in AB212 and CARES; fewer children receiving developmental screenings and fewer identified as needing assessments; and less contact between district specialty service providers and kindergarten teachers regarding kindergarten transitions. An improvement strategy should be developed around each of these areas.
- **Continue collaboration between SR providers, other First 5 Initiatives, and community agencies.** Many SR programs successfully partnered with other First 5 agencies and some made connections beyond First 5. In several cases, community agencies reached out to SR programs for collaboration. Creating and maintaining ties to outside entities is a key step in creating sustainable programs and systems to serve children and families. First 5 San Diego should help strengthen these bonds to increase exposure in the community for future service planning and development.
- **Sustain programs over time.** Both state and local First 5 funding for the School Readiness Initiative is only dedicated through 2011. First 5 San Diego and First 5 California are each embarking on strategic planning processes that will determine whether, or to what extent, SR funding will continue. Since the inception of the SR Initiative, the Commission expected that school districts would locate additional funding to sustain and expand the SR programs in their areas. At this important time, First 5 California, First 5 San Diego and the SR school districts must work together to address the timeline of SR funding and plan for changes in funding. School districts must actively seek additional funding and/or examine shifting existing district funds (i.e., Title I funding) to sustain and even expand their programs.
- **Increase the quality and quantity of outcome data.** This year, the quantity and quality of outcome data was satisfactory. The number of matched DRDP-R data decreased, in spite of a substantial increase in the number of children served. Matched ASQ data increased in actual number, but decreased in the percentage of children served. These decreases could be due to the mid-year implementation of the First 5 San Diego consent form, and there was additional confusion around reporting referral data. Implementing the consent process as part of enrollment, clarifying the referral process and the activation of CMEDS may ameliorate these issues. Some districts in particular had more difficulty in implementing informed consent. If this does not improve during the fall enrollment process, Commission staff should work with those districts to improve data collection standards and reporting.

A Final Word on School Readiness

The School Readiness Initiative has had a positive impact on improving children's readiness for school, parenting practices and staff development. Children exhibited improved outcomes in all developmental domains, parents exhibited improved outcomes on all four parenting practice topic areas, and staff participated in numerous professional development activities. In addition, School Readiness programs have connected to larger systems through community partnerships. These close partnerships have resulted in a smoother system of care for families navigating referrals. In many communities, programs are operating to capacity, and often with waiting lists, indicating a continued need for similar quality services in San Diego County.

Special Needs Demonstration Project

In 2005, the Chula Vista Elementary School District (CVESD) was one of ten sites across the state with a First 5 Special Needs Demonstration Project (SNP). The local project, named Kids on TRACK, is jointly funded by First 5 California and First 5 San Diego, for a total of $2,000,000 over four and a half years.[184] The project is designed around four goals:

- **Screening and Assessment:** Provide universal access to screenings in a designated catchment area, to promote 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.

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

In addition, 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 years 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.

Important Changes for the Special Needs Demonstration Project

While the Kids on TRACK project increased outreach, screenings, services, and referrals this fiscal year, important changes have occurred with this project at both the state and local level. The following changes will impact the project in FY 2008-09:

- ***First 5 California Evaluation:*** In Spring 2008, the First 5 California Children & Families Commission began the planning phases of evaluating the ten SNP demonstration sites across the State. Kids on TRACK will continue serving children and families and entering data into the statewide database. The evaluation plan will also include Parent and Provider Surveys, and possibly site visits.
- ***First 5 California Training and Technical Assistance:*** In Spring 2008, the new First 5 California Training and Technical Assistance consultant began their contract with the State. This contractor will work with the ten sites across the State in FY 2008-09. Representatives from this team have already participated in Kids on TRACK activities, such as the Community Action Planning Team.
- ***Shift to sustainable programming:*** The Kids on TRACK staff and various leadership teams will slightly shift their focus to creating a sustainable program in FY 2008-09. With local and State funds ending in 2009 under the current contract, Kids on TRACK has already started thinking about innovative ways to prolong and/or integrate the program.

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.[185] The program's annual goal is to provide health and developmental screenings for 500 children living in the CVESD catchment area.

In FY 2007-08, Kids on TRACK effectively increased outreach activities over FY 2006-07. *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 510 children, meeting the goal of 500, similar to last fiscal year.

Once a child has been screened and a concern is identified, the child is often referred to Kids on TRACK services. If in-house services do not address the need, children are referred to partner agencies. Sometimes, certain cases require additional scrutiny through Child Study Team (CST). The CST meets twice monthly and includes members representing SNP key program partners, CVESD Special Education Department, and School Readiness Initiative staff. The CST reviews individual child files and speaks to SNP Family Advocates and specialty service providers who work with the child and family. The CST determines appropriate referrals for the child and/or family, including the likelihood of the child to qualify for services mandated under the IDEA.

Below are some key results of SNP's Kids on TRACK:

- All 510 children screened received health survey, completed by a parent or guardian.[186]
- 508 children received an age-appropriate Ages and Stages Questionnaire: Social-Emotional (ASQ:SE) screening, completed by trained Kids on TRACK staff and parents/caregivers together. [187]
- 506 children received an age-appropriate Ages and Stages Questionnaire (ASQ), also completed by staff and parents/caregivers together.
- The majority of parents and caregivers of these children completed a Parent Stress Index: Short Form (PSI:SF) assessment (81.7%).[188]

Exhibit 4.19 displays the results of all 508 screenings this year, with comparison to FY 2006-07 local and FY 2005-06 local and statewide figures.[189] The percentage of children recommended for assessment in this fiscal year is similar to last fiscal year and closely matches the statewide percentage. Due to high staff retention rates,

---

[184] First 5 California provides $1,000,000 over four years and approved a no-cost extension for six months, until June 30, 2009. First 5 San Diego matches these funds dollar-for-dollar.

[185] 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

[186] 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.

[187] 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

[188] 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

[189] At the time of this publication, FY 2007-08 and FY 2006-07 statewide data was not available.

more children have been screened by trained and experienced screeners and are therefore more likely to be referred to the most appropriate services.

Exhibit 4.19. Screening Results by Fiscal Year

Screening Result	FY 2005-06* (n=258)	FY 2006-07 (n=501)	FY 2007-08 (n=508)	State**
	Local	Local	Local	
	Percent	Percent	Percent	Percent
No Concerns, No Risk Factors	40.0%	55.6%	65.3%	58.0%
No Concerns, Risk Factors	52.0%	26.8%	16.0%	21.0%
Recommended for Assessment	3.0%	17.6%	18.7%	17.0%
Unknown	5.0%	0.0%	0.0%	3.0%

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

***Spiker, Donna, Craig Zercher, Mario Crisp. "First 5 California Special Needs Project Year 1 Evaluation Findings." PowerPoint presentation. California Children and Families Commission Meeting. 19 October 2006. State data is from FY 2005-06, as, State data was not available for FY 2006-07 or FY 2007-08 at the time of this publication*

In addition to these first-time screenings, Kids on TRACK staff aim to rescreen as many children as possible. Rescreening children at regular intervals ensures children are displaying age-appropriate development and additional services when needed. This year, 143 children were rescreened using the SNP screening protocol. Almost all children rescreened had no concerns or risk factors (76.9%). Sixteen children were found to have no developmental concerns, but risk factors were present (11.2%), and seventeen children had both developmental concerns and risk factors present (11.9%). There may be additional children rescreened this fiscal year that were not included, as the project has stringent, statewide requirements for entering rescreen data for analysis.

Outreach Locations

This year, *Promotoras* conducted outreach at 161 events, to an estimated 2,094 families.

Locations include:

- CVESD Schools and School Readiness Programs, including Parenting Classes and Kindergarten Registration
- Private Child Care Facilities
- Apartments and Mobile Home Parks
- Discount and Grocery Stores
- Chula Vista Library
- Festivals and Carnivals

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, a district-funded Parent Intervention Program and

the Special Education Department, and also makes referrals to community organizations.[190] 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 752 service consultations this year, a 7.0% decrease over last 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 situations of families experiencing multiple stressors, such as domestic violence or parental mental health issues/illness, and other issues not traditionally supported directly by 0-5 funding.

Community Participation and Inclusion

Kids on TRACK continued both its community participation and inclusion activities in FY 2007-08. Community participation was accomplished through the efforts of three workgroups. First is the SNP 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 is 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 discussions that impact the overall delivery and philosophy of Kids on TRACK. Third, the statewide networking group held teleconferences during year to 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.[191]

Kids on TRACK in the Community

This year, Kids on TRACK staff have exposed the program to the community through various avenues:

- Presentations at:
  - First 5 San Diego Commission
  - First 5 California Annual Conference
- Site Visits by:
  - San Diego Family Justice Center
  - San Diego County Children's Mental Health Services
  - Alliant University
- Media Reports by:
  - San Diego Union-Tribune
  - Voice of San Diego

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

- ***Children with special needs are enrolled through the same procedures as typically developing children:*** Due to the partnership between community agencies and CVESD, the location for district preschool enrollment was changed. 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 now occurs in one place. Further, services for children with special needs are now available at

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

[191] Teleconferences were held in lieu of statewide meetings as the statewide evaluator and training and technical assistance contractors were not selected until late in the fiscal year.

more school sites throughout the district. These are key steps toward routinely placing children with special needs in classrooms with typically developing children.

- ***Enhancing services for children with special needs:*** Last year, Kids on TRACK became 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. This year, CSEFEL expanded into all CVESD early childhood programs; including State funded preschool and local Head Starts. To guide and support this expansion, Kids on TRACK and CVESD staff developed an "All Aboard!" inclusion technical assistance leadership team. Plans for a parent training component of CSEFEL is in development for FY 2008-09

"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

- ***Participation in various community organizations:*** Several members of the SNP Leadership Team participated in various community organizations leading efforts for the special needs community in San Diego County, including the Child Care Planning Council, Early Childhood Mental Health Community, and First 5 Healthy Development Service (HDS).

Inclusion activities this year included:

- ***Classroom-based services for children and teaching staff:*** Kids on TRACK staff facilitated 164 services for 82 children with children with special needs in an inclusive classroom setting, exceeding this year's goal (50 services and 25 children, respectively). This also marks a 193% increase in services over the previous fiscal year.
- ***In-home services:*** Kids on TRACK staff provided services to 58 families with children with special needs in their homes, falling short of the goal of 75. In contrast, last fiscal year, staff exceeded this goal by 34.0%.
- ***Inclusion classes and workshops:*** Kids on TRACK staff, in collaboration with key partners, provided a space for 1,390 children with and without with special needs and their parents and caregivers to learn and be active together. The attendance in these classes, as well as "Music and Movement" and "Baby Yoga", exceeded the goal by 110.6%.

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. Moreover, 75 trainings were offered on topics such as screening tools (ASQ, ASQ:SE, PSI:SF), health screenings, case management, home visiting, Individualized Education Plans, social-emotional curriculum, brain development, parent-child attachment, and children's exposure to violence. Attendance has consistenty exceeded the project goal.

Summary

This fiscal year brought about consistent outreach, screening, and services for children and families participating in Kids on TRACK. Several of previous years' challenges, such as statewide evaluation and training and technical assistance gaps, have been addressed. While future challenges do exist, SNP staff continue to expand and integrate into programs in the local community. Systems change and sustainability are focus areas for FY 2008-09.

The SNP Screening Protocol: Parents' Perspective

It is challenging for parents to go through the process of learning their child has a developmental disability or delay. Reactions can include denial, withdrawal, and reluctance or resistance to pursuing treatment. Parents from the Kids on TRACK Special Needs Demonstration Project shared their experience during a focus group conducted in the Spring of 2008.

Initial Contact

Participants in the focus group first heard of the program through some of the outreach activities such as flyers, referrals from either First 5 funded programs or Head Start, or school personnel. As one participant described: "I [called] only because I really needed help and I started looking through what I had. I noticed that the classes where close to my home so I called." Focus group participants noted that they would encourage friends and family members to attend the classes and connect to Kids on TRACK. This has been shown to be an important recruitment method within the Latino community – a community represented both in the focus group and in the population served by Kids on TRACK.

Experiencing the ASQ

Performing a developmental assessment on their child was both a new and intimidating experience for most participants. Parents in the focus group expressed strong feelings about their participation in the process. "I felt frustrated because… my tolerance [was] rather short," one parent reflected. Another parent stated that she was so concerned with what the results would say about her, and that she had "no idea" if her daughter had the abilities necessary to complete the tasks. Still another mother noted, "When they gave me the [screening] I felt like I was not educating my children correctly."

Two Phases of Understanding: Results and Change

Several mothers described a two stage process when it came to the screening results. The first came in finding out the results of the screening. They commented on the importance of the screening and the relief that came with knowing the child had not demonstrated significant delays. "Thank God that when they answered my phone call they told me that my kids were 100% okay." Another mother relayed her reaction when the results were not what she had hoped: "With the [screening] I asked myself what is going on here? …Is it me? I did not want to accept it. I wanted to say NO! I already have two grown children, how could it be me?"

Throughout the screening process, the SNP staff play the critical role of helping parents become more knowledgeable and active participants in their child's development. In particular, SNP staff assist parents in the difficult first phase of when a children is identified with special needs.

The second phase for many of the parents participating in the focus group was the realization that *they* had to make changes in order to help their child's development. One mother whose child demonstrated delays commented that she initially felt overwhelmed by what lay ahead. "How do I even attempt that?" she said, adding, "I really am determined to change because it's a whole lifetime that you have been that way." For another mother the review of the screening results helped her see more clearly how she could make the changes that would help her child: "[I] realized that my child needed to socialize with other children because we are a military family and we move a lot."

Access to Services

Many focus group participants revealed that they had not received other referrals since receiving services provided by Kids on TRACK. All commented that they were able to participate in the classes and several stated that they had been participating for several months. Several women laughed when they stated that they were afraid they would be asked to stop coming – "they must be getting tired of seeing me." However, some new parents noted that they were unsure what Kids on TRACK program components they could access.

Seamless Referral Process

To better understand the referral process from an end-user perspective, focus group participants were asked about their experience with the referral process. Most were unfamiliar with a formal referral process. However, a couple of mothers had been referred to Kids on TRACK by school or Head Start staff, or other First 5 funded programs. Participants expressed confidence that their needs could be met by Kids on TRACK. They also expressed comfort with the services and their ability to share needs to the staff members. One mother said, "[The staff] has a way of saying things in a way that doesn't hurt your feelings. She says it so that you'll see your problems and move forward. She does it because she wants to help." These parents' feedback speaks positively to the Special Needs Project's goals of being a comprehensive and inclusive program model.

"All of us are very lucky because we know about these classes. I commented to my pediatrician and she was surprised that there were so many of us coming to these groups."

– Special Needs Demonstration Project Parent

Case Study 4

School Readiness and Preschool for All: Working Together to Create Services for Children

In Spring 2008, Harder+Company conducted visits to three early care and education sites funded by First 5 San Diego through both the School Readiness (SR) and Preschool for All (PFA) projects. In total, five staff members in Escondido, National, and San Ysidro school districts were interviewed. The purpose of the visits was to gain a better understanding of how the contractors blended/braided their funds, and how having the two funding sources affected their work.

Funding Source

National and San Ysidro programs began with SR funds in fiscal year 2002-03, and Escondido began in 2003-04. The PFA awards were made in the past two years. Overall, the funding sources as follows:

- PFA: PFA funds are used in the same way across all sites, i.e. primarily for preschools. In addition, for all of the sites, there are additional PFA funds that are used to enhance other non-PFA programs, such as State preschools and SR-funded child development programs.
- SR: All three sites differ in how they use SR funds, and in National, the use of SR funds has shifted since the initial contract. However, all three sites provide support services to PFA programs through SR-funded activities, such as staff development, child intervention, outreach, and supplies.

Managing Multiple Funding Sources

Although there was some difference in terminology (e.g. blending, braiding, combining funds), all three Directors were clear in how they closely managed multiple budgets, with each source of funds going to specific, albeit differing, activities and, in other cases, the activities complement each other. The following describes, in more detail, how each site earmarks its funds:

- Escondido: SR and PFA funds are not considered blended, as they are used for completely separate, yet complementary, programs: PFA funds are used for staffing, materials, and supplies at specific preschool classrooms. Additionally, SR funds reach the community at large via activities, such as parent and child activity centers as well as parent education classes. In addition, SR funds provide support to a number of Head Start, community child care and preschool programs (including PFA preschools), particularly in the area of behavioral consultation and intervention services.
- National City: PFA monies are used to fund slots for children who do not qualify for State preschool, as well as to enhance State preschool by providing classroom materials and supplies. The SR monies are used strictly for support services, such as speech intervention, behavior support, English language development, staff development, outreach, materials, and supplies. To summarize, all specialty service providers are paid through SR funds. National School District also renovated classrooms and facilities with a capital projects grant from First 5 San Diego.
- San Ysidro: PFA funds support fully-funded preschool slots as well as provide instructional materials and staff development opportunities for all classrooms (PFA, SR and State preschool). The SR contract funds child development programs for families that are not eligible for State preschool. It also funds specialized services, such as developmental screenings, speech therapy, and behavior intervention that are available for all children in the catchment area. San Ysidro School District also built new facilities with a capital projects grant from First 5 San Diego.

Service Delivery – Outsiders' Perspective

Overall, school district managers have more clarity on what aspects of their early education programs are supported by First 5, than do the families and children served. Only Escondido has a visible distinction between its parent/child activity centers (SR) and its preschool classrooms (PFA). However, even in Escondido, the staff development (funded through SR) is offered to teachers of many programs, including PFA. As staff at one site explained, families probably cannot tell the difference between funding sources. They may be aware that there are multiple sources of funding and there is a demonstration project, but they do not know which source is paying for the various components of the programs.

Benefits and Challenges

All three Directors commented on how the combination of funds has enabled them to reach more children than just those attending preschool, and to identify and address potential developmental issues prior to preschool age by working with parents of toddlers. One Director noted how, thanks to early intervention, some cases are closed before children reach kindergarten. Other benefits include:

- Enhancing the materials and classrooms of the preschools
- Reaching other populations, such as teen parents and parents of infants
- Ability to complement both programs; as one Director explained, to "fit the holes of the other [program]"

While there were no disadvantages to having both funding sources, a few challenges were mentioned:

- *Reporting Requirements:* Two sites shared that having both SR and PFA funding means more reporting and more time is spent on paperwork and evaluation. One staff member mentioned that her team sometimes wonders if the stringent First 5 requirements are worth the trouble. Another wishes that PFA and SR used the same format. Interestingly, there were mixed opinions on whether the reporting requirements were similar or different between the two contracts. There was also differing opinions on the PFA requirements: one Director said PFA reporting requires more detail than SR, another said PFA reporting was more straightforward and had fewer requirements, while the third felt it was too soon to tell due to the newness of PFA.
- *Evaluation Materials:* All three site Directors mentioned challenges related to evaluation tools. One Director felt that the PFA assessment ECERS was "overkill" and should be simplified. The other two sites expressed some concern about First 5's requirement that all programs use the same tools and assessments across the SR contracts, and also commented that having a common evaluation across the different programs raised challenges to ensuring the data are reflective of the work accomplished in each unique SR program.[1] Some directors commented that it is important to recognize that each community is different, and that certain tools may not work in them all. For instance, one Director felt parents were confused by the Parent Retrospective Survey and teachers are troubled when results show that parents appear to know less after participating in the program than when they started.[2] Additionally, in Escondido it has been challenging to find a common assessment tool because, unlike regular preschools, the program focuses on social services and enrolls children year-round, and may serve clients for up to 5 years. One site noted that it ensures its staff is knowledgeable about, and involved in, the evaluation and that has helped the evaluation process.

[1] When the SR Initiative was launched in 2002, districts were not required to have common programs. As a result, each of the 8 SR programs has a different design.

[2] This observation may not hold true for all parents as the evaluation results for this tool show significant improvements in parental knowledge from fall to spring.

Recommendations

Interviewees had the following suggestions for agencies considering having both PFA and SR contracts:

- Keep the paperwork and budgets of the two contracts separate, and be very clear on reporting.
- Look at both programs and their goals, and align them so that they complement each other: "Look at your community and see how the two can work together" to make the most of existing funds and avoid duplication.
- Be sure to provide services that are responsive to community needs, and work closely with the school district staff.

While the success and challenges experienced at dually funding SR/PFA sites are unique, overall the merging of First 5 funds has resulted in more and higher quality services for children and families. Such strategic planning for services in each of these districts adds to the sustainability of programs. However, SR and PFA contractors must continue to seek additional, non-First 5 funding to ensure the future for their programs.

CHAPTER 5

Preschool for All

"[PFA] has helped my children develop tremendously both socially and developmentally."

—PFA Parent

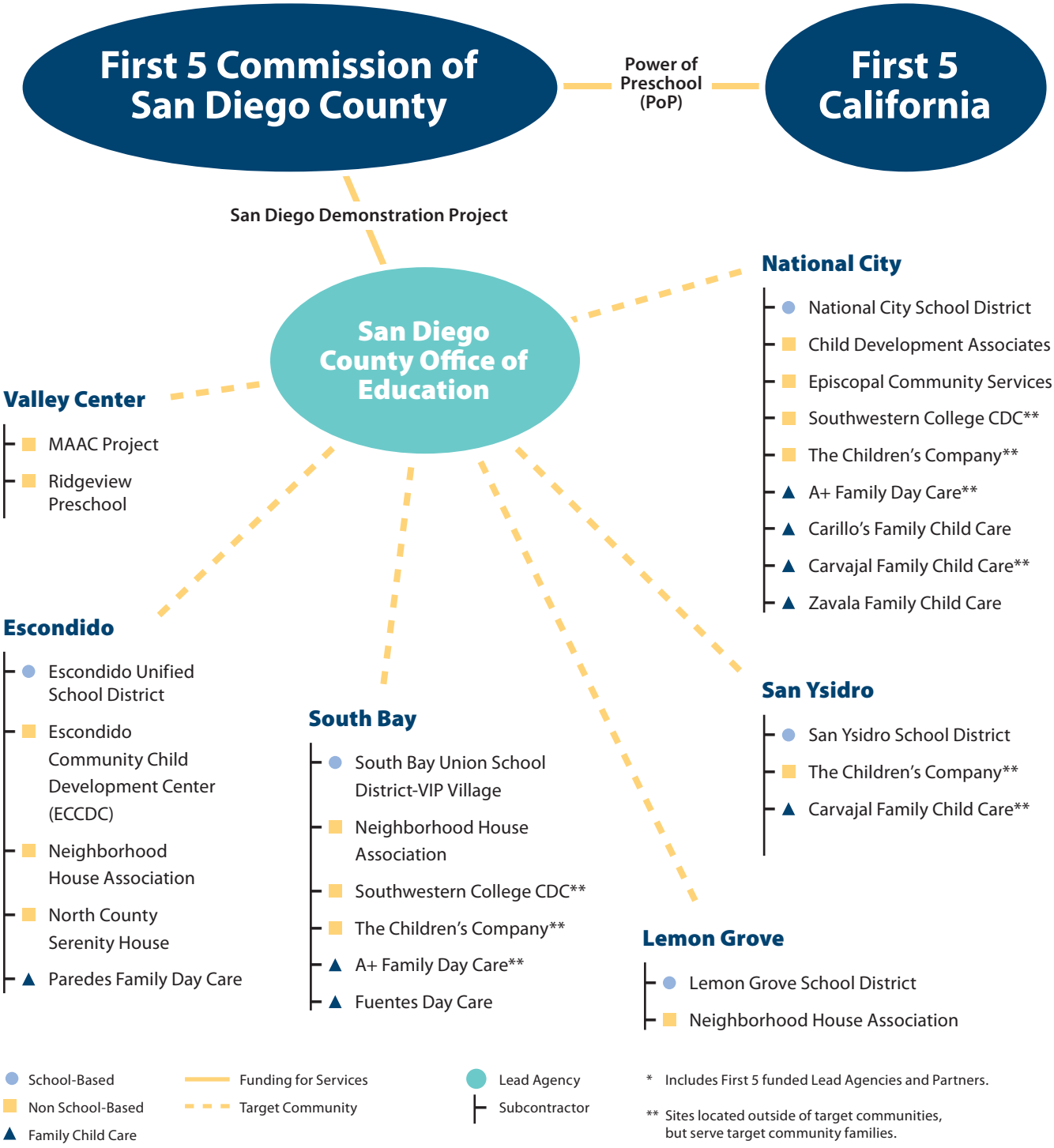
Key Results

- **Year 2 of the Preschool for All (PFA) Demonstration Project provided 142 preschool sessions throughout the six target communities.** Across the County, 2153 children were given a quality preschool experience through PFA.
- **Children improved in each of the four domains measured by the DRDP-R.** Like last year, the most improvement was in the area of "effective learning" (i.e., cognition, math ability, and literacy), but all improvements were statistically significant ($p<.001$).
- **Parents participated in numerous parent engagement opportunities.** Parents were offered a variety of opportunities to attend parent education classes, volunteer in class and at preschool events, and become involved in organizational activities, such as provide advisory committees. All parents reported an improvement in parenting skills, with those attending parent education classes reporting more improvement than other parents. Like last year, parents were highly satisfied with the PFA Demonstration Project.
- **Improvement in workforce quality.** This year more teachers were educated at or above the Bachelor's level, which is consistent with the increase in Tier 3 level sessions. Administration of the CLASS tool, which measures teacher/child interaction in Tier 3 sessions and the support of the SDCOE professional development coaching team, ensures that PFA quality will continue to improve even once sessions are designated "PFA Quality."
- **Children were screened for developmental delays.** This year approximately three-quarters of children enrolled in PFA were screened for developmental delays, and approximately 11% received services for having a developmental delay.

Summing It Up

- 2,113 slots were funded by First 5 San Diego's PFA Demonstration Project (516 new preschool slots were fully-funded by PFA funds and 1,404 existing preschool slots received PFA funds to enhance existing services). Actual enrollment was 89.0% of the target enrollment (of 2,420 children) for Year 2.
- An estimated 75.4% of children were screened for developmental delays using the PEDS, a large increase from last year, when only 15.9% of children served by PFA were screened.
- A total of 632 parent engagement opportunities were offered this year, compared with 279 opportunities last year.
- The quality of preschool teaching increased; 40.3% of lead teachers were educated at or above the Bachelor's level this year compared to 32.9% last year, while 84.3% of lead teachers were educated at or above the Associate's level compared to 83.6% last year. 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, require fewer special education services, and are more likely to graduate from high school and attend college.[184]

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.[185] These communities, which serve approximately 4,400 preschool-age children, were targeted based on their 2004 elementary schools' low Academic Performance Index (API) scores and population demographics, such as number of English language learners and average family income. To coordinate the PFA project, First 5 San Diego contracted with the San Diego County Office of Education (SDCOE) to support program implementation in each target community. SDCOE in turn contracts with school-based, non-school-based (includes for-profit, private non-profit, faith-based, and Head Start), and family child care providers to provide quality preschool in each community.

PFA has succeeded in enhancing overall classroom quality, involving parents, increasing workforce quality, and ensuring that children are screened for developmental delays. 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. By doing so, the project will have the necessary data to support their project as they look for other funds and resources. The First 5 San Diego PFA evaluation plan weaves together three, interconnected components: First 5 California Statewide Power of Preschool (PoP) Evaluation, First 5 San Diego Evaluation Efforts, and the PFA Master Plan Evaluation. The results presented in this report include process data collected by SDCOE, as well as data collected through a variety of assessment tools (see Making a Difference section for a listing of tools).

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.

---

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

[185] 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 countywide 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. UDecember 5, 2005. Accessed 4 September, 2007 <http://www.sdcoe.net/student/eeps/pfa/pdf/mplan_12-05.pdf>

- Encourage workforce/professional development of PFA provider staff with higher education, training, 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 including Escondido, Valley Center, Lemon Grove, National City, South Bay, and San Ysidro. There are also three providers located in Chula Vista, which is not one of the six designated PFA regions, but serves children who live in two of the identified communities (National City and South Bay). Within these communities, there were a total of 20 PFA sites participating in the Demonstration Project in Year 2, including school-based, non-school-based, and family child care as listed in Exhibit 5.1.

Exhibit 5.1 Preschool For All Demonstration Project Sites by Region FY 2007-08

Region	Program Name	Setting
Escondido	Escondido Community Child Development Center (ECCDC)	Non-School-Based
	Escondido Unified School District	School-Based
	Neighborhood House Association	Non-School-Based
	North County Serenity House	Non-School-Based
	Paredes Family Day Care	Family Child Care
Lemon Grove	Lemon Grove School District	School-Based
National City	Carrillo's Family Child Care	Family Child Care
	Child Development Associates (CDA)	Non-School-Based
	Episcopal Community Services	Non-School-Based
	National School District	School-Based
	Zavala's Family Child Care	Family Child Care
San Ysidro	San Ysidro School District	School-Based
South Bay	Fuentes Day Care	Family Child Care
	South Bay Union School District - VIP Village	School-Based
Valley Center	MAAC Project	Non-School-Based
	Ridgeview Preschool	Non-School-Based
Other*	A+ Family Day Care	Family Child Care
	Carvajal Family Child Care	Family Child Care
	The Children's Company	Non-School-Based
	Southwestern College CDC	Non-School-Based

**These sites are located outside PFA target communities but serve families who live in target communities.*

The overall goal of the PFA is to successfully enroll and serve 70% of 4-year-olds located in all target communities by FY 2010-11. 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 (PFA Pre-Entry). All sessions are designated a "Tier level" based on quality criteria which includes the session's ECERS/FDCRS score and 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.

Summing it Up: Number of Children and Families Reached

In FY 2007-08, PFA funded a total of 20 sites – five school-based, six family child care (FCC), and nine non-school-based (Exhibit 5.2). Overall, these sites held 142 sessions (a 20.0% increase from last year),[186] filled 2,113 slots (a 23.2% increase from last fiscal year), and served 2,153 children (an increase of 21.3% from last fiscal year).[187] [188]Actual enrollment was 89.0% of the target enrollment for Year 2 of 2,420 children, which is an increase compared to the 71.1% of the target population enrolled last year.[189]

The majority of sessions, 79.8%, were held at school-based sites, where 74.4% of all slots were located. Nearly one quarter, 24.4%, of all PFA student slots were fully-funded, meaning sites used PFA funds to create new slots for children, while 66.4% 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, sites had more enhanced slots than fully funded slots.

Exhibit 5.2 Preschool For All Demonstration Project Process Numbers FY 2007-08

Setting	Number of sites	Number of sessions	Fully-funded slots	Enhanced/subsidized slots	Pre-entry slots	Total Slots
School-based	5	87	442	1130	0	1,572
Family child care	6	8	29	7	3	39
Non school-based	9	47	45	267	190	502
Total	**20**	**142**	**516**	**1,404**	**193**	**2,113**
Total FY 2006-07	**16**	**103**	**383**	**1,279**	**N/A**	**1,662**
Percent Change from FY 2006-07	**+20.0%**	**+27.5%**	**+25.8%**	**+8.9%**	**N/A**	**+21.3%**

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

[187] The number of children is different than the number of slots because some children leave before the end of the year and new children are enrolled.

[188] In last year's evaluation report, the percentages of total children receiving tools and services were calculated using the number of total slots as the denominator. This year, percentages were calculated using the number of children served as the denominator. Where applicable, last year's percentages were updated.

[189] Percentages were calculated by dividing total number of children served by target population.

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.

Outcome Measures

- **Classroom Quality**: Early Childhood Environment Rating Scale: Revised (ECERS-R); the Family Child Care Environment Rating Scale: Revised (FCCERS-R); the Classroom Assessment Scoring System (CLASS); and interviews with PFA teachers and SDCOE's professional development coaching team.
- **Child Development:** Desired Results Developmental Profile (DRDP-R)
- **Parenting Skills and Satisfaction:** PFA Parenting Survey and the DRDP-R Parent Satisfaction Survey
- **Workforce Quality:** PFA Teacher Survey and interviews with PFA directors.

Please see Appendix B for additional information on PFA outcome measures.

Ensuring Quality Classrooms

To measure the quality of PFA classrooms, the Demonstration Project used the Early Childhood Environment Rating Scale-Revised Edition (ECERS-R), the Family Child Care Environmental Rating Scale-Revised Edition (FCCERS-R), and the Classroom Assessment Scoring System (CLASS). These tools are among the nationally recognized instruments designed to measure various aspects of classroom and child care site quality. [190] [191] [192] The overall ECERS-R and FDCRS score is one of three components that determine 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.

Last year, the ECERS-R and FCCERS-R were administered to all sites, however, this year they were administered at Tier 1 and 2 sessions only because the CLASS tool was introduced to provide more in-depth assessment of Tier 3 sessions, which have reached PFA Quality standards.[193] The following sections outline the results of the different assessment activities.

Growing classroom quality: Results of the ECERS-R and FCCERS-R.

This year, the ECERS-R and FCCERS-R were administered to Tier 1 and 2 sessions, while last year the tool was administered to Tier 1, 2, and 3 sessions. Because the tools were not administered at the highest quality sessions this fiscal year, ECERS-R and FCCERS-R were lower this year. Thus, year-to-year comparisons of

[190] ECERS-R is reliable at the item, indicator, and scale level, 86.1% agreement across all items. 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.U Frank Porter Graham Child Development Institute, The University of North Carolina at Chapel Hill, 2005.

[191] The FCCERS-R is reliable at the item, indicator, and scale level, with 88.4% agreement across all items. Harms, Thelma, Richard M. Clifford, and Debby Cryer. Family Child Care Environment Rating Scale: Revised Edition. Frank Porter Graham Child Development Institute, The University of North Carolina at Chapel Hill, 2007.

[192] CLASS scores are stable across time and the tool has a high level of inter-rater reliability, with 78.8 – 96.9% inter-rater agreement. Hamre, Bridget, Karen M. La Paro, Robert C. Pianta. Classroom Assessment Scoring System Manual: Pre-K. Paul H. Brookes Publishing Co, Inc. Baltimore, 2008.

[193] It is still to be determined whether or not Tier 3 sessions will receive the ECERS-R/FCCERS-R again throughout the course of PFA

exact scores are not possible. Additionally, the tool administered at FCC providers was changed from the FDCRS tool of the previous fiscal year to this year's FCCERS-R (a revised version of the FDCRS). This further limits year-to-year comparisons.

Overall, the ECERS-R and FCCERS-R have similar subscales with comparable categories - they each include scales from one (inadequate) to seven (excellent), as is noted in Exhibit 5.3. Highlights are as follows:

Exhibit 5.3 ECERS-R and FCCERS-R Subscale Comparison and Brief Overview

ECERS-R (school and non-school based sites)	FCCERS-R (family child care sites)	Brief Overview (Select Items)
Space and Furnishings for Care and Learning	Space and Furnishings	Furniture, space for learning play and privacy, display for children
Basic Care	Personal Care Routine	Greetings, naps, meals, health and safety practices
Activities	Activities	Fine motor, art, music and movement, blocks, math/science
Language-Reasoning	Listening and Talking	Books, pictures, helping children communicate and understand
Interaction	Interaction	Interaction between children, child/staff interaction, discipline, supervision
Program Structure	Program Structure	Schedule, free play, group time, provisions for special needs children
Parents and Staff	Parents and Provider	Provisions for parents, personal needs of staff, opportunities for professional staff, staff interaction and cooperation

- At **school-based sites**, this fiscal year's scores for all subscales ranged from 4.81 to 6.50. The ECERS-R subscales that scored the highest in both years were *Interaction* and *Parents and Staff*. The lowest score this fiscal year was in *Basic Care*, while the lowest score last fiscal year was for *Program Structure*.

- At **non-school-based sites**, this fiscal year's scores for all subscales ranged from 5.61 to 6.56. Interaction and parents and staff scored the highest last year, while *Program Structure* and *Parents and Staff* scored the highest this year. The lowest score this year was in *Learning Activities*, while the lowest score last year was in *Basic Care*.

- At **family child care sites**, this fiscal year's scores for all subscales ranged from 5.07 to 6.39. This year, FCC providers scored highest in *Program Structure* and *Parents and Staff*, which is consistent with the non-school-based providers' scores. The subscales with the highest mean scores last year were *Adult Needs* and *Social Development* – two subscales not included in the FCCERS-R. The lowest score for both years was for *Space and Furnishings*.

Enhancing high performing classrooms: Results of the CLASS

The CLASS is comprised of ten dimensions, and measures the interactions between teachers and students as grouped into three domains, which include emotional support, classroom organization, and instructional support. Scores range from one (low) to seven (high).[194] *Emotional Support* measures the teacher's ability to support social and emotional functioning in the classroom. It includes the dimensions of positive climate, negative climate, teacher sensitivity, and regard for student perspectives. *Classroom Organization* measures the

[194] Ibid.

teacher's ability to monitor behavior, maximize time, and engage students in material. Additionally, the *Classroom Organization* domain includes the dimensions of behavior management, productivity, and instructional learning formats. Finally, *Instructional Support* focuses on the ways in which teachers implement their curriculum to effectively support cognitive and language development. It includes the dimensions of concept development, quality of feedback, and language modeling. Exhibit 5.4 shows the mean scores of each dimension, while Exhibit 5.5 shows the mean score by domain. Highlights are as follows:

- *Emotional Support:* Sessions scored highest, between 4.95 and 5.94, in emotional support dimensions, with a mean of 5.65. Sessions scored particularly high on negative climate and positive climate.
- *Classroom Organization:* Sessions scored between 4.91 and 5.26 in classroom support dimensions, with a mean of 5.11. Within classroom organization, sessions scored the highest on behavior management.
- *Instructional Support:* Sessions scored the lowest, between 3.98 and 4.33, in instructional support dimensions, with a mean of 4.20. Sessions scored particularly low on concept development and language modeling.

Exhibit 5.4 Mean CLASS Scores by Dimension (n=32)

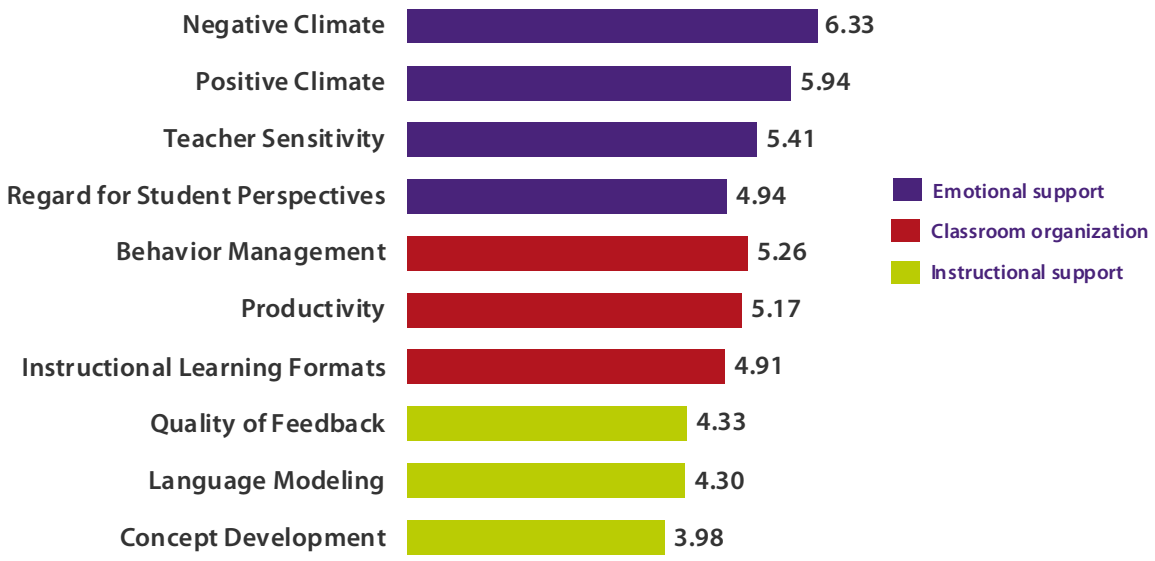
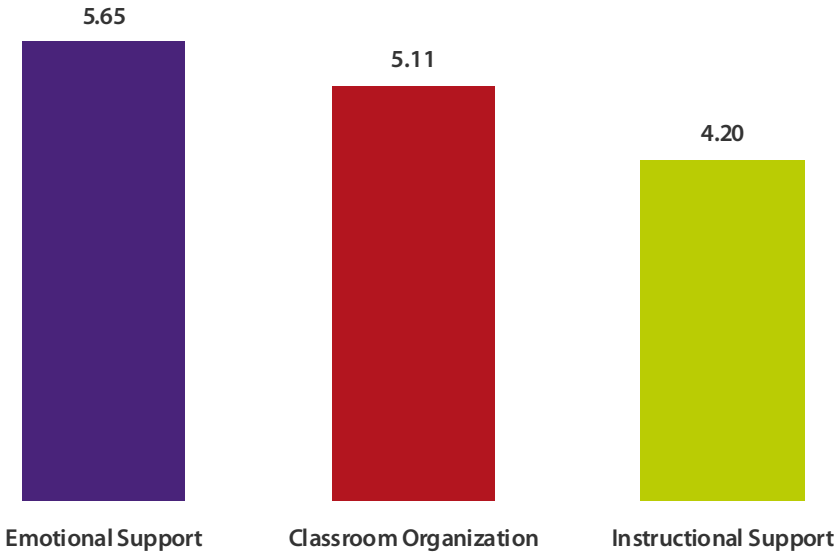


Exhibit 5.5 Mean CLASS Scores by Domain (n=32)



Developmental Gains for Children

The Desired Results Developmental Profile (DRDP-R) measures a child's development in four domains including personal and social competence, effective learning, physical and motor competence, as well as safety and health. DRDP-R assessments were completed for children from 121 PFA sessions and represent matched Fall and Spring scores (n=1,083).[195]

Developmental Scores in Fall and Spring

The DRDP-R consists of 39 questions and asks teachers to rate children's skills on a scale of zero to four, with zero being the lowest score and four being the highest score. Numerical scores were assigned to each of the four categories, from *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.[196] As Exhibit 5.6 illustrates, mean scores in each category increased from the Fall to the Spring, with all of the increases being statistically significant (p<.001).

"I have been so surprised in the depth of learning and variety of things [my child] is learning."

– PFA Parent

The mean increases for FY 2007-08 DRDP-R domains are slightly lower than last fiscal year (see Exhibit 5.7). This year, DRDP-R score

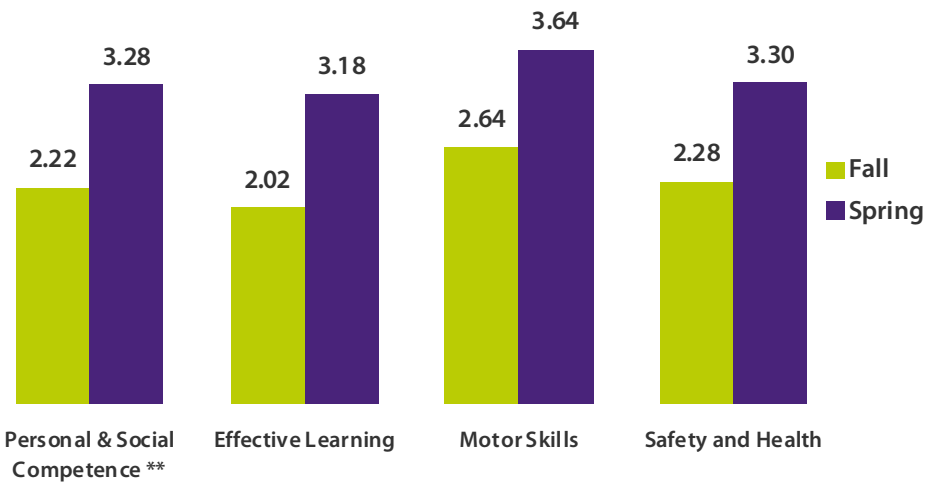
[195] Only scores from Tier 1, 2, and 3 sessions where parents consented to reporting their child's scores were included in analysis. Additionally, only children with both a pre- and post-score were included. The total number of children with pre- and post-DRDP-R scores (n=1,083) represents 84.1% of the children whose parents consented, 85.2% of all sessions, and 50.3% of all children served by PFA.

[196] Most surveys measuring baseline scores were administered in October and November while most Spring surveys were administered six months later in April and 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.

increases from Fall to Spring were from 0.99 to 1.16 points, while last year Fall to Spring increases were from 1.01 to 1.23 points. The smaller increases in this fiscal year may be due to the fact that mean Fall scores were slightly higher this fiscal year, leaving less room for children to improve. The changes in *Effective Learning* from Fall to Spring were the largest for both years. While the magnitude of this change was the greatest, this domain had the lowest mean Spring and Fall scores compared to other domains. This is true for both fiscal years. By contrast, *Motor Skills*, the area with the least amount of change, had the highest mean score both in Fall and Spring.

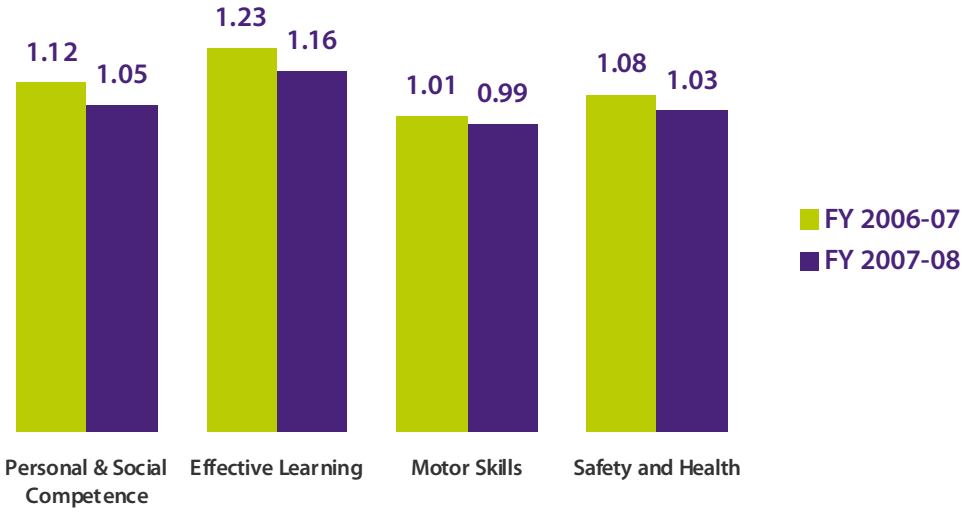
As Exhibit 5.8 demonstrates, Spring scores for both years were the same or similar. *Motor Skills* and *Safety and Health* scores are almost the same for both years, while scores for *Effective Learning* and *Personal and Social Competence* are slightly higher this year. As PFA continues, future data may shed light on why these trends occur.

Exhibit 5.6 Mean DRDP Scores by Domain *
FY 2007-08 (n=1,082)



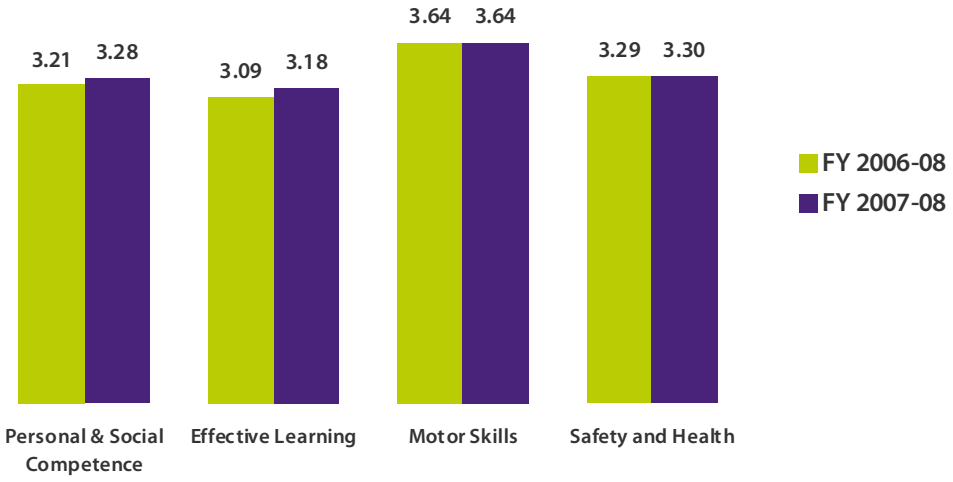
**Changes in scores were statistically significant (p<.001) for every domain*
***Personal & Social Competence (n=1063). Valid n is different for this category because only matched cases were used.*

Exhibit 5.7 Mean Changes in DRDP Scores by Domain*
FY 2006-07** and FY 2007-08***



*Changes in scores were statistically significant (p<.001) for every domain.
**FY 2006-07: Personal & Social Competence (n=1348), Effective Learning and Safety and Health (n=1365), Motor Skills (n=1364).
***FY 2007-08: Personal and Social Competence (n=1063), Effective Learning, Safety and Health, and Motor Skills (n=1082).

Exhibit 5.8 Spring DRDP Scores by Domain
FY 2006-07* and FY 2007-08**

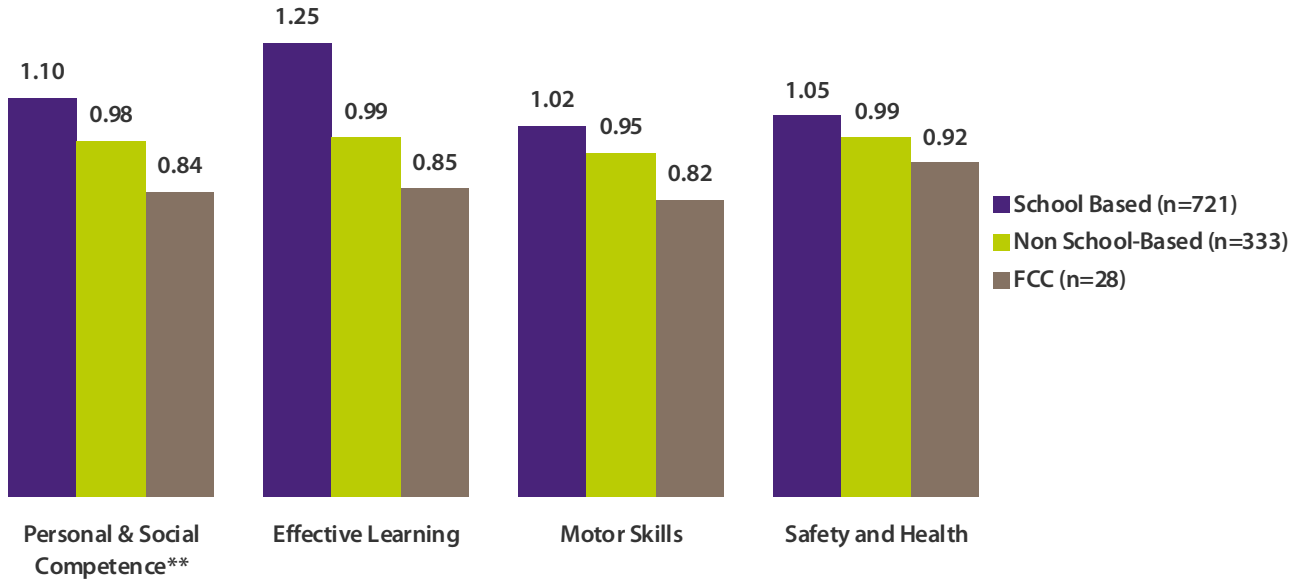


*FY 2006-07: Personal & Social Competence (n=1348), Effective Learning and Safety and Health (n=1365), Motor Skills (n=1364).
**FY 2007-08: Personal and Social Competence (n=1063), Effective Learning, Safety and Health, and Motor Skills (n=1082).

Differences in Scores by Site Type

Exhibit 5.9 illustrates mean changes across domains by the type of setting: FCC, school-based, or non-school-based.[197] For all three site types, children had the smallest increase in scores for *Motor Skills.* Children in school-based programs had the largest increase in scores for *Effective Learning,* and children in non-school-based programs had similar results, with *Effective Learning* and *Safety and Health* increasing by the most. Meanwhile, children in FCC programs had the largest increase in scores in *Safety and Health.* Some of these differences may be due to variations in the way the tool is interpreted and administered by teachers.

Exhibit 5.9 Mean Changes in DRDP Scores by Domain and Setting *
FY 2007-08



**Changes in scores were statistically significant (p<.001) for every domain.*
**School-Based (n=711), Non-School-Based (n=325), FCC (n=28). The valid n for this category is different because only matched cases were used.*

[197] The majority of children (91.7%) with submitted matched DRDP-R scores were 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. Differences in mean changes by site type were not tested for statistical significance.

Professional Development Coaching

The professional development coaching team at SDCOE worked directly with teachers, observing and directing them, in order to improve and maintain quality their classrooms. This opportunity was made available to PFA teachers this year for the first time, and in order to document successes and challenges, the evaluation team interviewed two coaches, six teachers, and conducted a focus group with a group of teachers.

Establishing a Connection

Professional development was available to all PFA providers, but sites were not required to utilize the service. Both teachers and coaches reported that, generally, the coaches facilitated on-site group training, and then interested teachers would volunteer to receive individual coaching. Though teachers were sometimes hesitant to work with the coaches, they reported that this hesitation quickly dissipated due to their close professional relationship with the coach. In fact, most teachers cited their relationship with the coach as the most beneficial aspect of the professional development. One teacher noted that the coach built a relationship with her before coming into the classroom, and another teacher said, "[I] felt completely supported, like someone was really behind me." Teachers also appreciated the fact that coaches were willing to work with them during the children's' nap time, before school, or after school.

The coaches agreed that the personal relationship between teacher and coach enhanced the experience for the teacher: "The relationship stays even if they've only visited three or four times. Their [coach is] now like their [teacher's] special contact with PFA."

Improving Classrooms

Teachers generally received coaching in order to achieve the highest possible score on ECERS-R, FCCERS-R, or CLASS. The professional development team provided coaching on various topics including hand-washing, rearranging classrooms, transition activities, and challenging behaviors. Teachers appreciated the coach's feedback, acknowledging that there was always room for improvement. One teacher noted that her coach "was very positive about everything we were doing right." Coaches, similarly, reported that their goal was to make the experience a positive one for the teacher. In one coach's words, "One teacher told me that she was feeling very overwhelmed…I start thinking, 'How can I help her?' I came up with bringing in a visual activity for her to understand. It took one minute and she was able to see, 'Oh, ok that's what you mean by that.'

Remaining Challenges

Teachers reported that they wanted more individual and group sessions with coaches, but didn't know if that was possible. Coaches similarly reported the desire to have more workshops and group sessions. Additionally, coaches reported that it was challenging to find time to meet with teachers since most of them do not have that much free time. In one coach's words, "The only time is the playground time so they're talking during that time. We feel like we are giving them the wrong message because we want them to be with the children on the playground, not talking to us."

Screening for Developmental Delays and other Special Needs

Early identification and intervention for developmental delays is a key goal of all First 5 projects.[198] Early identification and intervention can dramatically improve a child's health and learning, as well as social and emotional development; intervention just a few years later becomes more challenging and less effective. 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 tracked the number of developmental screenings as well as the number of children who are referred for an IEP (Individualized Education Plan) or further assessment. The hope is that universal screenings will identify children with "mild" to "moderate" delays that often go undetected and/or unaddressed by existing identification protocols and programs.[199] Indeed, the American Academy of Pediatrics cites studies that indicate that intervention prior to kindergarten has enormous academic, social, and economic benefits, including savings to society of $30,000 to $100,000 per child. [200]

PFA uses three screening tools for identification of developmental delays: the PEDS (Parents Evaluation of Developmental Status), the ASQ (Ages and Stages Questionnaire), and the Acuscreen. The PEDS and the ASQ are recognized by the American Academy of Pediatrics as reliable and valid tools for children ages 0-5.[201] The Acuscreen has been validated on over 3,000 children and fulfills the requirements of early childhood screening.[202] The PEDS was used as a preliminary screening tool for all children, and the ASQ or Acuscreen was a secondary screening tool if the PEDS results indicate a concern. 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 the Healthy Development Services Project (see Chapter 3).

Exhibit 5.10 shows the number of children who were given the PEDS and ASQ or Acuscreen as well as those who were referred for services onsite and/or offsite and who received services for developmental delays either onsite and offsite.[203] Of the 2,153 children served by PFA this year, an estimated 75.4% of children were screened using the PEDS.[204] This is a large increase from last fiscal year, when only 15.9% of children served by PFA were screened.[205] An estimated 10.9% of children (234 children) served by PFA were referred for services and the same percentage received services. This percent receiving services for developmental delays is on par

[198] 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.

[199] 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.

[200] 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>.

[201] 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>.

[202] Bergan, John, Kristie Cunningham, Jason Feld, Kristin Linne, and Michael Rattee. The Galileo System for the Electronic Management of Learning. Assessment Technology Inc, 2003. Accessed 1 October, 2008. < http://www.ati-online.com/galileoPreschool/resources/articles/galileotechmanual_files/welcome.html>.

[203] Some sites offer services on site and may or may not have tracked referrals for these services.

[204] Some of the children screened by agencies this year were not enrolled in PFA, thus this percentage is an estimate.

[205] This percentage was calculated by dividing the number of children returning the PEDS last year by the number of children served by PFA last year.

with national statistics assume between 8%-17% of children have special needs[206] though are low compared to the results found by the Commission's Healthy Development Services (HDS) project. According to the HDS Countywide Coordinator, HDS providers are finding in low-income areas that 20-27% of children screened demonstrate some form of developmental delay. Part of the picture may be the limitations to the screening methodology used in PFA. The PEDS is a parent self-report tool and therefore relies on parental concern to identify children. There are cultural barriers as well as reliance on parents' knowledge and perception of child development that place limitations to the effectiveness of PEDS as a universal screening tool.

It is important to note that the percentage of children referred for services and receiving services for a delay may not be the same children. For example, some providers offer onsite services and may or may not count referrals made to these services. Thus, some children are counted as receiving services even though they are not counted as being referred for services.

Exhibit 5.10 Developmental Screening Results FY 2007-08

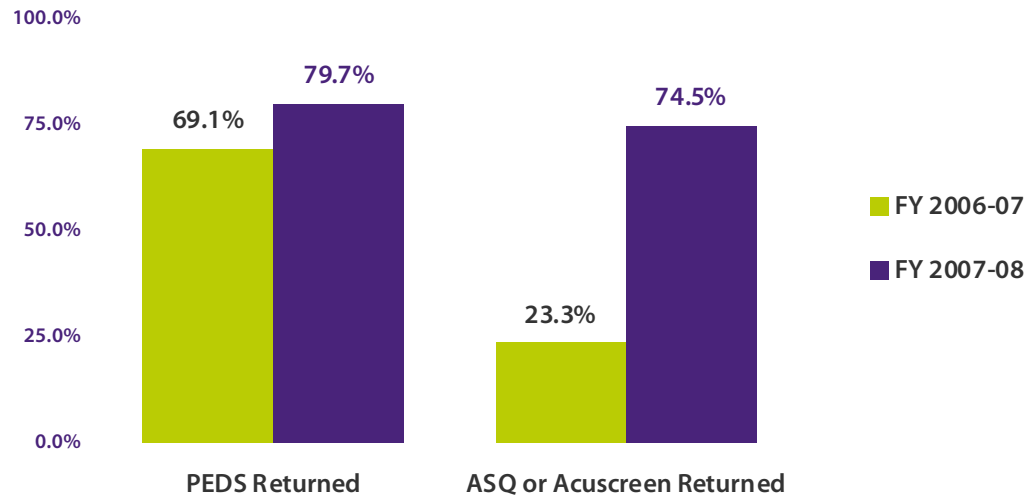
Provider Type	PEDS distributed	PEDS returned	ASQ/Acuscreen* distributed	ASQ/Acuscreen* returned	# children referred	# children received services
School-Based	1,636	1241	154	77	168	185
Family Child Care	44	33	3	2	2	2
Non-School-Based	357	350	211	194	64	47
Total	**2,037**	**1,624**	**368**	**274**	**234**	**234**

**Acuscreen is an alternate screening tool that was reviewed and approved by the AAP. Acuscreen is used nationally by Headstart programs.*

Response rates for the PEDS and ASQ or Acuscreen increased compared to last year (see Exhibit 5.11). Of the 2,037 parents who were invited to complete the PEDS, 1,624 were returned (79.7% response rate). Of these, 368 parents (22.6%) were invited to complete the ASQ or Acuscreen, and 274 were returned (74.5% response rate).

[206] 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: "Child Development: Developmental Screenings." Centers for Disease Control and Prevention. 2005. U.S. Department of Health and Human Services. 12 Sept. 2008. http://www.cdc.gov/ncbddd/child/devtool.htm, A sample based national study, conducted in 2001, estimated that approximately 8% of children aged 0-5 had special needs: "The National Survey of Children with Special Health Care Needs Chartbook 2001." The U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. 2004. U.S. Department of Health and Human Services. 10 Sept 2007. http://mchb.hrsa.gov/chscn/index.htm.

Exhibit 5.11 Response Rates for Developmental Screening Tools
FY 2006-07 and FY 2007-08



This fiscal year exhibited a decrease in the percentage of children who had Individual Education Plans (IEPs), meaning that these children were identified under State guidelines to have special needs warranting additional assistance. At the beginning of this school year, 94 children already had IEPs, and at the end of this school year, a total of 107 children. Last fiscal year, 68 children had IEPs upon entering the PFA program, while 145 children had IEPs at the end of the program. The reason for this decrease is unknown, but comparison of these data to future years' data may shed more light on possible explanations.

Assessing Parent Engagement and Satisfaction

Parental involvement and satisfaction with their child's classrooms is a key goal of PFA and a priority for the First 5 Commission.[207] 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.[208] 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.[209]

Parent Engagement

Parent engagement is comprised of three core activities: parent involvement (such as volunteering in the classroom, field trips, special events), parent education (such as parenting classes, nutrition classes), and

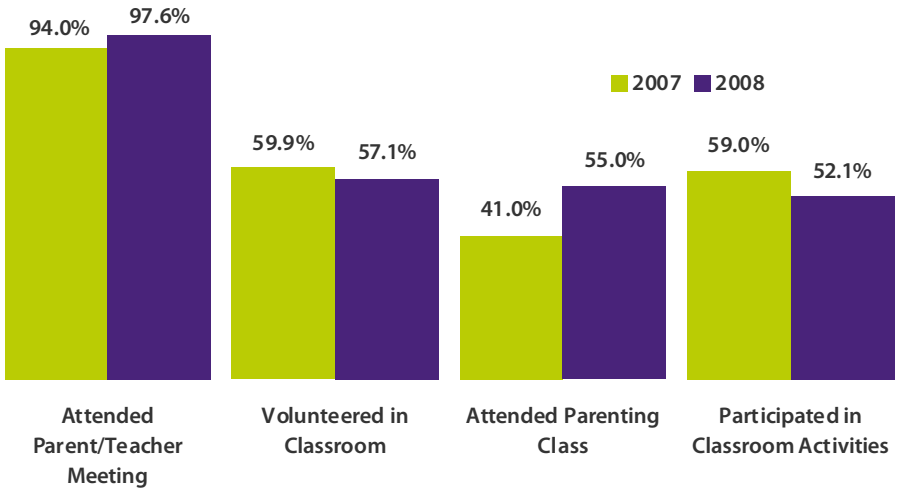
[207] State Evaluation Question 6.
[208] Issue Area 3.1: Parent and Family Development and Resources.
[209] Preschool California. "What is Effective Pre-Kindergarten." Accessed 10 September 2007. <http://www.preschoolcalifornia.org/for-policymakers/fact-sheets.htm>

organizational involvement (such as serving on advisory committees). Providers reported offering a total of 632 parent engagement opportunities, an overall average of 37 per site.[210] Results from the parent survey (62.5% of parents responded to this survey) suggested the level of involvement of parents in their preschools according to these three core parent engagement activities.

- ***Parent education*** was the most commonly offered activity reported by providers (311 activities). Of those responding to the parent survey, over half (55.0%) noted that they attended parenting classes.
- ***Parent involvement*** was the second most commonly offered activity reported by providers (249 activities). Of those who responded to the parent survey, nearly all (97.6%) reported participating in parent/teacher meetings, and more than half of these parents reported volunteering in the classroom (57.1%) or participating in classroom activities (52.1%).
- Parent involvement in ***organizational*** activities was the least common activity reported by providers (72 activities).

Somewhat more respondents reported participating in parent engagement activities in FY 2007-08 than in FY 2006-07 (62.5% and 54.8%, respectively). However, the overall breakdown of participation in different types of activities was fairly similar between the two years. The most notable differences from last year were an increase in parents attending a parenting class and a decrease of parents participating in classroom activities.

Exhibit 5.12 Percent of Parents Attending Parenting Activities*
FY 2006-07 (n=461) and FY 2007-08 (n=585)



** Counts within each fiscal year are not mutually exclusive.*

[210] The average number of opportunities by site type is not provided for several reasons: not all opportunities were funded by PFA and sites varied in the number of PFA sessions they offer, in the type of slots (enhanced versus fully-funded) they had, and in the number of children they served.

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 child development 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. 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.[211] About 43% of PFA parents (926 parents) completed this survey.[212]

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). Findings within each category for the current year include:

"This program has met my child's needs in all ways possible – physical, emotional, intellectual – and [it] has also met our family's needs."

– PFA Parent

- *Knowledge:* Items in this category asked parents to rate their own knowledge of their child's physical growth, cognitive development, and behavior. Knowledge items had the lowest mean "then" scores, but showed the greatest overall improvement.
- *Confidence:* This referred to a parent's confidence in their own parenting skills, ability to set appropriate limits, and ability to help their child learn. The confidence statement that showed the most improvement was "my confidence that I can help my child learn at this age" and the one that showed the least was "my confidence in myself as a parent."
- *Ability:* Within this category, the most improvement was seen in parents' ability to identify and respond to their children's needs. The least improvement was seen in parents' ability to attend to their children's health and safety. Overall, ability statements had the highest ratings – both "then" and "now."
- *Behavior:* This section measured changes in parent behaviors including engaging in activities with their child, reading with their child, and connecting with other families that have children. This category had the lowest "now" scores, and showed the least improvement. Within the behavior category, parents showed the most improvement on the statement "the amount I read to my child."

While respondents as a whole showed significant improvement on all items, parents who did not participate in any parenting activities only showed significant improvement on five of the twelve items. These parents did not improve significantly on any of the behavior or ability items, suggesting that parental engagement in preschool activities may help parents become more effective in their role as parents. Additionally, among parents who participated in at least one parent involvement activity, those attending parenting classes reported the largest increases overall, while those attending parent teacher meetings reported the smallest increases. These findings are consistent with last year's findings and while a causal relationship between parent engagement and

[211] "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.

[212] The percent of parents completing surveys was calculated by dividing the total number of surveys received by the number of children served by PFA. An exact response rate could not be calculated because the total number of surveys distributed is unknown.

increased parenting skills cannot be established, these findings suggest involvement in preschool activities was linked to an increase in parenting skills. It may be that parents benefit from more intensive involvement in preschool activities, and it may also be that parents who choose to become involved in preschool activities were also pursing additional activities to improve their parenting skills.

"This is an amazing program that has brought more confidence and joy to my child's life!"

– PFA Parent

Mean differences in "then" and "now" statements were relatively unchanged between this year and last year. For both years, the greatest increases were seen in knowledge, followed by confidence, ability, and behavior. Likewise, as Exhibit 5.13 illustrates, the six items that showed the greatest and least improvement were consistent from this fiscal year to last. Even the items with the highest overall "then" and "now" scores ("my ability to keep my child safe and healthy") remained the same for both years, as did the items with the lowest overall "then" and "now" scores ("the amount I read to my child" and "my connection with other families that have children"). One difference between the two years is that mean "then" scores for every item were higher in this year compared to last year. These findings suggest that parents in FY 2007-08 began the PFA Demonstration Project with higher levels of knowledge, confidence, ability and positive parenting behaviors and, as such, showed somewhat more modest improvement in these areas.

Exhibit 5.13 Outcomes for Parenting Survey FY 2007-08

Survey Item	Mean "Then" (Before PFA)	Mean "Now" (After PFA)	Mean Difference	Mean Difference FY 2006-07
My knowledge of how my child is growing and developing. (n=778)	4.25	5.20	0.96*	0.89*
My knowledge of what behavior is typical at this age. (n=770)	4.15	5.02	0.87*	0.80*
My knowledge of how my child's brain is growing and developing. (n=767)	4.15	5.06	0.91*	0.85*
My confidence in myself as a parent. (n=769)	4.54	5.26	0.72*	0.68*
My confidence in setting limits for my child. (n=761)	4.37	5.15	0.78*	0.70*
My confidence that I can help my child learn at this age. (n=772)	4.51	5.36	0.85*	0.75*
My ability to identify what my child needs. (n=772)	4.46	5.30	0.84*	0.70*
My ability to respond effectively when my child is upset. (n=769)	4.40	5.12	0.72*	0.66*
My ability to keep my child safe and healthy. (n=773)	5.04	5.63	0.59*	0.54*
The amount of activities my child and I do together. (n=767)	4.39	5.05	0.66*	0.61*
The amount I read to my child. (n=770)	3.94	4.74	0.80*	0.66*
My connection with other families with children. (n=771)	4.07	4.75	0.68*	0.61*

**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. This survey was completed by about 72% of PFA parents (n=1,558). [213] [214] The survey is a series of satisfaction questions about components typically included in early care and education programs. Key findings are shown on Exhibit 5.14 and include the following:

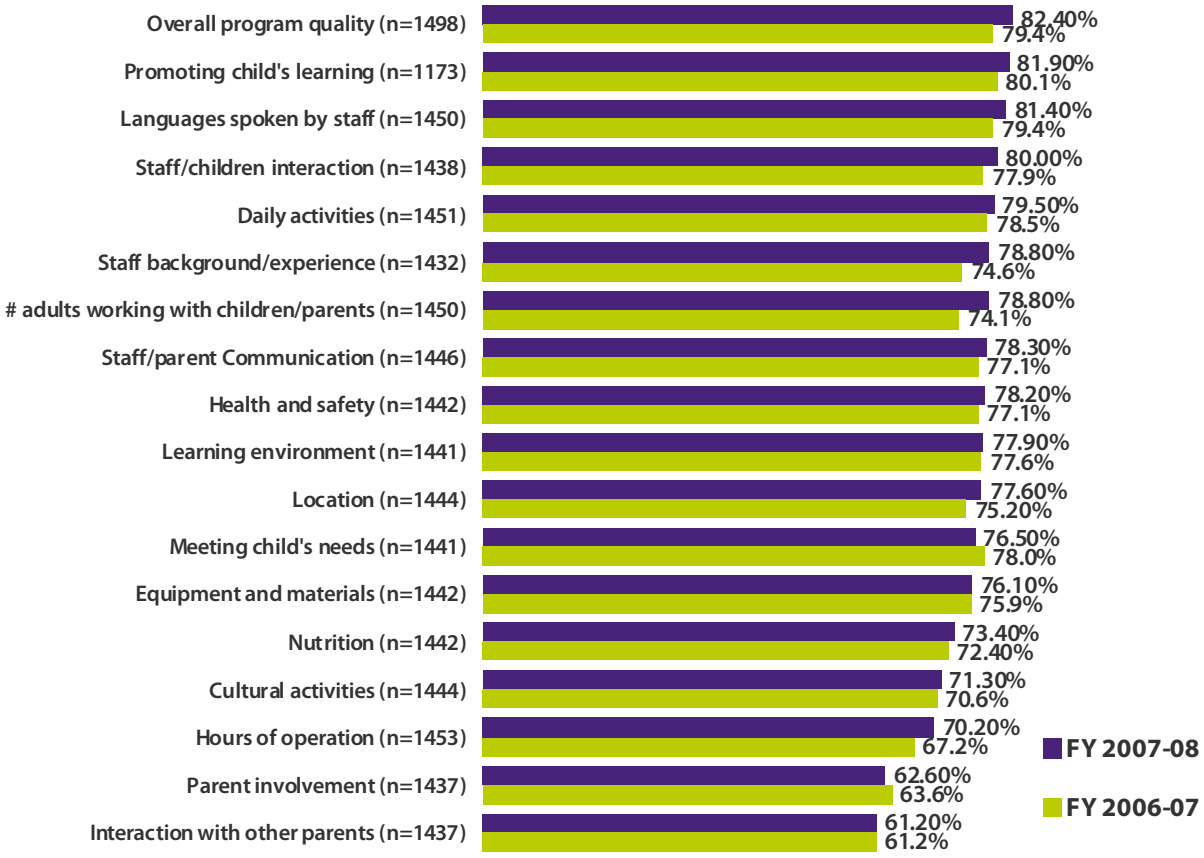
- The majority of parents were very satisfied with each program component. Across all components, an average of 75.9% of parents were "very satisfied."
- The highest percentage of parents felt very satisfied with the *Overall Quality of the Program* (82.4%). Several parents made positive comments about the quality of the program such as, "I think the program is excellent and nothing needs to be changed" and "It couldn't improve—their program is amazing!"
- For each component of the parent survey, less than 2% of parents said they were "not satisfied."
- The only components in which less than 70% of parents were "very satisfied" were *Interaction with Other Parents* (61.2%) and *Parent Involvement* (62.6%). Parent suggestions for increasing parent interaction and involvement included providing more opportunities to help out in the classroom, more parent-teacher conferences, and more parent-child activities.
- *Hours of Operation* received one of the lower satisfaction ratings. Several parents commented that they would like the hours of the program to be extended (PFA is a half-day program).

From FY 2006-07 to FY 2007-08, slight increases were seen in the percentage of parents who were "very satisfied" for 15 of the 18 components. Across all components, the average increase between the two fiscal years was one and a half percentage points. The two components that showed the greatest improvement (more than four percentage points each) were *Staff Background/Experience* and *Number of Adults Working with Children/Parents.* The only areas in which the percentage of parents who were "very satisfied" remained the same or decreased slightly (less than two percentage points) were *Satisfaction with Meeting Child's Needs*, *Parental Involvement*, and *Interaction with Other Parents*. Two of these areas, *Parental Involvement* and *Interaction with Other Parents*, also received the lowest satisfaction scores in both fiscal years, and thus may be important areas to target for improvement during the next program year. The area that received the third lowest satisfaction ratings, *Hours of Operation,* also remained consistent between the two years, as did parent comments expressing a desire for extended program hours.

[213] The percent of parents completing surveys was calculated by dividing the total number of surveys received by the number of children served by PFA. An exact response rate could not be calculated because the total number of surveys distributed is unknown.

[214] At some sites the DRDP-R Satisfaction Survey and the Survey or Parenting Practices were distributed separately, thus, the response rate for the two surveys was different.

Exhibit 5.14 Percentage of Parents Who Were "Very Satisfied" by Component FY 2006-07 and FY 2007-08*



**Valid n provided for each category is for FY 2007-08. Valid n's for FY 2006-07 are different.*

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, interaction with kindergartens, kindergarten transition, and school readiness awareness. In all, 112 PFA teachers completed the survey, a 84.8% response rate.[215]

According to these teachers' self reports:

- Teachers' strengths are in education and experience.
- Teachers' do not interact with kindergarten teachers as much as they could or should. While most teachers met with parents to discuss their child's transition into kindergarten, there was a decrease in the percentage of teachers creating transition files for children, compared to last fiscal year. Less than half of teachers attended meetings and trainings with kindergarten teachers.

[215] Although there were 132 lead PFA teachers in FY 2007-08, the number of teachers who received the survey is unknown, thus the response rate is an estimate. This year's response rate is higher than last year's response rate of 74.0%,

- Teachers have improved their interactions with parents compared to last year, with almost all teachers participating in parent conferences and in-person and telephone meetings, and inviting parents to volunteer in classrooms and participating in activities.

Each of these three overall findings is further explored below.

Education and Experience

In comparison to last fiscal year, PFA lead teachers had more experience this fiscal year. This fiscal year, 70.6% had taught preschool for over five years, compared to 63.0% last year, with 52.7% teaching at their current preschool for over five years (compared to 48.6% last fiscal year).[216] Comparison data indicates PFA teachers remain in their positions longer than their peers. Only 39% of center-based providers in California have been employed in their current setting for over five years. [217]

"I have gotten great ideas and feedback from professionals in this field to improve my skills as a teacher and provide a better learning environment for my children in the classroom."
- PFA Teacher

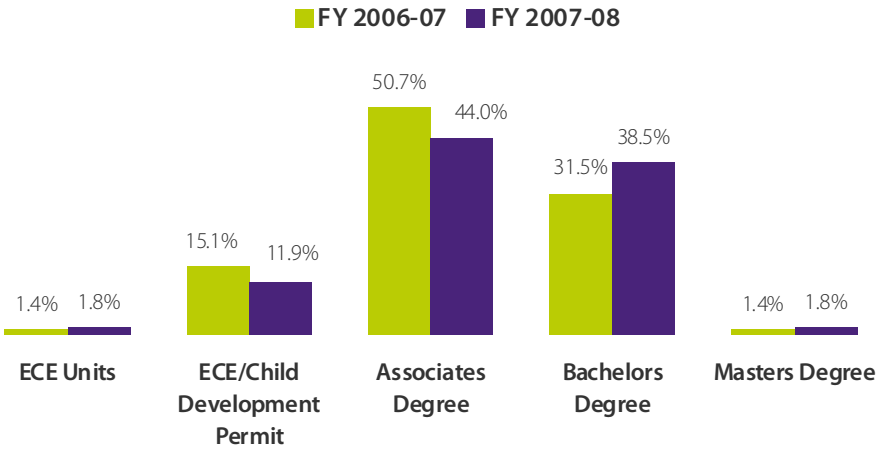
Although fewer teachers were enrolled in degree programs this year compared to last year, the level of education increased. As Exhibit 5.15 demonstrates, this fiscal year, 40.0% of teachers were enrolled in a degree program at a university or community college – a decrease from last year's 60.3%. While the percentage of teachers educated at, or above, the Associate's level was consistent this fiscal year and last year (84.3% this fiscal year compared to last year's 83.6%), more teachers were educated at or above the Bachelor's level (40.3% this fiscal year compared to last year's 32.9%). This suggests that PFA teachers are no longer enrolled in degree programs because they have already reached their desired educational goals and received a Bachelor's degree. This is consistent with the increase in Tier 3 sessions this fiscal year. Last fiscal year 28 sessions were designated as Tier 3, while this year 38 sessions were designated as Tier 3. Comparison data indicate that more PFA teachers have an Associate's degree than their peers, while about the same percentage have Bachelor's degrees or higher: in California, an estimated 67% preschool-age children in non-school-based settings have lead teachers with at least an Associate's degree, and 42% percent have a teacher with a Bachelor's degree or higher.[218]

During the school year 90.1% of teachers were offered the opportunity to supplement their experience and/or formal education with professional development activities, such as training on the DRDP-R and CLASS or working with children with special needs. Almost all teachers (93.3%) participated in activities and took advantage of this opportunity, with 71.4% of teachers participating in activities to better meet the needs of children with special needs or English language learners. Survey participants attended an annual average of 7.6 activities in FY 2007-08, an increase from last year's average of 5.9 activities. Many teachers view PFA as opening up opportunities to participate in training that allow them to offer more tools to the children, as well

[216] Percentages reported are valid percentages based on the number of valid responses to each survey item.
[217] "California Early Care and Education Workforce Study: Licensed Child Care Center and Family Child Care Providers." Center for the Study of Child Care Employment. 2006. Institute of Industrial Relations, University of California at Berkeley, California Child Care Resource and Referral Network. July 2006. 18 Sept 2008 <http://www.iir.berkeley.edu/cscce/workforce_study.html>.
[218] Karoly, Lynn A., et al. "Prepared to Learn: The Nature and Quality of Early Care and Education for Preschool-Age Children in California." Preschool California. 2008. RAND Corporation. 18 Sept. 2008. <http://www.preschoolcalifornia.org/rand-study/rand-study-3.html>.

as professional growth for themselves. In one teacher's words, "By participating in PFA, I've been able to grow professionally."

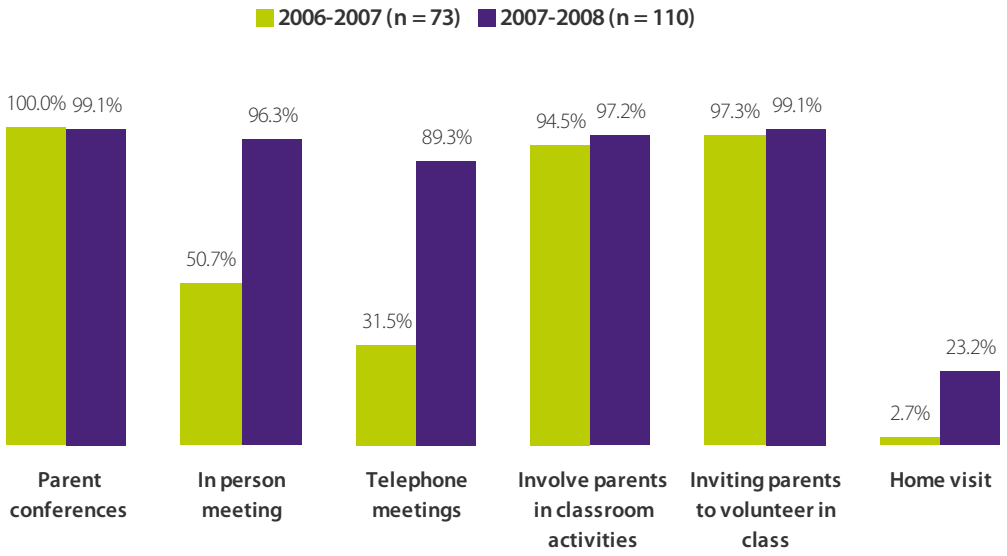
Exhibit 5.15 Level of Teacher Education
FY 2006-07 (n = 73) and FY 2007-08 (n=107)



Interaction with Parents

As Exhibit 5.16 shows, the most common parent involvement activities remained consistent from FY 2006-07 to FY 2007-08, with the three most common activities being parent conferences (99.1%), inviting parents to volunteer in the classroom (99.1%), and involving the parents in classroom learning/play activities (97.2%). The percentage of teachers participating in these three activities this year was similar to last year. Though the least common activity in both years was home visits, this year there was a substantial increase in the percentage of teachers participating, from 2.7% last year to 23.2% this year. This increase is largely due to the addition of a new provider who engages in home visits. Similarly, there was an increase in the percentage of teachers meeting parents in person, from 50.7% last year to 96.3% this year, and talking to parents on the telephone, from 31.5% last year to 89.3% this year. Overall, PFA teachers interacted and involved parents in more types of activities this year as compared to last year.

Exhibit 5.16 Activities Involving Parents*
FY 2006-07 (n=73) and FY 2007-08 (n=110)



**Categories within each fiscal year are not mutually exclusive*

Interaction with Kindergartens

Like last fiscal year, the majority of PFA teachers do not have extensive interaction with kindergarten teachers, with just over a quarter (28.3%) of PFA teachers having met with kindergarten teachers to discuss their students' transition. However, compared to last fiscal year, there was an increase in PFA teachers who said they attended meetings with kindergarten teachers (46.7% in FY 2007-08 versus 37.5% in FY 2006-07). There was also an increase in teachers who attended training with kindergarten teachers (26.9% in FY 2007-08 compared to 20.3% in FY 2006-07). Most PFA teachers (88.8%) met with parents to prepare them for their child's transition (similar to last fiscal year). However, there has been a decrease from last fiscal year in PFA teachers who created transition files for students going to kindergarten (78.6% in FY 2007-08 compared to 90.9% in FY 2006-07). For the most part, while some indicators of kindergarten interaction improved, the majority of preschool teachers were not in direct communication 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 2 included observational and secondary data gathered from the PFA Leadership Team meetings, interviews with 15 PFA site directors, and data from SDCOE. The purpose of this section is to document the continuing and new successes and challenges of the project.

Successes

The second year of PFA has seen the addition of five new sites, for a total of 20 sites in the six designated areas of San Diego County. Directors from 15 of these sites were interviewed and continued to be excited about the successes of the project. Most of the successes that emerged this fiscal year are the same as the successes identified last year. Continuing achievements included improved access to quality preschool, educational

advancement of teachers, and involvement of parents and the community. A new success included the professional coaching services offered by SDCOE.

- **Improved access to quality Preschool.** Last fiscal year, PFA Directors said that the project was an opportunity to raise the quality of education they provided and expand quality services to children in need. This year, Directors continued to praise PFA's ability to provide quality preschool to a broad cross-section of children. PFA's enrollment criteria have allowed children who otherwise would have fallen through the cracks to access quality education - specifically, children with family incomes too high for state preschool, but who cannot afford private preschool benefitted the most. Directors said that the support and funding available through PFA have allowed them to raise the quality of services they offer through training opportunities for teachers, classroom activities and curriculum, and upgrades to classrooms and playgrounds. Most sites continued to be pleased with the high quality guidelines set by PFA, and smaller providers and family-based sites have used these quality guidelines to enhance their program offerings. As one director explained, "It provided an additional way for us to move towards the quality standards that we're interested in."

"I can provide service to 60 kids who wouldn't have otherwise gone to Preschool. It isn't only improving quality, it is increasing access."
- PFA Director

- **Encouraging educational advancement for teachers.** Last fiscal year, directors noted that participation in PFA encouraged teachers to pursue B.A. degrees and look more objectively at their classrooms. This fiscal year, the same was true. Most Directors believed that advancing teachers' education had a positive impact on the classroom environment, most often citing the less advanced teacher education level as the reason classrooms did not achieve higher Tier levels. Being involved with PFA gave many teachers the motivation and financial support needed to advance their education and career. Most directors reported actively encouraging their teachers to further their education, and many provided flexible scheduling options to allow teachers to work towards their A.A. or B.A.

- **Involvement of parents, families and the community.** Last fiscal year, PFA providers had numerous partnerships with community agencies and local businesses in order to increase the resources available to families. In Year 2 of PFA, providers continued to engage a variety of community organizations in providing services. Common partnerships included the YMCA, local libraries, as well as vision, hearing and health screening centers (providers were unsure if these services were First 5 funded). Like last year, FCC providers had the fewest and most informal partnerships, and most agencies did not know whether the agencies they collaborate with were First 5 funded. However, many of the directors interviewed noted that their involvement with PFA facilitated the establishment of new partnerships.

"We have good parents and they want to be around their child and school."
- PFA Director

Additionally providers offer diverse activities in order to involve as many families as possible in the PFA Demonstration Project. All sites offer parent involvement activities (such as volunteering in the classroom, field trips, special events), parent education (such as parenting classes, nutrition classes), and organizational involvement (such as serving on advisory committees). Directors stated that while participating/volunteering in the classroom was

not mandatory, between 10% and 100% of parents volunteered. Parents who could not – or did not – spend time in the classroom often participated in other activities such as parent advisory committees, family nights, and other special events.

- **Support and professional coaching services provided by SDCOE.** This fiscal year, SDCOE offered professional coaching services to PFA teachers (see Professional Development Coaching text box on page 151 for more information). Most of the PFA Directors saw the professional coaching services as a tremendous benefit to their teachers, although some of them wanted the service to focus more on child outcomes and less on ECERS-R and FCCERS-R scores. The directors viewed the services as a valuable tool for improvement, noting that both new and old teachers have room for improvement. According to directors, some teachers were initially hesitant to receive coaching, but the coaches did a good job of breaking down barriers and establishing trust. In fact, many teachers proved more receptive to feedback from an external source. One director explained the coaching program's success by saying, "Sometimes it's good to have someone objective – not an evaluator like myself or principal. [The teachers] feel more comfortable asking the coaches for feedback." Overall, PFA Directors felt strongly supported by the SDCOE staff. Many commented on the quick response time on emailed questions, and the general helpfulness of SDCOE staff.

Challenges

Many of the challenges identified in the first fiscal year of the PFA Demonstration Project have been overcome. However, there are still programmatic issues posing a challenge for Demonstration sites. This section includes an update on challenges identified last fiscal year as well as challenges that emerged this year. Continuing challenges include administrative requirements, workforce quality and participation, and new challenges include assessments and sustainability.

- **Administrative Requirements/Startup.** Last fiscal year, many providers noted that the administrative requirements associated with PFA were often overwhelming. They also noted that there were delays associated with start up, such as communicating the data collection requirements to PFA Directors, which added to their frustration surrounding the requirements. This year, although PFA Directors said there was a decrease in the time and energy spent on administrative requirements, many said the requirements for PFA were still burdensome. One PFA Director explained the burden was largely due to different reporting formats and categories for PFA and other funders. A number of Directors overcame this issue by tailoring databases to PFA reporting requirements. Despite the perceived burden, Directors reported that SDCOE staff provided valuable technical assistance, assisting some of the providers in developing processes and/or worksheets to fulfill their reporting requirements.

- **Workforce Quality.** Last fiscal year, providers identified two challenges around workforce quality. They noted that it was difficult for lead teachers to find the time and money to reach the qualifications required for PFA Quality (Tier 3), and that it was difficult to find qualified instructional assistants. This year, Directors continued to find that recruiting and retaining a qualified workforce difficult. This was particularly true for Tier 3 level teachers. One Director explained his challenge replacing a Tier 3 teacher mid-year, "Her replacement was Tier 3 education level…as we get more Tier 3 people it is a challenge to maintain." PFA sites in rural areas of the county particularly noted difficulty recruiting qualified personnel due to long commute times.

- **Participation.** One of the success stories of PFA in San Diego is that it has a diverse system of providers – including school based, Headstart, private, family care and faith based centers. In this area, the SDPFA project is regarded as a model demonstration project around the state. Although PFA recruited diverse providers in Year 1, participation was noted as a challenge due to limited involvement of FCC providers and lack of site type diversity within regions. There has been some improvement in participation; however, challenges remain. In Year 1 and 2, PFA did not meet its target for the number of children served. This fiscal year, the program served 90% of its target population, and last year the program served 69.4% of its target population. In Year 1, only three of the six regions had providers from the three different site types. This year; however, four of the six regions had providers from all three site types. Despite the increased parent choice, a smaller percentage of slots were located at FCC sites than last year. Last year, 2.5% of PFA slots were located in FCC sites, while this year even fewer slots, 1.8%, were located in FCC sites. Currently, 17 providers have pending applications or have submitted letters of intent to participate in PFA in FY 2008-08, and 11 of these are FCC providers. First 5 San Diego and SDCOE continue to work together to include a diverse range of preschool providers in each region.

- **PFA Assessments**. Some PFA Directors felt there was a disconnect between preparing children for kindergarten and performing well on PFA assessments, particularly the ECERS. Some directors desire more emphasis on children's educational outcomes, as opposed to environmental measures. One director asked, "You can have perfect scores on ECERS, but how do we know that [the children are] ready for kindergarten?" Some directors believe the coaching services should be aimed at increasing student outcomes, not on improving ECERS scores.

- **Sustainability.** Many PFA Directors expressed concern about losing PFA funding. They saw universal preschool as a need for many children in their communities, and were worried about what would happen to those children if PFA was discontinued. The uncertainty about PFA's future also made at least one director hesitant about making changes in her current program, "If you go through a lot of work and make changes, but [PFA] doesn't stick around, what's the point of making a long-term change?"

Update on Recommendations from FY 2006-07

The following actions were recommended in First 5 San Diego's Annual Evaluation Report. First 5 and SDCOE made the following changes to address these recommendations.

Recommendation 1: First 5 San Diego and SDCOE should work together to coordinate administrative requirements.

Update: First 5 San Diego created a Provider Evaluation Committee, attended by staff from First 5, PFA providers, SDCOE, and Harder+Company. The group meets quarterly to discuss evaluation-related requirements including reporting and data collection requirements and timelines. The Committee is also a forum where directors can share their ideas about how to improve the evaluation. In year 2, SDCOE staff created better reporting templates with clearer instructions. Providers also received requirements before preschool sessions began.

Recommendation 2: Continue to improve classroom quality.

Update: The professional development coaches worked closely with teachers this year to help improve classroom quality. The implementation of the CLASS tool helped to ensure that PFA classrooms continue to excel even once they have reached the level of PFA Quality (Tier 3). This tool is administered only at Tier 3 level classrooms and measures teacher-student interaction.

Recommendation 3: Encourage collaboration between PFA providers and First 5 Initiatives.

Update: Like last fiscal year, most providers did not know if the agencies they worked with were funded by First 5, although it is likely that they are. In order to promote collaboration, the PFA and Healthy Development Services (HDS) Leadership Teams have shared membership; one member of the PFA Leadership Team is also a member of the HDS Leadership Team. Although this helps to raise awareness of collaborative opportunities among leadership, First 5 and SDCOE could continue to raise awareness among providers about collaboration opportunities with other First 5 Initiatives; especially within FCC providers. School and non-school -based providers already have numerous partnerships within the community to meet students' needs.

Recommendation 4: Improve screening and referral processes.

Update: Last fiscal year, approximately 15.9% of children at PFA sites were screened for developmental delays. This fiscal year, approximately 75.4% of children were screened. Additionally, the response rates for both the PEDS and the ASQ were much higher this fiscal year. This fiscal year, 79.7% of distributed PEDS were retuned, compared to69.1% last fiscal year. Similarly, this fiscal year, 74.5% of distributed ASQs were retuned, compared to 23.3% last fiscal year. Overall, the screening process has improved, with more children being screened.

Recommendation 5: Continue to provide families with choices.

Update: Last year, the evaluation report recommended that SDCOE assist sites who have submitted letter of intent with meeting PFA quality standards. This year the professional development SDCOE coaching team worked with PFA Tier 1-3 level sites, as well as designated "pre-entry sites," to help ensure these sites meet PFA standards in the coming year. SDCOE should continue this practice in order to increase the choices available to families.

Recommendations

The following recommendations were developed based on the second full year of PFA implementation.

- **Expanding the Focus on Special Needs.** Early identification of special needs and treatment of mild to moderate delays is a cornerstone of First 5 San Diego. Data from this year show two areas that need to be addressed. Screening for special needs should be universal. In FY 2007-08, screenings improved substantially, but were still only 74.5% (as performed through the PEDS survey). This is an area for further improvement. Additionally, the PEDS instrument, which relies upon self-reporting by parents, may not be the best tool for the PFA population. The overall result is that fewer than 11% of children in PFA programs (those screened and not screened) received services for a developmental delay. Data from HDS and CDC figures suggest that this figure should be closer to 20%, given the population served. Ensuring true universal screening and improving the identification and treatment of children with developmental delays should be a priority for this year. In addition, it is unclear why the number of children qualifying for IEPs dropped by 26% in FY 2007-08, when both the number of children enrolled increased 21% and the number of screenings increased by nearly 60%. This warrants additional investigation.

- **Continue to Offer Professional Development Opportunities.** The professional development coaching team should continue to work with teachers, expanding their focus and providing increased support. Overall, teachers were satisfied with the assistance provided by the professional development coaching team. Teachers appreciated the professional relationship they had with their coach and felt supported in their work as a teacher. Many teachers expressed the desire to receive additional individual and group coaching, but did not know whether or not it was available. Meanwhile, directors noted that they wanted the coaches to focus on child outcomes versus scores on tools. Although the professional development team often provides materials and resources for classrooms, they could focus more on this, and provide ongoing support to teachers even once the review process is complete. In addition, more information could be shared about the overall approach of First 5 programs – focusing on the whole child and family -- and also the connection between some of the assessments and child outcomes.

- **Expand Connections**. First 5 and SDCOE should increase efforts to connect PFA providers, especially FCC providers, to other First 5 Initiatives. A new resource for teachers and providers is the new "warmline" (1-888-5First5), which connects callers to special operators at 211 San Diego who have been trained on First 5 programs and other resources serving young families in this area. In addition, SDCOE is well positioned to take a leadership role in building better connections between preschool and the K-12 system could facilitate connecting preschool teachers to kindergartens. Like last fiscal year, the majority of PFA teachers do not have extensive interaction with kindergarten teachers. First 5 and/or SDCOE could notify PFA providers of opportunities for their teachers to attend trainings with kindergarten teachers. Additionally, they could sponsor a training to provide a space for kindergarten and preschool teachers to interact. Along with facilitating connections between preschool and kindergarten teachers,

- **Identify Ways to Increase Parent Engagement.** SDCOE and PFA providers could identify ways to increase parent engagement given that parents who participated in preschool activities showed a greater increase in parenting skills than those who did not. In particular, those who attended parenting classes reported the largest increase in skills and confidence as a parent. Parent education could be increased through offering more classes at various times throughout the day or through distributing class-related materials to all parents even if they cannot attend classes. In addition, parents noted that the smallest

increase in managing behavior issues with children. Special efforts could be made to increase class offerings to parents in this area.

- **Improving Data Collection.** PFA is a demonstration project, funded for five years by the Commission to create a platform and demonstrate to the public and policymakers the importance of quality early education. As such, the data collection and evaluation are critical to this project. Response rates need to be improved for the DRDP, the PEDS and the parent survey. This was the first year of implementing some data collection protocols, which affected data collection especially the DRDP. This should be resolved this year as the consent process becomes part of initial registration. There needs to be additional improvements in ensuring data is collected in all areas and response rates for the PEDS (74.5%) and the Parenting Survey (43%) are improved. One solution is to have teachers administer a screening for children whose parents do not complete a PEDS.

- **Work to Sustain Programs Over Time.** PFA funding is dedicated through 2011. Key to sustainability is advocating for recognition of the importance of preschool, and securing a stable funding stream for the continuation of PFA. Promoting funding for universal preschool in California is highlighted in the PFA Master Plan for San Diego County and is supported by the community base that developed the Plan. In addition, SDCOE and its partners should continue to look for opportunities to develop additional funding opportunities to sustain this project beyond First 5 San Diego. Although there are few funding sources that are available to directly fund preschool sites, there may be opportunities to leverage opportunities with the local school districts, such as using some Title I funds for preschool, or to identify new funding streams through local foundations.

A Final Word on the Preschool for All Demonstration Project

During the second year of the Preschool for All Demonstration Project, 2,113 slots were provided for children in the six target communities to receive a quality preschool experience. The San Diego County Office of Education worked closely with school-based, non-school-based, and family 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, administering the CLASS, and through support provided by the professional development coaching team. In addition, parents were offered numerous opportunities to participate in their child's education by volunteering in the classroom, participating in after school activities, serving on advisory committees, and attending parent education classes. Some of the challenges from the previous fiscal year continued to be challenges this year, such as limited family care provider participation and maintaining a qualified workforce; however, many of the challenges associated with the start-up phase of the project are no longer as significant an issue. The second year of PFA resulted in many achievements such as a significant increase in mean DRDP-R scores from Fall to Spring, an increase in the percentage of teachers with Bachelor's degrees, a high level of parent satisfaction, and an expansion of quality preschool throughout San Diego County. Preschool for All will be expanding into two new communities in FY 2008-09 – Vista and the Mountain Empire area. This is a testament to the program and its reputation in the San Diego community.

Case Study 5
Learning for Your Kids*

Dina's Full House

Dina has lived in San Diego for the last 18 years. She has seven children, with three under the age of 5 years. After the birth of her youngest children, twin boys, Dina attended a class at North County Health Services (NCHS) that educated mothers about the benefits of breastfeeding. After attending this class, Dina was contacted by a NCHS parent educator who was recruiting parents for a new series of First 5 San Diego funded parent education classes. These classes launched a long standing relationship between Dina and NCHS that saw her youngest daughter, Kylee, off to kindergarten and has helped her with her twin boys.

Classes for Everyone

Over the course of the six classes, Dina was offered information about how to address behavioral issues with her children, how to manage stress related to parenting, and how to seek out and attain resources from both NCHS and other community agencies. The sessions offered Dina a space for her to express typical parenting anxieties, while having an informed parent educator available to orient her on how to autonomously tackle those concerns. Upon completing the six class series, Dina, with a new sense of confidence, sought information about other services being offered through NCHS. It was then that Dina became aware of the numerous interactive parent-child classes offered. NCHS offers parents of children ages 0-5 years classes from an array of topics, such as music and movement, arts and crafts, and outdoor play. Dina feels that her participation in these classes prepared her children for kindergarten and contributed to their independence as well as their calm and appropriate behavior at school.

"…They told me they were giving the classes every given day of the week. And I came and I grabbed a calendar and that was how I started to come to classes."
- Dina, First 5 Parent

Over the last several years, Dina has routinely picked up a monthly NCHS calendar, which forecasts classes for that entire month and she proactively enlists in the parenting classes of interest to her. Dina regularly attends classes four to five times a week and takes classes she can apply to her family. "[I try to] learn about what they teach…and put it into practice," Dina affirmed. One class, in particular, teaches positive discipline and she has been able to apply these lessons to her children. Dina has found the program to be very accommodating with staff asking her for input on class topics. "When we first arrived, they gave little pieces of paper on Fridays and asked for suggestions about what one wanted to see more of at the center," Dina said. Based on Dina's suggestions, the program has held classes on nutrition and emergency preparedness for families with young children.

One of the important outcomes of her participation at NCHS has been that she has learned how to accommodate her children's preferences, which she feels are different from other children who have not participated in educational classes. Dina presents her children with toys and activities that inspire their curiosity and are attuned to their preferences. She recognizes now that 4-year-old Kylee does not have fun with dolls. Instead, she likes to feel the surface of shaving cream on glass windows and "she likes to paint, use clay, [and] crafts," she said. Dina recognized that her children's exposure to these sorts of toys and activities has positive influences on their physical and cognitive development. Dina highlights this fact by stating that Kylee has picked up on skills that will prepare her for school, such as using scissors and feeling comfortable in a classroom setting. She recently began to bring her young niece to the weekly classes, thinking that she too could benefit.

Connecting to Other Programs

During her interaction with NCHS, Dina has also been connected to another First 5 funded agency, Children's Care Connection (C3), which offers similar classes for parents. Dina now feels that she does not need to attend classes at another center because she is satisfied with the classes offered at NCHS.

Expectations Met

Dina feels that Kylee's participation in these programs has given her the opportunity to learn things that other girls her age do not know. Dina has seen real outcomes in Kylee. "…What I had achieved with her is that she's real independent," she said. Kylee has shown improved social skills and a sense of independence, such as dressing herself and being able to do many things by herself that her friends are unable to do. Dina also notices these same attributes with her twin boys. Because of NCHS, Dina feels that she is a confident parent who understands that help is available if, and when, she needs it.

**All names were changed to protect confidentiality*

CHAPTER 6

First 5 for Parents Project

" [First 5 for Parents] helped me as a parent, looking from the outside in, realizing that doing more interaction with your children… and even just playing a game can be a learning tool for them to carry with them on their future years."

—F5FP Parent

Key Results

+ **Findings indicate high levels of parental knowledge on most commonly measured indicators.** Nearly all parents demonstrated knowledge of the benefits of playing with children, talking to their children before they are able to articulate words, reading aloud to their children, and facilitating the child's play with other children of the same age. Additionally, nearly all parents demonstrated knowledge of the lifelong benefits of nutrition and exercise, as well as the link between parents modeling healthy behaviors and their children adopting those behaviors.

+ **Findings suggest that incremental changes in behavior occurred according to several commonly measured indicators.** Positive behavior change was observed with respect to: increasing the number of days parents read to their children, telling stories or singing songs, engaging in physical activity; increasing the number of days that children engage in physical activity; and decreasing the number of hours that children watch television, play video games, or spend time on the computer.

+ **Parents reported increased confidence in their parenting skills.** Parents reported higher levels of confidence in their ability to raise, discipline, and help their children learn, as well as make decisions about the services their children need.

Summing It Up

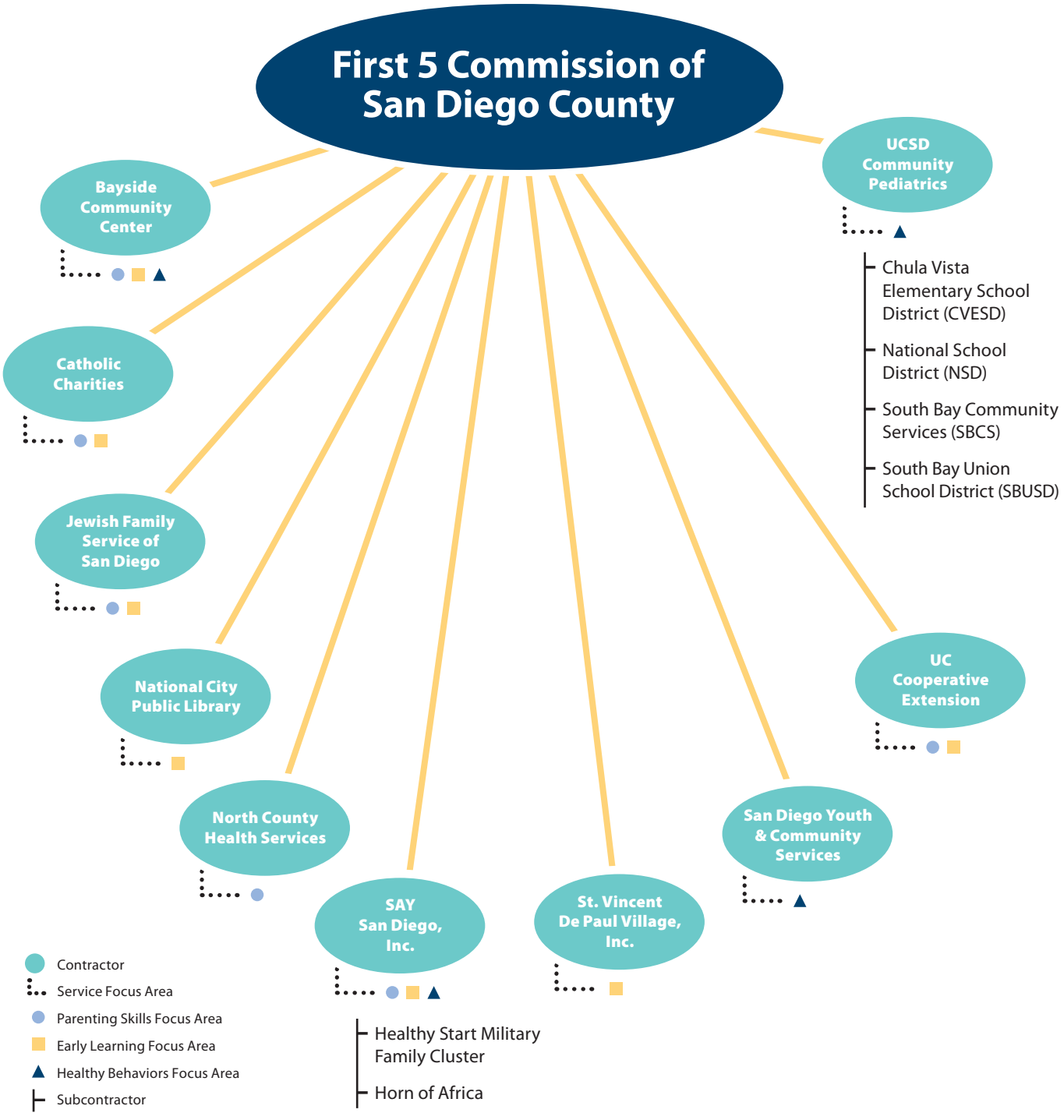
+ Approximately 4,622 parents and approximately 17,234 children ages 0-5 years were served by First 5 for Parents contractors in FY 2007-08, an increase of 1,281 parents and 7,344 children served from the previous fiscal year.

+ 6,038 home visits were made, an increase of 3,671 from the previous fiscal year.

+ 5,332 classes were held, an increase of 3,277 from the previous fiscal year.

+ 1,122 workshops were held, an increase of 484 from the previous fiscal year.

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."[219] 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.[220]

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."[221] 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.

To support parents in their important role, First 5 San Diego developed the Parent Development Initiative (see textbox at right) and launched the "First 5 for Parents" Project (F5P) in March 2006, allocating up to $7.63 million dollars over a three-year

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. Information from parents, providers, key informants, Commission staff and the Commission's Technical and Professional Advisory Committee (TPAC) was gathered and synthesized by Nash & Associates. The consultants also conducted a review of parent development activities, best practices and model programs of First 5 Commissions across the state as well as model programs across the country. Results and recommendations from this study were presented to the Commission in June 2008. See the "Making the Connection" section for findings.

[219] 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.

[220] Weiss, Heather, Margaret Caspe, and M. Elena Lopez. Family Involvement in Early Childhood Education. Cambridge: Harvard Family Research Project, 2006.

[221] "Healthy Youth!," 2007, Centers for Disease Control and Prevention, 9 September 2007 <http://www.cdc.gov/HealthyYouth/overweight/index.htm>.

period. F5P supports the Commission's vision that *every child enters 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.*[222]

The First 5 for Parents Project provides direct services to parents. Since the inception of the project in March 2006, First 5 for Parents has touched over 8,000 parents/participants and over 27,000 children. In two years, First 5 for Parents has offered 8,405 home visits, 7,387 classes and 1,760 workshops to parents/caregivers in each of the six county regions.

Key Elements

First 5 for Parents seeks to strengthen parents' knowledge and encourage behavior change in three Service Focus Areas:

1. Developing more effective parenting skills (Service Focus Area 1)
2. Promoting children's early learning and early literacy development (Service Focus Area 2)
3. Fostering healthier behaviors with proper nutrition and exercise (Service Focus Area 3)

To this end, ten 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 6.1).
- ***Different audiences:*** In launching First 5 for Parents, the Commission asked potential contractors to consider the needs of single parents, fathers, parents in immigrant families, parents with lower literacy levels and 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 years.
- ***Different curricula:*** The Commission requires contractors to employ curricula that are evidenced-based or are promising practices to meet the needs of parents and participants.[223] However, since programs address different Service Focus Areas and different audiences, they do not use the same, or even similar, curricula.

[222] First 5 for Parents falls under the Commission's Strategic Plan Issue 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.

[223] 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 6.1).[224] The intensity of service varies greatly. A parent may participate in a drop-in workshop for a total of less than one hour, or could take part in a class that meets for 90 minutes per week for three months and that offers follow-up home visits for six months after completing the class.

Exhibit 6.1 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

Summing It Up

FY 2007-08 marked the second year for First 5 for Parents. During the first year, 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. By the start of the second year, programs had already begun enrolling parents and offering services; the significant increase in the number of participants served and service units offered reflects this.

[224] 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.

- ***Increased number of parents/participants:*** In FY 2007-2008 First 5 for Parents reached 74.3% more children ages 0-5 years and 37.9% more parents/caregivers (see Exhibit 6.2).[225] The number of senior volunteers refers to the seniors participating as mentors and in other capacities in programs with an intergenerational component. It is of note that in some cases, parents may participate in multiple First 5 for Parents funded programs at the same agency. There may be some clients that are duplicated in the child and parent counts.
- ***Increased number of home visits, classes and workshops:*** As Exhibit 6.3 indicates, contractors offered more services in FY 2007-08. These included a range from light touch services such as drop-in classes, to weekly classes for several weeks to home visits over several months. Some offer both light touch and intensive services (see Exhibit 6.1).
- ***English language learners predominate:*** The majority of parent/participants speak a language other than English at home (67.4%). These languages include Spanish, Arabic, Chinese, Japanese, Kirundi, Somali, Swahili and Vietnamese.

Exhibit 6.2 Number of Participants

	FY 2006-2007	FY 2007-2008
Total children 0-5*	9,890	17,234
Children 0-2	5,170	6,492
Children 3-5	4,720	10,742
Parents/caregivers*	3,381	4,662
Senior Volunteers**	36	46

**In some cases, parents can participate in multiple programs at the same agency. There may be some clients that are duplicated in the child and parent counts. Additionally, one contractor offers a two-program sequence in which the first program is a prerequisite to the second; to avoid duplication the number of parents/caregivers served in the second class was omitted from the total number of parents/caregivers served.*
***Four contractors' programs use intergenerational service delivery models*

Exhibit 6.3 Number of Service Units by Type of Service

	FY 2006-2007	FY 2007-2008
Home visits *	2,367	6,038
Classes **	2,055	5,332
Workshops ***	638	1,122

** Five of 10 contractors offer home visits*
*** Seven of 10 contractors offer classes*
**** Seven of 10 contractors offer workshops*

[225] The total number of parents/caregivers served is based on the number of parents/caregivers who attended at least one class, workshop or home visit; it does not reflect the number who completed the program.

Making a Difference

Given the variety of focus areas addressed – audiences, curricula, and modalities – it was challenging to develop and implement an evaluation to address project and Commission level outcomes, which is also sensitive enough to capture changes among the wide variety of programs. The evaluation methodology and findings from years 1 and 2 are presented in this section.

Creating a Cohesive Evaluation Plan across Diverse 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 the first 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. After a six month pilot, modifications were made, and a revised survey was implemented in July 2007. For comparability across contractors, only results for common survey questions are presented here. (See Appendix B for additional notes on the development of the F5P evaluation).

Limitations of Common Survey Data

- ***Follow-up data are not available for every participant:*** Only data for participants with pre- and post-test survey data (matched cases) are reported here.
- ***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 First 5 for Parents programs through their contracts. 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.
- ***Attendance data is not available for analysis:*** Contractors do not collect individual-level attendance data. Therefore, the evaluation team assumed that matched pre- and post-test surveys indicated that a participant completed the program (and therefore attended the optimal number of classes for that program).
- ***The Common Survey changed between Year 1 and Year 2:*** The Common Survey was revised at the end of FY 2006-07 to strengthen the design after several months of implementation. As a result some questions were eliminated and new questions were added. Wherever possible, comparable data are presented to facilitate comparisons in outcomes between years 1 and 2.

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. [226] The findings in this section present comparable data from years 1 and 2 wherever possible.

Common Survey Results

Findings for selected outcome indicators for Focus Areas 1, 2 and 3 are presented in this section. Harder+Company only included parents with matched pre- and post-test survey data in the analysis of outcomes. Furthermore, individual-level attendance data is not available for analysis. Consequently, for the purposes of analysis, the evaluation team assumed that matched pre- and post-test indicated that the parent not only completed the program, but also attended a sufficient number of classes (referred to as dosage) to reasonably expect an observed knowledge and behavior change at follow-up. It should be noted that the percentage of matched cases for FY 2007-08 was only 30.6% and is not representative of all parents/caregivers served.[227] The relatively low number of matched cases may reflect low retention and program completion rates because parents/caregivers may attend one or more class sessions but miss the survey administration at baseline, follow-up or both.[228] About half (50.3%) of participants who completed a pre-test survey have a matched post-test survey. These percentages suggest that contractors face challenges in ensuring that participants complete the common survey, but they may also suggest that contractors face challenges in retaining clients until the target follow-up period. Beginning in FY 2008-09 contractors will begin tracking individual-level attendance data, program completion rates, and retention rates. These additions will strengthen the evaluation design and enable us to link the amount of exposure to the intervention (dosage) to the observed outcomes measured by the common survey.

Using data from the subsample of participants with matched survey data available, Harder+Company assessed changes from pre- to post-test for over 80 questions on the Year 1 (FY 2006-07) and Year 2 (FY 2007-08) Common Surveys. The results of outcome indicators of particular significance are presented here.

Parents' knowledge of the benefits of parent-child interaction and early learning opportunities (Service Focus Areas 1 & 2)

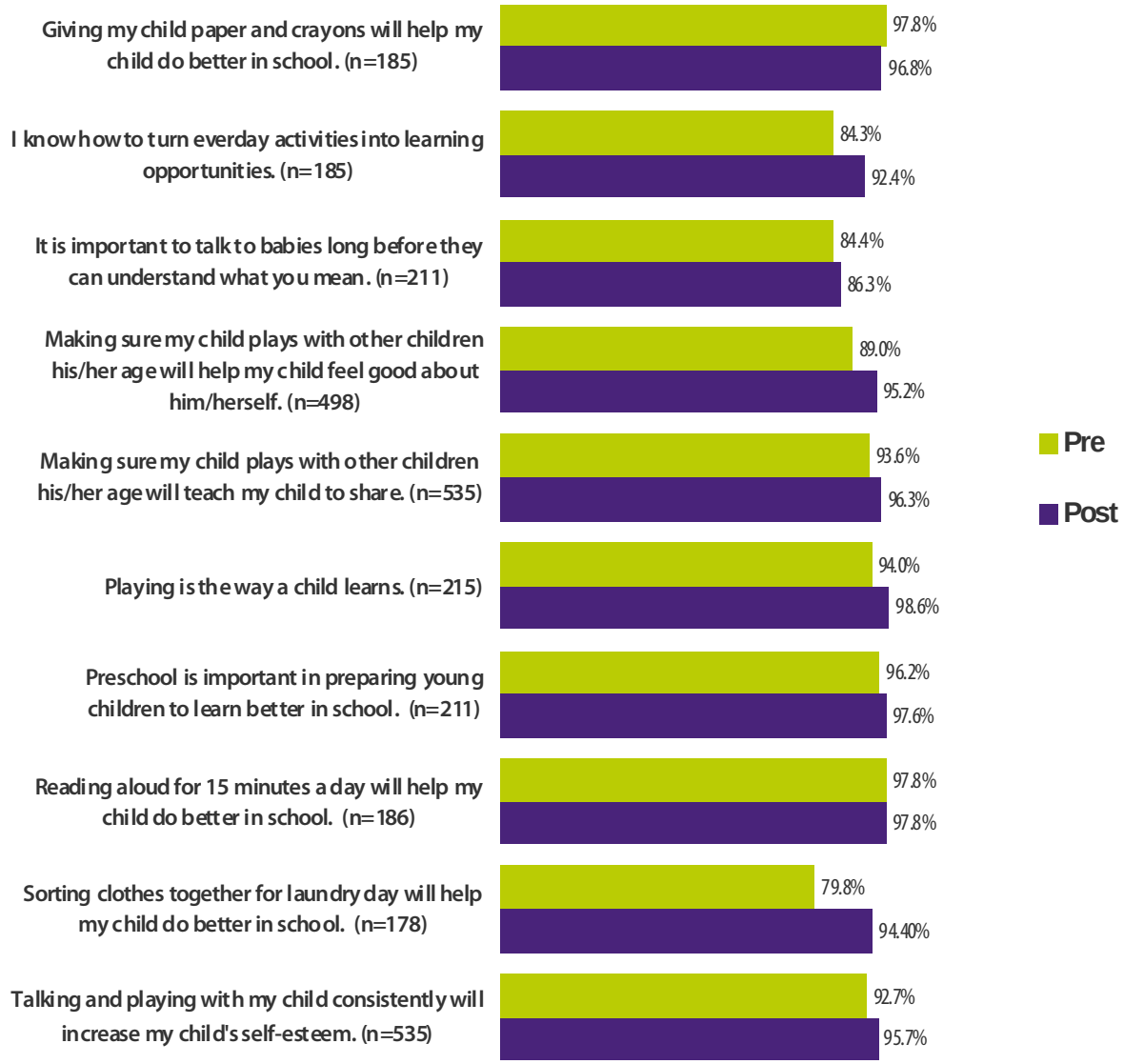
- ***High levels of knowledge of the benefits of parent-child interaction and early learning opportunities:*** In years 1 and 2 nearly all parents demonstrated knowledge of the benefits of playing with their children, talking to their children before they are able to articulate words, reading aloud to their children, and facilitating the child's play with other children his/her age. The results for parents with matched data in FY 2007-08 are presented here. As shown in Exhibit 6.4, gains were noted in all but one knowledge area, though the high levels of knowledge at pre-test precluded significant increases in knowledge at post-test. The more significant changes between pre- and post-test were measured in parent behavior.

[226] 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.

[227] Overall, 60.9% completed a pre-test survey, while only 34.0% completed a post-test survey in FY 2007-08. Of those who completed a pre-test survey, 50.3% had a matched post-test survey.

[228] There may be some parents enrolled late in the year who may not have reached the specified follow-up period to complete the post-test before the end of the fiscal year; however this number was small for parents enrolled in FY2006-07.

Exhibit 6.4 Parents reporting correct responses to questions demonstrating knowledge of the benefits of parent-child interaction and early learning opportunities, FY 2007-08.*



**Includes the valid percent of responses for parents with matched survey data before and after the program.*

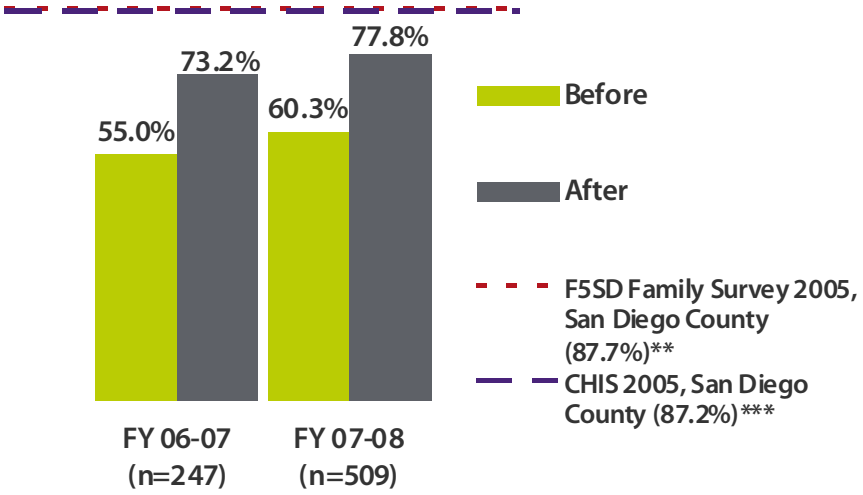
Parents reading to children (Service Focus Areas 1 & 2)

- ***Improvement in frequency of reading to children:*** In both years, parents demonstrated an increase in the number of days that they read to their children. Findings from the 2005 First 5 San Diego Family Survey and the 2005 UCLA CHIS survey demonstrate that just under 90% of parents of children under age 6 in San Diego County read to their children three or more days per week. Most parents served by Parent Ed agencies read to their children much less frequently when they started the programs. However, at post-test approximately three-quarters of parents reported reading to their children three or more days in a typical week, indicating a substantial improvement (see Exhibit 6.5).

"A lot of my parents, since they have never been read to, they have learned to like reading to their kids ."

-First 5 Provider

Exhibit 6.5 Parents who read to their children 3 or more days in a typical week.*



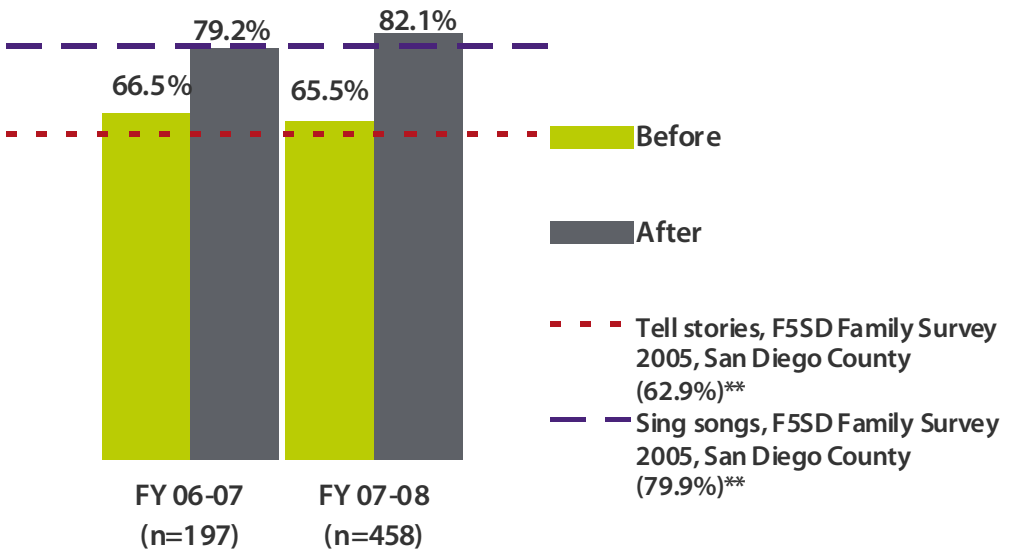
**Includes the valid percent of responses for parents with matched survey data before and after the program.*
***Source: First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.*
****Source: UCLA. California Health Interview Survey (CHIS) 2005.Accessed 10 Sept. 2007. Available at http://www.chis.ucla.edu/*

Note: CHIS asked about the number of days per week parents read to children (age 0-5 years). The Family Survey asked about the number of times parents read to children in a typical week. F5P SURVEY asked about number of days in a typical week.

Parents telling stories or singing songs (Service Focus Area 1)

- ***Improvement in frequency of telling stories or singing songs with children:*** In both years, parents demonstrated an increase in the number of days that they tell stories or sing songs with their children. Findings from the 2005 First 5 San Diego Family Survey suggest that just under two-thirds of parents in San Diego County tell their children stories three or more times per week, while just under 80% sing songs with their children three or more times per week. Most parents served by First 5 for Parents contractors reported engaging in these activities somewhat less frequently at pre-test, but nearly all had met or exceeded these benchmarks at post-test (see Exhibit 6.6).

Exhibit 6.6 Parents who tell their children stories or sing songs 3 or more days in a typical week.*



**Includes the valid percent of responses for parents with matched survey data before and after the program.*
***Source: First 5 San Diego. Family Survey Report. San Diego, CA: Author, 2005.*

Note: The First 5 San Diego Family Survey asked questions about telling stories and singing songs separately. F5P SURVEY asked about them together. The Family Survey asked about the number of times parents told stories or sang songs in a typical week. F5P SURVEY asked about number of days in a typical week.

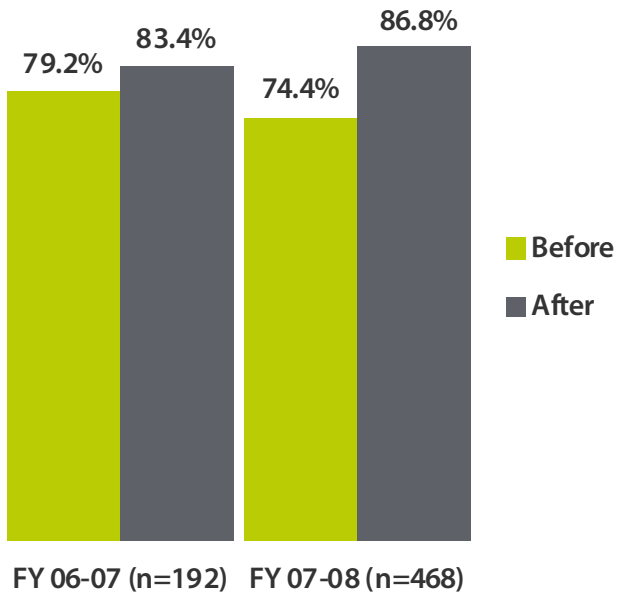
Parents playing with children (Service Focus Area 1)

- ***High frequency of playing with children:*** Approximately three-quarters of parents reported playing with their children three or more days per week at pre-test. There was an increase in the percentage reporting the same at post-test; however, the high rates at pre-test precluded substantial improvement.

"[The program] keeps me inspired to keep teaching my kids."

– SDF5 Parent

Exhibit 6.7 Parents who play with their children 3 or more days in a typical week.*



**Includes the valid percent of responses for parents with matched survey data before and after the program.*

Parents' confidence in their parenting skills (Service Focus Areas 1 & 2)

- ***Significant improvement in parents' confidence in their parenting skills:*** Parents indicated a significant, positive increase in confidence on all measured items in both years (Exhibit 6.8). On average parents begin programs with somewhat low levels of confidence in their parenting skills (range of 0 as low to 6 as high), but demonstrate significant improvement by the end of the program.

"It gives [parents] a feeling of empowerment because now it's education for them; they are being told about what's right for development."

Exhibit 6.8 Parents' Confidence in their Parenting Skills, FY 2007-08**

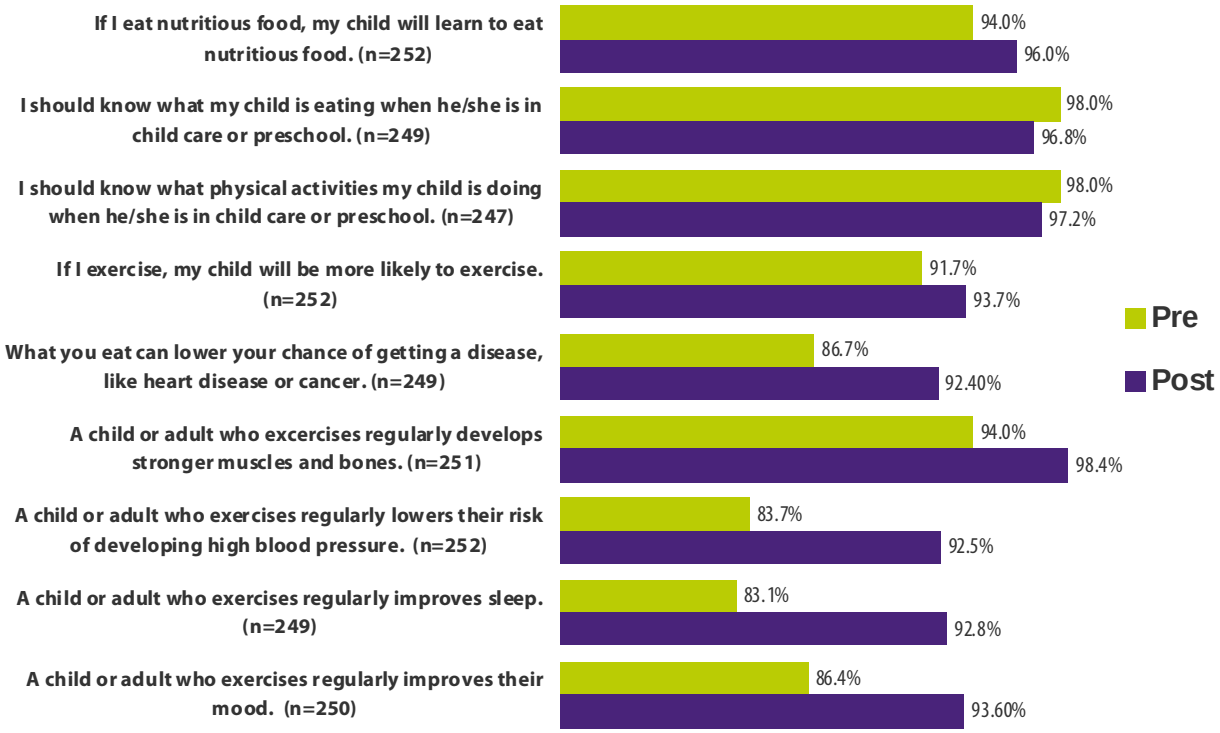
Survey Item	Mean "Then" (Before Program)	Mean "Now" (After Program)	Mean Difference	Mean Difference FY 2006-07***
I am confident that I know what is right for my child. (n=483)	3.34	5.35	2.01*	0.76*
I am confident in my ability to handle the day-to-day challenges of raising my child. (n=484)	3.33	5.25	1.92*	0.87*
I am confident in my ability to discipline my child. (n=479)	3.34	5.28	1.94*	1.02*
I am confident in my ability to help my children learn. (n=482)	3.58	5.43	1.85*	0.94*
I am confident in my ability to make decisions about the services my child needs. (n=480)	3.78	5.42	1.65*	n/a

**Significant at the p≤0.05 and p≤0.01 levels.*
*** Includes the valid number of responses for parents with matched survey data before and after the program.*
****In FY 2007-08, questions about parental confidence before and after the program were asked only at the end of the program on the post-test survey. In FY 2006-07, these questions were asked separately at pre- and post-test; therefore, the results are not precisely comparable due to the change in the timing of administration of the questions.*

Parents' knowledge of the benefits of nutrition and exercise (Service Focus Area 3)

- ***High levels of knowledge of the benefits of good nutrition and regular exercise, including lifelong benefits:*** In years 1 and 2, nearly all parents demonstrated knowledge of the link between parents modeling healthy behaviors and their children adopting those behaviors (such as exercise for lowering risk of disease). The results for parents with matched data in FY 2007-08 are presented here. As shown in Exhibit 6.9, the high levels of knowledge at pre-test precluded significant increases in knowledge at post-test.

Exhibit 6.9 Parents reporting correct responses on questions that demonstrate knowledge of the benefits of nutrition and exercise at baseline and follow-up, FY 2007-08.*



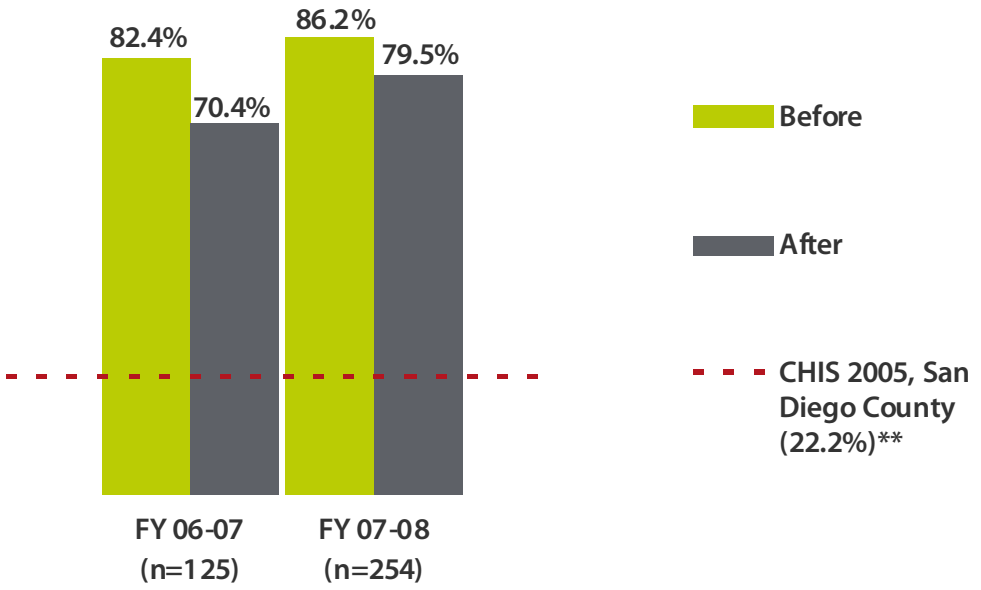
*Includes the valid percent of responses for parents with matched survey data before and after the program.

Eating fast food

- ***Little improvement in decreasing fast food consumption:*** In both years, a very high percentage of parents reported eating fast food at least once in a typical week at pre and post. County comparison data from the 2005 UCLA CHIS offers a benchmark for how many residents with children ages 2-5 years reported eating a fast food meal on the previous day (22.2%). Although the reference periods are different, a much higher percentage of parents served by First 5 for Parents report eating fast food. There was no significant change in fast food consumption at post-test. This finding held when the analysis was restricted to FY 2007-08 data, which asked parents to report the number of days (from 0 to 7) that they eat fast food in a typical week, rather than in broad categories. Usually a range of values is a more sensitive measure of small changes in behavior than categorical responses; however, a difference in means test restricted to FY 2007-08 parents showed no significant change at post.

> **"I want to eat better now, too, 'cause I know what the food is doing to me, and I know more about health."**
>
> **- First 5 Parent**

Exhibit 6.10 Parents who reported that their families eat meals out at fast food restaurants at least one day in a typical week.*



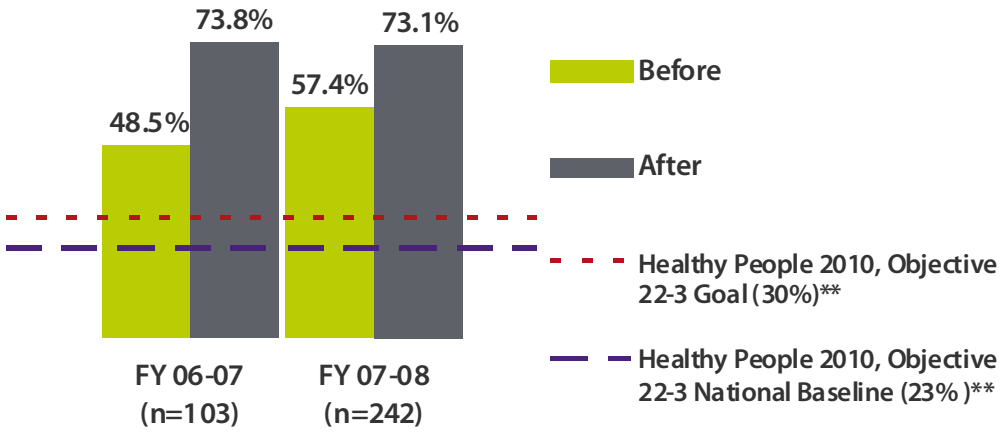
**Includes the valid percent of responses for parents with matched survey data before and after the program.*
*** Percentage of respondents with children ages 2-5 who reported eating fast food one or more times on the previous day.*
Source: UCLA. California Health Interview Survey (CHIS) 2005.Accessed 26 Sept. 2007. Available at http://www.chis.ucla.edu/

***Note: CHIS asked how many times respondent had eaten fast food on the previous day. F5P SURVEY asked the number of days that the family eats fast food at breakfast, lunch or dinner in a typical week.*

Physical activity of parents and children (Service Focus Area 3)

- ***Parents increased the frequency of their physical activity:*** Parents reported significant increases in the number of days in a typical week when they engage in physical activity that makes them sweat or breathe hard for at least 20 minutes. In addition, the percentage of parents reporting that they engage in such physical activity 3 or more days in a typical week substantially exceeds the Healthy People 2010 Goal and National Baseline for frequency of comparable exercise at pre- and post-test in both years (see Exhibit 6.11). One of the Healthy People 2010 Physical Activity and Fitness Goals is that 30% of U.S. adults will participate in "vigorous physical activity that promotes the development and maintenance of cardio respiratory fitness for at least 20 minutes per day 3 or more days per week" (Objective 22-3). The Healthy People 2010 National Baseline indicates that 23% of U.S. adults participate in "vigorous physical activity that promotes the development and maintenance of cardio respiratory fitness for at least 20 minutes per day 3 or more days per week". The goal and national baseline data is comparable to the measure used in the First 5 for Parents Common Survey.

Exhibit 6.11 Parents who reported participating in physical activity for at least 20 minutes (that makes them sweat or breathe hard) 3 or more days in a typical week.*

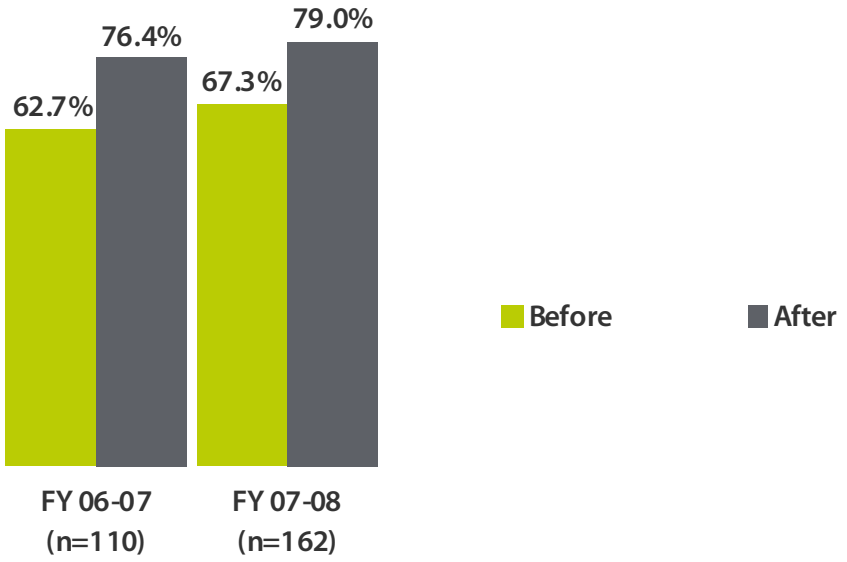


**Includes the valid percent of responses for parents with matched survey data before and after the program.*
*** The Healthy People 2010, Objective 22-3 Goal is that 30% of U.S. adults will participate in "vigorous physical activity that promotes the development and maintenance of cardio respiratory fitness for at least 20 minutes per day 3 or more days per week". Source: Healthy People 2010, Physical Activity and Fitness Indicators. Accessed 25 Sept. 2008. Available at http://www.healthypeople.gov/*

***Note: The Healthy People 2010 Objective 22-3 Goal is stated in terms of " vigorous physical activity that promotes the development and maintenance of cardio respiratory fitness" for at least 20 minutes per day 3 or more days per week. PE Common Survey asked respondents how many days in a typical week that they participate in physical activity for at least 20 minutes that makes them "sweat or breathe hard".*

- ***Children exercise more often than their parents do:*** At pre-test, approximately two-thirds of parents reporting on behalf of a children ages 2-5 years indicated that their children engaged in physical activity for at least 10 minutes 5 or more days per week. This data suggests that children engage in physical activity at substantially higher rates than their parents do.[229] Given the relatively high frequency of physical activity of children by this measure, there was only moderate room for improvement between pre- and post-test.

Exhibit 6.12 Parents who reported that children ages 2-5 participated in physical activity for at least 10 minutes at a time 5 or more days in a typical week.*



**Includes the valid percent of responses for parents with matched survey data before and after the program.*

- ***On average parents and children ages 2-5 years increased the number of days that they engage in physical activity by half a day:*** The average number of days that parents and children engage in physical activity showed statistically significant improvement at post-test (see Exhibit 6.13). On average at post-test, parents responded that they increased the average number of days that they engage in physical activity in a typical week by 0.50 days. At pre-test, parents on average engaged in physical activity 3 days per week.[230] Given that behavior change often happens in small increments and the average number of days of physical activity was already high for parents served compared to national benchmarks, an increase of half a day is a noteworthy improvement. Parents reporting on behalf of children ages 2-5 years similarly indicated an increase of 0.59 days that children engage in physical activity between pre- and post-test.

[229] The duration of physical activity specified in the question is lower for children than parents and the level of intensity is not specified.

[230] Analysis was restricted to parents who completed the FY 2007-08 Common Survey. Parents answered questions by specifying a range of days (0-7 days).

Exhibit 6.13 Number of days in a typical week that parents and children ages 2-5 years participate in physical activity, FY 2007-08**

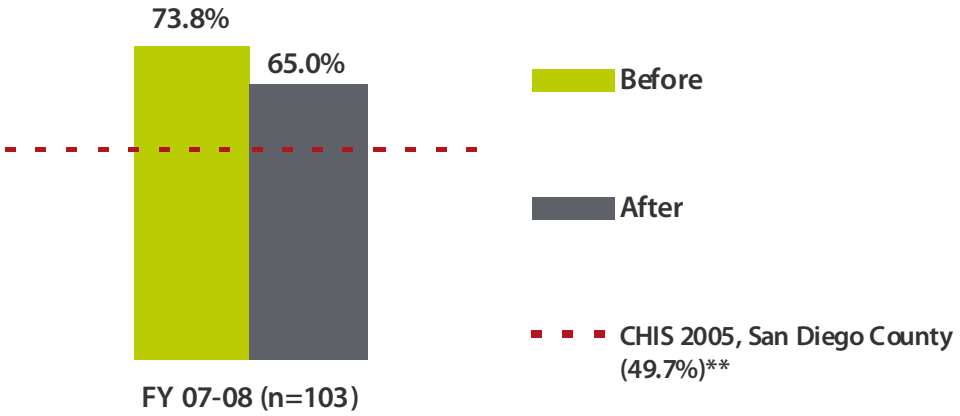
Survey Item	Pre	Post	Mean Difference	Mean Difference FY 2006-07***
Number of days in a typical week that parent participates in physical activity for at least 20 minutes that makes him/her sweat or breathe hard. (n=242)	3.02	3.52	0.50*	1.33*
Number of days in a typical week that children ages 2-5 years participates in physical activity for at least 10 minutes at a time. (n=162)	5.25	5.85	0.59*	n/a**

**Significant at the p≤0.05 and p≤0.01 levels.*
*** Includes the valid number of responses for parents with matched survey data before and after the program.*
****In FY 07-08, the questions about physical activity of parents and children ages 2-5 asked for the number of days that parents/children participated in physical activity in a typical week. In FY06-07, only the parents were asked for the number of days. Responses for child physical activity were in categories that cannot be used to compare means in the present analysis.*

Amount of time children spend watching television (Service Focus Area 3)

- ***Children spend a large amount of time watching television, playing video games, and/or spending time on the computer:*** Nearly all parents reported that their young children watch television, play video games, and/or spend time on the computer on a typical weekday in both years. In FY 2007-08, a follow-up question was added to the Common Survey that asked parents reporting on behalf of children ages 3-5 years to indicate the number of hours that the child engaged in these activities. This addition provides a more sensitive measure of change. Of those who reported engaging in these activities on a typical weekday in FY 2007-08, approximately three-quarters reported the child engaged in these activities for 2 or more hours on a typical weekday.

Exhibit 6.14 Percentage of children ages 3-5 who watch television, play video games and/or spend time on the computer for 2 or more hours on a typical weekday, FY 2007-08.*



**Includes the valid percent of responses for parents with children ages 3-5 years with matched survey data before and after the program. In FY 07-08, if parents reported that their children watch television, play video games and/or spend time on the computer on a typical weekday, then they were asked to report the number of hours that the child spends on a typical weekday. This follow-up question was not asked in FY 06-07 so no data is available for FY 06-07 for this analysis.*

*** Percentage of parents with children ages 3-5 reporting that children watch television for 2 or more hours on weekdays. Source: UCLA. California Health Interview Survey (CHIS) 2005.Accessed 26 Sept. 2007. Available at http://www.chis.ucla.edu/*

***Note: CHIS asked the amount of television that children age 3-5 watch on weekdays. F5P SURVEY asked parents to report the number of hours that their children watch television, play video games and/or spend time on the computer on a typical weekday.*

- ***Although children continue to watch television, play video games, and/or spend time on the computer at follow-up, the number of hours significantly decreased:*** When restricting the analysis to matched cases available for the FY 2007-08 survey, the average 0.71 difference in mean hours indicates a statistically significant decrease in the number of hours that children ages 3-5 years engage in these activities at post-test.

Exhibit 6.15 Number of hours children ages 3-5 years watch television, play video games and/or spend time on the computer on a typical weekday, FY 2007-08**

Survey Item	Pre	Post	Mean Difference	Mean Difference FY 2006-07***
Number of hours children ages 3-5 years watch television, play video games and/or spend time on the computer on a typical weekday. (n=103)	2.68	1.97	-0.71*	n/a

*Significant at the p≤0.05 and p≤0.01 levels.
** Includes the valid number of responses for parents with matched survey data before and after the program.
***In FY 2007-08, if parents reported that their children watch television, play video games and/or spend time on the computer on a typical weekday, then they were asked to report the number of hours that the child spends on a typical weekday. This follow-up question was not asked in FY 2006-07; therefore, no data is available for FY 2006-07 for this analysis.

General findings

The following findings outline some of the overarching trends that emerged from the data or through observations of the First 5 for Parents implementation process.

- ***Knowledge versus Behavior:*** Part of the F5P Survey measured parents' knowledge of the benefits of parent-child interaction, early learning opportunities for children and the lifelong benefits of good nutrition and exercise. Responses were high at baseline, so there was not substantial improvement in knowledge. As the data indicate, knowledge itself is not sufficient to generate behavior change. Survey change on behavior change did show more improvement pre- and post-test.

- ***Incremental Changes in Behavior:*** The FY 2007-08 Common Survey was significantly strengthened to ask parents to report the number of days and hours that behaviors of interest occur, rather than asking parents to choose from predetermined frequency categories. This change has increased the sensitivity of the measures of behavior change, which is very important to adequately capture changes that occur, particularly in the case

"…I see progress in my kids' child care with how they can pick their colors, they understand words, they can see a picture and name the picture, so it's definitely been a positive progress for my two children…"

First 5 Parent

of behaviors that are difficult to modify such as eating and exercise habits. The Common Survey results highlighted here suggest that small increments of behavior change have occurred with respect to several indicators, including increases in the number of days parents read to their children, tell stories or sing songs; increases in the frequency that parents engage in physical activity; increases in the number of days that children engage in physical activity; and decreases in the number of hours that children watch television, play video games and/or spend time on the computer.

- ***Adopting and Adapting Curricula:*** 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 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.

Making the Connection

The findings from the 2007 Parent Development Initiative Study (see textbox at right) echoed the findings from last year's interviews with key experts, suggesting that community leaders in early childhood sectors were not yet fully aware of First 5 for Parents. In response to recommendations last year, First 5 for Parents contractors have begun to promote their programs to parents and other First 5 San Diego contractors. First 5 for Parents contractors have increased their linkages with service providers contracted to provide developmental screenings as part of the Healthy Development Services Initiative (described in Chapter 3) and have begun actively referring their clients to these providers for routine developmental screenings. There is a continued need to further enhance linkages and facilitate referrals across First 5 San Diego initiatives.

The 2007 Parent Development Initiative Study also indicated that many parents are not aware of parent development services and/or have the perception that what exists is not relevant to them. The study also indicated that barriers to accessing services exist for many parents, including lack of child care during parenting classes, lack of access to transportation, not enough classes offered at night or on the weekends when parents are available, and lack of classes in languages other than English and Spanish. To address these barriers and enhance participation, the Commission offered additional funding of up to $10,000 to each of the First 5 for Parents contracts to implement and evaluate strategies to improve access. Results of these efforts will be available at the end of FY 2008-09.

Parent Development Initiative Study Recommendations & Results

In May 2007 the Commission contracted a study to identify additional parent development strategies as part of a process to expand the initiative, including community strengthening and awareness; provider training and capacity building; and systems change and development.

Results and recommendations from this study were presented to the Commission in June 2008. Recommendations include the following[1]:

- Develop and support activities that address barriers to access, including allocation of funds to offer child care during parenting classes and produce culturally specific outreach materials;
- Implement education campaigns that impact parent behavior and community norms;
- Support parent leadership and engagement;
- Strengthen the capacity of parent educators;
- Use technology to its full potential.

As a result of these recommendations, the Commission plans to implement the following activities in FY 2008-09:

- Enhance the First 5 San Diego website to serve as a resource for parents;
- Develop and implement a program to promote child and family friendly business practices among San Diego County employers;
- Increase access to and improve awareness of existing parent development resources and services;
- Develop and coordinate activities providing professional development and support of parent educators.

[1]*Parent Development Initiative: Opportunities and Recommendations, Executive Summary, Nash & Associates, January 2008.*

Update on Recommendations from FY 2006-07

Last year, Harder+Company made the following recommendations to improve the First 5 for Parents Project and facilitate learning across contractors. The findings of the 2007 Parent Development Initiative Study highlighted some of the challenges mentioned and suggested possible causes for barriers to access and retention. A summary of the progress to date on these recommendations is discussed below.

Recommendation 1: Link First 5 for Parents programs to other programs and initiatives.
Update: As noted in the Making the Connection section, last year's interviews with key experts suggested that community leaders in early childhood sectors were not yet fully aware of First 5 for Parents, and there was a need to promote First 5 for Parents programs to parents and community leaders. In response, this year First 5 for Parents contractors have cultivated linkages with service providers funded through the Healthy Development Services Initiative and referred their clients to providers who offer routine developmental screenings. Although progress has been made toward integrating First 5 for Parents into the wider network of First 5 San Diego services, continued efforts in this area are needed.

Recommendation 2: Learn from the wide base of existing curricula and narrow the focus in the future.

Update: As noted last year, 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 engenders the opportunity to examine the curricula and methods used and create a learning community among First 5 for Parents contractors. 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. Now that matched data for a sample of clients is available to review, the Commission could facilitate dialogue and generate recommendations for new parent development services in this area.

Recommendation 3: Extend programming to a more ethnically and linguistically diverse audience.

Update: One of the aims of the project at its start was to engage immigrant parents. As noted last year, contractors have successfully engaged parents from Latino populations, but are serving other immigrants to a much lesser extent. There continues to be an important opportunity to expand services to underserved immigrant populations, while maintaining services for Latino families. The findings from the 2007 Parent Development Initiative Study highlighted cultural and linguistic barriers to accessing parent development services, including a lack of classes offered in languages other than English and Spanish and the need to develop culturally specific outreach materials. To address these needs, the Commission offered additional funding of up to $10,000 to each of the First 5 for Parents contractors to implement and evaluate strategies to improve access that became effective in April 2008. The results of these efforts will be available at the close of FY 2008-09.

Recommendations

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

- **Improve linkages with other First 5 San Diego programs and initiatives**. This year First 5 for Parents contractors have worked to better integrate their clients into the Healthy Development Services Initiative's spectrum of services. There is opportunity to continue building these linkages and referral networks. Additionally, Parent Education classes could provide an effective vehicle for linking parents with very young children to Oral Health Initiative providers and services. As suggested last year, there are a number of opportunities First 5 for Parent contractors could take to enhance participation in their programs by drawing on the network of services funded by First 5 San Diego. For example, the 2007 Parent Development Initiative study noted that many parents and providers are not aware of 211 San Diego, which is an information and referral line for health and human services. First 5 for Parents contractors could partner with 211 to maximize outreach to parents and appropriate referrals to parenting programs. Similarly, teachers in School Readiness and Preschool for All programs could be contacted and encouraged to provide parents with information on First 5 for Parents classes. In the coming year, First 5 for Parents contractors will continue to promote their programs to parents and other First 5 contractors across First 5 San Diego initiatives.
- **Facilitate learning communities to explore the efficacy of evidence-based interventions that have been modified and/or adapted to meet the needs of multiple immigrant populations who often speak languages other than English or Spanish**. Several contractors provide services to multiple immigrant populations, often in languages other than English or Spanish. As a result, all of the First 5 for Parents contractors have adapted or combined evidence-based curricula to meet the needs of their clientele. The results of the 2007 Parent Development Initiative Study reflected these realities and noted that agencies in San Diego working with immigrants and parents who speak languages other than English or Spanish often have to modify and/or adapt evidence-based curricula to meet the needs of their target groups, with whom the curricula have not previously been tested. The study also noted that parents who speak languages other than English or Spanish often have the perception that agencies do not have the capacity to serve them in their native tongue (even though agencies report that they do have this capacity), a finding which may shed light on barriers to access and problems with retention that have been observed. In anticipation of the final year of the First 5 for Parents Project, the Commission could facilitate a learning community to address the lessons learned in this process of modification/adaptation and explore which evidence-based curricula have been the most flexible and effective with a variety of immigrant populations in San Diego County.
- **Facilitate learning among agency partners about effective recruitment, retention and incentives for completion of program activities as designed**. Now in its third year, First 5 for Parents contractors have much experience and insight to offer one another. As part of the proposed learning community, the Commission could facilitate dialogue about effective recruitment, retention, and incentives for completion of programs. The barriers to accessing parent development services noted in the 2007 Parent Development Initiative Study may be contributing to low retention rates and low program completion rates suggested by the relatively low percentage of matched data available in both years. The Commission could host a special learning community at the end of FY 2008-09 to share the results and impact of the additional resources allocated for this fiscal year to improve outreach and access across contractors. Retention and program completion continue to be challenges that agencies face, and the shared knowledge and expertise could

help to improve the number of participants who successfully complete all program activities and demonstrate improvement at follow-up assessment.

A Final Word on the First 5 for Parents Project

Although creating a common evaluation across disparate programs has been a challenge, this year's report indicates that improvement on several core outcome indicators has been achieved across contractors. As the First 5 for Parents project enters its third year, the Commission will be reflecting on the successes and challenges of its first major effort to provide direct services to parents of children ages 0-5 years through the Parent Education Project. To this end, the Commission funded the 2007 Parent Development Initiative study to explore ways to better meet the needs of parents and has already begun to respond to its findings released in January 2008. The successes and challenges of the First 5 for Parents Project to date will provide rich information and experience to inform strategies to provide parent development services going forward.

Case Study 6
An Angel Extends a Helping Hand*

Vivian's First Child

When Vivian gave birth to her first child, Eddie, the hospital contacted Rady Children's Hospital Home Care (Rady), which provides newborn home visits. Shortly thereafter, Vivian was offered a home visit through First 5 San Diego's Healthy Development Services (HDS) project. After Vivian and Eddie had been home for about a week, she decided to take Rady up on their home visit offer: "…I didn't know everything about how to take care of the baby because I'm a first-time mom….And it's a big help, really, it's a big help." But unfortunately Vivian had no way of knowing that she would be returning to the hospital in the middle of her first "home visit."

A Home Visit Cut Short

Vivian calls Elaine, the "angel of my baby" because after Eddie was discharged from the hospital he got sick. Vivian received a call from Elaine, a home visitor from Rady, checking in on Eddie's status. When Elaine found out that Eddie was sick she decided to drop by Vivian's house. Once Elaine arrived, she and Vivian began talking and within five minutes of their conversation, Vivian noticed that Eddie was unconscious. "His lips were blue-violet and he [was] just like a vegetable; he [didn't] move." Elaine took control and realized that Eddie had no heartbeat and called 911. Meanwhile, while they waited for the ambulance, Elaine performed CPR and Eddie began breathing again.

Eddie was taken to the hospital and transferred to the Intensive Care Unit where he received numerous tests and was sedated for one week. Vivian initially received differing opinions on Eddie's condition and diagnosis, but she finally learned that he had a reflux condition in which the milk he consumes automatically comes back up from his stomach. Elaine continually checked in on Eddie and Vivian while they were in the hospital. When Eddie was released from the hospital, Vivian was able to learn from Elaine different ways to handle Eddie's condition. "She just [taught] me how to feed the baby…the proper way to incline him," Vivian said. "He needs to be inside every time I feed him, and then after I feed him…the burping is very important." With these teachings, Vivian was able to avoid a potential surgery for Eddie's condition.

Healthy Development Visits

Vivian has received a total of two visits from Rady, the first was when she was rushed to the hospital with Eddie and the second took place at her house after Eddie was discharged – when he was one month old (these are called At-Risk Home Visitations, provided by the HDS providers). During the first visit, Elaine had the opportunity to speak to Vivian about her experience as a mom and also her experience about her baby [who] has a reflux. During the second visit, Elaine presented, and explained, the Kit for New Parents to Vivian (this kit is a project funded by First 5 San Diego). During this visit, Elaine recorded some general physical development information. "She just [checked] my baby's weight, his length," Vivian recalled. "She gave me this book…she told me I can read it to my baby to help his brain development."

"Actually, I'm satisfied because almost all of my questions have been answered, so I don't need to ask, they just give me the information, they just feed me the information that I need."

- Vivian, First 5 Parent

Lessons Learned

From the Kit, Vivian learned about child development and baby care topics, such as brain development, baby earwax, sore throats, and burping a baby. Elaine also taught Vivian the proper incline position, how to obtain the baby's temperature, how to feed the baby, as well as how to use the sanitizer when holding Eddie and exposing him to sunlight. Vivian now gives Eddie a sponge bath so that he does not sit in water for a long period of time to avoid a cough or cold.

Eddie and Vivian Now

Vivian is thankful for Eddie's condition. He has not gotten sick again. "He's doing good," Vivian said. "He's healthy, and he's starting to gain weight now." In a couple of months, Eddie will be 3 months old and Vivian hopes that his reflux will be gone.

"I'm just…always thanking [Elaine] and thanking the program and everything because it's fantastic."

- Vivian, First 5 Parent

Vivian has experienced much in the first month of her son's birth and from the information that Rady has provided, she has taken away many valuable lessons. "…Being a parent is a process that you can't learn it right on the spot," Vivian said. Rady has provided Vivian with knowledge and hands-on assistance that will enable her to care for Eddie for many years to come.

**All names were changed to protect confidentiality*

CHAPTER 7

Non-Initiative Contractors and Activities

"We know that what happens in the first five years of a child's life has a huge amount of influence on everything that happens afterwards."

—Ed Balls, British Secretary of State, Department of Children, Schools and Families

The primary efforts of the Commission are accomplished through its large-scale long term initiatives. However, the Commission also supports a limited number of non-initiative contractors that provide needed services in the community. It selects and funds non-initiative contractors according to five funding strategies: 1) providing a local match to State First 5 individual contractor projects; 2) supporting projects of county-wide importance; 3) utilizing Responsive Funds to invest in projects that target emerging needs in the community; 4) funding new direct service approaches or techniques that support early childhood development through Innovative Grants, and 5) supporting infrastructural enhancements for children's services through their Capital Campaign project. This chapter reviews the contributions of these non-initiative First 5 contractors that enhance systems of care for young children and families and 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 (Kit) has been a flagship program of First 5 California since its launch in 2001. The Kit contains DVDs, 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,[231] with over 272,811 distributed in San Diego County alone.[232] Locally, the Kit is distributed by UCSD Regional Perinatal System's Welcome Baby Program (WBP), which enhances the Kit by including San Diego specific resources and provides training using the *Creating Teachable Moments* curriculum (CMT). WBP also provides distribution support to over 800 local agencies, such as clinics, hospitals and resource centers, that in turn issue the Kits to the parents they typically serve. The Kit is available in English, Spanish and Chinese (Mandarin).

***Completely Revised Kit for New Parents**

The number of Kits distributed in San Diego County increased by almost 18,000 between FY 2006-07 (total of 47, 361) and FY 2007-08 (total of 65,207). This increase was largely due to the release of the new Kit in English

[231] First 5 California. "Kit for New Parents Q & A." Accessed 2 September 2008. <http://www.ccfc.ca.gov/kit/documents/QA.DOC>

[232] Advanced Logistics Operations Manufacturing (ALOM) Database. Accessed September 2008. <https://www.ccfc.alom.com>

and Spanish with much anticipated new items.[233] Released in spring of 2007, the Kit has been completely revised and updated to include the latest early childhood development information, new content, user-friendly improvements, a fresh look and technical upgrades.[234] It now contains DVDs (instead of VHS), a developmental guide book divided by ages and stages for ease of reference, 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. As one partner stated, "It's very useful because it offers parents alternative solutions rather than a bunch of don'ts." [235]

"It's not just about getting them out, but making sure they're being effectively used."

- Kit Distributor

The success of the Kit program is not only evident in the number of kits distributed annually and in the number of partnerships the Kit for New Parents includes, but also in the program's ability to maintain long-term community partnerships. In FY 2007-08, WBP shifted its focus from recruitment of new community partners to retention and maintenance of existing partnerships within the community. According to the FY2007-08 Quarterly Progress Report, Kit for New Parents maintained 90% of their partners throughout the year. This high rate of retention was achieved through WBP site visits, emails, and phone calls to established partners in order to inquire whether or not the Kit is still being offered, identify any obstacles the partner may experience when distributing the Kit, and to offer support to the partner. WBP also held thirteen primarily on-site training sessions – three of them in Spanish – surpassing their training goal of eight for FY 2007-08. Partners that participated in the training program strongly recommended that all partners distributing the Kit should be trained to increase the partner's ability to engage parents more effectively in using the information in the Kit. [236]

This year, WBP held provider focus groups to discuss successes, challenges, and best practices for Kit distribution.[237] The groups' topics and recommendations are listed in Table 1. WBP has used the information received from the focus groups to create a stronger, more efficient program.

[233] Communication with Amy Chatten, Welcome Baby Program Coordinator, UCSD Regional Perinatal System, 7 October 2008.

[234] First 5 California. "Kit for New Parents Q & A." Accessed 2 September 2008. <http://www.ccfc.ca.gov/kit/documents/QA.DOC>

[235] First 5 San Diego. "Best Practices and Challenges to Kit Distribution Focus Group Evaluation Project." San Diego Welcome Baby: Kit for New Parents Newsletter. May 2008. Issue 7.

[236] First 5 San Diego. "Best Practices and Challenges to Kit Distribution Focus Group Evaluation Project." San Diego Welcome Baby: Kit for New Parents Newsletter. May 2008. Issue 7.

[237] First 5 San Diego. "Best Practices and Challenges to Kit Distribution Focus Group Evaluation Project." San Diego Welcome Baby: Kit for New Parents Newsletter. May 2008. Issue 7.

Exhibit 7.1: Topics and Recommendations Discussed at the WBP Focus Group
Hospitals- Show video clips from the Kit during the patients' stay at the hospital.
Clinics- Give the Kit to mothers during pregnancy. It was suggested that the best time for a parent to receive the Kit is during the 1st trimester, as it allows the parent to have more time to look at the Kit's content before the baby is born.
Case Managers/Home Visiting Nurses- Use the Kit as a storage device. One case manager shared that the parents continue to use the Kit to store all the baby's important papers, thus making it a keepsake
Educators- Partners who have participated in the CTM (Creating Teachable Moments) training program strongly recommend that all partners distributing the Kit should be trained. This training enhances the Partner's ability to engage the parents more effectively in using the information in the Kit.
Social Services- Encourage mothers to host a Welcome Baby party. These "parties" are at the home of the mother with a DVD player to watch video segments and provide support for one another.
Librarians- Providers can encourage low-literacy parents to watch the DVD and have an older child read the materials with them. Participants also suggested incorporating the Kit into a literacy program
** First 5 San Diego. "Best Practices and Challenges to Kit Distribution Focus Group Evaluation Project." San Diego Welcome Baby: Kit for New Parents Newsletter.. May 2008. Issue 7.*

An identified challenge in previous years of the program was the lack of communication between Kit coordinators of different counties. This fiscal year, Kit Coordinators held a meeting at the First 5 State Conference and connected further through a Southern Region conference call. Coordinators spoke about issues both unique to their counties and shared between counties. At the First 5 State Conference, Kit coordinators across the State also made an effort to sit down in a structured meeting environment to discuss their experiences and focus group findings.

What to Do When Your Child Gets Sick: Training the Trainers Curriculum-CHIP

The Community Health Improvement Partners (CHIP) is a non-profit collaborative organization of 30 San Diego Hospitals, health plans, community clinics, physicians, universities, community based organizations, and the County of San Diego Health and Human Services Agency. Under the general oversight of CHIP's Access to Care Work Team, the *What to Do When Your Child Gets Sick?* project aims to increase parental education and awareness of child illness. To accomplish this, CHIP developed a "Train-the-Trainers" curriculum. The Kit for New Parents and CHIP have built a notable relationship with each other, supporting one another in areas where their two missions overlap, and promoting each other's training. Ultimately, CHIP hopes to reduce the number of unnecessary or inappropriate uses of emergency departments and clinics, as well as the number of days parents miss work and children miss preschool or daycare.

The *What to Do When Your Child Gets Sick?* curriculum is a two-day training program designed to educate 100 "master trainers" from community based organizations, such as those that have Women, Infants and Children (WIC) and Head Start sites throughout the county. In turn, the master trainers will instruct 1,000 parents and caregivers over a two-year period to utilize the *What to Do When Your Child Gets Sick?* book. The book was designed for low-literacy readers, providing easy-to-understand information on more than 50 common childhood medical issues such as fevers, minor scrapes, chicken pox, head lice, etc.

Fiscal Year 2007-08 was a planning year for the *What to Do When Your Child Gets Sick?* program, characterized by outreach efforts and groundwork. One of the main challenges in the past year involved employee turnover – specifically in the curriculum developer and trainer consultant positions. Both are key positions for the development and dissemination of the *What to Do When Your Child Gets Sick?* program. Despite staffing delays, at the end of FY 2007-08 CHIP was prepared to begin their training. As a result of this year of preparation, in FY 2008-09, the project is expected to train a high number of trainers and even a higher number of parents.

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 child care 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 First 5 California.

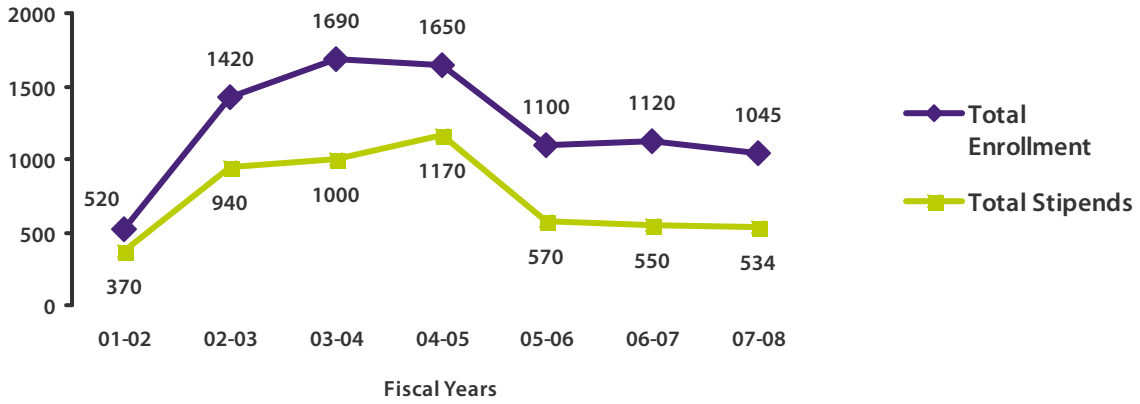
CARES provides stipends to teachers and administrative staff to reward and encourage educational attainment. As redesigned in 2005, CARES participants are assigned to one of the following five tracks to work toward a CARES Stipend: [238]

- 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)

During FY 2007-08, there were approximately 1,045 participants enrolled in CARES. Of those who initially enrolled, 534 (51.1%) completed their coursework and received their stipend. As Exhibit 8.1 illustrates, CARES enrollment increased dramatically in the first three years of the program. From its inception year to its peak in FY 2003-04, there was a 225% increase in enrollment, from 520 to 1,690 respectively. The number of stipends paid also increased during this same period by 63%, from 370 in FY 2001-02 to 1,000 in FY 2003-04. Despite the surge in enrollment seen over the course of the first three years, the number of enrollments began to fall in FY 2004-05.

[238] First 5 California. CARES Training and Technical Assistance Project: About the Project. 2007. Accessed 14 September 2007. <http://cares.w4qcc.org>

Exhibit 7.2 San Diego CARES Participants: Total Enrollment vs. Total Stipends by Year



The History of CARES

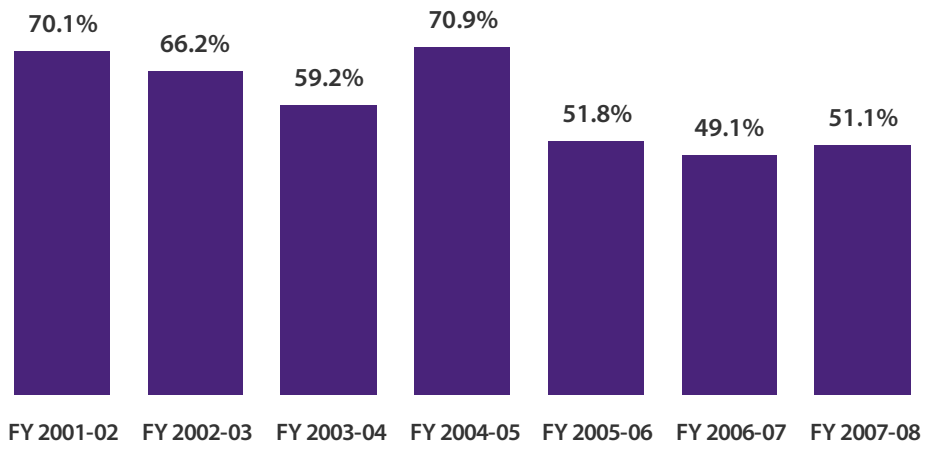
The California Comprehensive Approaches to Raising Educational Standards (CARES) initiative (formerly called *Compensation and Retention Encourage Stability)* originated in 1997 in response to a major child care crisis throughout the State. At that time, child care centers and family child care homes 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 this initiative to increase the number of highly skilled providers and improve staff retention with the use of rewards. Providers were given incentive stipends for pursing early childhood education courses. 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.

In FY 2001-02, First 5 San Diego allocated the 80% match to the State's funds to initiate a CARES program in an effort to improve the continuity and quality of child care in the County. Now in its eighth year across the state, CARES has implemented programmatic modifications in order to increase enrollment rates and stipends awarded. Examples of these modifications include the implementation of a pre-entry track in FY 2003-04, which allowed providers with less than 6 units of coursework to participate. These participants could receive stipends for attending professional training rather than completing college coursework (thereby explaining the spike in enrollment that year). In FY 2005-06, the CARES program model was again modified to create five different tracks (listed above in the main text) and tightened eligibility requirements for reimbursement (thereby explaining the decrease in enrollment and stipends). During FY 2007-08, CARES increased the number of units Permit and Degree participants can complete towards their stipend to 12 units. Those who fulfill 12 units of college coursework toward their approved degree or higher level permit are now eligible for a $3,000 stipend (an increase from the previous maximum of 9 units with a $2,250 stipend). Additional modifications include the reintroduction of Permit Stipends at Year 4 level and the introduction of a $250 stipend to Permit and Degree participants who fulfilled Environmental Rating Scale (ERS) requirements. To encourage the utilization of an ERS by track participants, the stipend offered to CARES advisors who assist others in the ERS process increased to $100. Further modifications to the CARES model will continue with the intent of increasing program participation and completion in the coming years.

Source: First 5 California. CARES Training and Technical Assistance Project: CARES History. 2007. <http://cares.w4qcc.org>

In looking at program completion rates over time (the number of enrolled participants who received a stipend), an interesting trend emerges (see Exhibit 8.2). Up to FY 2004-05, program completion rates ranged from 59% to 70%, while from FY 2005-06 to the current year, completion rates hovered around 50%. These changes in enrollment and stipends paid are likely due to programmatic modifications over time, which are discussed in further detail in the "History of CARES" text box (page 202). However, it is of note that the rate of completion of the program is relatively low. The graph below shows the enrollment to stipend receipt ratio of San Diego CARES participants since its inception year.

Exhibit 7.3 San Diego CARES Completion Rates by Year



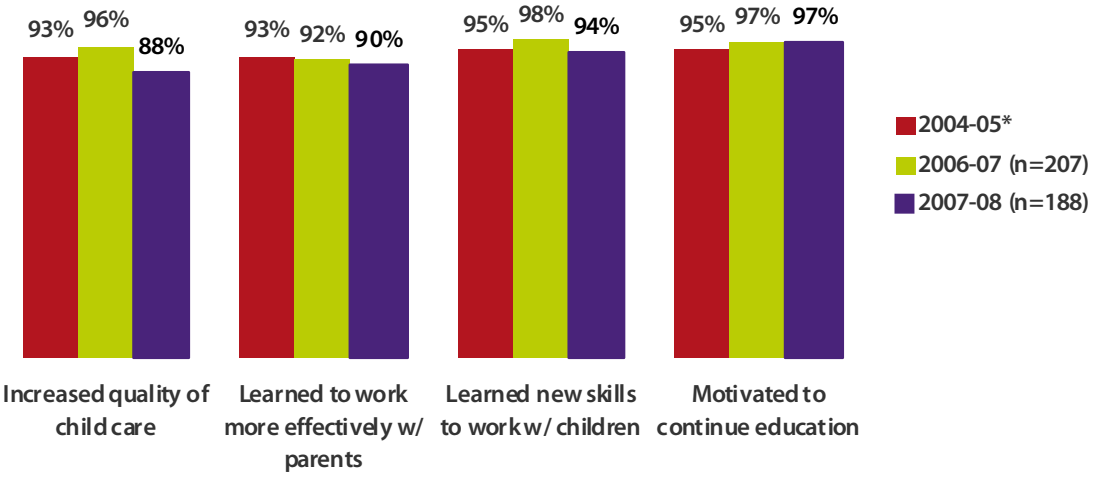
Participants continue to express overall satisfaction with their experience with the CARES program. This year's participation satisfaction survey found that a majority of CARES participants continue to give San Diego CARES high ratings in terms of how the program has affected their ability to: provide quality child care, effectively work with parents, learn new skills in working with children and stay motivated to continue their education (see Exhibit 8.3). [239] Recent participant surveys revealed that 98% of survey participants were satisfied with services received by San Diego CARES staff, an increase from last year's reported 90%. Although most opinions about the program remained positive, about 29% of respondents found completing the program requirements challenging, which contributed to the relatively low enrollment to stipend receipt ratio, as illustrated in Exhibit 8.2. The following are some of the reasons respondents found the program requirements challenging:

- Conflicts with work hours and class schedules
- Lack of class availability
- Cost of registration and books[240]

[239] YMCA Childcare Resource Service Participant Satisfaction Survey Results. San Diego CARES. 2006-2007.
[240] The CARES stipend is issued to a participant after classes are completed. Participants must pay upfront costs.

Even with these challenges, 81% of the respondents felt these difficulties would not impede them from completing the program requirements.[241] Similar to last year's suggestions, participants shared that more weekend and evening classes at colleges near their residence, as well as the availability of more online classes, would increase their ability to complete their course work and receive their stipend.

Exhibit 7.4 San Diego CARES Participants' Perceptions by Year



**The total number of respondents was not available.*

211 San Diego: Information and Referral Service

211 is the national dialing code for information about community health and disaster services, and also offers callers personalized information by a live phone specialist regarding a variety of nonprofit services and agencies. Locally, 211 is available 24 hours per day, 7 days per week, and plays a critical role in the community. For example, during the 2007 wildfires, 211 answered 11,000 calls per day and 120,000 calls total during the course of the fires linking people to critical needed services. First 5 San Diego has been the primary financial supporter of San Diego County's 211 information and referral service since 2003. First 5 San Diego's funding has broadened community awareness of the service, increased call handling capacity, and provided ease-of-access to First 5-funded service providers throughout the County. This fiscal year, the ease of accessing First 5 San Diego funded services was enhanced through the implementation of a "warmline" established within the 211 network. This warmline is a direct number (1-888-5-First5) that was included in a broad-based community awareness campaign to provide parents and caregivers a direct line to First 5 funded services information and referral.

"211 was a tremendous service to the public and removed a lot of calls that would have otherwise gone to 911."

- Board of Supervisor Greg Cox, speaking of 211's role in the 2007 wildfires

http://www.nctimes.com/articles/2008/02/26/news/top_stories/1_45_022_25_08.txt

[241] Ibid.

During FY 2007-08, 211 assisted a total of 162,857 callers in finding needed health and social services, 24% (n=38,696) had a child aged 0-5 years. According to a recent "snapshot" of 211 callers, 54% of those callers eligible for First 5 services were calling 211 for the first time. Of those callers, approximately 72% indicated that 211 was the first number they tried. In total, 211 made 27,385 referrals to First 5 funded programs in FY 2007-08. Ultimately, callers are offered referrals, to both First 5 and non-First 5 funded agencies, that address numerous needs including child abuse prevention, basic needs (e.g. food and shelter), legal services, disaster relief, physical and mental health services, parenting programs and employment assistance.

In an effort to gain a better understanding of the quality of services provided by 211, an annual Client Satisfaction Survey was conducted in FY 2007-08. A total of 352 callers agreed to participate in this survey.[242] Of those callers who participated in the survey, 99% of respondents said the 211 representative they spoke to understood their needs, 99% noted the service was helpful (87% saying "very" and 12% "somewhat" helpful), and 90% noted that they have a better understanding of the help that is available to them. Overall, 99% of survey participants said they would call 211 again and 98% would recommend 211 to someone else.

Language & Access to 211

211 staff is trained to assist non-English speaking callers by utilizing the Tele-Interpreter telephone translation service. Use of the Tele-Interpreters will ensure:

- Callers receive help at the time of their call regardless of language spoken
- Minimized miscommunication and error due to language and cultural barriers
- 211 services are accessible in all languages – 24-hrs a day, 7-days a week
- Collection of accurate call statistics for reporting purposes

"[There are] very caring and understanding people at 211."

– 211 caller

In an effort to track the entire 211 referral process, participants of the initial survey were asked if they would be willing to participate in a follow up survey 2-3 weeks after their initial call. The survey would determine if those callers were able to utilize the referrals offered to them by 211. Twenty-four percent (n=85) of the originally interviewed callers were reached for a follow up survey during FY 2007-08. Of these respondents, everyone remembered calling 211 (100%), with the majority (98%) reporting that they had received a referral. There was a slight decline from FY 2006-07 to FY 2007-08 in the number of 211 callers that reported having tried to call or visit an agency they were referred to (92% to 89%, respectively). While 11% of participants stated they had not tried to follow up with the referral they received, only 56% of those who followed up on their referral said that the agency they called or visited met their needs. This was a drop from the 64% reported last fiscal year. When asked about their attitude towards 211, respondents overwhelmingly agreed (87%) with the following statement: "As a result of calling 211, I feel more confident to make informed decisions."

[242] The CAPSTONE Group. "211 San Diego Client Satisfaction Evaluation Report: FY0708." San Diego, CA: June 2008.

Beginning in FY 2007-08 First 5 initiated a "secret shopper" evaluation to assist 211 with improving the quality of service referrals. The text box below showcases the "secret shopper" project.

211 San Diego Secret Shopper Project

In FY 2007-08, First 5 issued a Secret Shopper project to enhance the existing 211 evaluation. The Secret Shopper Project allows First 5 to more fully assess the extent to which 211's service benefits callers with children ages 0-5 years and pregnant women with a primary focus on assessing the appropriateness and accuracy of the referrals.[243]

Also known as "mystery shopping", secret shopping is "the practice of using shoppers who have been specially briefed to anonymously evaluate customer service, operations, merchandising, product quality, and in special cases, employee integrity".[244,245] TrendSource Inc. will be subcontracted to complete 1,250 secret shopper phone calls, as well as follow-up phone calls on the referrals provided by the 211 call specialists.[246] Calls will be completed in English and Spanish during business hours and after hours. Data from each secret shopper call is made available to the Commission and 211 within 48 hours of the call via an Internet-based web portal.

Secret shopper calls for the 211 San Diego Secret Shopper project began April 23, 2008 and secret shoppers continue to collect information. While the focus of the questions is on the appropriateness and accuracy of the referral, customer service data is also being collected and used to inform the outcome of this study.

As a partner in this project, 211 is motivated to make programmatic changes in response to the data findings. The Secret Shopper Project is facilitating 211 to continue to work with First 5 in addressing referral appropriateness and accuracy through the development of initiative specific referral pathways. Working under the premise that a caller should be referred to "the right place the first time," the referral pathways will include points at which 211 can administer screening questions to assist callers in obtaining the most appropriate referral for the expressed need.

[243] Accuracy is defined as meeting the caller's needs in terms of the type of service, region/locality and language.

[244] Mystery Shoppers Providers Association of North America; http://www.mysteryshop.org/index-na.php, accessed July 11, 2007

[245] While this project is called "secret shopping" market researchers might call it an "unrevealed survey."

[246] TrendSource®, a leader and innovator in the industry since 1989, is a premier mystery shopping and evaluation firm offering customer experience evaluations (mystery shops), market research, compliance audits, reward programs, competitor shops, pricing audits, business verifications, physical inspections and merchandising.

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 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. [247] 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. [248]

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. During the FY 2007-08, ROR San Diego partnered with San Diego County Libraries, the San Diego City Libraries, Community Clinics, Children's Primary Care Medical Groups, and Native American Health Centers in order to better provide for participating ROR sites. Monies awarded by First 5 San Diego has supported ROR San Diego in expanding their model to new sites and has allowed them to purchase more books to distribute to young children and their families. In FY 2007-08, First 5 San Diego funding allowed ROR San Diego to add ROR to seven new sites, all of which received training, and a reported purchasing of 8,329 books.

Capital and Equipment Grants: Building Critical Infrastructure

As a strategic effort to address the limited funding sources for public and nonprofit agencies, the Commission approved the Capital and Equipment Campaign in FY 2004-05. This one-time expenditure of $60 million dollars was allotted in order to invest in the physical infrastructure of programs that support children ages 0-5 years. Funds are released in three separate cycles each fiscal year. Exhibit 8.4 displays the projects that received funding for capital improvements during FY 2007-08.

Exhibit 7.5
Capital Project and Equipment Grants

Capital Improvements	Use of Funds
Blessed Sacrament Parish Preschool	Improve infrastructure in the preschool and pre-K classrooms.
Borrego Community Health Foundation	Additional exam room with equipment at the Centro Medico.
Casa de Amparo	Purchase playground equipment, furniture for toddler and preschool classrooms, and office furniture for the Child Development and Family Services Center.

[247] reachoutandread.org. 2003-2006. 22 August 2007 < http://www.reachoutandread.org/about.html>.
[248] Needlman R, Klass P, Zuckerman B, "Reach out and get your patients to read," Contemporary Pediatrics (2002) 19:1

Exhibit 7.5 (continued) Capital Project and Equipment Grants	
Community Health Systems (Fallbrook Family Health Center	Equipment for the Women's Health Center to provide state-of-the-art prenatal care.
Jewish Family Service of San Diego	Purchase of a van for the Preschool in the Park Program.
La Maestra Family Clinic	New equipment for three pediatric clinics in City Heights, El Cajon, and National City.
North County Serenity House, Inc.	Refurbish the Child Development Center and purchase computers equipment.
Oceanside Unified School District-LISTOS Center	Expand the children's learning areas by providing additional furniture, equipment, and activities at the LISTOS Center.
Palomar Pomerado North County Health Department, Inc. on behalf of Palomar Pomerado Health	Purchase two new ALGO 3 Newborn Hearing Screeners.
Palomar Pomerado Health	Purchase of computer equipment and a file server needed to implement a new client data collection and interface system for the Welcome Home Baby home visitation program.
Pregnancy Care Center DBA East County Pregnancy Care Clinic (ECPCC)	Purchase of additional medical, exam rooms, and office equipment.
Ridgeview Preschool	Improvements to the gross motor play area of the preschool.
San Diego Youth & Community Services	Improve facilities for adolescent parents and their children 0-5.
Santee School District	Purchase indoor and outdoor equipment for the Children & Families Ready $ School (CFR4S) program.
Southern Indian	Purchase two dental chairs and other dental equipment to equip two pediatric dentists in the clinics.

Exhibit 7.5 (continued) Capital Project and Equipment Grants	
Health Council	
United Cerebral Palsy Association of San Diego County	Purchase a full utility van for use by the staff of the Toy and Software Lending Library to serve children ages 0-5 years.
Vista Community Clinic	Purchase one ultrasound machine, one exam table, six Non-Stress Test monitors and other equipment for pregnant women undergoing testing at several clinic sites.

Innovative Grants: Responding to Emerging Needs and Strategies

The Commission 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 ages 0-5 years 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 seven Innovative Grants that received funding during the FY 2007-08. Each program displayed provided direct services to young children and/or their families.

Exhibit 7.6 Innovative Grants	
Grantee/Program	**Description of Project/Services**
Horn of Africa *Families Together Program*	Families Together Program (FTP) is an affiliate program of Healthy Families America (HFA) a program that will focus on East African families and their children age 0 to 5. FTP provides a comprehensive assessment of the family, and home visiting staff provides weekly home visits to families to implement an individualized plan of care.
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.
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.
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.

Exhibit 7.6 (continued) Innovative Grants	
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.
Riding Emphasizing Individual Needs & Strengths (REINS) San Diego *Therapeutic Consulting Partnership*	Provide therapeutic riding lessons to children with a variety of disabilities.
SDSU Foundation Exceptional Family Resource Center (EFRC) *NICU Family Support Project*	Implements Systematic NICU Referral for Support Protocol, instates a MOU between EFRC and 4 hospitals and identifies families with infants who experienced NICU care.
San Diego Community College Auxiliary Organization/San Diego State University Research	Provides education, practice, and support for fathers of preschool children.
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.
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.
Social Advocates for Youth (SAY) San Diego, Inc. *Talk To Me*	Provide information for parents & community about 1) the importance of building vocabulary early in life; 2) formulating culturally appropriate community awareness strategies on this topic; 3)implementing strategies to help low-income families improve their children's vocabulary levels; & 4) utilizing partnerships and networks to carry the message & engage parents in interactive behaviors with children.
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.
University Of San Diego – *SOLES/COMPASS Family Center Transition Support Program*	The project will help prepare parents to effectively transition from an Individualized Family Service Plan (IFSP) to an Individualized Educational Program (IEP) when their child with special needs reaches the age of 3 years old.

Case Study 7
A Neighbor and a Resource*

Introducing Miriam

Miriam is of Mexican origin and a mother of five active children, three under the age of 5 years, who has lived in San Diego for the last 7 years. One day, about 6 years ago, she contacted Bayside Community Center for help in dealing with an undisclosed problem with a neighbor. Miriam was connected with an individual who provides the guidance she needed to resolve her situation. Since she had children at the time, Bayside offered to connect Miriam to other services for her family, such as an after school program for her children, and lead paint testing. Several years later, when she gave birth to her third child, Beatriz, Bayside began providing monthly in-home parent education, funded by the First 5 San Diego Parents as Teachers program. Miriam came to Bayside because of a troublesome neighbor, but was seamlessly integrated into the services that brought deep benefits to her children.

Connecting to Services

Once her daughter was born, Miriam's parent educator provided her with new information on how to help her daughter's development and growth. A couple of years after Beatriz was born, Miriam welcomed the birth of twins. Miriam now had three children under the age of 5 that were eligible for the First 5 funded services offered at Bayside.

Miriam decided to enroll herself and her children in several First 5 funded parenting education programs at Bayside. She enrolled her children in "Ready to Succeed," a reading program that she felt provided more than just a learning experience. "They read stories to them, teach them, above all, to familiarize [my children] with other kids, to become more sociable," she said. Miriam and her three youngest children attended ten parent-child interaction classes and received a diploma upon completion. These classes also focused on promoting her children's optimal development. Currently, Bayside staff visit the house and provide interactive parent and child education classes using the Parents as Teachers curriculum.** Miriam also learns what to expect of her children's development so that she could help them along the way.

Miriam took the initiative to enroll herself in other parenting education components supported by First 5 San Diego, such as monthly nutrition classes, where she learned how to compliment nutrition with exercise. In all, she has participated in Parents as Teachers (PAT) home visits, development classes focused on cognitive, fine/gross motor, language, and social emotion issues and now attends parenting classes at Bayside with her husband. Miriam applies the lessons she learned and has begun teaching her children at an earlier age so that they are better prepared for preschool.

At Bayside, Miriam also found help with essential needs, as Bayside was able to provide bags of food during the times her family was in need. The program's staff, in particular Mary, was very proactive in arriving at Miriam's house and providing any assistance they could. "…Without me calling her or anything, [she] came to see what was happening and helped me and so I continued with the classes…," she said. Miriam took advantage of some of the other services offered at Bayside, such as being connected to the Healthcare Access Initiative through First 5 when it became financially difficult to maintain her children's private insurance.

Learning at Any Age

Bayside helped Miriam learn the skills she needed as a parent to advocate and provide her children with the necessary skills to be successful in school and health. Miriam would like to continue learning about how "to

better treat her children, to be a better person." Bayside also helped Miriam recognize the importance of education for developing her children's character and future career goals. She hopes for her children to attend a university and achieve a better education. Miriam believes that by motivating her children while they are young, they can develop healthier study habits and increase their potential for doing better in school and ultimately in their future. "And, more than anything else, I would like my kids to have a career," Miriam urged, adding that she wants them to be "good people, good citizens, and good students, honestly." Having three young and active children under the age of 5 years can also be stressful. Miriam learned how to better approach her children and herself in relation to so much activity. As a result, she learned techniques in how to communicate with her children more effectively, working with them one-on-one, and identifying the best approach for each of her children.

Miriam noticed positive results in her children's learning abilities since participating in Bayside, including improved speech and better vocabulary. She noted that her children now think before they speak and are talking at an earlier age. The children are now learning at their age level and are currently learning about colors and the alphabet.

Looking Towards the Future

Miriam plans to continue taking her children to classes to maintain their learning and she plans to continue taking nutrition classes. Miriam has come to see the program as providing valuable assistance in guiding her in discovering her children's abilities and challenges. She is interested in participating in other classes that focus on health, food, and child development to continue to improve as a parent. Miriam feels strongly about advocating not only for her children, but also for the program to people she knows and meets so that they can get the same help she receives. "I want them to have the services, as well, for themselves, so that they'll help their children, because a lot of people need that help and are not aware that there is that help."

"Sometimes I am even talking with women and I'll recommend they go there, to those classes with the kids and to nutrition or whatever it is that they require."
- Miriam, First 5 Parent

**All names were changed to protect confidentiality*
*** An evidence based curriculum*

CHAPTER 8

Making the Connection: An Overview of First 5 San Diego's Approach

" I think that First 5 funds provide an important role in the community. Without it, there's no single voice on the impact on children 0-5 and their families."

—Health Stakeholder

From its inception over a decade ago, the First 5 Commission of San Diego County (First 5 San Diego or the Commission) has held the overarching goal of creating a lasting impact on the children and families of San Diego County. As the only funder in the county that is solely devoted to issues related to children ages 0-5 years, the Commission works to achieve this goal through a systems change vision. As part of this vision, the Commission seeks to encourage collaboration between services, strengthen the connections between existing programs and providers, develop initiatives, and focus funding to fill service gaps. This chapter provides a broad overview of the Commission's achievements and opportunities from FY 2007-08. The current general evaluation was not designed to collect standardized, cross-initiative findings that could be aggregated to a general, systems-level evaluation. Rather, the findings presented in this chapter are based on a meta-analysis of the individual initiative's evaluation results, observations made by the evaluation team over the course of the year, and interviews with key stakeholders in the community.[149]

Enhancing and Connecting Services

The following section highlights the areas in which the Commission has enhanced the systems of care that support San Diego's children ages 0-5 years and their families.

- ***Developing care continuums:*** A number of the initiatives seek to address the care continuum from screening to treatment. For example, the Oral Health Initiative (OHI) and Healthy Development Services (HDS) both were developed to include early identification of issues, further assessment of needs and provision of necessary clinical services to address identified needs. As part of developing care continuums, new strategies have been incorporated into the initiative designs. For example, OHI funds care coordinators that dedicate themselves to ensuring that a child or pregnant woman identified as needing further assessment or treatment receives that service. In addition, both HDS and OHI have developed clear referral pathways and partnership agreements to

"Before [First 5], bonds between San Diego (County) and providers wasn't strong…First 5 has really facilitated that process. They like 'bringing (sic) people to the table' as they say."

- Education Stakeholder

[149] Key stakeholder interviews were conducted in July 2008 of individuals representing the health care and early childhood education fields in San Diego County. Of the twenty-one interviewees, fourteen were from the health care field and seven were from the early childhood education field. See Appendix B for details.

ensure that organizations with a specialization on one point in the continuum connect with organizations at other points in the continuum.

- ***Connecting previously disconnected services and systems:*** First 5 San Diego required many previously disconnected services to collaborate by structuring their RFPs to require lead/subcontractor relationships. This was true of HDS, where the Commission required the lead contractor in each region to submit a proposal that included a minimum of four different partners to provide, with a plan for creating an integrated provider network offering a broad range of developmental services. As a result, some of these HDS regional networks now include over a dozen providers that previously did not work together. This regional approach to establishing service networks has been a springboard for expanding relationships with other existing services, such as the public health nurses (funded through HHSA Maternity and Child Health) and local pediatricians. Another connection that is still being forged is between the health and education providers. In FY 2007-08, more education and health providers were working together than in previous years. For example, School Readiness (SR) contractors referred the children they serve to OHI in light of the AB1433[150]. Also, both SR and Preschool for All (PFA) have begun to more frequently refer children to HDS for mild to moderate developmental issues not generally covered by school district services. There, children are often identified as a result of the First 5 contractual requirement that every core child served in its early care and education programs receive a developmental screening.
- ***Ensuring multiple levels:*** In developing initiatives, the Commission also looks at the needs of children and families from a number of vantage points – including the individual child, parent, provider, and community. As an example, OHI funds direct dental services, parent and provider education, provider capacity (by training general dentists, pediatricians and OBGYN's on the importance of early oral health), and a strong community-wide, public health prevention approach through the Community Water Fluoridation Project.
- ***Providing services to children not served by existing programs and services:*** A number of the initiatives were specifically developed for children who have "fallen through the cracks" in the existing services system. For example, HCA contractors expand their reach to families through subcontracts with key partners in order to reach more families effectively – such as San Diego's many refugee and immigrant communities. PFA provides services for children with family incomes too high for state preschool, but who cannot afford private preschool. Similarly, HDS provides needed services for children with mild to moderate delays, which are delays that frequently go unaddressed because they are not severe enough to be covered by insurance or to qualify for school-based services under IDEA (Individual with Disabilities Education Act), but treatments are too expensive for families to pay out-of-pocket.
- ***Expanding the definition of care for children***: The Commission also strives to redefine how providers think about the services provided to children. Embracing the "whole child" approach that First 5 was built upon, the Commission requires their contractors to expand their vision of how they interact with children. For example, the Commission requires both SR and PFA to ensure all children receive a developmental screening using a standardized tool in addition to the early education and family support activities that the schools are more accustomed to providing. This required early care providers to systematically assess a child's development, make a needed referral and, most importantly, incorporate those initial results into their daily interactions with the children. This last anticipated result has yet to be fully realized in SR and

[150] In September 2006 the California Governor signed Assembly Bill 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).

PFA. In another example, the Healthcare Access Initiative provides "hardship funds" for families who have difficulties paying health care premiums or who have difficulty getting their children to doctor visits due to transportation challenges. The hardship fund ensures that families not only are enrolled in health care, but that they retain this care and access to needed health services.

- ***Increasing the quality of services*:** In a number of initiatives, First 5 has provided funds to implement new standards of care or strategies that have the potential of leaving a lasting effect on these services, long after the provision of First 5 funding. For example, OHI is currently working on implementing a Carries Risk Assessment, a national best practice to assess children's risk for dental carries and improve the tracking of high-risk children to ensure they continue to get the services they need. In this instance, First 5 provided the necessary space for innovation and improvement among the initiative's providers and is supporting the service enhancements needed to implement the new tool. In the case of both PFA and SR, teachers are seeking and finding support (some through the First 5 funded CARES program) to pursue additional or higher education.
- ***Increasing provider awareness and capacity:*** *An important aspect of* many initiatives, including health and education services, is to work with direct service providers to both enhance their awareness of the importance of the first five years as well as increase their ability to identify needs and treat young children.

  Below are examples of this commitment to increase provider awareness and capacity:

  - SR is designed to build a bridge between early care providers and kindergarten teachers to ensure a smooth transition from preschool to kindergarten.
  - PFA providers are regularly given quality assessments to gauge their current abilities and performance and are provided coaching to address any identified issues.
  - The OHI coordinator (Council of Community Clinics) provides training to general dentists, pediatricians and primary care providers to train them on the importance of dental care in the first five years.
  - HDS has enhanced provider capacity to provide referrals for additional services through developing clear clinical pathways and referral processes. Through HDS, the American Academy of Pediatrics (AAP) offers provider training sessions on topics such as the Ages and States Questionnaire, a developmental assessment tool, and autism.
  - The HDS Countywide Coordinator (AAP) works with local pediatricians to change standards of practice to make developmental screenings part of well-child check-ups and refer eligible children needing follow-up to HDS.
- ***Promoting community awareness:*** This fiscal year, the Commission contracted a media consultant to better inform parents of young children about the First 5 funded services available to them and inform the broader community of the importance of the first five years of life. Most stakeholders interviewed for this project noted that the Commission should be more proactive in their outreach. For example, one health stakeholder notes, "I don't know if there's public awareness. That's a big challenge outside of community, funders and those that work with them." An education stakeholder expanding on this saying, "I think they could have more visibility […] I think they have a good start, but more advertising or publishing of achievements would be great."

Opportunities for Additional Focus

While First 5 San Diego has made great strides in enhancing and strengthening the services that support young children and their families, there continues to be opportunities for additional focus in the coming year. Below is a brief highlight of some of the core opportunity areas.

- ***Internal collaboration within Initiatives:*** Each initiative has regular working meetings to discuss the challenges and successes of service provision as well as develop better ways to integrate services. However, the initiatives are each wrestling with difficult issues, such as state insurance or service requirements, ensuring referral and data sharing protocols are HIPAA compliant, as well as establishing common service standards, data collection protocols and clinical pathways, and following the Commission's contractual requirements. For most initiatives, these meetings are an ongoing source of support and problem solving. However, it is clear that the need to continue these meetings in an effort to support internal collaboration is needed. For example, the HDS regional networks have made great strides in facilitating critical communication lines and referrals, but the intricacies and scale of the initiative will require more years of discussions, problem solving, and work in order to ensure effective service provision between partners.
- ***Cross initiative collaboration:*** While intra-initiative collaboration has worked relatively well, inter-initiative collaboration is still a challenge. Currently, the First 5 holds "All-Contractor Meetings" several times a year, encourages key leaders from one initiative to join the Advisory Board of another (e.g., PFA and HDS), and facilitates cross-initiative presentations and project-level meetings. Still, this was a theme among stakeholders. As one Health Stakeholder stated:

  > *"I think [the Commission] could encourage more collaboration and integration. I think it's important. One of the things I see is little intersect between initiatives. …[H]aving an integrated plan that talks about how initiatives intersect, that's very important so contractors can work more closely together."*

  The above statement is true on two fronts. First, providers from different agencies are sometimes not aware of all the different services funded by First 5. For example, SR providers are not always clear on what services are provided by HDS and how to refer their children to these services, despite cross-initiative presentations of services. In this instance, there is neither an established referral protocol nor a Business Service Agreement or Memorandum of Understanding to facilitate information exchange between these organizations. Some OHI care coordinators assist families with Medi-Cal paperwork instead of referring these individuals to HCA, an initiative which specializes in health enrollment and retention. Second, some organizations hold multiple First 5 contracts and yet the providers within the same organization are not aware of the services. Some OHI directors, for example, were not aware of the HDS services that were provided in the same clinic as their services. If the Commission wants to increase parents' access to needed services, starting with their contractor's knowledge of the First 5 network is an important first step.

"I haven't seen [First 5] at key collaborative meetings. . . . . They need to be more visible and way more proactive on communication about programs and what is going on."

– Health Stakeholder

- ***Cross initiative coordination:*** One of the goals of First 5 San Diego is to build connections across systems to create more seamless services for children. One of the largest coordination gaps to bridge is between the education and health and human services systems, which operate under different regulations and within different organizational cultures. While First 5 has promoted

coordination of services and referrals of children across initiatives, these systems have yet to effectively build service coordination bridges, such as the aforementioned Business Service Agreements or Memorandum of Understandings, Consequently, HDS and OHI contractors regularly conduct screenings and treatment for children who are in SR and PFA classrooms, and the results, while communicated to parents, cannot always be directly shared with the early care providers. The Commission has required coordination of services, and it can also promote cross-system agreements between providers to allow appropriate information sharing.

"When a grantee can show the grantor success with the program funded by First 5, it's a sign of legitimacy, and funders respect agencies that have been funded by First 5."

– Health Stakeholder

"I get the sense that the Commission primarily collaborates by…planning with other systems…But in terms of actually…putting the dollars on the table, that's what I don't see happening."

– Health Stakeholder

- ***Community input:*** Many stakeholders noted that they would like to see the Commission pursue more community input in their processes. Community input suggestions ranged from recommending the Commission to be more involved with county, funder, and local collaborations to increasing involvement with parents and providers in the initial design and development of initiatives. While this theme has emerged in past evaluation years, the Commission's two primary constraints to address this issue remains. First, the Commission has limited staffing, which precludes existing staff from becoming more involved in local workgroups and collaboratives. Second, government agencies are constrained from using potential bidders in designing scopes of work. First 5's participation in some local collaboratives could be later construed as preliminary design work, which would prevent participating organizations from competing for funds. This fiscal year, First 5 has worked to address this issue through soliciting community and stakeholder input for planning studies (such as the recent study for enhancing Parent Development activities) and in planning their FY 2008-09 strategic planning process. According to stakeholders, more could be done.

- ***Leverage resources and support:*** A key concern for most providers is the sustainability of their programs. First 5 San Diego has sent a clear message that contractors should be leveraging their First 5 program to proactively seek funds to continue it beyond First 5's involvement. However, the struggle for many providers is that First 5 is the only funder that solely focuses on the 0-5 age group. This is compounded by the recent budget crisis in which federal, state and county funds are shrinking. For example, the recent crisis in the budget has greatly decreased school district spending and restricted many districts to core services that do not include "prevention" oriented programs, such as SR. Further, the status of the California budget will make it challenging to garner statewide funding for PFA once the demonstration project concludes. Consequently, despite efforts to identify additional funds, many contractors are left with limited options to continue critical services to the community without First 5 funds. A frequent comment over the years has been that First 5, because of their prominence, has the ability to leverage their own funds to draw in additional foundation or government funding. This almost occurred one year ago for the Health Care Access Initiative with OERU funding[151] and there are plans to assist SR in sustainability planning for

[151] The State passed Outreach, Enrollment, Retention, and Utilization (OERU) in 2007– a program that offers the same services as the HCA but targets children and young adults ages 0-18. A number of the HCA grantees successfully won their bids for OERU funding only to have it line-item vetoed shortly thereafter.

FY 2008-09. However, there are a number of untapped opportunities, such as pursuing jointly funded projects with local and regional foundations and working with the County to integrate early childhood approaches and funding that could build a bridge between First 5 contractors and other funding sources. Additionally, the Commission could provide workshops or results fairs to introduce providers to potential funders. These could be coordinated jointly by local and regional foundations or with the San Diego Grantmakers.

A Final Word

First 5 San Diego remains in a unique position to change the way services and the larger community address the critical first five years of life. Over the years, First 5 has developed promising practices as a funder of services to help strategically guide the current services and plant seeds for the future. If the Commission continues to pursue these strategic funder activities, while balancing service provider and authentic community input, they have an opportunity to leave a lasting positive legacy for the San Diego community.

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. Oral Health Initiative

- *Community Clinics Health Network*

3. 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*

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*

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, Inc.*
- *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*
    - *American Academy of Pediatrics: Reach Out and Read*
    - *The Community Health Improvement Partners (CHIP): What to Do When Your Child Gets Sick*
    - *2-1-1 San Diego*
    - *UCSD Regional Perinatal System, Welcome Baby Program: Kit for New Parents*
    - *YMCA Childcare Resource Service, San Diego CARES*
    - *Capital Improvement and Equipment Projects*
    - *Innovative Grants*

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.

Contact Name:
Silvia Garcia
Phone:
(619) 422-9208 Ext.5462
Email Address:
sgarcia@home-start.org
Website Address:
www.home- start.org

Neighborhood Healthcare
East Region
Neighborhood Healthcare provides education, outreach, retention, and healthcare application assistance for children and pregnant women in the East region 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.

Contact Name:
DeWan Gibson
Phone:
(760) 520-8313
Email Address:
DeWang@nhcare.org
Website Address:
www.nhcare.org

North County Health Services
North Inland Region
North County Health Services is the lead in a partnership with Neighborhood Healthcare 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.

Contact Name:
Michelle Gonzalez
Phone:
(760) 736-8661
Email Address:
Michelle.Gonzalez@nchs-health.org
Website Address:
www.nchs-health.org

SAY San Diego, Inc.
Central Region
This program provides healthcare outreach and insurance enrollment and retention activities across the Central region of San Diego County in collaboration with Family Health Centers of San Diego, San Diego Youth and Community Services, Horn of Africa, O'Farrell Family Support Services, and Crawford Community Connection.

Contact Name:
Lynnae Milo
Phone:
(619) 582-9056 Ext. 234
Email Address:
lmilo@saysandiego.org
Website Address:
www.saysandiego.org

SAY San Diego, Inc.
North Central Region
This program provides outreach activities to locate families that need health insurance for their children. Certified Application Assistants help 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.

Contact Name:
Sandra Simmer
Phone:
(858) 974-3603 Ext.240
Email Address:
sandra@saysandiego.org
Website Address:
www.saysandiego.org

Vista Community Clinic
North Coastal Region
Vista Community Clinic provides outreach and support services that increase insurance enrollment and retention in North Coastal San Diego County. They work in collaboration with North County Health Services.

Contact Name:
Maria Mencias
Phone:
(760) 407-1220 Ext. 126
Email Address:
mmencias@vistacommunityclinic.org
Website Address:
www.vistacommunityclinic.org

2. 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. Fifteen 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
- Fallbrook Family Healthy Centers
- Family Health Centers
- Imperial Beach Health Center
- Indian Health Council
- La Maestra Community Health Centers
- Mountain Health & Community Services
- Neighborhood Healthcare
- North County Health Services
- Operation Samahan
- San Diego American Indian Health Center
- San Diego Family Care
- San Ysidro Health Center
- Southern Indian Health Council
- Vista Community Clinic

Other programs:

- County Office of Ed., SMILES
- Rady Children's Hospital/ Anderson Dental Center
- Share the Care/Health and Human Services Agency
- Technical advisors

Contact Name:
Kim Thomas
Phone:
(619) 542-4347
Email Address:
kthomas@ccc-sd.org
Website Address:
www.ccc-sd.org

3. Healthy and Development 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.

Contact Name:
Lily Lim Valmidiano
Phone:
(619) 281-2292
Email Address:
lvalmidiano@aapca3.org
Website Address:
www.aapca3.org

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.

Contact Name:
Phyllis Hartigan
Phone:
(858) 966-7585
Email Address:
phartigan@rchsd.org
Website Address:
www.smokefreefamilies.org

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
- Home Start, Inc.
- KIT Inc.
- Home Care-RCHSD
- San Diego Center for Children
- Shiley Eye Mobile-UCSD
- Union of Pan Asian Communities (UPAC)
- YMCA Childcare Resource Service

Contact Name:
Claudia Gastelum
Phone:
619-515-2405
Email Address:
cgastelum@fhcsd.org
Website Address:
www.fhcsd.org

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
- Home Start, Inc.
- KIT Inc.
- Home Care-RCHSD
- San Diego Center for Children
- Shiley Eye Mobile-UCSD
- YMCA Childcare Resource Service

Contact Name:
Heather Summers
Phone:
(619) 515-2462
Email Address:
heathers@fhcsd.org
Website Address:
www.fhcsd.org

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

Contact Name:
Cynthia Linder
Phone:
(760) 796-6859
Email Address:
cynthia.linder@pph.org
Website Address:
www.pphs.org

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:
- Children's Care Connection (C3)-RCHSD
- Chadwick Center for Children & Families-RCHSD
- Exceptional Family Resource Center
- Home Start, Inc.
- North County Health Services
- Speech & Language Department-RCHSD
- Vista Community Clinic
- Palomar Pomerado Hospital-Welcome Home Baby
- YMCA Childcare Resource Service

Contact Name:
Vyan Nguyen, MD
Phone:
(858) 576-1700 Ext. 6577
Email Address:
vnguyen@rchsd.org
Website Address:
www.rchsd.org

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:
• Children's Care Connection (C3)-RCHSD
• Chadwick Center for Children & Families-RCHSD
• Developmental Screening and Enhancement Program-CAPF & RCHSD
• Exceptional Family Resource Center
• Home Start, Inc.
• Home Care-RCHSD
• Speech & Language Department-RCHSD
• SAY San Diego Healthy Start Military Family Cluster
• Shiley Eye Mobile-UCSD
• Union of Pan Asian Communities (UPAC)
• Palomar Pomerado Hospital- Welcome Home Baby
• YMCA Childcare Resource Service

Contact Name:
Shelley Turner
Phone:
(858) 576-1700 Ext. 7346
Email Address:
snturner@rchsd.org
Website Address:
www.rchsd.org

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
• Episcopal Community Services
• Exceptional Family Resource Center
• Imperial Beach Health Clinic
• Operation Samahan
• Home Care – RCHSD
• Speech & Language Department-RCHSD
• Shiley Eye Mobile - UCSD
• UCSD – Division of Community Pediatrics
• YMCA Childcare Resource Service

Contact Name:
Valerie Brew
Phone:
619-420-3620 x168
Email Address:
vbrew@csbcs.org
Website Address:
www.southbaycommunityservices.org

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 home based parenting instruction provided by Parents as Teachers (PAT), and a Community Based English Tutoring (CBET) Program as well as regularly offered educational series for parents and caregivers. Also provided are a behavioral
specialist, nurse, a speech therapist, and a Family Resource Center.

Contact Name:
Virginia Pinkerton
Phone:
(619) 593-4576
Email Address:
pinkertonv@cajonvalley.net
Website Address:
www.cajonvalley.net

Chula Vista Elementary School District

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.

Contact Name:
Ginger Hartnett, Nancy Kerwin or Lisa Butler
Phone:
Ginger - (619) 425-9600 Ext. 1760
Nancy - (619) 425-9600 Ext. 1511
Lisa – (619) 425-9600 Ext. 1761
Email Address:
vhartnet@cvesd.k12.ca.us
nkerwin@cvesd.k12.ca.us
lbutler@cvesd.k12.ca.us
Website Address:
www.cvesd.org

Escondido Union School District

Serves seven elementary schools. Family resources are provided including Parent/Child Education Classes, the Parent/Child Activity Center, Parent Resource Library, parent education, parent to parent support, and home-based services. Early Literacy classes, KinderPrep Classes, a KinderPrep Summer Program, and Kindergarten Transition and Orientation are available as well as the Resource Library for pre-school and care providers. The program offers a variety of screenings including behavior and health consultation, vision, hearing, dental, nutrition, development and health screenings, and behavior support services to families, care providers, and preschools.

Contact Name:
Jan Zelasko
Phone:
(760) 489-4131
Email Address:
jzelasko@eusd4kids.org
Website Address:
www.eusd4kids.org

National School District

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.

Contact Name:
Rita Palet
Phone:
(619) 336-8672
Email Address:
rita.palet@national.k12.ca.us
Website Address:
www.nsd.us

Oceanside Unified School District

Serves four elementary schools through the Listos (Ready) Learning Center. This drop-in center is designed to be an educational supplement for preschool age children and a precursor to preschool for children ages 0-3. The district partners with community service providers to bring health and social services to the center. Family support services are provided through Mommy and Me classes, prenatal education, insurance enrollment, and case management for families in crisis. Health services include dental screenings, wellness checks, and follow up on family referrals for direct medical treatment. Community Based English Tutoring (CBET) is available.

Contact Name:
Maria Theresa (Teri) Porter
Phone:
(760) 966-1923
Email Address:
tporter@oside.k12.ca.us
Website Address:
www.oside.k12.ca.us

San Diego Unified School District
Early Link serves 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.

Contact Name:
Carol Berridge
Phone:
(858) 496-8123
Email Address:
cberridg@.sandi.net
Website Address:
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:
Claudia Uribe
Phone:
(619) 428-4476 Ext. 3541
Email Address:
claudiau@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:

- A+ Family Day Care
- Camacho/Ramirez Family Day Care
- Carillo's Family Day Care
- Carvajal Family Child Care
- Episcopal Community Services
- Escondido Community Child Development Center (ECCDC)
- Escondido Unified School District
- Fuentes Day Care
- Lemon Grove School District
- MAAC Project
- National School District
- Neighborhood House Association
- North County Serenity House
- Paredes Family Day Care
- Ridgeview Preschool
- San Ysidro School District
- South Bay Union School District-VIP Village
- Southwestern College CDC
- Zavala Family Child Care

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

6. 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:** Minh Duong **Phone:** (619) 470-5882 **Email Address:** minh.duong@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.Gonzalez **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:** Danna Belski **Phone:** (619) 446-2124 **Email Address:** danna.belski@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

7. Non-initiative contractors and activities

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**.**

Contact Name:
Tara Milbrand
Phone:
(619)281-2273
Email Address:
tmilbrand@aapca3.org
Website Address:
www.rorsd.org

Community Health Improvement Partners (CHIP)
***What to Do When Your Child Gets Sick*: Training the Trainers Curriculum**
Provides a two-day training program designed to educate 100 "master trainers" from community based organizations, such as those that have Women, Infants and Children (WIC) and Head Start sites throughout the county. The master trainers will instruct 1,000 parents and caregivers over a two-year period that aims to increase parental education and awareness of child illness.

Contact Name:
Shreya Shah Sasaki
Phone:
(858) 614-1550
Email Address:
ssasaki@hasdic.org
Website Address:
www.sdchip.org

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

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:
Amy Chatten
Phone:
(858) 536-5090
Email Address:
achatten@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

Capital Improvement and Equipment Projects

Blessed Sacrament Parish Preschool
Mary Castro
(619) 582-3862 Ext. 280

Borrego Community Health Foundation
Stephen Shubert
(760) 574-5179

Casa de Amparo
Erin Harmonson
(760) 453-2300

Community Health Systems (Fallbrook Family Health Center
Jack Johns
(760) 731-7779

Jewish Family Service of San Diego
Cheryl Alexander
(858) 637-3304

La Maestra Family Clinic
Zara Marselian
(619) 584-1612

North County Serenity House, Inc.
Dana Weevie
(760) 746-5747

Oceanside Unified School District-LISTOS Center
Teri Porter
(760) 966-1923

Palomar Pomerado North County Health Department, Inc. on behalf of Palomar Pomerado Health
Bradley Wiscons
(858) 675-5303

Palomar Pomerado Health
Annamarie Martinez
(760) 796-6823

Pregnancy Care Center DBA East County Pregnancy Care Clinic (ECPCC)
Josh McClure
(619) 442-4357

Ridgeview Preschool
Sara Lopez
(760) 751-9868

San Diego Youth & Community Services
Amy Garcia
(619) 221-8600

Santee School District
Hope Baker
(619) 956-5251

Southern Indian Health Council
Doug Burns
(619) 445-1188

United Cerebral Palsy Association of San Diego County
Mary Krieger
(858) 571-7803

Vista Community Clinic
Barbara Mannino
(760) 631-5000

Innovative Grants

Horn of Africa
Families Together Program
The project, Families Together Program (FTP) is an affiliate program of Healthy Families America (HFA). HFA is a national initiative that aims to reduce child abuse and foster healthy, happy and successful families by providing ongoing technical assistance and support to local affiliates. FTP is a HFA program that will focus on East African families and their children age 0 to 5. FTP provides a comprehensive assessment of the family, and home visiting staff provides weekly home visits to families to implement an individualized plan of care.

Contact Name:
Abdi Mohamoud
Phone:
(619) 583-0532
Email Address:
ahornofAfrica@aol.com

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

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) NICU Family Support Project Implements Systematic NICU Referral for Support Protocol, instates a MOU between EFRC and 4 hospitals and identifies families with infants who experienced NICU care.	**Contact Name:** Diane Storman **Phone:** (619) 594-7405 **Email Address:** dstorman@projects.sdsu.edu **Website Address:** www.EFRConline.org
San Diego Community College Auxiliary Organization/San Diego State University Research Provides education, practice, and support for fathers of preschool children.	**Contact Name:** Linda Arias **Phone:** (619) 338-1153 **Email Address:** lindareads@cox.net

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.
Talk To Me
Provide information for parents & community about 1) the importance of building vocabulary early in life; 2) formulating culturally appropriate community awareness strategies on this topic; 3)implementing strategies to help low-income families improve their children's vocabulary levels; & 4) utilizing partnerships and networks to carry the message & engage parents in interactive behaviors with children.

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:
Robert Felix
Phone:
(619) 294-3708
Email Address:
rfelix@ucsd.edu

University Of San Diego – SOLES/COMPASS Family Center
Transition Support Program
The project will help prepare parents to effectively transition from an Individualized Family Service Plan (IFSP) to an Individualized Educational Program (IEP) when their child with special needs reaches the age of 3 years old.

Contact Name:
Moises Baron
Phone:
619-260-4655
Email Address:
mbaron@sandiego.edu

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.

Focus Groups and Interviews

Two focus groups were held with parents from School Readiness and the Special Needs Project in order to compare their experiences with regard to developmental screenings. The purpose of these focus groups was to learn about the process of receiving a screening and subsequent referrals, learn what worked and what was difficult, as well as to learn about successes that can be implemented across contracts. 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. Parents who participated were offered a $20 incentive, and food and child care were provided. For each focus group, the evaluation team strove to have eight to 12 participants.

In order to obtain the perspective of direct service providers, interviews and focus groups were conducted with providers from various initiatives, including:

- *Healthcare Access Initiative:* A focus group with four HCA providers to obtain their feedback about the HCA Initiative. After the focus group, they answered questions via email regarding their partnerships. Two providers were unable to attend the focus group and answered the same questions over the telephone.
- *Oral Health Initiative:* Telephone interviews with eight OHI Dental Directors, one OHI Dental Coordinator, and one OHI Dental Manager were conducted in order to document how OHI clinics approach the initiative as well as document their successes and challenges.
- *School Readiness/Special Needs Project:* Telephone interviews with nine Coordinators (eight from School Readiness and one from Special Needs) to learn about a myriad of subjects, such as policies and procedures around referral tracking and care coordination, sustainability, community partnerships and their relationship with First 5.
- *Preschool for All:* In order to document successes and challenges, the evaluation team interviewed two coaches, six teachers, and conducted a focus group with a group of teachers. In addition, telephone interviews were conducted with 15 of the 17 PFA directors about their involvement with PFA. The interviews covered a variety of topics including the nature of their program, their partnerships with SDCOE and other agencies, the types of training and professional development offered to teachers, ways in which parents were involved in their program, and overall successes and challenges of implementing PFA. Additionally, sites that participated in PFA in FY 2006-07 were asked about changes in PFA since last year.
- *School Readiness and Preschool for All:* Staff conducted site visits to three First 5 San Diego Early Care and Education sites with combined School Readiness (SR) and Preschool for All (PFA) funding streams. Through this process, they interviewed a total of five staff members in Escondido, National, and San Ysidro school districts.
- *F5FP:* Telephone interviews were conducted with each of the ten contractors to document common survey administration and challenges to client follow-up.

Lead Contractor and 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 via SurveyMonkey, an online survey tool, to lead contractors and subcontractors under the Healthy Development Services Initiative and Healthcare Access Initiatives. The surveys were developed specifically to understand key areas of systems change, such as the leveraging of additional funds, and the program's experiences working under a lead organization funded by First 5. The HDS lead survey was completed by five out of six regional representatives. All HDS subcontractors (n=27) were invited to complete the online survey. A total of nineteen responses were received, a response rate of 70.4%. It is important to note that although agencies with subcontracts in multiple regions or across multiple service areas were instructed to complete the survey only once, duplicate responses from the same agency may have been submitted. The subcontractor survey was also received from nine out of thirteen HCA subcontractors (69.2% 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 through collaboration with the First 5 Commission Staff. Harder+Company contacted the selected individuals from each entity three times before abandoning the interview effort. In total, 21 interviews were conducted.

Case Studies

The case studies presented as chapter breaks and quotations from participants and providers referenced in this report were selected from interviews conducted as part of the new Qualitative Data Enhancement (QDE) Study that was launched in FY 2007-08. The new QDE study is more intensive than a typical case study: more families have participated, each "Focus Family" was interviewed up to four times over 6 months, and additional service data was collected from providers at the agencies where families received services. Case studies and quotations in this annual report were selected from the first wave of data collection between December 2007 and March 2008.

The QDE study was designed to understand the dynamics of accessing and utilizing First 5 San Diego services in three initiatives: Healthy Development Services (HDS), Oral Health Initiative (OHI), and First 5 for Parents (F5FP). Data collection for will be complete by December 2008. A separate report to present the findings of the complete QDE study will be available in Spring 2009.

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) were 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 a specific answer divided by the number of people that answered the question.

Many findings are noted as being "statistically significant." This means that there is statistical evidence that there is a difference observed between the groups being compared (most often the comparison is between Time 1 and Time 2 groups) and that this difference is not due to chance. 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 years years 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 preventive health services and families get the help they need to navigate the health care system.

Monthly Quarterly Reports

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, as well as the demographics of the population. Providers also provide narrative about their monthly successes and challenges. These spreadsheets are reviewed quarterly for errors or discrepancies. Fiscal year final numbers , which are used in this report, are provided in the Quarter 4 report.

Outcome Survey

Contractors collectively developed a survey to track enrollment status for all children and the following outcomes for enrolled children: 1) linkage to a medical home; 2) overall health; 3) utilization of health care; 4) utilization of dental care; 5) utilization of the emergency room. The survey consists of twelve questions and was translated into Spanish. Five of the providers submitted paper copies of the survey to Harder+Company, who entered them into a central file. One provider entered their surveys into their own database and Harder+Company downloaded the data from the system.

The survey is designed to be collected at 6-, 12-, and 18-month intervals by the contractors' line staff during normally scheduled follow-up calls to all enrolled families. This fiscal year, a quarterly sampling plan for collecting the follow-up survey was implemented in order to reduce the number of completed surveys but maintain a representative sample for evaluation. The survey is now only collected during the first and third quarters for families who are due for a follow-up survey during that time.

In September 2006, unique identifiers for each child were created so that the analysis could track individual children through their 6-, 12-, and 18-month follow-ups, and determine more specifically when and how they become disenrolled. This year, the analysis utilized cases from FY 2006-07 and FY 2007-08 for children who had a completed survey for 6 and 12 months (*Follow up 6-12)*, 12 and 18 months (*Follow up 12-18)*, or 6, 12 and 18 months (*Follow up 6-12-18)*. Families that agencies were unable to contact were excluded from the analysis, as were families that the agencies only contacted once.

Frequencies for medical home linkage and health care, dental care, and emergency room utilization for *Follow up 6-12 and 12-18* were based on surveys where the questions had valid answers at both time points. Similarly, frequencies for reasons for health care and dental care utilization were based on surveys where children had visited the doctor and/or dentist and where the questions had valid answers at both time points. Frequencies for reasons for emergency room utilization were based on all children who had visited the emergency room at any time point. The same is true of frequencies for reasons children are no longer enrolled. The analysis of *Follow up 6-12-18* includes used the Pearson chi-square to test for statistical significance.

Exhibit B.1 Healthcare Access Initiative Evaluation Table		
Data Elements	**Related Goal(s)**	**Method of Collection**
Demographic Data		
Children ages 0-5 years years: ethnicity, language, age, special needs	Goals 1-3	Tracking Tool
Process measures data		
Number of families with children ages 0-5 years assisted and enrolled in Medi-Cal/Healthy Families	Goal 1	Tracking Tool
Number of children ages 0-5 years years 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 years years linked to a medical home	Goal 2	
Number of children ages 0-5 years years linked to a medical home	Goal 2	
Number of families, pregnant women and children ages 0-5 years 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 years years assisted with reactivation and renewal of insurance enrollment	Goal 1	
Outcomes data		
Increase health insurance enrollment of eligible children ages 0-5 years 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	

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 areas:

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

OHI's six direct service areas 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 ages 0-5 years years and pregnant women received preventive and restorative dental care, oral health education, and how many were connected to oral health services. In addition, the evaluation captures oral health provider education results.[152]

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.[153] 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: telephone interviews with eight OHI Dental Directors, one OHI Dental Coordinator and one OHI Dental Manager and in-person interviews with three families whose children received OHI services. The findings of all of these methods are interwoven throughout the chapter.

[152] "Providers" refers to prenatal care providers, general dentists, and other primary care providers.

[153] 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.2 Oral Health Initiative Evaluation Table		
Data Elements	**Related Area(s)**	**Method of Collection**
Demographic data		
Children ages 0-5 years: ethnicity, language, age, special needs; Pregnant women: ethnicity, language	Areas 1-4	Tracking Tool
Process measures data		
Number of children ages 0-5 years and pregnant women who receive oral health screenings	Area 1	Tracking Tool
Number of children ages 0-5 years and pregnant women who receive dental exams	Area 2	
Number of children ages 0-5 years and pregnant women who receive routine/specialty treatment	Area 3	
Number of children ages 0-5 years and pregnant women who receive care coordination services	Area 4	
Number of children ages 0-5 years and pregnant women who receive educational messages *	Area 5	
Number of providers trained in relevant maternal & child oral health topics	Area 6	
Number and type of preventive services (sealants, fluoride varnishes, prophylaxis) delivered to children ages 0-5 years and pregnant women	Areas 1-2	
Number and type of restorative services (fillings, crowns, extractions, pulpotomies) to children ages 0-5 years and pregnant women	Area 3	
Outcomes data		
Identify previously unidentified oral health concerns in children ages 0-5 years and pregnant women	Areas 1-2	Tracking Tool
Reduce the proportion of children ages 0-5 years and pregnant women with untreated dental decay	Area 3	
Increase the proportion of children ages 0-5 years and pregnant women who have visited a dentist in the past year	Area 3	
Connect children ages 0-5 years and pregnant women with needed oral health services (exams, treatment, etc.)	Area 4	
Increase providers' knowledge of how to promote the oral health of children ages 0-5 years	Area 6	

*Children are indirectly served as oral heath education is directed at the parent or caregiver.

Healthy Development Services Initiative

The evaluation relies 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 2008. Interim outcome data reported at the mid-year point was used for quality checks; comprehensive outcome data reports were provided at the end of the fiscal year for complete analysis. The data presented in this report includes cases

where the disposition was determined (e.g., outcome determined, known lost to follow-up, case closure, etc) between July 2007-May 2008. No cases where outcomes were pending were included.

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.3
Healthy Development Services Evaluation Table

Data Elements	Method of Collection
Demographic data	
Children ages 0-5 years: 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 years and families served	
Number of children ages 0-5 years 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 6 weeks and 6 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 ages 0-5 years	

Limitations to Outcomes Data Collection

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.[154] Given the variety of instruments used, it would be a misrepresentation to collapse or compare data across agencies.

There are obvious limitations to how aggregate outcome data can be analyzed and reported.[155] Data reported in the HDS chapter presents a comprehensive review of outcomes for the fiscal year; however, comparisons between service categories should only be made with caution, as each service is unique in its service delivery, challenges, and capacity. Additionally, because of the aggregate nature of reporting, outcomes cannot be linked to other valuable information, such as client demographics and services received. It is anticipated that such analyses will be possible with the collection of client-level data in the forthcoming First 5 data system.

Update to Outcomes Data Collection

During FY 2007-08, the breastfeeding and medical home outcome measures were modified so that individual outcomes could 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 FY 2008-09, outcome measures will be reported at the individual client level via CMEDS. Reporting data at the individual client level will improve data quality and enhance the utilization of the data. Additionally, service areas will continue to meet in FY 2008-09 to discuss the standardization of outcome measures and the potential of sharing data across regions.

School Readiness Initiative

The School Readiness evaluation follows State First 5-mandated evaluation guidelines. Under the 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. For the FY 2007-08 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-R) 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

[154] Regional leads, regional evaluation staff, and Harder+Company reviewed and approved all instruments used by service providers. When available and appropriate, normed and validated tools were utilized. During FY 2007-08, AAP began to convene HDS providers and experts by service to begin discussions of standardizing service delivery and data collection. These discussions will continue with the goal of having some standardized instruments in place for FY 2009-10.

[155] The outcomes evaluation for FY 2007-08 specified reporting only clients who had a "determined disposition," and therefore clients who had pending services or results were not included in outcome reports. Therefore, not all clients served in the FY are represented here, rather only those who were eligible for outcome measurement. Only data on the referral outcomes were allowed to be reported through a true sampling design. Service providers were asked to provide referral outcome data for at least 25% of all clients.

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 years: 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 ages 3-5 years who 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

Child Development Assessment Tools

Providers administered the DRDP-R to SR children receiving classroom-based early care and education in the Fall and the Spring. Matching scores for all children whose parents gave consent were used in the analysis. The DRDP-R scores children's skills on a scale of 0 to 4 (0=not yet at first level; 1=exploring; 2= developing; 3=building; 4=integrating). The Spring and Fall scores were compared using a paired sample t-test, which compares the difference between the two mean ratings for each of the questions. Domains, indicators, and example measures are outlined in Exhibit B.5.

Exhibit B.5
DRDP-R Domains, Indicators and Measures

Desired Result	Indicator	Example Measure
1.Children are Personally and Socially Competent	Self Concept (SELF)	Identity of self
	Social Interpersonal Skills (SOC)	Expressions of Empathy
	Self Regulations (REG)	Impulse Control
	Language (LANG)	Comprehends meaning
2. Children are Effective Learners	Learning (LRN)	Curiosity and Initiative
	Cognitive Competence (COG)	Memory and knowledge
	Math (MATH)	Time
	Literacy (LIT)	Concepts of print
3. Children Show Physical and Motor Competence	Motor Skills (MOT)	Gross motor skills
4. Children are Safe and Healthy	Safety and Health (SH)	Personal care routines

The Ages and Stages Questionnaire (ASQ) has been identified as an appropriate tool for center-based interventions that can map to the DRDP. The ASQ system is composed of nineteen age-appropriate questionnaires and is designed to be completed by parents or primary caregivers.[156] The questionnaire for the age group closet to the child's age is used. Each questionnaire contains thirty developmental items that are divided into five domains: communication, gross motor, fine motor, problem solving, and personal-social. Analysis was utilized 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

In FY 2007-08, 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 0 to 6, 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 twelve 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.[157]

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.[158] 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

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).

---

[156] 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>

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

[158] "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.6 outlines the key data elements used for the PFA evaluation.

Exhibit B.6
Preschool for All Demonstration Project Evaluation Table

Data Elements	Method of Collection
Demographic data	
Children ages 0-5 years: 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	
Number and percent of parents who demonstrate increased knowledge (confidence and competence) to promote child's optimal development and school readiness.	First 5 Parent Survey
Number and percent of children making developmental progress in the areas of cognitive, social, emotional, language, approaches to learning and health/physical development	DRDP-R
Number of participants reporting satisfaction with the content, quality, and family centeredness of services	DRDP-R Parent Survey

Outcome Measures

In FY 2007-08, providers administered the "Survey of Parenting Practice" to parents whose children participated in PFA sessions. In addition, the DRDP-R was administered to PFA children in the Fall and the Spring, and matching scores for all children whose parents gave consent were used in the analysis (for details about the DRDP-R, see the "School Readiness" section above, subsection entitled "Child Development Assessment Tools"). The analysis described in the School Readiness section was also used for PFA outcome measures.

Pre-Entry Sessions

Pre-entry sessions are those that have not yet met the criteria for PFA Tier 1 (the lowest PFA Tier). SDCOE worked closely with these sites to improve classroom quality so that they can participate in PFA in the coming year. Although some of these sessions received ECERS-R and FCCERS-R scores and some of the children were

administered the DRDP-R, these scores were not included in the analysis because they do not represent the scores of PFA quality programs or the scores of children who are receiving PFA quality preschool.

In addition, the evaluation does not include the Teacher Survey, First 5 Parent Survey, or DRDP-R Parent Survey for any pre-entry sessions. It does, however, include process numbers related to developmental delays for some of the pre-entry sessions (the ones located at a site that also has other sessions) and the number of children served and slots filled for all pre-entry sessions. Additionally, several of the teacher interviews were conducted at PFA pre-entry sessions.

First 5 for Parents Project

The First 5 for Parents Project provides direct services as part of the Commission's Parent Development 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 (Service Focus Area 1)
2. Promoting children's early learning and early literacy development (Service Focus Area 2)
3. Fostering healthier behaviors with proper nutrition and exercise (Service Focus Area 3)

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	Quarterly Progress Report
Process measures data	
Number of new parents	Quarterly Progress Report
Number of new children ages 0-2 and 3-5 years	
Number of new families	
Number of senior volunteers (for four intergenerational programs)	
Number of service units by type (classes, home visits, workshops)	
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 the 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 possessed 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 in the first year (FY 2006-07). 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. Some questions were eliminated, and new questions were added. Additionally, the survey was significantly strengthened to ask parents to report the number of days and hours that behaviors of interest occur, rather than choosing from predetermined frequency categories. This change increased the sensitivity of the measures of behavior change, which is very important to adequately capture changes that occur, particularly in the case of behaviors that are difficult to modify, such as eating and exercise habits. A new version of the Common Survey was implemented beginning in July 2007. When possible and appropriate, comparable data is presented to facilitate comparisons in outcomes between Year 1 and Year 2.

Findings for selected outcome indicators for Focus Areas 1, 2 and 3 are presented in the First 5 for Parents chapter. Harder+Company only included parents with matched pre-test and post-test survey data in the analysis of outcomes. Using data from this subsample of participants, Harder+Company assessed changes from pre-test to post-test for over 80 questions on the Year 1 (FY 2006-07) and Year 2 (FY 2007-08) Common Surveys. The results of outcome indicators of particular significance were selected and highlighted in the chapter. For comparability across contractors, only results for common survey questions are presented.

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-test and post-test surveys are matched to allow assessment of changes in knowledge and behavior at the individual participant level.
- ***Only data for participants with pre-test and post-test survey data available (matched cases) was included in the analysis of outcomes.*** The number of matched cases available is significantly less than the total number of parents served. Additionally, some programs may have opted to collect the survey for a *sample* of participants. It should be noted that the percentage of matched cases for FY 2007-08 was only 30.6% and is not representative of all parents/caregivers served. Of those who completed a pre-test survey, about half (50.3%) had a matched post-test survey. The relatively low number of matched cases may reflect low retention and program completion rates because parents/caregivers may attend one or more class sessions but miss the survey administration at baseline, follow-up, or both. There may be some parents enrolled late in the year who may not have reached the specified follow-up period to complete the post-test before the end of the fiscal year; however this number was small for parents enrolled in FY2006-07. These percentages suggest that contractors face challenges in ensuring that participants complete the common survey, but they may also suggest that contractors face challenges in retaining clients until the target follow-up period.
- ***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.

Analysis of the Common Survey

To facilitate comparison of outcomes between FY 2006-07 and FY 2007-08, differences in proportions were presented to demonstrate changes in knowledge and behavior between pre-test and post-test among participants with matched data available for each question. Wherever possible, County comparison data or national benchmarks were presented to provide context to the findings. Observed differences in proportions were tested for statistical significance using the McNemar test of difference in proportions for matched, dependent samples. However, given the underlying limitations of the evaluation methodology discussed above (including parents' exposure to dissimilar curriculum content, varying service intensity and different follow-up periods), Harder+Company decided that a discussion of trends between pre-test and post-test assessments in each fiscal year was more appropriate than presentation of statistical tests of significance.

For participants who completed the revised survey in FY 2007-08 and for whom more sensitive measures of behavior change were available, Harder+Company analyzed the responses to these questions separately. In these cases, a range of responses was available for analysis (e.g., a range of 0-7 for the number of days in a typical week that the participant exercises or the number of hours on a typical weekday that a child watches

television). Using a range of values, a paired (dependent) samples t-test was used to assess whether or not the difference in means between pre-test and post-test among participants with matched data available for each question was statistically significant. In doing so Harder+Company was able to better detect small, incremental changes in behavior between pre-test and post-test, particularly for outcomes where behavior change is most difficult to achieve such as eating and exercise habits.

In both years, the same questions assessing participants' confidence in their parenting skills were asked. However, the timing of the administration of these questions changed. In FY 2006-07 participants completed this set of questions separately, first at pre-test and then at post-test. In FY 2007-08 participants completed the second version of the survey in which questions about parental confidence at pre-test and post-test were both asked at post-test. This methodology is similar to that of the retrospective Survey of Parenting Practice in School Readiness. The post-test and retrospective pre-test responses to each of the parental confidence items were compared using a paired (dependent) samples t-test for participants completing assessments in FY 2007-08; the same analysis was conducted to compare responses given separately at pre-test and post-test in FY 2006-07. As expected, the differences in means for questions administered separately at pre-test and post-test in FY 2006-07 were lower than those observed in FY 2007-08 when the questions were asked at post-test only.

Beginning in FY 2008-09 contractors will begin tracking individual-level attendance data, program completion rates, and retention rates. These additions will strengthen the evaluation design and enable us to link the amount of exposure to the intervention (dosage) to the observed outcomes measured by the common survey.

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., health care, child care, school system)	X		
			…how to access and assess quality child care		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 preventive / well-child health care		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 child care			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., health care, child care, 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

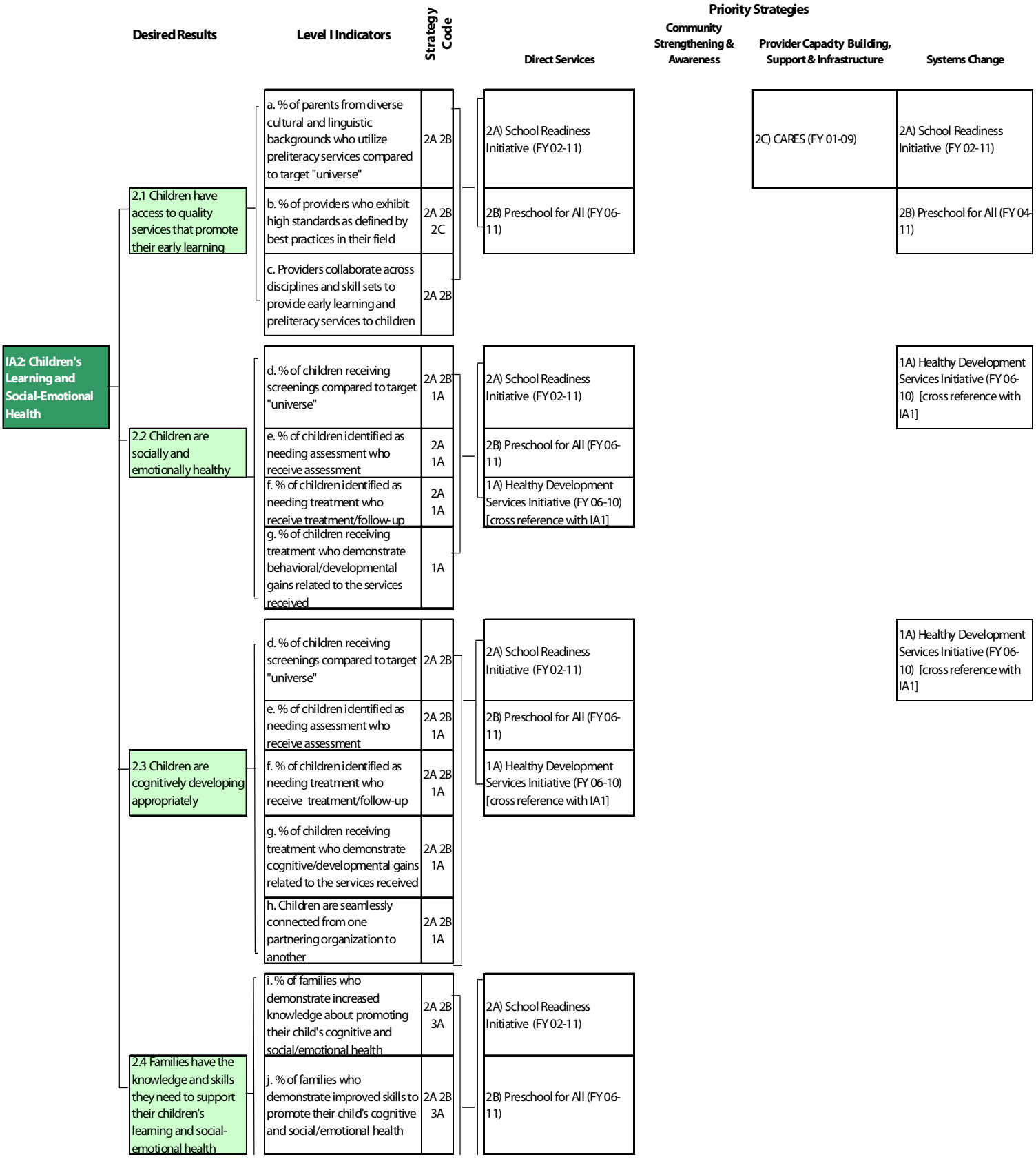
Outcomes				How Measured		Contractors
				Common Survey	*Individual Instruments*	
Service Focus Area 3	***Knowledge Outcomes***	Increased knowledge about…	…nutrition (balanced diet, serving size) and culturally-based healthy alternatives		X	***Mandatory*** All four contractors that address Service Focus 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

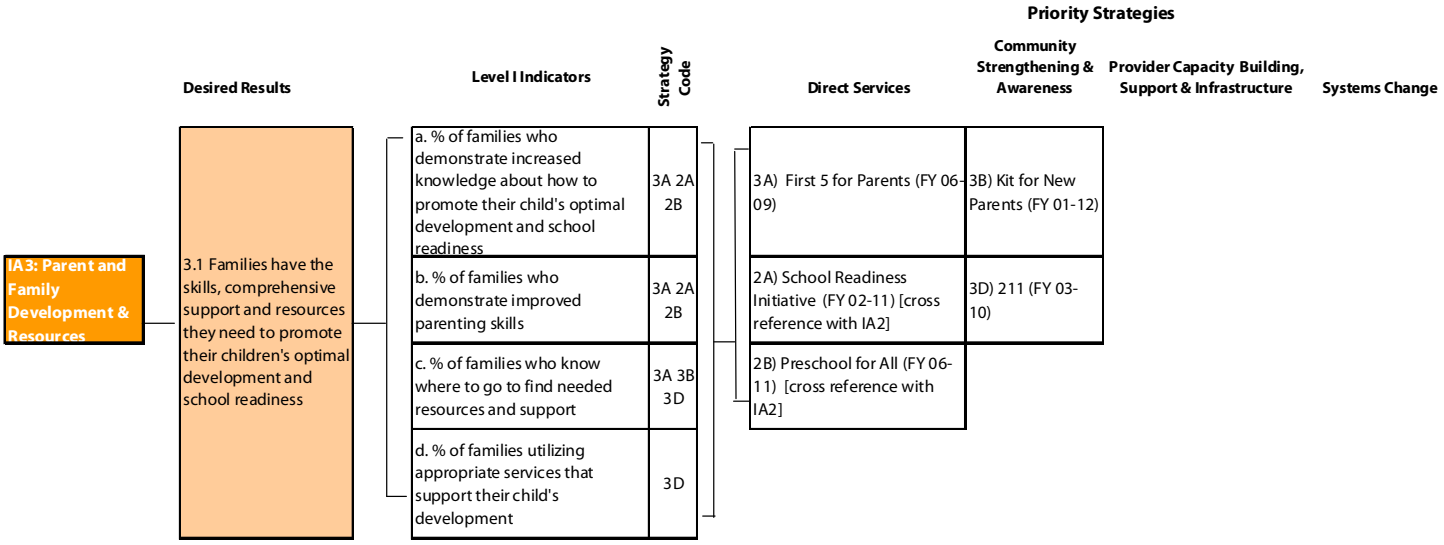
Issue Area 1: Children's Health

Desired Results	Level I Indicators	Strategy Code	Priority Strategies: Direct Services	Community Strengthening & Awareness	Provider Capacity Building, Support & Infrastructure	Systems Change
IA1: Children's Health						
1.1 Children are born and stay healthy	a. % of children who are enrolled/stay enrolled in health care	1B	1A) Healthy Development Services Initiative (FY 06-10)	1A) Healthy Development Services Initiative (FY 06-10)	1C) Oral Health Initiative (FY 05-10)	1A) Healthy Development Services Initiative (FY 06-10)
	b. % of children utilizing appropriate health care resources (both preventative and urgent)	1A 1B 1C 1D	1B) Health Care Access Initiative FY 04-08)			1D) Flouridation
	c. % of children receiving screenings compared to target "universe"	1A 1C 2A 2B	1C) Oral Health Initiative (FY 05-10)			
	d. % of children identified as needing assessment who receive assessment	1A 1C	2A) School Readiness Initiative (FY 02-11) [cross reference with IA2]			
	e. % of children identified as needing treatment who receive treatment/follow-up	1A 1C	2B) Preschool for All (FY 06-11) [cross reference with IA2]			
	f. % of children receiving treatment who demonstrate improved health conditions related to the funded services they receive	1A 1C				
	g. % of children being breastfed at all at the time of hospital discharge, at 6 weeks, at 6 months	1A				
1.2 Children have access to preventative and comprehensive health care services	a. % of children who are enrolled/stay enrolled in health care	1B	1A) Healthy Development Services Initiative (FY 06-10) First 5 for Parents (FY 06-09)		1A) Healthy Development Services Initiative (FY 06-10) First 5 for Parents (FY 06-09)	1A) Healthy Development Services Initiative (FY 06-10)
	b. % of children utilizing appropriate health care resources (both preventative and urgent)	1B	1B) Health Care Access Initiative (FY 04-08)		1C) Oral Health Initiative (FY 05-10)	1C) Oral Health Initiative (FY 05-10)
	c. Providers collaborate across disciplines and skill sets to provide health services to children	1A 1C	1C) Oral Health Initiative (FY 05-10)			
1.3 Families have the knowledge, skills and resources they need to promote their children's optimal health	i. % of families who demonstrate increased knowledge about how to promote their child's health	1A 1B 1C 3A	1A) Healthy Development Services Initiative (FY 06-10)		1A) Healthy Development Services Initiative (FY 06-10)	
	j. % of families who demonstrate improved skills to promote their child's health	3A	1B) Health Care Access Initiative (FY 04-08)			
	b. % of families utilizing appropriate health care resources (both preventative and urgent)	1A 1B 1C	1C) Oral Health Initiative (FY 05-10)			
	k. % of households in which someone smokes	1A	3A) First 5 for Parents (FY 06-09) [cross reference with IA3]			

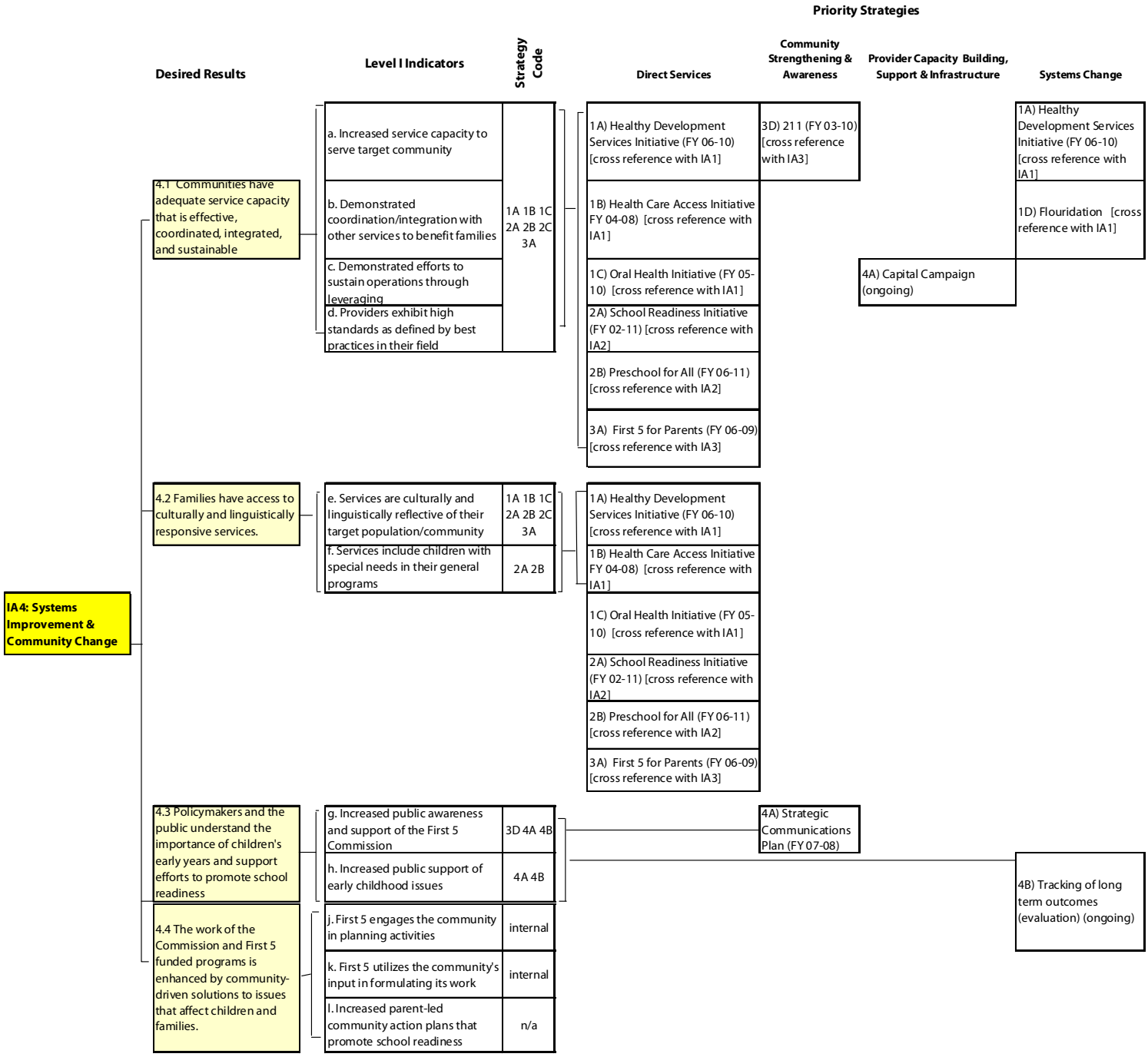
Issue Area 2: Children's Learning and Social-Emotional Health



Issue Area 3: Parent and Family Development and Resources



Issue Area 4: Systems Improvement and Community Change



Founded in 1986, Harder+Company Community Research is a comprehensive social research and planning organization located in San Diego, Los Angeles, 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 training for a wide range of clients across the country.