First 5 San Diego

First 5 Commission of San Diego County

Annual Evaluation Report FY 2009–2010

Improving the Lives of Children 0–5

January 2011

harder+company community research

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

Acknowledgements

This report reflects the collaborative effort of hundreds of individuals and agencies, including the First 5 contractors and staff, as well as First 5 program participants. First 5 contractors provide critical data on the First 5 programs on a regular basis to First 5, tracking clients from entry into the program to completion of services and even follow-up. This on-going collection of data allows the commission to keep abreast of program operations, as well as identify program and system level barriers. It also allows the First 5 Commission staff to monitor contracts and to stay aware of challenges in program implementation. Program participants took time out of their busy schedules to answer questions about themselves and their families, as well as reflected on the impacts First 5 San Diego may have had in their lives. Without all of these individuals working together to measure the impact of the First 5 programs, this evaluation would not be possible.

In particular, Harder+Company Community Research would like to thank the following people and organizations for their assistance with his evaluation report:

- 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: Diane Jacob (Chair 2009, 2010), Nick Macchione, Dr. Wilma J. Wooten, Carol Skiljan and Sandra L. McBrayer.
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Executive Summary

Fiscal Year 2009-10 marks one decade since the First 5 Commission of San Diego first began developing needed programs for children ages 0 through 5 and their families, funded through Proposition 10 tobacco tax revenues. Over these ten years, the Commission has become more streamlined as an organization, more strategic in its vision and fund utilization, and better able to articulate the results of its endeavors. During this most recent fiscal year, a total of $ 80,602,444 was invested in a broad array of programs and services for children ages 0 through 5, their families, and the providers who serve them. During this fiscal year, First 5 San Diego continued its major initiatives, funded new projects, redesigned the delivery of some services, and continued its support of a variety of responsive, capital, and innovative projects to create a broad network of care for children and parents in San Diego County.

The comprehensive impact of these services on the health, development, and well-being of the children and families served is impossible to measure completely. At a systems level, First 5 San Diego programs have changed the way that health insurance and health care are accessed by parents of children from 0 through 5; expanded access to quality preschools; developed an integrated system for assessing and treating child behavior and development; improved how children transition to kindergarten; and enhanced services to children in foster care. These programs have changed not only the landscape of service providers, the type and quality of services delivered, and the referral patterns between providers, but also how providers deliver services and respond to the needs of families in need. Providers have been as shaped by the program as the children and families they serve, guided by participant feedback, evaluation data, and the First 5 Commission staff.

First 5 San Diego At-A-Glance

Vision
All children ages 0 through 5 are healthy, are loved and nurtured, and enter school as active learners

Mission
To lead the San Diego community in promoting the vital importance of the first 5 years of life to the well-being of children, families and society.

Goal Areas
- Health
- Learning
- Family
- Community

Amount Distributed in FY 2009-10: $ 80,602,444

Number of Contracts: 65

Number of Organizations Providing Funded Services: 51

During FY 2009-10, the role of First 5 San Diego was more important than ever to the health and well-being of young children and their families. As the economic recession deepened, First 5 San Diego provided critical resources to support safety net programs for the most vulnerable populations. This included funding services for children in foster care, to support children needing health insurance, and expand support for early education and the health needs of children and pregnant women. As other state and county funded programs were reduced or eliminated, First 5 San Diego stepped into the gap and funded critical services.

To assess the impact of First 5 funded initiatives and programs, each year the First 5 Commission invests in a comprehensive evaluation of the system of care is has created and supports. This report summarizes the major findings from this evaluation, focusing on both client-level results as well as systems-level impacts.

Evaluation results are reported by the initiative level (i.e., a group of providers that share the same goals, objectives, and data collection strategies). The monitoring of individual contractor's progress is conducted internally by First 5 San Diego staff.

Initiative Goals and Impact

Evaluation findings from each of the initiatives and individual projects are presented in the following pages. Exhibit A.1 presents a matrix of the key initiatives, desired impact, and populations served in FY 2009-10 within each goal area. In all goal areas, the First 5 programs have met key goals and have had a significant impact on children and families in San Diego. This report was developed not only to inform the Commission of the results of its investments, but also to provide initiative-level feedback to First 5 San Diego funded contractors on the results of their collective impact.

Exhibit A.1 Goals, Initiatives and Impact

First 5 Strategic Goal Area	Initiative/ Program	Impact	Numbers Served
HEALTH	Healthcare Access Initiative (HCA)	Insurance coverage & linkages to healthcare	9,227 children 2,389 pregnant women
	Healthy Development Services (HDS)	Developmental screening & treatment	36,576 children 13,571 parents
	Oral Health Initiative (OHI)	Dental screening, treatment and education	19,289 children 2,344 pregnant women
LEARNING	Preschool for All (PFA)	Access to quality preschool in 8 communities	3,906 children
	School Readiness (SR)	Preparation for Kindergarten	5,353 children
FAMILY	Parent Education (First 5 For Parents)	Parent skills and behaviors re: child health & development	3,790 parents
COMMUNITY	Child Welfare Services (CWS)	Improved assessment, planning & stability for children in foster care	1,004 children
	211 San Diego Parent and Public Education	Community awareness of services for children 0-5 and families	37,385 callers 2.1 mil residents

The FY 09-10 Evaluation Report

In addition to the analysis of the service delivery and outcomes data for each initiative and individual project funded by First 5 San Diego, this year's report includes Scorecards for each initiative. These scorecards provide one to two-page snapshots of the services provided and selected outcomes, relative to targets, for each initiative.

Health

The Strategic Plan goal for Health is "to promote each child's healthy physical, social and emotional development." This goal is met through three major initiatives: Health Care Access (HCA), Healthy Development Services (HDS) and the Oral Health Initiative (OHI). In addition to these major initiatives, the Black Infant Health program and the countywide Childhood Obesity Initiative were also funded to support child health.

Health Care Access (HCA)

- The HCA program exceeded its goals of enrolling and retaining health insurance among children and pregnant women. The program reached out to more than 70,000 families that may have been without health insurance and provided information, enrollment assistance and connections to medical care.
- Overall, the HCA project enrolled 9,227 children and 2,389 pregnant women in health insurance programs and assisting 6,301 children in staying enrolled.
- At 12-18 month follow-up, 86.6% of children had retained their health insurance, exceeding a comparable statewide rate of 62%.
- The impact of these services includes increases in primary care visits for children from birth to 5 (96.6%) and a low rate of (16.5%) emergency room visits. In addition, HCA encourages parents to take children to the dentist, resulting in high rates of annual dental visits among children. (65.5%-68.8%)

Healthy Development Services (HDS)

- More than 36,576 children were provided developmental screenings or treatment, while 13,571 parents received coaching or parenting classes to help promote their child's development.
- More than 30,000 children had some type of developmental, behavioral or vision screening, providing early identification of issues and referrals to needed services at an appropriate age.
- Between 90-95% of children receiving HDS behavioral, developmental and speech/language treatment services demonstrated measureable gains.
- Home visits were provided to more than 8,800 new parents and their infants, and more than 2,700 families received at-risk home visitation. These services lead to improved knowledge and skills for parenting and referred family members to smoking cessation services.
- The HDS program significantly improved parenting skills and knowledge among nearly 3,000 parents participating in classes, workshops and consultations. More than 97% of participating parents reported gains in knowledge and/or skills.
- The HDS initiative supports a large and complex network of providers. This system has made significant advances during FY 09-10 year, including changes to service delivery.

Oral Health Initiative (OHI)

- OHI reached 19,289 children and 2,344 pregnant women with oral health screenings, dental exams, treatment and education. The initiative met all of its goals in FY 2009-10.

- The number of children from 1 to5 who received dental examinations was nearly double the annual target, at 11,652. The proportion of children receiving a first time exam increased by 5.4% indicating appropriate and effective outreach to populations in need.
- The impact of the OHI initiative on pregnant women was greater this fiscal year than ever, reaching its largest number with exams (1,753) and treatment (3,444).
- One of the ways that OHI increases screening and treatment rates is through its outreach, coordination of services and education. These services also showed significant growth, with nearly 10,000 parents receiving education about promoting children's oral health and more than 2,500 pregnant women receiving education about the importance of oral health care during pregnancy.
- The system of outreach, screening and treatment for dental services through OHI continues to improve each year with a network of 18 providers around the county offering and coordinating services. These providers also made referrals to other initiatives, including HDS and PFA, showing important initiative integration.

Black Infant Health and What to Do When Your Child Gets Sick

- The Black Infant Health project provided prenatal care outreach, case management, social support, health education and treatment to more than 300 pregnant African American women. These services resulted in improved prenatal care, reduced tobacco use and improved birth outcomes to participating women.
- More than 125 trainers at 26 sites were trained in a new curriculum based on the book, "What to Do When Your Child Gets Sick." These trainers will continue providing education to parents on recognizing illnesses and appropriate use of medical services.

Learning

The Strategic Plan goal for Learning is to "Support each child's development of communication, problem solving, physical, social-emotional and behavioral abilities building on their natural ability to learn." This goal is met through the Preschool for All and School Readiness Initiatives as well as through the Mi Escuelita, Reach Out and Read, Preschool Learning Foundations and the CARES programs. The key findings from the initiatives include:

Preschool for All (PFA)

- The PFA initiative met all of its five performance goals, exceeding targets in many areas.
- PFA provided quality preschool experiences to more than 3,900 children attending sessions at 28 agencies in eight areas of the county.
- Average child development scores and classroom ratings increased significantly in all domains.
- Developmental screenings were provided to 76.2% of children. The number of children served with special needs, with Individual Education Plans (IEP's) and referred for special needs services were lower than anticipated.
- More than 99% of PFA teachers participated in professional development activities and the proportion of teachers with a Bachelor's degree or higher increased slightly over last year.
- Overall, the PFA program has collaborated with many First 5 initiatives including OHI and HDS. Agencies refer families for dental care, developmental needs and other services.

School Readiness (SR)

- The SR initiative met all of its performance goals, exceeding its targets by 40% or more on some measures. Overall, SR provided preschool education services to 947 children, and activity-based education services to another 196 children and parents.
- At the end of the school year, participating children had made significant developmental gains, relative to their entry levels, in all domain measures.
- 88.6% of children regularly participating in SR programs received developmental screenings.
- More than 5,350 children participated in kindergarten transition activities.

Mi Escuelita, Reach Out and Read, Preschool Learning Foundations and the CARES Projects

- Mi Escuelita Therapeutic Preschool served 36 preschool children exposed to domestic violence and their families for a full year. Mi Escuelita delivered needed educational interventions, parenting classes, family counseling sessions, occupational and physical therapy and speech therapy. As a result, children made significant developmental gains throughout the school year. This program is an example of the value of targeted comprehensive educational and family support services to meet the need of the most at-risk young children in San Diego.
- Reach Out and Read (ROR) is a pediatrician-developed program that uses regularly scheduled doctor's visits to encourage parents to read frequently to their children. ROR provided services to 2,187 children and distributed 4,375 books.
- The Preschool Learning Foundations program provides training to preschool teachers on the California Department of Education's "Preschool Learning Foundations." The Foundations outline what preschoolers should learn in key areas. The attendance at all PLF classes totaled over 300; attendees reported improved learning that will be valuable in their classrooms. Others received one-on-one mentoring to employ the Foundations in their classrooms.
- San Diego CARES (Comprehensive Approaches to Raising Educational Standards) offers stipends to child care providers who complete college coursework. In 2009-2010, 556 teachers received stipends to assist them in completing a degree or attaining a California Child Development Permit.

Family

The Strategic Plan goal for Family is to "strengthen each family's ability to provide nurturing, safe and stable environments. " This goal was addressed by the First 5 for Parents and Child Welfare Services Initiatives, as well as by the Foster Care Respite program, the Families Together, Kit for New Parents and SANDAPP programs. Key findings from these projects include:

First 5 for Parents (F5FP)

- The First 5 for Parents program met all of its performance goals, providing critical parent education, positive parenting skills and enhancing children's early literacy. A total of 4,067 parent education classes were provided.
- A total of 3,790 parents and caregivers participated in programs. Participants reported increased confidence in their parenting and increased knowledge of both learning and parenting.
- As a result of the First 5 for Parents program, increases in activities that promote early learning, including the percent of parents reading or singing to their children , and the percent of parents that played with their children increased.

F5FP also addressed several of the County of San Diego's Health Strategy Agenda goals for building better health, by providing education to parents about healthy nutrition and exercise. As a result, reductions in the percent of families using fast food restaurants, increases in the percent of children with daily physical activity and reductions in the percent of television/video game playing time were reported.

Child Welfare Services (CWS)

- The CWS Early Childhood Services and DSEP projects form the newest First 5 San Diego initiative. It began service delivery in the middle of the fiscal year. Extensive planning has led to rapid implementation and the meeting of project goals. In FY 2009-10 more than 1,000 children in foster care were screened for developmental and behavioral needs.
- 524 children with identified needs and their caregivers were provided support, case management and coaching.
- Teen parents residing at the Polinsky Center also received education and case management to improve their abilities to parent.
- This new initiative is showing great promise to identify, treat and support San Diego's most at-risk children.

Foster Care-Respite, Families Together Program, Kit for New Parents and SANDAPP

- The Foster Care Respite program provides support to foster parents and other caregivers. In FY 2009-10, 243 parents and 527 children were served by this program. Of these, 88% foster parents reported decreased stress as a result of the program, and 62% reported improvements in their relationships with the children in their care.
- The Families Together Program, delivered by Horn of Africa, provides intensive family support to at-risk children and families through home visiting, assessment and care plans. In FY 2009-10, the program served 147 new and continuing families, including 302 children. The impact of this program was seen in improved medical care use, child developmental screening and improve of parent-child interactions.
- A total of 33,305 Kits for New Parents were distributed to parents of children ages 0 to 5 in FY 2009-2010. These kits contain valuable information about how to support the learning and social-emotional development of children and how to access resources.
- San Diego Adolescent Pregnancy and Parenting (SANDAPP) provided home-based case management and support services to 424 pregnant and parenting youth in FY 2009-10. Of these, only 1 had a repeat pregnancy, and 100% met their educational goals.

Community

The Strategic Plan goal for Community is to "Build each community's capacity to sustain healthy social relationships and support families and children." This is achieved through the Parent and Public Education media campaign, the information and referral services (211 San Diego) and the innovative and capitol projects supported by First 5 San Diego. Key outcomes include:

- More than 2.1 million residents viewed the Parent and Public Education campaign that focused on the importance of the health and developmental needs of children ages 0 through 5
- More than 37,385 families with children ages 0 through 5 accessed 211 San Diego in search of services. Of these 2,166 were directly referred to a First 5 San Diego program. First 5 San Diego also invested $22,992,762 to support a number of capital projects, from child development facilities to preschool areas in libraries.
- First 5 San Diego's Innovative Grants invested in unique programs for targeted populations. More than 1,500 families and children were served through such projects headed by the Alliance for African Assistance, Jewish Family Service of San Diego, Resounding Joy, and the Vista Community Clinic.

Overall, the First 5 San Diego programs are achieving high levels of performance in meeting the Commission's strategic goals. Most importantly, the First 5 programs are successfully serving thousands of children and families who would otherwise be without access to needed health care, education, family support and developmental services. The remainder of this evaluation report provides more detailed analysis of the successes and challenges of each initiative and project of First 5 San Diego.

Health

Goal: Promote each child's healthy physical, social and emotional development.

Health Care Access
Oral Health Initiative
Healthy Development Services
- Black Infant Health
- Childhood Obesity Initiative

First 5 San Diego

CHAPTER 1.
Health Care Access

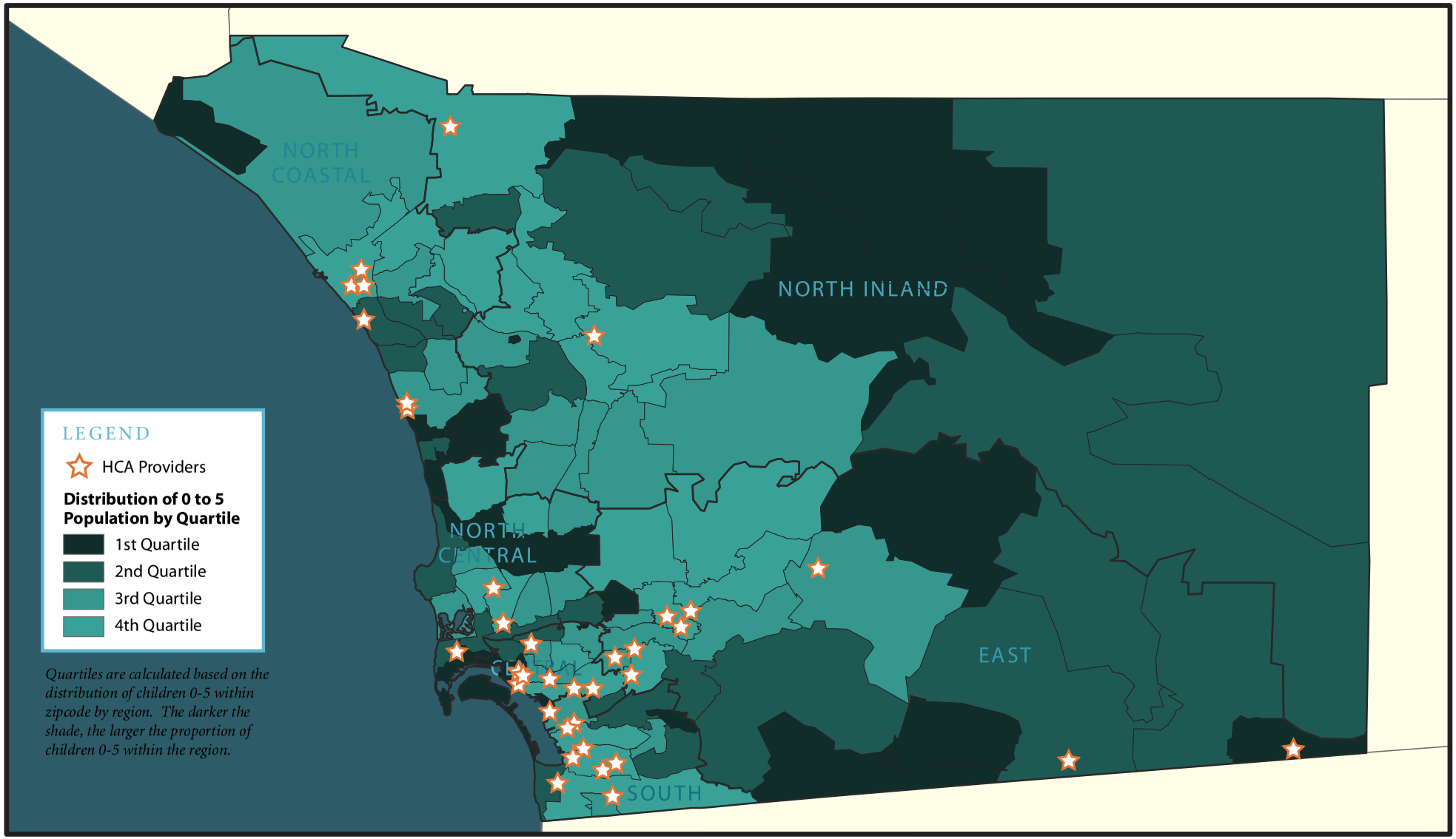
2009/2010 Scorecard

Goals	Measures	Target	Actual	Performance
1: Increase and sustain enrollment of eligible children from birth through age 5 and pregnant women in existing plans	Number of children assisted with health insurance	12,920	13,565	
	Number of pregnant women assisted with health insurance	4,210	3,593	
	Number of children enrolled into health insurance	8,120	9,227	
	Number of pregnant women enrolled into health insurance	3,545	2,389	
	Percent of children maintaining health insurance coverage for 1 year*	60%	86.6%	
2: Link enrollees to a medical home*	Percent of children 0-5 who are linked to medical home	91%	98.8%	
3: Support appropriate utilization of services, ensuring that children and pregnant women receive preventative health services and families get the assistance needed to navigate the healthcare system.*	Percent of children who went to the doctor in the past year	65%	96.6%	
	Percent of children who went to the ER in the past year	No target	16.5%	
	Percent of children who went to the dentist in the past year	60%	65.5%	

90% or above target 75-89% of target <75% of target

*Data represents Follow Up 12-18 group.

Health Care Access Providers



Introduction

"I think [HCA] not only promotes insurance, but also other ways of better living."
- HCA Provider

Health care coverage improves a child's ability to receive medical services and promotes appropriate preventative care. Children enrolled in insurance are more likely to be in better health than their uninsured counterparts.[1,2,3]

Census data shows that San Diego County experienced a 7.0% increase in the number of children insured from last year.[4] However, 4.1% of San Diego's children from birth to 5 remain uninsured.[5] To meet this need, the First 5 Commission of San Diego Health Care Access Initiative (HCA) conducts health insurance application assistance and ongoing support to maintain insurance coverage for children birth to 5 and pregnant women. HCA staff assists children birth to 5 who are eligible for Medi-Cal and Healthy Families but are not enrolled. They also work to enroll pregnant women who may be eligible for state and federal programs such as Medi-Cal or Access for Infants and Mothers (AIM), but may not be enrolled. Since its inception in February 2004, First 5 San Diego has committed $11,249,600 to HCA ($3,087,538 in FY 2009-10). Five organizations are the lead agencies providing HCA services to 6 San Diego regions: Social Advocates for Youth (SAY) San Diego (2 regions), Home Start, Inc., North County Health Services, Neighborhood Healthcare, and Vista Community Clinic.

Initiative Goals

- Increase and sustain enrollment of eligible children from birth through age 5 and pregnant women in health insurance
- Link enrollees to a medical home
- Support appropriate utilization of services ensuring that children and pregnant women receive preventive health services and families get the help they need to navigate the healthcare system

Key Elements

HCA focuses its efforts on enrolling San Diego County's eligible uninsured children from birth to 5 and pregnant women by: 1) identifying and reaching out to families in need of healthcare; 2) assisting families in completing enrollment applications; 3) providing ongoing support to families to ensure they remain enrolled in insurance; and 4) educating families on the importance of establishing a link to medical homes and appropriately utilizing healthcare services.

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[1] US Census Bureau. *Health Insurance Coverage of Children Under Age 19: 2008 and 2009*. Issued September 2010.

[2] March of Dimes. *March of Dimes Data Book for Policy Makers: Maternal, Infant, and Child Health in the US 2008*. Retrieved [08/24/09] from www.marchofdimes.com.

[3] Institute of Medicine. America's *Uninsured Crisis: Consequences for Health and Health Care*. Retrieved [09/28/09] from www.iom.edu.

[4] Children NOW. 2010 California County Scorecard: San Diego County Retrieved [11/18/10]

[5] California Health Interview Survey, 2007.

Summing it Up

"We make sure that the children are well attended… have access to medical [insurance] and other resources so the family is not isolated … and can get follow up."

- HCA Provider

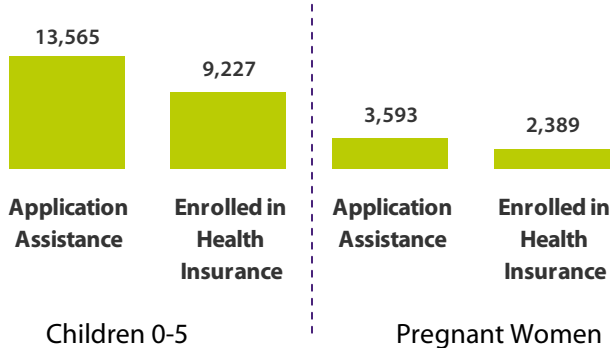
Fiscal year 2009-10 marks the sixth year of the HCA initiative. Since its inception in February 2004, HCA has provided extensive services to the uninsured:

- **86,584 children ages birth to 5** assisted with enrolling or renewing enrollment into a health insurance program
- **61,534 children ages birth to 5** enrolled (or renewed enrollment) in a health insurance program
- **22,164 pregnant women** enrolled into health insurance

How many children and pregnant women were served this fiscal year?[6]

Exhibit 1.1 presents data on children from birth to 5 and pregnant women served by HCA in FY 2009-10. Of those participants who received application assistance, 68.0% of children birth to 5 and 66.0% of pregnant women were enrolled into a health insurance program. The reasons children were not enrolled are discussed later in this chapter.

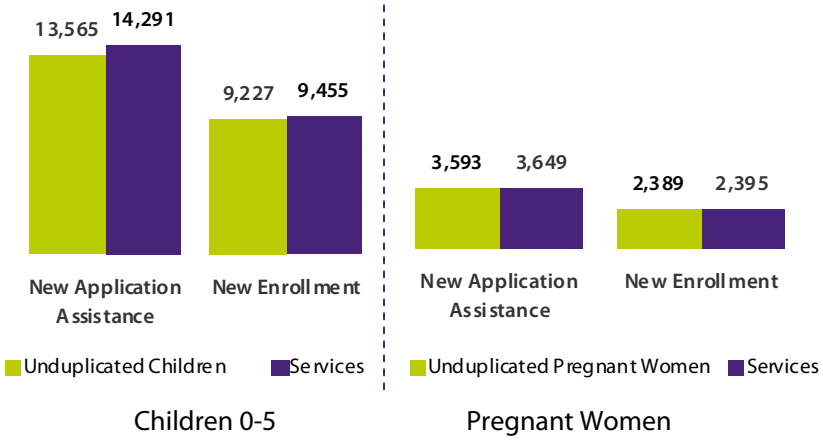
Exhibit 1.1 FY 2009-10 Number of People Receiving HCA Services



[6] The Implementation of Commission's CMEDS database improved the ability to accurately measure all aspects of the initiative, establish a true unduplicated count of children and pregnant women served, and increase specificity about outreach activities. This improvement prohibits year to year comparisons for some measures.

Exhibit 1.2 shows the number of unduplicated children and pregnant women who received application assistance and the number enrolled along with the number of services delivered. The total number of services was greater than the number of clients served primarily because some clients may apply for insurance more than once in the fiscal year. (This might be due to delays with the enrollment process or a missed renewal, as example.)

Exhibit 1.2 FY 2009-10 Number of HCA Clients and Services Provided



What families received outreach and what did outreach look like?

HCA contractors conduct ongoing outreach to identify potential families who are eligible but are not enrolled in state and federal health insurance plans. In FY 2009-10, 70,035 families received outreach through direct contact. Contractors continued to expand their reach into target communities by using subcontractors with a deep knowledge of targeting First 5 populations. A resounding theme communicated by contractors is the importance and challenge of locating the uninsured population. Additionally, contractors noted that their long standing presence in the community has contributed to their visibility and effectiveness.

How many renewals and new enrollments did HCA conduct?

Exhibit 1.3 presents the number of health insurance renewals and new enrollments for FY 2008-09 and FY 2009-10. Due to improvements in data collection and reporting, data are not completely comparable between years. Yet, comparison of these data show the general success of the program in assisting and enrolling children and pregnant women in insurance, especially in helping families renew and retain their child's health insurance. It is of note that in FY 2009-10, over twice as many families renewed their insurance as compared to those enrolled for the first time by an HCA contractor. This finding illustrates the importance of continued contact with families to ensure they maintain health insurance. Families may have been concerned about the challenges of re-enrolling in insurance programs due to cuts in the state budget and focused efforts on retaining health coverage.

Exhibit 1.3 Number of People Reached by the Healthcare Access Initiative FY 2008-09 & FY 2009-10

Enrollment Activity	FY 2008-09			FY 2009-10		
	Renewals	New	Total	Renewals	New	Total
Children ages 0-5 assisted	4,890	11,372	**16,262**	5,069	8,496	**13,565**
Children ages 0-5 confirmed enrolled**	3,262	8,509	**11,771**	6,301	2,926	**9,227**
Pregnant women enrolled	N/A	4,981	**4,981**	N/A	2,389	**2,389**

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

***Includes children enrolled into Medi-Cal, Healthy Families, and other types of insurance.*

Making a Difference

"I feel like we have had really strong retention services, the people we assist… come back year after year and they stay in the program."

- HCA Contractor

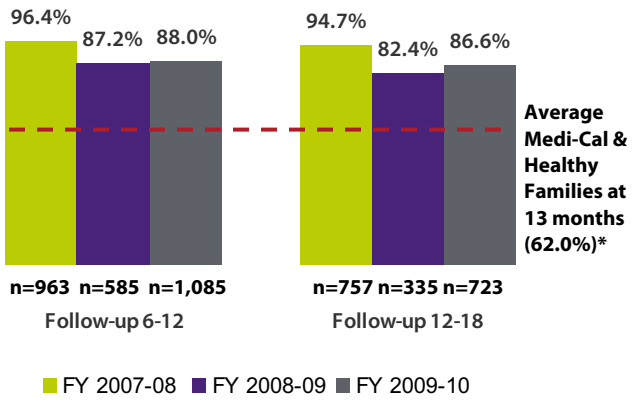
Once families are enrolled into a health insurance program; HCA contractors schedule follow-up appointments to ensure that families understand their benefits and are educated about the importance of using and retaining healthcare. Retention Specialists and Certified Application Assistants (CAA) administer 6, 12, and 18 month follow up surveys over the phone after enrollment to ensure that families have maintained their insurance and are accessing appropriate medical care. The results of the surveys are presented below and focus on the following five key outcomes: 1) retaining coverage; 2) linkage to a medical home; 3) regular doctor visits, 4) regular dental visits; and 5) reduced and appropriate emergency room utilization.[7]

Maintaining Coverage

Are children 0 - 5 retaining enrollment in existing health plans?

Exhibit 1.4 demonstrates trends in health insurance retention between 2007 and 2010 for the two follow-up periods. The graph shows that, despite a drop from 2007-2008, insurance retention increased slightly in FY 2009-2010: 0.8% at the 6-12 month period and 4.2% at the 12-18 month period. HCA's retention rates also surpassed comparable California state data related to children maintaining insurance coverage.

Exhibit 1.4 Children Retained in Insurance for 1 year



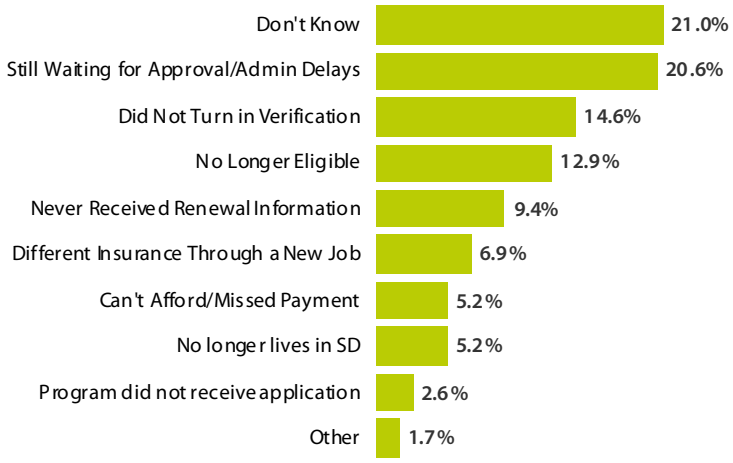
*Source: G. Fairbrother, J. Schuchter. Stability and Churning in Medi-Cal and Healthy Families. March 2008. The California Endowment, 14 September 2009. Children's ages were noted as 0-18 years of age.e

[7] The results presented include comparisons between follow-up surveys given at 6-12 months and 12-18 months. Analysis is not matched based on the sample size. The data are comparable from year to year.

What are the reasons children 0 - 5 are not retaining enrollment in existing health plans?

The two most common reasons for HCA clients not retaining health insurance this fiscal year was "Don't know" the reason they were no longer enrolled (21.0%) and that "their application was still pending approval" (20.6%), which was noted last year as the primary reason for not being enrolled. Contractors noticed that the continued identified or expressed lag in Medi-Cal application wait times have left clients uncertain of their application status.

Exhibit 1.5 Reasons Children are No Longer Enrolled in Health Insurance (n=233)*



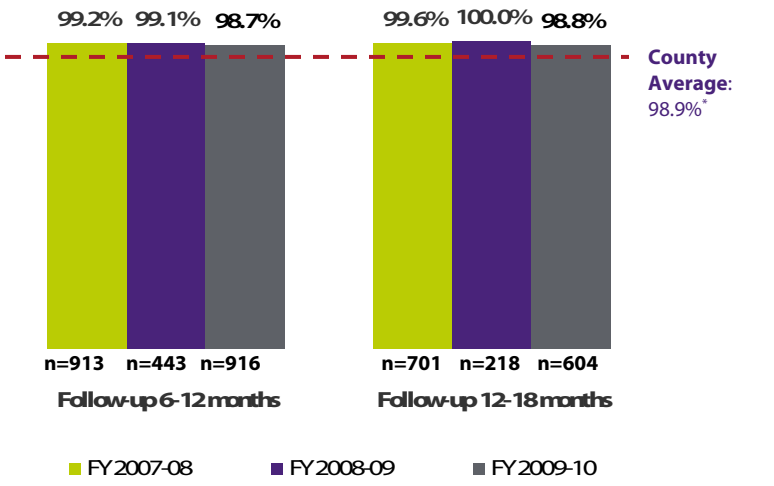
Includes responses from all surveys. Categories are not mutually exclusive.

Maintaining Linkage to Medical Home

Are children 0 - 5 being linked to a medical home?

For children that maintained enrollment in a health insurance program, there was a slight decrease in parents' ability to name their child's clinic or doctor (a proxy for medical home) in FY 2009-10 compared to FY 2008-09. However, linkage to a medical home continues to remain high in FY 2009-10 and past years, and is nearly equivalent to the county percentage for this measure.

Exhibit 1.6 Parents Who Can Name Their Child's Clinic or Doctor



California Health Interview Survey, 2007. Question asked "Has Usual Source of Care?"

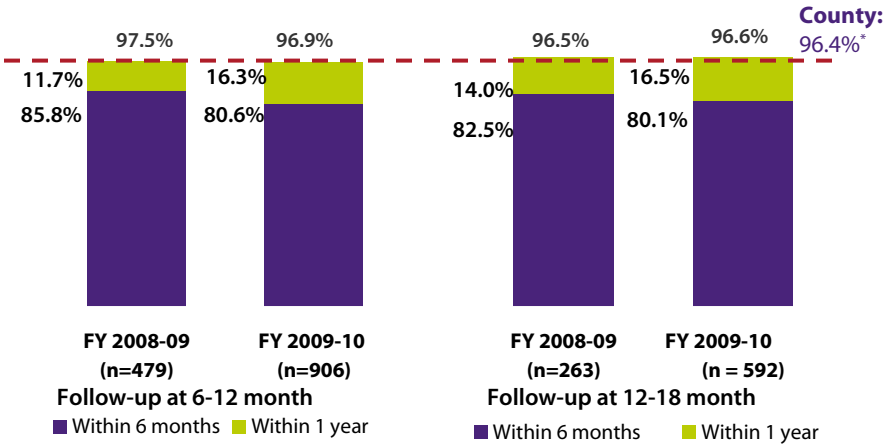
Utilization of Healthcare Services

Healthcare utilization services for children who are enrolled in a health insurance program include measures of children's visits to the doctor, emergency room, and dentist. In all areas, children served by HCA utilized health and dental services at rates near or better than county-wide data. This is an important result as children served by HCA live at or below the federal poverty level. The following healthcare utilization outcomes are based on children surveyed at 6, 12 and 18 months who reported they were still enrolled in a health insurance program.

Are children age 0 - 5 visiting the doctor?

Among participants in HCA, doctor visits remained high in FY 2009-10, with over 96.6% of children visiting the doctor within the year. This figure is similar to the average county rate of doctor visits within a year (96.4%). However, doctor visits in the past 6 months decreased in FY 2009-10 compared to past years (85.8% to 80.6% and from 82.5% to 80.1%). Doctor visits within the last year decreased among the 6-12 month follow-up group and increased in the 12-18 month Follow-Up group compared to previous years.

Exhibit 1.7 Visits to the Doctor for Children



California Health Interview Survey, 2007. The American Academy of Pediatric recommends children under 3 years of age to visit the doctor every 6 months, while children above 3 years of age to visit the doctor annually. A more in depth analysis of doctor visits will be discussed for next year's analysis.

What are the reasons children age 0 - 5 are visiting the doctor?

The most common reasons for visiting the doctor within 6 months in FY 2009-10 are for preventative services such as check-ups and immunizations. The second most common reason reported for a doctor visit in the past 6 months was illness (31.6% at 6-12 month follow-up and 37.3% at 12-18 month follow-up).

Exhibit 1.8 Reasons Children Visited the Doctor FY 2009-10

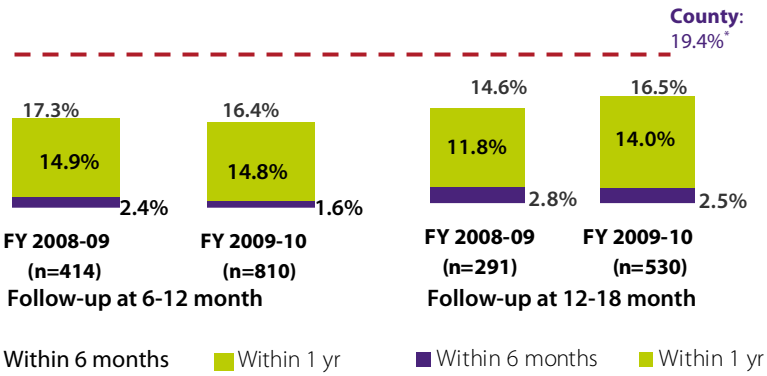
	Follow-up 6-12 (n=730)		Follow-up 12-18 (n=474)	
Activity/Item	**6 mo**	**12 mo**	**12 mo**	**18 mo**
Regular Check-Up	69.2%	63.7%	63.3%	59.9%
Immunization	15.7%	15.5%	13.3%	19.0%
Illness	31.6%	38.5%	37.3%	35.7%
Accident	0.7%	0.5%	0.4%	0.4%
Other	6.6%	7.1%	7.2%	8.9%

Is HCA reducing visits to the emergency room?

Exhibit 1.9 shows the percentage of children who visited an emergency room (ER) in the past 6 and 12 months for each follow-up period. The goal is that access to preventative care as well as education efforts by the CAA's will reduce usage of the ER for non-emergency reasons. The percentage of children in FY 2009-10 visiting the emergency room (ER) in the past 6 months declined slightly between 6 and 12 months and increased slightly at 12-18 months follow-up.

For both HCA follow up groups, children maintained a notably lower ER utilization rate than the children in the county at 19.4%

Exhibit 1.9 Children Emergency Room Visits

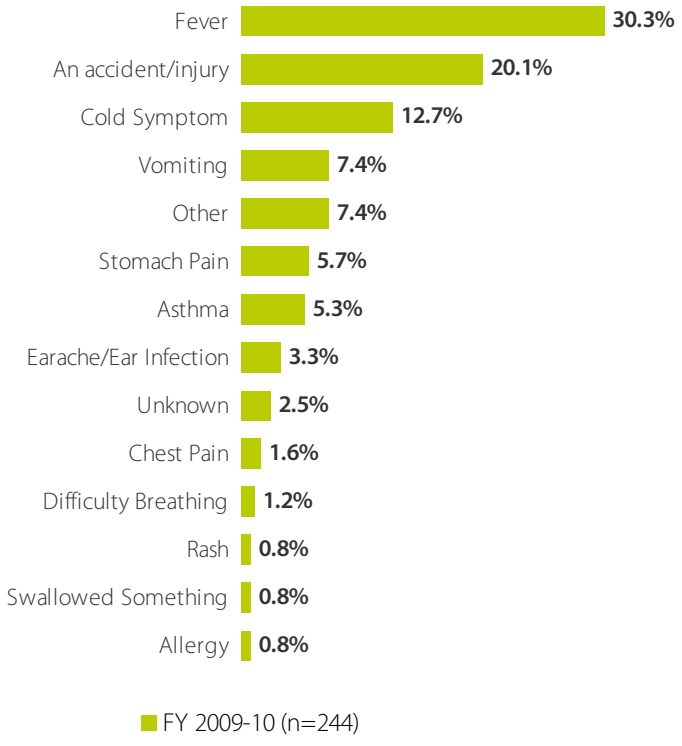


* *California Health Interview Survey, 2007.*

What were the reasons children age 0 - 5 are visiting the emergency room?

The two most common reasons for children visiting the Emergency Room were fever (30.3%) followed by accidents/injuries (20.1%). It is of note that while these data provide additional information, it is not possible to assess if the visit was appropriate. [8]

Exhibit 1.10 Reasons Children Visited the Emergency Room*



* *Includes responses from all surveys. Categories are not mutually exclusive.*

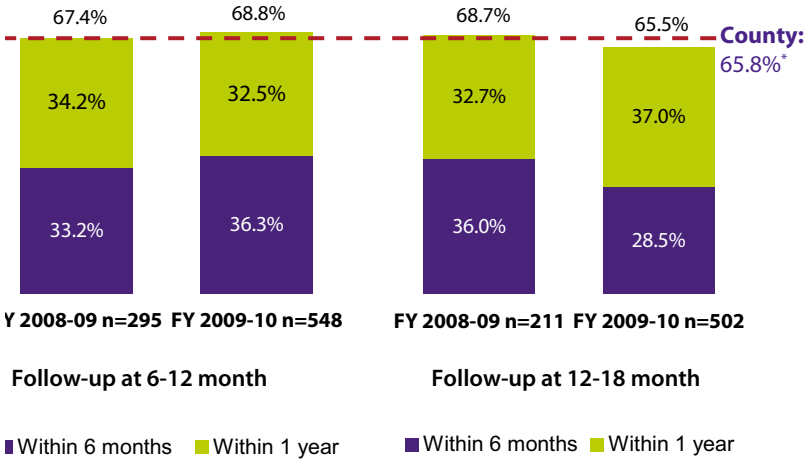
[8] It is notable that FY 2009-2010 saw a rise in the number of H1N1 cases which affect ER usage.

How does insurance enrollment affect dental visits for children from birth to 5?

The American Academy of Pediatric Dentistry Guidelines specify that children should visit the dentist every 6 months.[14] Exhibit 1.11 shows two-year trends in the proportion of children 1-5 who had dental visits within the past 6 months or 12 months, by follow-up group. These data show that while the follow up 6-12 month group exhibited a slight increase in the percentage of dental visits in the past 6 months, the follow-up 12-18 month group experienced a decrease in the percentage of dental visits in the past 6 months but an increase in children that visited the dentist within the past 1 year.

Compared to county data, a greater percentage of children in the 6-12 month follow-up group visited the dentist in the past 6 months while nearly the same percentage of children in 12-18 month follow-up group visited the dentist in the past year.

Exhibit 1.11 Visits to the Dentist for Children



First 5 San Diego, The Status of San Diego County's Children 0-5, 2007.

Why are children from birth to 5 visiting the dentist?

Exhibit 1.12 summarizes the most common reasons for children ages 1-5 visiting the dentist at 6 and 12 months for each follow-up group. In FY 2009-10, the most common reason for children visiting the dentist across all periods, was for check-up/cleanings (See exhibit 1.12). This demonstrates that the majority of children visited the dentist for preventive services which aligns with the First 5 goal on prevention. Another quarter of children, regardless of survey period, went to the dentist to address a cavity. Both results are positive outcomes for HCA's work toward ensuring that young children can access dental care.

Exhibit 1.12 Reasons Children Visited the Dentist FY 2009-10

	Follow-up at 6-12 mos (n=199)		Follow-up at 12-18 mos (n=143)	
Activity/Item	**6 mo**	**12 mo**	**12 mo**	**18 mo**
Check-up/Cleaning	77.9%	67.8%	74.8%	74.1%
Cavity	21.1%	26.1%	21.7%	20.3%
Cleaning and Cavity	0.5%	4.5%	0.0%	5.6%
Other	0.5%	2.0%	3.5%	3.5%

[14] http://www.aapd.org/media /Policies_Guidelines/G_Periodicity.pdf

Making the Connection

All HCA contractors have partnerships with other community organizations across San Diego County. This network of providers allows HCA contractors to better achieve goals and effectively reach the often difficult to locate population of the uninsured. Contractors and subcontractors responded to a survey on their experiences in working with HCA during FY 2009-10, i.e., how it impacted the services they provide and their relationships with clients and partners. In total, 38 staff members completed the survey. This highlights the most common responses by staff members who participate in outreach, application assistance, client education, and retention activities. Additionally, contractors met in a learning community to discuss the workings of HCA during FY 2009-2010.

What are some of the successes and challenges faced by HCA Contractors?

The program's strong retention services and positive relationships between CAAs and clients have resulted in high rates of insurance maintenance among clients. Outreach efforts to locate potential new clients present an ongoing challenge.

The program has positive community recognition making the agencies' presence a valued resource for enrollment and retention. However, some clients remain reluctant to obtain health insurance for fear of family members being deported.

Providers use a variety of education and incentive efforts to effectively promote dental care utilization and positive dental habits.

The program has improved its outreach services and now reaches more clients through its subcontractors. However, many families struggle to pay premiums, due to the economy. This restrains growth of the program.

There continues to be long application wait times to obtain Medi-Cal approval, despite the implementation of San Diego County's ACCESS Customer Service Center, an extension of Family Resource Centers (FRCs). This leaves clients uncertain about their insurance status.

The removal of the Healthy Families wait list created a back log of clients awaiting approval.

What are the concerns of HCA line staff?

Outreach

About a third of respondents felt that outreach efforts have become more difficult than in the past for reasons such as:

- challenges in finding new families; and
- the population of uninsured has changed due to the economy.

Client Education

Currently, the three most common topics for clients are:

- how to stay enrolled;
- how to use their insurance; and,
- establishing a medical home.

Areas where more client education is needed include:

- preventing child obesity; and
- the importance of establishing a medical home.

Application Assistance

The most common reason clients seek application assistance is because of the complexity of the insurance application process. Respondents cited these as factors as the key challenges in providing assistance:

- clients' reluctance to provide all information required;
- increase in premiums makes some clients reluctant to seek coverage; and
- wait time -- Half of the respondents noted that Medi-Cal wait times are 1-3 months while almost a third noted wait times of 3-6 months.

Retention practices

These factors contributed to increasing the retention rates this year:

- the potential of being placed on a waitlist for Healthy Families if a child was disenrolled motivated many families to contact HCA agencies to initiate the renewal process; and
- follow-up calls were the most effective technique in getting clients to initiate and complete the renewal process.

Respondents also noted there was a difference in the time it took for clients to hear back on the status of their renewal application: Healthy Families was about 2 weeks, while Medi-Cal was1-3 months.

Update on FY 2008-09 Recommendations

Last year's Recommendation	Update on Recommendation
Encourage clients to take a proactive role in the health insurance application process.	✚ HCA contractors have encouraged clients to get involved in the application process by educating them on how to follow their Medi-Cal application. ✚ HCA staff has established relationships with local Family Resource Center (FRC). ✚ CAAs counseled clients on the importance of informing the county and HCA of any address or phone number changes and to keep receipts for the items they submit to the Medi-Cal office so that they are more aware of their insurance coverage status. ✚ HCA staff attended the Community Engagement Action Forum (CEAF) meetings and provided updates on First 5 services and the barriers associated with client applications. Additionally, they stayed up to date on any changes in the health insurance programs (for example, Healthy Families premium increases, CA Kids, etc.) so that they could better inform and educate clients on taking a proactive role in the health insurance application process.
Improve collaboration with local Medi-Cal offices to facilitate the status of applications and the process for approval.	✚ Some HCA providers established closer relationships with local Family Resource Centers (FRC) to better facilitate the application process. ✚ HCA contractors worked in collaboration with the Consumer Center for Advocacy to assist clients having difficulties getting their cases approved.

Recommendations

The following recommendations are based on FY 2009-10 data and evaluation findings.

- **Provide training and refresher courses to CAAs and any HCA staff who assist clients.** In their responses to surveys, a majority of HCA staff stated that CAAs and other HCA staff should receive refresher training on the application process and receive updates on any changes in county processes. This will improve efficiency and service and keep HCA staff abreast of issues that may affect their work.

- **Increase communications between HCA and Medi-Cal staff.** The economic downturn has strained many system resources. In both the learning community and in survey responses, HCA contractors and staff stated that increased wait times to reach Medi-Cal staff were challenges in this period to tracking the application and insurance status of their clients. HCA staff recommended strengthening relations and improving communications pathways between HCA and Medi-Cal staff to: provide HCA staff with better information on the status and progress of their clients' health insurance applications, increase efficiency across the system and ultimately increase enrollment rates.

- **Offer training and information on assisting the newly unemployed.** The contractors discussed in the learning communities, that there has been a change in HCA clientele due to the economic downturn. They are serving families that have never sought public assistance before. Many are middle class professionals that are now in crisis due to a job loss. The clients often become emotional and it has been more challenging for CAAs to serve this new population. All providers noted that they would benefit from training on how to best serve these clients.

- **Encourage new outreach methods to reach the target population.** On-going and creative outreach efforts are needed to reach the changing population of residents eligible for HCA services. Two HCA providers shared that they are approaching businesses to set up presentations and insurance enrollment services for their employees. Partnering with businesses that do not provide health insurance offers opportunities to reach new populations of the uninsured.

- **More client-centered training, serving broader variety of populations.** Providers stated in the learning communities that their CAA staff has expressed the need for cultural competency training. Providers in East County in particular wanted assistance in serving their growing population of Middle Eastern immigrants.

CHAPTER 2.
Oral Health Initiative

2009/2010 Scorecard

Goals	Measures	Target	Actual	Performance
1. Increase oral health screenings in a clinic setting coupled with education	Number of children who received a health screening	4,225	8,392	
	Number of pregnant women who received a health screening.	1,055	1,995	
2: Increase the number receiving dental examinations	Number of children 1-5 receiving dental exams	5,775	10,932	
	Number of pregnant women receiving dental exams	1,085	1,753	
3: Increase the number of children and pregnant women with oral health issues who receive appropriate treatment	Number of children 1-5 that received treatment services	4,280	11,756	
	Number of pregnant women that received treatment services	810	3,444	
4: Provide oral healthcare care coordination services for those at risk.	Number of children 1-5 receiving care coordination.	3,255	4,818	
	Number of pregnant women receiving care coordination	750	1,290	

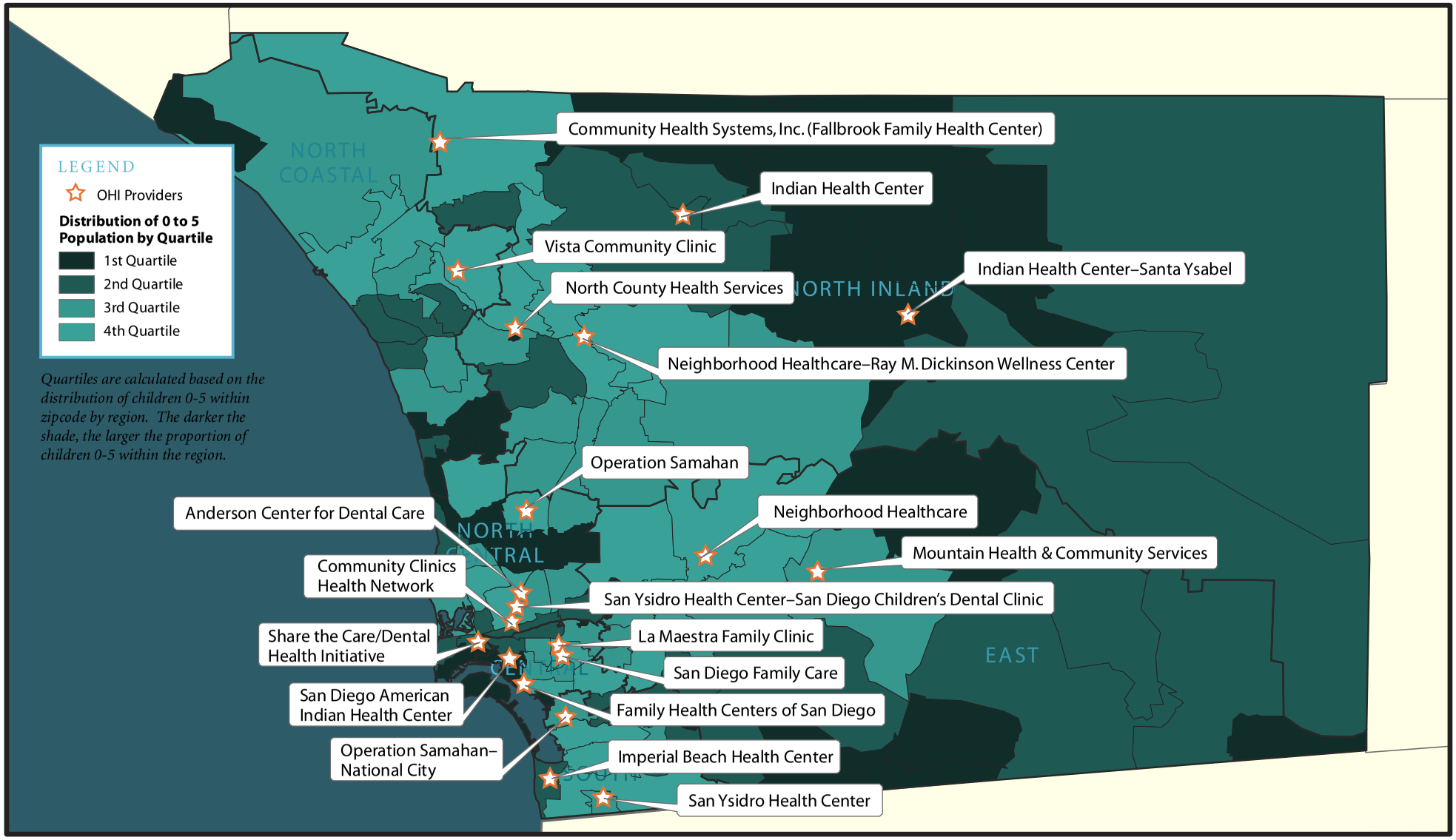
90% or above target 75-89% of target <75% of target

OHI 2009/2010 Scorecard, continued

Goals	Measures	Target	Actual	Performance
Goal 5: Increase the number of parents/caregivers who are knowledgeable about promoting children's oral health.	Number of parents/caregivers participating in educational outreach.	5,965	9,741	
	Number of pregnant women participating in educational outreach.	795	2,586	
6: Increase the number of providers who are knowledgeable about how to promote children's oral health.	Number of providers given education/training: - Prenatal - Dental - Primary Care - Ancillary staff	 40 100 40 40	 47 155 49 50	
7: Increase Oral Health screenings in a community setting.	Number of children ages 1-5 screened in a community setting	5,405	10,897	
	Number of pregnant women screened in a community setting	310	349	

 90% or above target  75-89% of target  <75% of target

Oral Health Initiative Providers



Introduction

"The success of OHI can be attributed to its multi-pronged approach, in working with both clients and providers and dealing with issues relating to prevention, treatment, and access to care."

- First 5 OHI Staff

Dental disease is preventable, yet the Center for Disease Control reports that it is one of the most prevalent childhood diseases in the nation. [1] Untreated, oral health disease may cause pain; affect a child's nutritional status and diet, sleep patterns, and appearance; impair psychological status and social interaction; and cause problems with speech and language development[2]. It is reported that over one-third (36.4%) of San Diego County's children ages 1-5 have never visited a dentist.[3] Children with untreated dental disease require more extensive and expensive care, where early detection can improve a child's oral health and overall quality of life.[4] Dental treatment is also critical to pregnant women, as untreated dental disease increases the risk of preterm deliveries and low birth weight babies.[5]

Initiative Goals

- Improve the oral health of children ages birth through 5 and pregnant women through expanded outreach, education and prevention, direct patient care, and increased provider and community capacity
- Provide coordinated, comprehensive oral health care countywide while meeting the unique needs different cultures and communities

The First 5 San Diego Oral Health Initiative (OHI) was launched in 2005 to address the oral health needs of young children and pregnant women in San Diego County. With an annual budget of $2,482,500, OHI provides screenings, examinations, care coordination, preventive oral health services (such as fluoride varnishes), and comprehensive treatment options to young children and pregnant women in need who would otherwise not receive oral health services.

[1] U.S Dept of Health and Human Services. "Oral Health in America: A Report of the Surgeon General." Rockville, Md: US Dept of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health; 2000.

[2] Centers for Disease Control and Prevention. Oral Health: Preventing Cavities, Gum Disease and Tooth Loss. 2006. Accessed 26 November, 2010. < http://www.cdc.gov/chronicdisease/resources/publications/AAG/doh.htm >

[3] University of California, Los Angeles. California Health Interview Survey. 2007. Accessed October 9, 2009. <www.chis.ucla.edu>.

[4] Lee, JY, Bouwens TJ, Savage MF, Vann WF Jr Examining the Cost-Effectiveness of Early Dental Visits. Pediatric Dentistry 2006; 28(2):102-5, discussion 192-8.

[5] Boggess, K.A., Edelstein, B.L. "Oral Health in Women During Preconception and Pregnancy: Implications for Birth Outcomes and Infant Oral Health." Maternal Child Health J. 2006 September; 10(Suppl 1): 169–174. Published online 2006 July 1. doi: 10.1007/s10995-006-0095-x.

Key Elements

As the lead agency, the Council of Community Clinics (CCC) oversees a large network of community clinics, hospitals, County programs, and private dental providers. Services provided by these partners include:

- Oral health screenings for children ages 1-5 years and pregnant women in clinic and community settings;
- Dental examinations for children ages 1-5 years and pregnant women;
- Treatment services and follow-up for children ages 1-5 years and pregnant women;
- Care coordination services for high risk children ages 1-5 years and pregnant women;
- Oral health education for parents and caregivers of children ages 1-5 years, pregnant women, child care providers, and staff at community-based organizations (CBOs); and
- Training for prenatal care providers, general dentists, primary care providers, and ancillary staff.

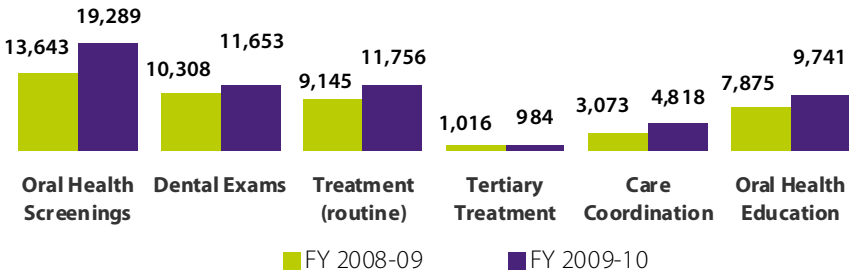
Summing It Up

Fiscal Year 2009-10 marks the fifth year for OHI. This section compares results from FY 2008-09 and FY 2009-10 for the number of children and pregnant women who received screenings, exams, treatments, care coordination, and education.[6] The data below show that there were increases in nearly all service areas from last fiscal year to the current year. Explanations for these increases offered by providers include: the creation of the treatment fund for pregnant women, greater outreach and awareness efforts, and a growing uninsured population due to economic conditions. [7]

How many children 1-5 received oral health services?

Exhibit 2.1 summarizes the number of services provided to children by OHI in FY 2008-09 and FY 2009-2010, as well as the percentage change in these services. The number of children served in FY 2009-2010 increased markedly across all services, with the exception of tertiary treatment which declined just over 3%.[8] The increases ranged from 13.0% to 56.8%. The greatest increases were seen in care coordination (56.8%), followed by oral health screenings (41.4%) and routine treatment.

Exhibit 2.1 Number of Services for Children 1-5 FY 2008-09 & 2009-10



% change	↑	↑	↑	↓	↑	↑
	+41.4%	+13.0%	+28.6%	-3.1%	+56.8%	+23.7%

[6] 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.

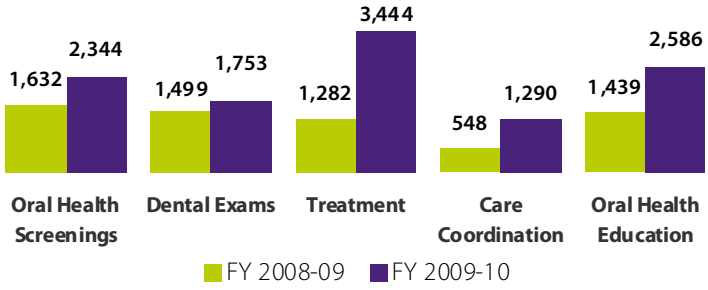
[7] The OHI treatment fund is a payer of last resort for children ages 1 to 5 and pregnant women in need of dental services.

[8] Dental services provided by specialty providers equipped with diagnostic and treatment facilities not generally available at local clinics.

How many pregnant women received oral health services?

The number of pregnant women served by OHI increased from FY 2008-09 to FY 2009-10 across all OHI service areas. The increase in the number of pregnant women served ranged from 16.9% to 168.6%. The greatest increases were seen in treatment services (168.6%), followed by care coordination services (135.4%). These increases were attributed to provider trainings on expanding treatment to pregnant women and the new treatment fund for pregnant women. This was critical in FY 2009-10 as Denti-Cal funding for pregnant women was cut from the State budget.

Exhibit 2.2 Number of Services for Pregnant Women FY 2008-09 & 2009-10



% change	↑	↑	↑	↑	↑
	+43.6%	+16.9%	+168.6	+135.4%	+79.7%

What provider trainings were offered?

Exhibit 2.3 summarizes the number of provider trainings offered in FY 2008-09 and FY 2009-10. OHI contractors exceeded all of their target numbers for the number of provider trainings. However, the number of providers receiving training decreased from FY 2008-09 to 2009-10, particularly for primary care providers, ancillary staff and CBO's. Providers stated that the trainings offered this fiscal year were also provided in the past. Offering new topics in the coming years may spark greater interest in future trainings and increase participation.

Exhibit 2.3 Overview of the Number of OHI Providers Receiving Trainings, Comparing FY 2008-09 to FY 2009-10

Results	FY 2008-09	FY 2009-10	% Change
Dental Providers	159	155	↓ -2.5%
Prenatal Providers	49	47	↓ -4.1%
Primary Care Providers	115	49	↓ -57.4%
Ancillary Staff	86	50	↓ -41.9%
CBOs	490	406	↓ -17.1%

Fluoridation

First 5 San Diego initiated a project to invest in the fluoridation of the drinking water treated by the Metropolitan Water District (MWD). These efforts are intended to standardize the fluoride levels among communities with unregulated fluoride. The effect of fluoridating the city of San Diego is estimated to benefit about 112,210 children ages 1-5, or 41.2% of the population of San Diego County under the age of 6. In FY 2009-10, First 5 San Diego supported this project with funding of $4,209,561. As a result of these efforts, the City of San Diego is scheduled to have fluoridated water by January 2011.

Making a Difference

FY 2009-10 represents the fifth year OHI has been providing screenings, exams, treatments, and services to children and pregnant women in the community. This was the second year for care coordination services which focused on more intensive services and high risk clients. Care coordination services track clients throughout their treatment. The five-year data trends presented below represent all services areas, with the exception of care coordination.[9]

Oral Health Services for Children

The following section represents the oral health outcomes of all oral health services provided to children served by OHI.

Oral Health Screenings

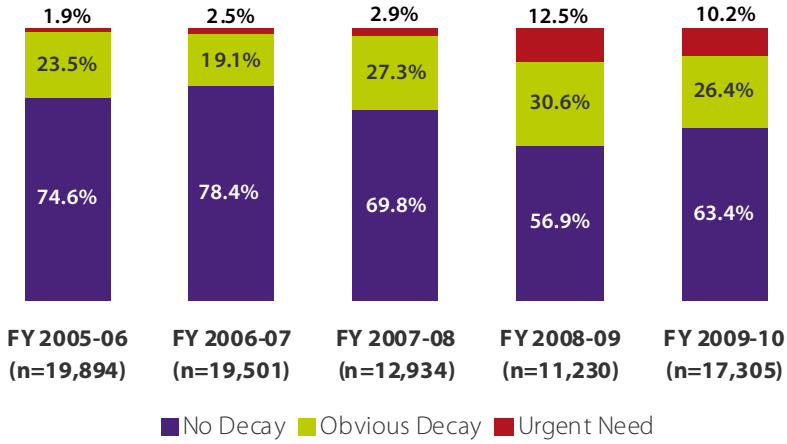
The following results represent the outcomes from OHI oral health screenings in both the clinic and community settings for children.

What are the results of oral health screenings for children 1-5?

In FY 2009-10, there was a 6.5% increase in the number of children with no decay at screening (Exhibit 2.4). This is the first increase in the past three years.

The percentage of children identified with urgent needs decreased from 12.5% to 10.2%. Overall, the five-year trend for screening results demonstrates an increase in the percentage of patients with urgent dental needs.

Exhibit 2.4 Results of Oral Health Screenings for Children FY 2005-10

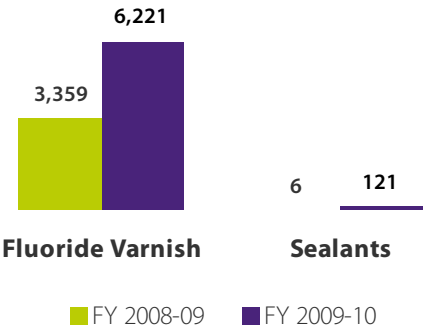


[9] Client level data in OHI is tracked for high risk clients receiving care coordination.

Are OHI children receiving preventative treatment at community screenings?

OHI screenings provided in community settings include the treatment of fluoride varnishes and sealants. During FY 2009-10 there was a significant increase in both the number of fluoride varnishes and sealants provided to children ages 1-5 compared to the previous fiscal year. There are two key reasons for these increases: OHI clinics increased their efforts to provide screenings and prevention services at schools, and some used the First 5 treatment fund to pay for preventative services.

Exhibit 2.5 Fluoride Varnishes & Sealants in Community Screenings for Children 1-5



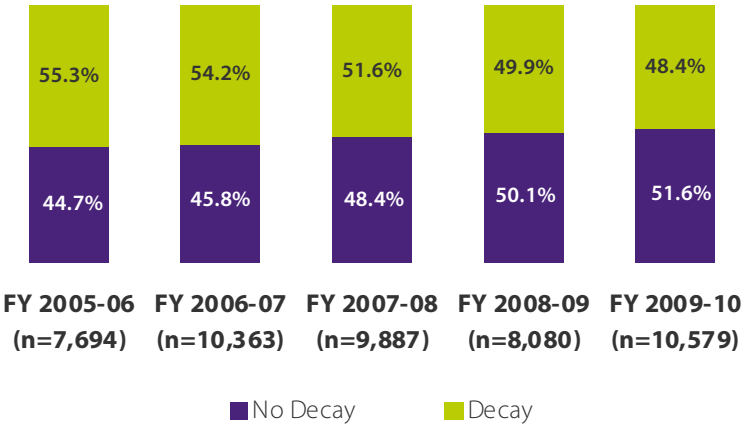
Results of Oral Health Exams

Data from the OHI oral health exams provide information on the percentage of children experiencing decay as well as the time lapse since their last dental exam. These results provide a picture of the oral health of children seen through OHI.

What are the results of dental exams among children 1-5?

Dental exam results in FY 2009-10 exhibited a slight improvement in children identified with no decay, as compared to FY 2008-09 results. Over the past five years, exam results have continuously improved, with just over half (51.6%) of children in FY 2009-10 who received an exam identified without decay at the time of the examination. These results have improved almost 7.0% since the inception of OHI.

Exhibit 2.6 Results of Dental Exams for Children FY 2005-10



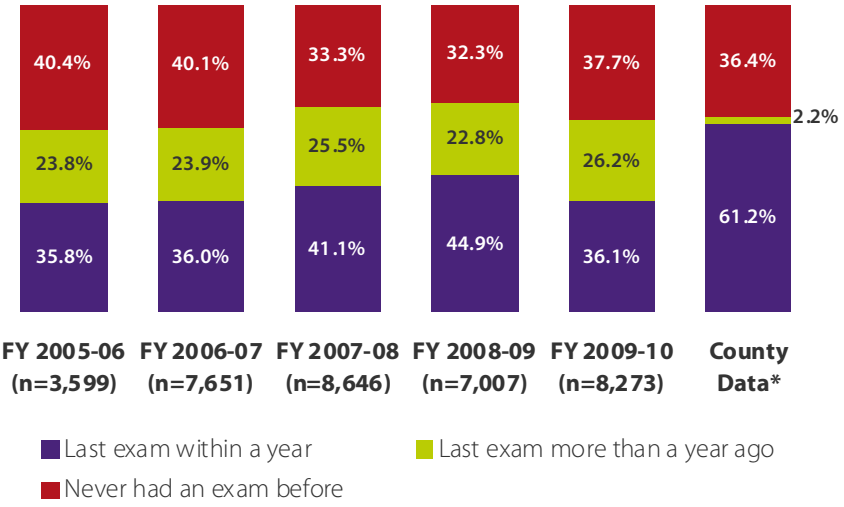
Timely Access to Dental Exams

What is the time lapse since last dental exam for children 2-5?

The percentage of children aged 2-5 years old who had a dental exam within the past year dropped 8.8% from FY 2008-09 to FY 2009-10. However, the percentage of children who had an exam more than a year ago (26.2%) was greater in FY 2009-10 than in all previous fiscal years.

The number of children who never had an exam before increased from 32.3% to 37.7%. This is similar to county-wide data where 36.4% of children ages 2-5 never had an exam.

Exhibit 2.7 Time Lapse since Last Dental Exam for Children 2-5 years FY 2005-10



Source: California Health Interview Survey, 2007.

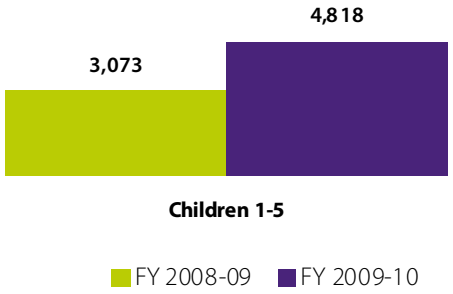
Care Coordination

FY 2009-10 is the second year in which OHI implemented the care coordination process. The Caries Risk Assessment (CRA) – a national best practice - is administered to clients during oral health screenings or exams to assess their risk for dental disease and other oral health problems (see Exhibits 2.10-2.11). Clients who are found to be high risk receive additional treatment, follow up , and a variety of care coordination services to promote the completion of all needed services and oral health education. These clients are tracked for the services, treatment, and education they receive as part of the care coordination process.

Are high risk children age 1-5 receiving care coordination?

Among all OHI clients who received an exam, 4,818 children were deemed high risk and received care coordination (Exhibit 2.8). This represents a 56.8% increase over FY 2008-09 data.

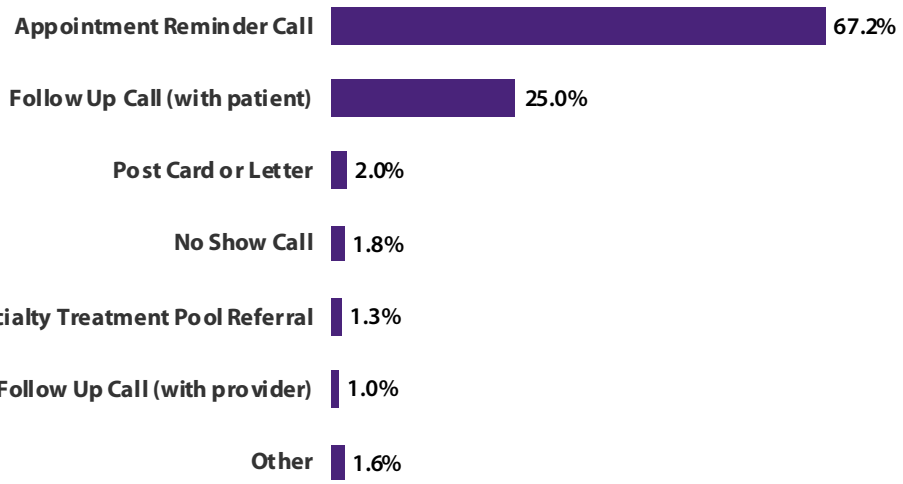
Exhibit 2.8 Number of Identified High-Risk Children FY 2008-09 & 2009-10



What care coordination services are children 1-5 receiving?

Exhibit 2.9 shows that children receive multiple services through care coordination. The most common care coordination service provided was an appointment reminder call, followed by a follow up call with the patient after the exam or treatment.

Exhibit 2.9 Care Coordination Services for Children



Caries Risk Assessment

The Caries Risk Assessment (CRA)[11] is a national best practice that provides data on individual and family oral health habits in order to develop a targeted treatment plan to reduce dental disease. It combines the results of a patient interview and a clinical exam to determine a client's risk level. During the patient interview, the CRA takes into account any protective factors or risk indicators that determine a patient's risk level. Protective factors are assessed to evaluate whether measures are being taken to prevent dental disease from developing. Protective factors for children include: mother/caregiver/sibling had no decay for past three years; regularity of dental care; the use of fluoridation; regularity of fluoride varnishes; and the mother/caregiver's use of xylitol gum.[12] Risk indicators are examined to assess any factors or habits that may have the potential to cause poor oral health. The risk factors for children include: mother/caregiver/siblings with decay in past 12 months; irregularity of dental care; bottle use with liquids other than water; sleeping with bottle; the frequency of sweetened drinks/snacks; developmental delays; and medications. The second portion of the CRA involves a clinical exam that determines any decay, plaque, history of restorations[13], orthodontic appliances[14], or dry mouth, and thus concludes the risk assessment of the child. Based on an assessment of all these outcomes, the provider determines the caries risk level of the child as low, moderate, or high.

> **"I like it [CRA] because it gives us an idea of what parents are feeding their kids and we can tell [them about] what's best instead."**
>
> – First 5 OHI Provider

The following represent the risk/protective factors and clinical exam results of children that were deemed high risk. More than one type of risk/protective/clinical factors may be identified for each child.

[10] Caries is the medical term for cavities.

[11] Xylitol gum is a naturally occurring sugar alcohol and low-calorie sweetener that is clinically proven to reduce cavities and help prevent tooth decay and gum disease.

[12] Restoration includes a variety of dental procedures such as fillings, crowns, and implants to name a few.

[13] Orthodontic appliances are a variety of devices used to adjust teeth or change the relationship of the teeth, such as braces.

What are the most common risk indicators and protective factors reported by high risk children 1-5?

Patient interviews with caregivers of children identified the most common risk indicators and protective factors. Caregivers of high risk children reported the use of fluoridated toothpaste as the most common protective measure taken to prevent dental disease.

Almost 64% of high risk children had a household member with recent dental decay. This increases the risk of transmitting dental disease to children.

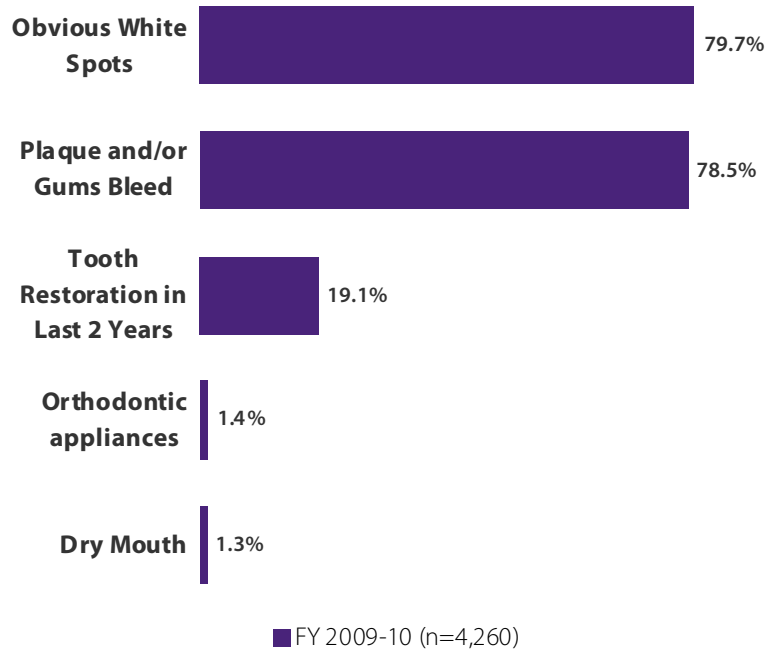
Exhibit 2.10 Most Common CRA Protective Factors and Risk Indicators of Children FY 2009-10

Indicator/Factor	Children (n =4,260)	
	Issue	%
Protective Factor	Uses fluoridated toothpaste	78.7%
Risk Indicator	Mother, caregiver, sibling(s) with decay in past 12 months	63.8%
Risk Indicator	Frequently drinks sweetened beverages or snacks (more than 3 times/day)	62.0%
Risk Indicator	Child has episodic dental care	38.7%

What risk factors are most prominent among high risk children 1-5?

Similar to last year, clinical exam results for high risk children (Exhibit 2.11) show that the most common risk factors are: obvious white spots (79.7%) followed by plaque and/or bleeding gums (78.5%), and tooth restoration in the past two years (19.1%).

Exhibit 2.11 CRA Clinical Exam Results of High-Risk Children FY 2009-10



Prevention and Treatment Services Provided to High-Risk Children 1-5

The following data summarize the prevention and treatment services that were provided to children who were deemed high risk by the CRA.

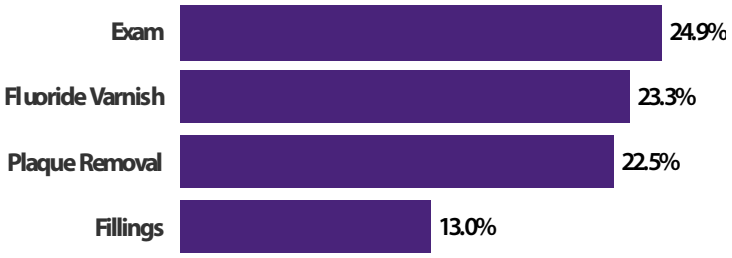
What prevention/treatment services were provided to high risk children 1-5?

In FY 2009-10, the most common prevention/treatment services provided to high risk children were:

- Exam (24.9%)
- Fluoride varnish (23.3%)
- Plaque removal (22.9%)

These results were similar to the treatment services results in FY 2008-09.

Exhibit 2.12 Prevention/Treatment Services Provided to High Risk Children



Education and Assistance Topics Provided to High-Risk Children 1-5

The following outcomes represent the education and assistance services provided to children who were deemed high risk from the CRA.

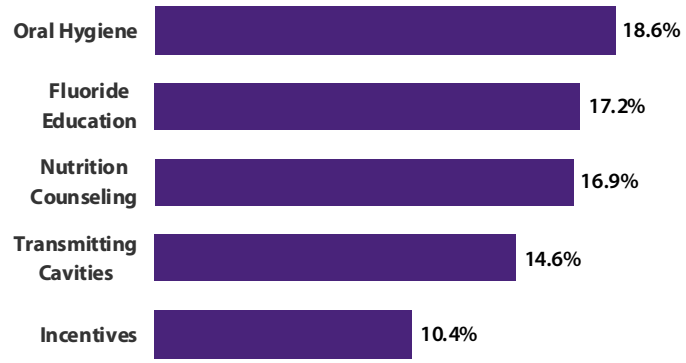
What education/assistance services were provided to high risk children 1-5?

In FY 2009-10, among all education/assistance services provided to high risk children and their caregivers the most common services provided were:

- Oral hygiene (18.6%)
- Fluoride education (17.2%)
- Nutrition counseling (16.9%)

These results were also similar to the results in FY 2008-09.

Exhibit 2.13 Education/Assistance Services Provided to High Risk Children



Oral Health Services for Pregnant Women

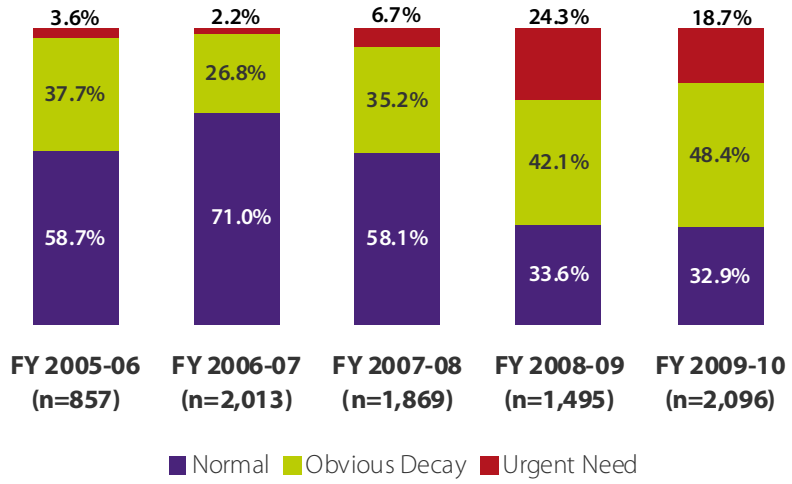
The following section presents data on the oral health services provided to pregnant women served by OHI.

Oral Health Screenings

The following results represent the results of the OHI oral health screenings in both the clinic and community settings for pregnant women.

What are the results of oral health screenings among pregnant women?

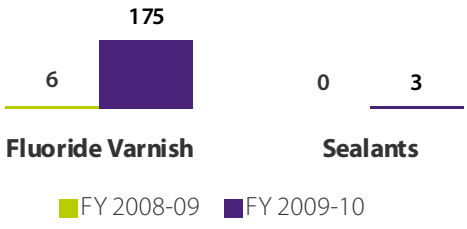
Exhibit 2.14 Results of Oral Health Screenings for Pregnant Women FY 2005-10



Are pregnant women receiving preventative treatment at community screenings?

During FY 2009-10, there were increases (Exhibit 2.15) in both the number of fluoride varnishes and sealants provided to pregnant women compared to the previous fiscal year. This increase has been attributed to the availability of the First 5 treatment fund to pay for preventative services that were not covered by Medi-Cal.

Exhibit 2.15 Fluoride Varnishes & Sealants in Community Screenings for Pregnant Women



Results of Oral Health Exams

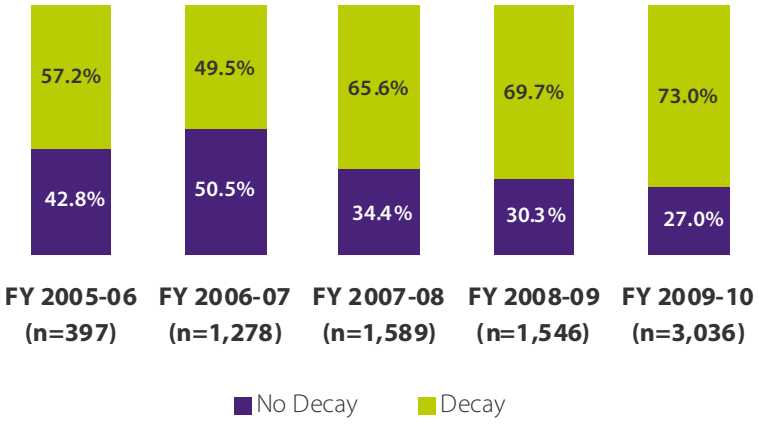
The results of OHI oral health exams show the percentage of pregnant women experiencing decay as well as the time lapse since their last dental exam. These results provide a picture of the oral health of pregnant women upon examination.

What are exam results among pregnant women?

Since FY 2005-06, there has been a steady increase in the percentage of pregnant women who had examinations which showed the presence of dental decay, with a 3.3% increase in FY 2009-10.

As a result of concerted efforts by primary care and OBGYN physicians to refer pregnant women to dental clinics, OHI saw almost twice as many pregnant women in FY 2009-10, and reached a higher need population. These increased outreach efforts as well as the creation of the treatment fund are believed to explain some of the increase in patients with greater dental decay.

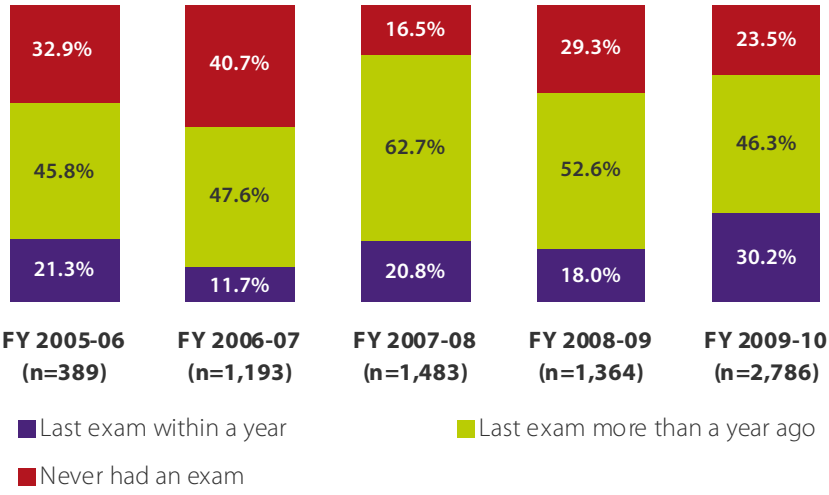
Exhibit 2.16 Results of Dental Exams for Pregnant Women FY 2005-10



What is the lapse of time since last dental exam for pregnant women?

In FY 2009-10, 30.2% of pregnant women seen had received an exam within the year – the greatest percentage in OHI's history. Additionally, a smaller percentage of pregnant women reported never having an exam in FY 2009-10 compared to the previous fiscal year.

Exhibit 2.17 Time Lapse since Last Dental Exam for Pregnant Women FY 2005-10



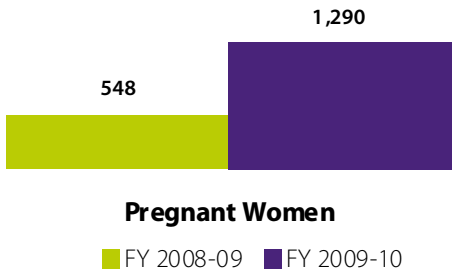
Care Coordination

As was noted in the previous section, FY 2009-10 is the second year in which OHI implemented the care coordination process. The Caries Risk Assessment (CRA) is administered to pregnant women during oral health screenings or exams to assess their risk for dental disease and other oral health problems (see Exhibits 2.20-2.21). Pregnant women who are found to be high risk receive additional treatment and follow up as well as a variety of care coordination services to promote the completion of all needed services and oral health education. The services, treatment, and education received by pregnant women as part of the care coordination process is carefully tracked and is reported below.

Are high risk pregnant women receiving care coordination?

Among all pregnant women served by OHI who received an exam, 1,290 were deemed high risk and received care coordination (Exhibit 2.18). This was a 135.4% increase over FY 2008-09.

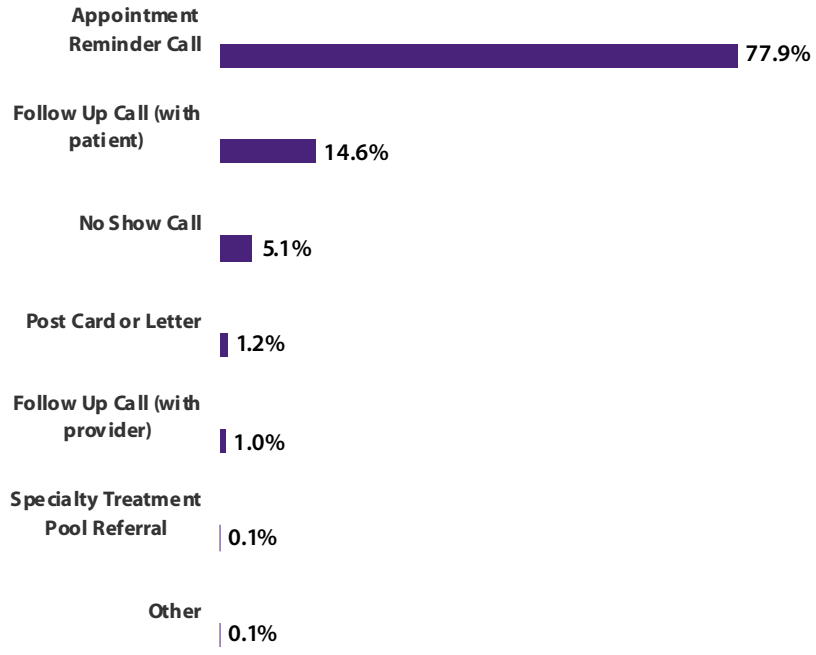
Exhibit 2.18 Number of Identified High-Risk Pregnant Women FY 2008-09 & 2009-10



What care coordination services are pregnant women receiving?

Exhibit 2.19 shows the most common care coordination services provided to pregnant women. These include: appointment reminder calls, followed by a follow up call with the patient after the exam or treatment, and a no show call. These services are similar to the patterns seen above in care coordination services for children.

Exhibit 2.19 Care Coordination Services for Pregnant Women



OHI Specialty Treatment Pool

Since it was established in 2006, the OHI Specialty Treatment Pool has served children with severe dental needs who require oral surgery or who are unable to be treated without anesthesia. Since its inception in 2006, the specialty treatment pool has:

- expended $524,080 for specialty treatment services;
- treated 207 children (unduplicated); and
- conducted 4,679 procedures.

In FY 2009-10, OHI provided 64 children with 1,156 specialty treatment services totaling $158,024. There were up to four providers who provided treatment for children in the OHI specialty treatment pool.

Treatment Fund

In FY 2009-10, OHI was able to offer treatment to uninsured/underinsured children and pregnant and postpartum women. The Treatment Fund is the payor of last resort for uninsured children 1-5, pregnant women, and women who had a baby within 90 days who are in need of dental services. Patients may be seen at any dental clinic of a participating OHI clinic corporation. The treatment fund has:

- expended $843,468 on treatment services;
- treated 1,629 children, 942 pregnant women, and 239 postpartum women (unduplicated); and
- conducted 10,353 procedures.

Caries Risk Assessment

During the patient interview, the CRA assesses protective factors and risk indicators to determine a patient's risk level. These protective factors for pregnant women include the use of fluoridation in water, toothpaste, and mouth rinse, the use of xylitol gum, and the use of chlorhexidine rinse.[15] The risk factors for pregnant women include the history of cavities in the last three years, frequency of sweetened drinks/snacks, dry mouth, and medications. The second portion of the CRA involves a clinical exam that determines any decay, plaque, history of cavities, lesions, orthodontic appliances, dry mouth, deep pits, and exposed roots and thus concludes the risk assessment of the pregnant woman. Based on an assessment of all these outcomes, the provider determines the caries risk level of the pregnant woman as low, moderate, or high.

The following represent the risk/protective factors and clinical exam results of pregnant women that were deemed high risk. More than one type of risk/protective/clinical factors may be identified for pregnant women.

[15] Chlorhexidine rinse is as an active ingredient in mouthwash to reduce dental plaque and oral bacteria.

What are the most common risk indicators and protective factors reported by high risk pregnant women?

Patient interviews with pregnant women revealed the most common risk indicators and protective factors. High risk pregnant women reported the use of fluoridated toothpaste as the most common protective measure taken to prevent dental disease, while the greatest risk factor was caries in the last 3 years.

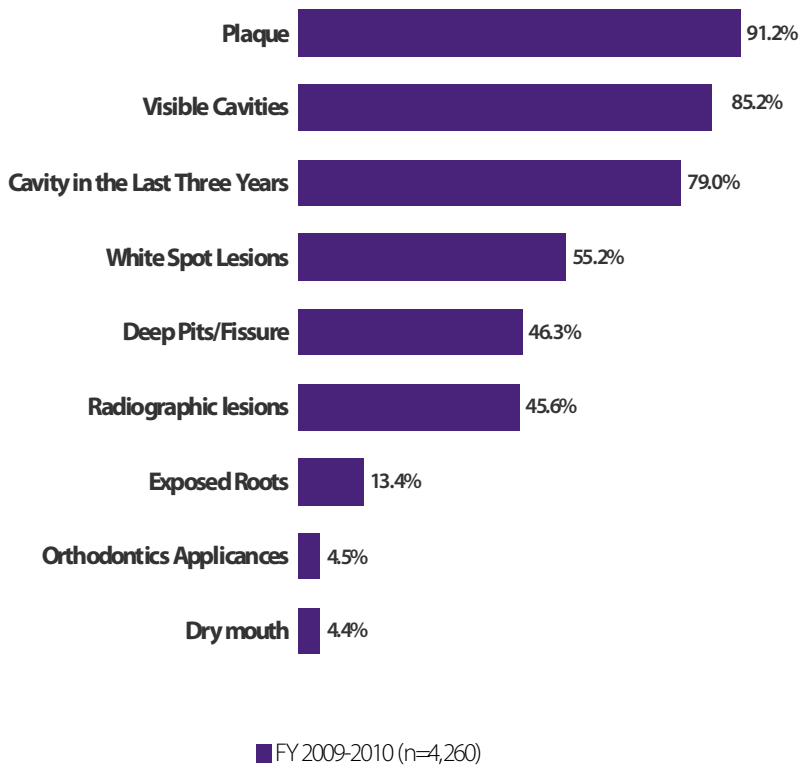
Exhibit 2.20 Most Common CRA Protective Factors and Risk Indicators for Pregnant Women FY 2009-10

Pregnant Women (n =1,307)		
Indicator/Factor	**Issue**	**%**
Protective Factor	Uses fluoridated toothpaste	85.7%
Risk Indicator	Caries in the last 3 years	80.5%
Risk Indicator	Frequently drinks sweetened beverages	54.9%
Risk Indicator	Frequent snacks of sweet/starches (more than 3 times/day)	54.1%

What risk factors are most prominent among high risk pregnant women?

Clinical exam results for high risk pregnant women revealed plaque (91.2%), visible cavities (85.2%), a cavity in the last three years (79.0%), and a white spot lesion (55.2%), deep pits/fissure, (46.3%) and radiographic lesions[16] (45.6%) as the most common exam results contributing to a high risk categorization.

Exhibit 2.21 CRA Clinical Exam Results of High-Risk Pregnant Women



[16]Radiographic lesions are the results of radiographic examinations for cavities.

Prevention and Treatment Services Provided to High-Risk Pregnant Women

The following summarizes data on the prevention and treatment services that were provided to pregnant women deemed to be high risk based on the CRA.

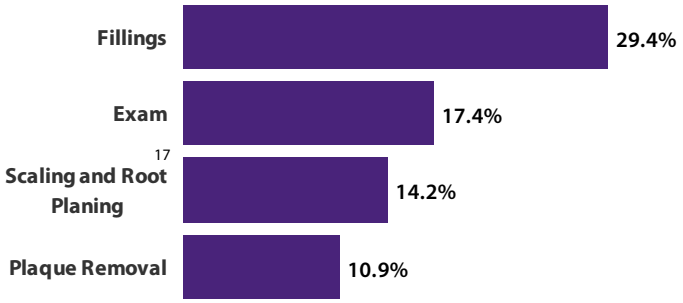
What prevention/treatment services were provided to high risk pregnant women?

Of the prevention/treatment services provided to high risk pregnant women in FY 2009-10, the most common treatments were as follows:

- fillings (29.4%);
- exams (17.4%); and
- scaling and root planing (14.2%).

These results were similar to FY 2008-09.

Exhibit 2.22 Prevention/Treatment Services Provided to High Risk Pregnant Women



Education and Assistance Topics Provided to High-Risk Pregnant Women

The following outcomes represent the education and assistance services provided to pregnant women who were deemed high risk from the CRA.

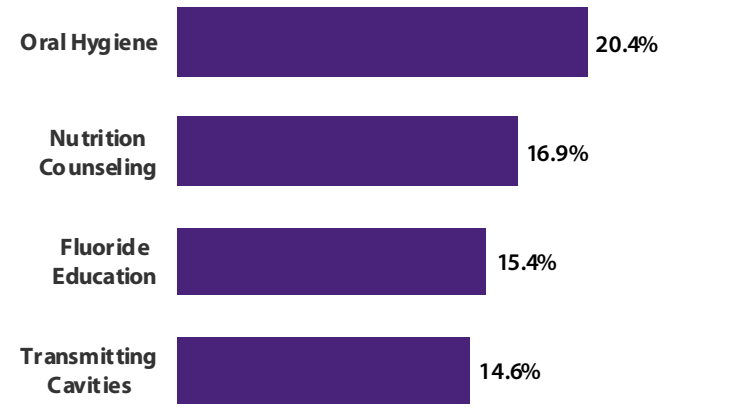
What education/assistance services were provided to high risk pregnant women?

Of the education/assistance services provided to high risk pregnant women in FY 2009-10, the most common services provided were:

- oral hygiene instructions (20.4%)
- nutrition counseling (16.9%)
- fluoride education (15.4%)

These results were similar to the FY 2008-09 results.

Exhibit 2.23 Education/Assistance Services Provided to High Risk Pregnant Women



[17] Scaling and root planing is the removal of tartar and plaque that attach to the tooth surfaces and making the root surface smooth to remove any remaining tartar and smoothes irregular areas of the root surface.

Making the Connection

OHI's six service areas incorporates a comprehensive approach to promoting and actively ensuring positive oral health habits and practices among children 1-5 and pregnant women. The Council of Community Clinics, participating clinics, and a network of private practitioners (10 pediatric dentists and 55 general dentists) work together to meet the high need of the target population. Great strides have been made by both the contractors and First 5 staff to promote OHI as a service to the other First 5 funded initiatives. Additionally, OHI contractors pursued targeted trainings to private dental practitioners on specific oral health topics in an effort to improve OHI services and visibility on a system level. This overview of the interconnections of the initiative includes data collected through interviews and surveys with OHI staff as well as discussions at the OHI Learning Community and monthly coordination meetings.

What activities were implemented to promote First 5 cross initiative collaborations?

OHI made significant efforts to collaborate with other First 5 funded initiatives. OHI provided oral health trainings to Healthy Development Services (HDS) care coordinators while the HDS countywide coordinator provided basic trainings to the OHI care coordinators. Additionally, OHI and HDS are planning meetings between the initiatives to promote further collaboration. In FY 2009-10, OHI worked with the Preschool for All (PFA) initiative as part of its community screenings service area. OHI clinics provide both screenings and education at several PFA sites and materials and information about the OHI treatment fund were disseminated to all PFA preschools.

> **"I learned that pregnant women should get the same standard of care as everyone else."**
>
> – First 5 OHI Provider

What was done to promote best practices for OHI providers?

As a result of findings from last year, OHI focused on promoting best practices for serving pregnant women across all OHI services at the OHI-sponsored provider training conference. Over 100 professionals attended the conference and of these attendees, 88 completed a conference evaluation survey. Key highlights of this survey regarding the treatment of pregnant women found that 99.0% of respondents felt:

- more knowledgeable about oral health concerns in pregnancy, and
- more knowledgeable about evidence-based guidelines for oral health treatment during pregnancy.

Provider Perspectives on Treating Pregnant Women

A total of 21 dental providers completed an online survey assessing their perspectives on treating pregnant women after attending the OHI sponsored training conference. Of these respondents, 20 noted that they see pregnant women in their practice. The following are key findings from these 20 providers:

- All but one respondent felt that pregnancy was not a reason to defer treatment.
- All respondents considered a comprehensive treatment plan as important for pregnant women.
- 84.2% of respondents reported that they are familiar with ADA guidelines released in February 2010 on oral health during pregnancy.

It is of note that one provider incorrectly stated that fillings were unsafe to perform any time during pregnancy and one felt that treatment should be deferred until after pregnancy.

Update on FY 2008-09 Recommendations

Last year's Recommendation	Update on Recommendation
Standardize the way clients' risk level is categorized to ensure that all OHI clients receive the same care. One possible method to standardize the way the CRA is implemented would be to follow the American Dental Association guidelines on evaluating clients' risk of developing dental disease.	+ In May, 2010, staff from CCC, First 5 San Diego, and Harder + Company Community Research met with the creator of the Caries Risk Assessment, Dr. Francisco Ramos-Gomez. Dr. Ramos- Gomez reviewed the OHI scoring methodology and agreed that the OHI use of the CRA was appropriate.
Providers should be educated on the American Dental Association best practices of maintaining good oral health throughout pregnancy to ensure overall positive health outcomes of both the expectant mothers and their babies.	+ CCC organized the 5th Annual Oral Health Initiative Conference held on April 15, 2010, "Working Together to Advance Excellence in Oral Health: Guidelines and Techniques for Working with Pregnant Women and Young Children." A total of 103 attendees received training on the ADA 2010 guidelines for oral health treatment for pregnant women. All participants agreed that they would be able use the information from the conference in their practice. + A Dental Director Meeting facilitated by CCC in May of 2010 focused on the ADA guidelines for oral health treatment during pregnancy. + The OHI May 2010 Newsletter featured a summary of the Annual OHI Conference. The newsletter was distributed to OHI clinic staff, providers, and other community partners.
Integrate education programs during the community screening process, in outreach sessions and/or at schools to help bolster oral health education services and create new ways to educate and outreach to the target population.	+ Subcontractors provided dental screenings and education in community-based settings, such as schools, child care centers, Head Start, WIC, prenatal classes, libraries, community centers and health fairs. In 2009-10 community education to parents and primary caregivers of children 1-5 increased. In 2010-11, a new Outreach Coordinator position was funded which will enhance the education element of OHI even further.
OHI clients need health insurance enrollment assistance and oral health education. Clients could be referred to First 5's Healthcare Access (HCA) program to address any health insurance needs. Dental staff could also collaborate with the First 5 School Readiness (SR) and Preschool For All (PFA) programs to provide oral health education or services in the school setting.	+ CCC continues to collaborate with other First 5 funded programs. In 2010, Healthcare Access (HCA) and 211 San Diego presented information about the program to OHI care coordinators and CCC also maintained ties with Preschool for All (PFA) and Healthy Development Services (HDS). In 2009-10 OHI clinics performed dental screenings at PFA preschools, and CCC met with the PFA Communications and Community Outreach Project Specialist to strategize ways to coordinate OHI and PFA services.

Recommendations

The following recommendations are based on FY 2009-10 data and evaluation findings.

- **Promote referrals to dental clinics across clinic departments**. One of the systems changes generated from OHI is having OB/GYN and pediatric departments perform visual oral screenings and make patient referrals to the dental clinic when there is obvious decay. These practices have expanded outreach and helped identify and assist high need patients receive needed treatment. This collaboration across medical departments has improved patient care and is believed to be the best practice that should be implemented in all clinics. These practices should be promoted for all OHI providers.

- **Facilitate insurance eligibility for pregnant women.** A lack of insurance is sometimes a barrier for care. Contractors at the OHI Learning Community meeting identified the Perinatal Care Network (PCN) as a potentially underutilized referral option. PCN works with women eligible for pregnancy related Medi-Cal to assure that they receive prenatal care in addition to other services needed. One feature of the PCN is that an assessment can be completed over the phone and then submitted by the PCN to Medi-Cal to then make an appointment. Additionally, temporary coverage lasting up to 30 days can be obtained through the PCN that includes emergency Medi-Cal services. Promoting all available health insurance program options to pregnant women can help to increase enrollment and alleviate barriers to dental care.

- **Continue to standardize data collection and use CMEDS for program improvement.** Due to the variety of providers in the OHI network, many different practices for the recording and documentation of patient care are used. Throughout its history, OHI has continually improved data collection. Discussion was held at the OHI Learning Community to identify existing, consistent data documentation processes that could be more fully utilized across providers. It was agreed that a standardization of the documentation of referrals to the various sources of care, such as specialty treatment pool and support services, would improve the program. By strengthening client tracking, gaps in service provision can be better identified and addressed.

CHAPTER 3.

Healthy Development Services

2009/2010 Scorecard

HDS Service Area/Goals	Measures	Target	Actual	Performance
Numbers Served	Number of children served	No target set	36,576	
	Number of parents served	No target set	13,571	
Parent Support and Empowerment **Goal: Increase parent knowledge and skills to promote child's developmental and social-emotional health by providing parent sessions**	Percent of parents reporting knowledge gains	No target set	97.2%	
	Percent of parents reporting skills gains	No target set	92.8%	
Behavioral Services **Goal: Provide early identification and treatment of behavioral needs**	Percent of children with identified needs that received treatment	No target set	82.0%	
	Percent of children treated who made gains	No target set	97.5%	
Developmental Services **Goal: Provide early identification and treatment of developmental delays**	Number of children screened for developmental needs	11,094	12,477	
	Percent of children with identified needs that received treatment	No target set	65.7%	
	Percent of children treated who made gains	No target set	90.5%	

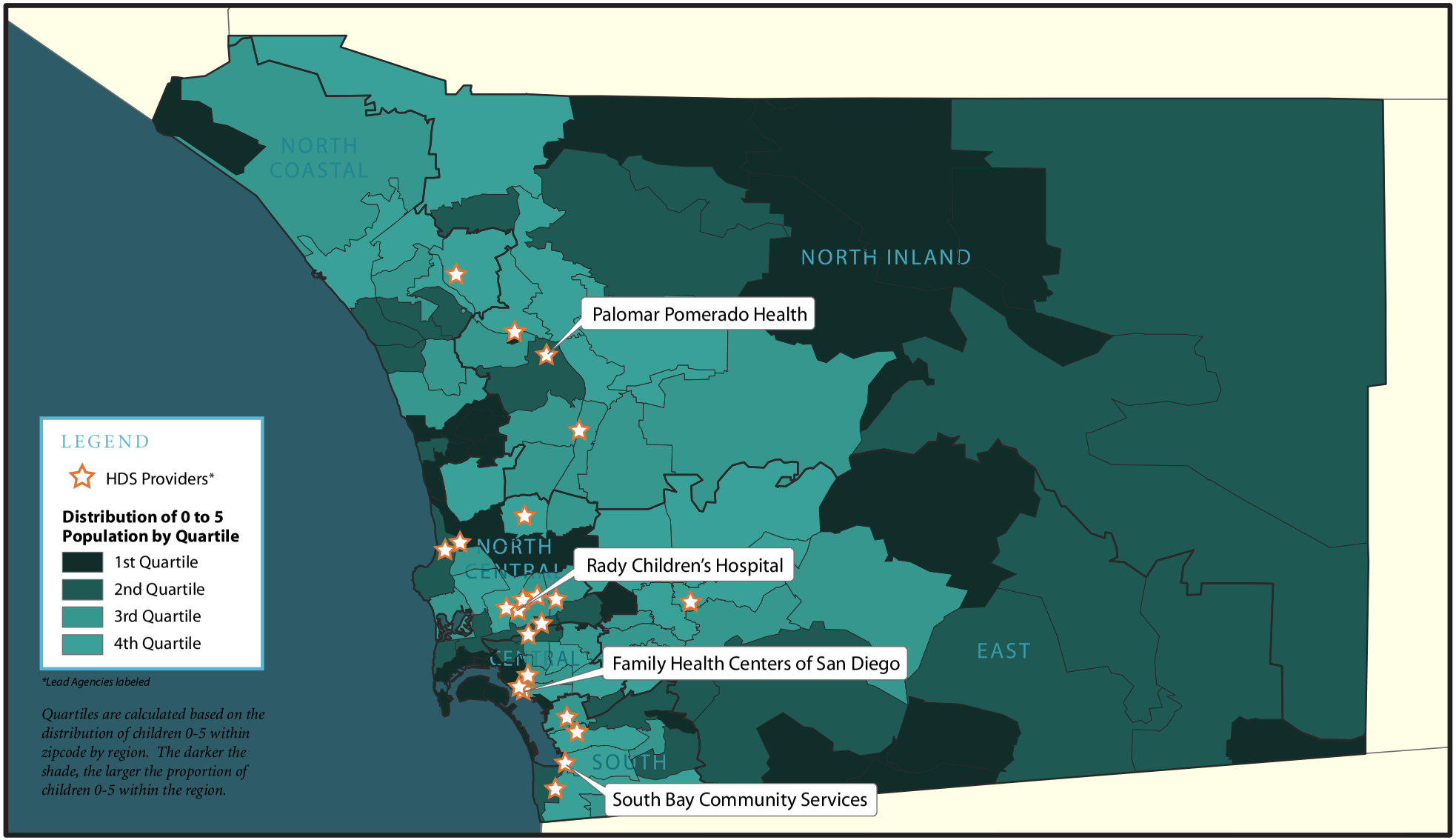
90% or above target 75-89% of target <75% of target

HDS 2009/2010 Scorecard, continued

HDS Service Area/Goals	Measures	Target	Actual	Performance
Speech and Language Services **Goal: Provide early identification and treatment of behavioral needs**	Percent of children with identified needs that received treatment	No target set	56.8%	
	Percent of children treated who made gains	No target set	91.5%	
Vision and Hearing Services **Goal: Provide early identification and treatment (or referrals to treatment) for vision and/or hearing needs**	Number of children screened for vision	7,791	13,539	
	Number of children screened for hearing	7,844	11,403	
Care Coordination **Goal: Assist families in navigating the system of care to connect children to treatment**	Number of children 0-5 who enter care coordination	No target set	4,288	
	Number of children who are case managed	No target set	2,568	
Home Visiting **Goal: Encourage parent-child bonding, attachment and breastfeeding; establish medical home; provide support to at-risk families; reduce exposure to second hand smoke**	Number of newborns who received a NMHV	7,860	8,882	
	Number of families who received an At-Risk Home Visitation	2,580	2,701	
	Number of mothers referred to smoking cessation services	No target set	522	

 90% or above target  75-89% of target  <75% of target

Healthy Development Services Providers



Introduction

"I never had this opportunity but … I wanted [this chance] for my kids."

- HDS Parent

Research shows that early identification and early intervention of developmental delays in children can lead to substantially better prognoses and fewer maladaptive behaviors, increasing the chance for success when they enter school.[1] Although the average age at which parents report initial concerns is around 17-18 months, most children are not diagnosed with developmental delays until age 4 or later. This is especially true among children growing up in low socio-economic urban areas.[2] There are substantial costs (estimated at between $30,000 and $100,000 per child) resulting from the failure to identify and address developmental problems in the early years of a child's life.[3] Much of this cost is ultimately borne by the education system, when children with preventable delays enter school without receiving early intervention.

In response to the need to identify and treat developmental delays as early as possible, First 5 San Diego 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 and succeed. The initiative follows the research recommendations of developing systems that reduce gaps and improve the coordination of early childhood services.[4] In FY 2009-10, the final year of the original contract, First 5 San Diego allocated $15.1 million to the HDS project. During this year, HDS providers continued to deliver services to tens of thousands of children throughout San Diego County, while strengthening system-level efforts to improve the delivery of those services and create a more responsive and more effective system of care.

Initiative Goals

- Provide first time parents with a **no-cost newborn home visit** and provide at-risk families with **ongoing in-home support services**
- **Empower parents** to acquire the knowledge and skills necessary to support and/or improve their children's health and development
- **Promote early identification of developmental needs** by increasing access to screening, assessment, and treatment for cognitive, behavioral, and developmental delays
- Ensure that children receiving health and developmental services are showing **appropriate gains**

[1] Eaves, L., & Ho, H. (2004). Brief report: stability and change in cognitive and behavioral characteristics of autism through childhood. Journal of Autism and Developmental Disorders, 26, 557–569.; Harris, S., & Handleman, J. (2000). Age and IQ at intake as predi ctors of placement for young children with autism: A four to six-year follow-up. Journal of Autism and Developmental Disorders, 30, 137–142.

[2] Gray, K., Tonge, B., & Brereton, A. (2006). Screening for autism in infants, children, and adolescents. International Review of Research in Mental Retardation, 32, 197–227.

[3] 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.

[4] Ibid.

Key Elements

HDS is a service continuum composed of: 1) the parents' ability to support their child's development; 2) early identification of developmental delays; and 3) early intervention. For each of these components, each Regional Service Network (RSN) provides care coordination (i.e., case management) as well as the following health and developmental services to children birth through 5 years of age and their families:

1) Parents' ability to support their child's development includes:

- *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" that includes support and case management to meet a variety of family needs;*
- *Tobacco use screening and cessation referral services for new parents to reduce children's exposure to tobacco in the home; and*
- *Parent Education to increase parents' knowledge regarding their child's healthy development.*

2) Early Identification of developmental delays includes:

- *Screening services for children in the areas of behavior, development, hearing and vision; and*
- *Parent Support and Empowerment (PS&E) services that assist parents of young children to navigate the system of care and to gain the knowledge and skills needed to promote their child's development.*

3) Early Intervention includes:

- *Assessment and treatment* for children in the areas of vision, hearing, speech and language, development, and behavioral services; and
- *Health and Behavioral Consultation* services for licensed and license-exempt early care and education providers and the families they serve.

The initiative pursues these three elements through the regional focus of lead contractors. Each regional lead is responsible for implementing HDS in the context of their HHSA region. All regional leads have subcontractors that specialize in various components (generally developmental, behavioral, and parent support services) creating an integrated regional network that builds on the strengths of existing services. Additionally, over the past four and one half years of the initiative, approaches and interventions have become increasingly more standardized across regions, to ensure evidence-based practices within and between regions. This standardization process is facilitated by the American Academy of Pediatrics (AAP) which provides comprehensive programmatic support and coordination for the six lead contractors and 49 subcontractors[5] of the HDS initiative. The following sections present an analysis of the data submitted by each regional lead and their subcontractors.[6]

[5] Some contractors serve multiple regions so there is a total of 25 unique agencies contracted or subcontracted by HDS. For a list of all subcontracted service providers, see the agency listings under HDS in Appendix A.

[6] All data reported in this chapter include only valid responses; missing or unknown responses are not included. All n's are the total number of valid responses. Throughout the chapter, data from the most appropriate source are utilized and the source is identified under each exhibit. Data in this chapter are collected from three possible sources: 1) aggregate data submitted by providers; 2) service data assigned to individual client records; or 3) assessment data assigned to individual client records.

Summing it Up

"[The parents] didn't expect all the services we offered and they ended up receiving more than they expected and are very thankful." - HDS Care Coordinator

How many children were served by HDS this Fiscal Year?

During this fiscal year, 36,576 unduplicated children and 13,571 unduplicated parents were served through HDS.[7] This suggests that 13.2% of San Diego's 277,372 children ages 0-5 accessed HDS services.[8] In addition, the unduplicated count does not fully reflect the breadth of HDS services provided to children, families, and providers who received multiple services.

Exhibit 3.1 shows the number of services that were provided during FY 2009-10. These numbers are based on the number of children served by type of service. Again, these numbers cannot be compared from year to year due to methodological changes.[9]

It is of note that HDS provided behavioral consultations to providers in the early care environment. In FY 2009-10, 460 providers received behavioral consultations. Of those, 373 providers received short term consultations and 320 received more intensive behavioral consultations, such as including observations of classrooms and teacher/child interactions.

Exhibit 3.1 Number of Children Served FY 2009-10

Service		New Children Served*	All Children Served**
Development	Screening (Development)	12,477	15,640
	Screening (Hearing)	11,403	12,022
	Assessment	4,543	4,952
	Treatment (Development)	3,299	3,920
	Treatment (Speech /Language)	3,527	3,948
Behavior	Screening	1,060	1,199
	Assessment	995	1,045
	Treatment	823	1,006
	Consultation	1,498	1,515
Home Visiting	Newborn Medical Home Visitation	8,882	8,983
	At-Risk Home Visitation	2,701	3,223
Vision	Screening	13,539	13,705
	Assessment	1,268	1,335
	Treatment	731	773
Parent Support	Parent Support and Empowerment***	2,893	2,969
Care Coor-dination	Care Coordination	4,288	4,288
	Case Management	2,568	2,568

** "New" children received HDS services for the first time ever based on services entered in CMEDS. Children and others may have received multiple services, and are therefore duplicated across service areas. Exception is screenings, which were more accurately reported in aggregate.*

*** "All Served" is number of children who received each service at least one time in the fiscal year based on services entered in CMEDS. Includes duplicates across service areas. Exception is screenings, which were more accurately reported in aggregate.*

[7] Cross year comparisons of the number served were not possible due to modifications in data collection from last fiscal year.

[8] Based on the number of children ages 0-5 in San Diego County provided by SANDAG.

[9] Methodological changes include changes in how providers counted participation in services as well as improvements in utilizing the CMEDS database. For this year, the evaluation team determined the most accurate number in CMEDS based on either aggregated Performance Measures or client level service counts.

Making a Difference

"I personally strive to remember that [HDS services] start with customer service and building relationships."

-HDS Care Coordinator

HDS is a service continuum composed of: 1) enhancement of parents' ability to support their child's development; 2) early identification of developmental delays; and 3) early intervention. This section presents key process data and core outcomes associated with each component of the HDS initiative.

First Contact: Newborn and At-Risk Home Visitation

HDS Newborn Medical Home Visit (NMHV) has been a gateway service into the HDS system and aims to provide education, support, and health assessments to all first time parents and their infants within the first two weeks of the child's life. Families identified as having a child with developmental concerns or other needs may be referred to At-Risk Home Visitation (ARHV) to support the family while they gain knowledge and access services to support their child. FY 2009-10 was the final year of home visitation as a component of the Healthy Developmental Services initiative. Under the Commission's new strategic plan, targeted home visitation will become its own focused initiative.

What is the system of care for HDS newborn medical home visitations and at-risk home visitations?

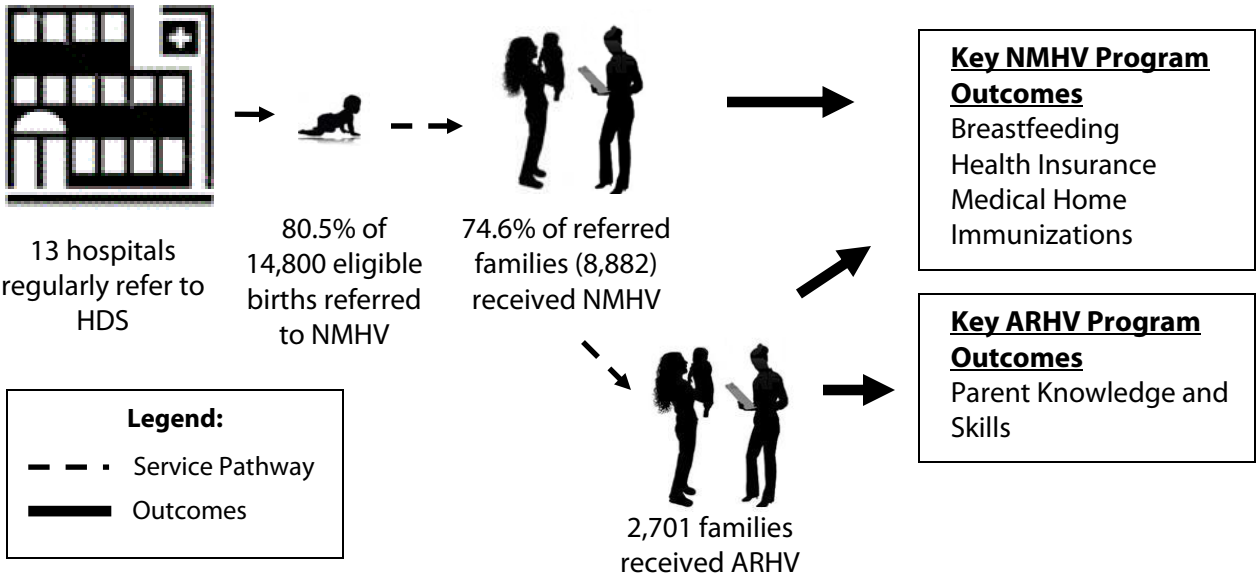
Exhibit 3.2 is a diagram of how families were identified and received NMHV and ARHV services. The diagram shows that, in FY 2009-10, 13 of the 16 birthing hospitals in San Diego County referred 80.5% of their eligible patients to HDS NMHV. Of the eligible families that were referred to services, 74.6% (8,882 families) initiated a home visit. Providers offered a number of reasons for this drop, ranging from systems-level to client-level issues (see text box). The most common issue noted by HDS NMHV providers was their inability to contact or locate the family. This occurred in over half (54.7%) of cases that did not receive an initial home visit.

Approximately 2,700 families received At-Risk Home Visitation Services. These visits assist families with additional needs such as services to prevent child abuse and neglect, to improve health outcomes and to strengthen family skills.

Reasons for Not Connecting to Services

The NMHV workgroup worked throughout the year to improve the education process for eligible clients. Providers noted that hospital staff often introduced First 5, HDS, and the NMHV at hospital discharge, when parents are barraged with information. Thus, while some hospitals had standing orders for all first time parents to be referred to NMHV, parents were not always well informed about the service or next steps. Furthermore, some families were suspicious and reluctant to invite any government-funded program into their home. Providers and AAP worked throughout the year to identify ways to improve the messaging of services, from the timing of the message to how it was delivered, which should improve the rate of service initiation for the future initiative.

Exhibit 3.2 Newborn Medical Home Visitation and At-Risk Home Visitation Service Diagram



Who was served by NMHV and ARHV in FY 2009-10?

A review of the data exhibited the following results:

- The number of new children served through Newborn Medical Home Visitation (NMHV) increased by 13% in FY 2009-10.
- Over two-thirds (68.3%) of NMHV clients received a visit within the goal of 2 weeks of child's date of birth in FY 2009-10.
- At initial contact, families are identified as "at-risk" for family stress or a possible child developmental delay and receive At-Risk Home Visitation (ARHV). In FY 2009-10, the number of children served through ARHV increased significantly (32.3%).

It is important to note that, due to contract changes, FY 2009-10 was the last year for these services within HDS, yet the numbers remained remarkably high.

Exhibit 3.3 New Children Served by NMHV and ARHV, by Fiscal Year*

Type of Service	FY 2007-08	FY 2008-09	FY 2009-10**	Percent Change from FY 2008-09 to FY 2009-10
Newborn Medical Home Visitation	8,331	7,860	8,882	+13.0%
At-Risk Home Visitation	2,157	2,041	2,701	+32.3%

** These numbers include clients new to HDS during the designated fiscal year, and thus may not reflect all clients served in the fiscal year (i.e., continuing clients who began services in a previous year).*

*** FY 09-10 data are based on client level service data.*

Did NMHV and ARHV improve child's healthcare utilization?

Key to all parents' ability to support their child's development is a clear understanding and appropriate use of health resources. HDS home visiting services collect three data points related to children's access to and use of health care in order to assess their progress on informing parents: 1) health insurance; 2) a primary medical provider/medical home; and 3) up-to-date immunizations. These data, displayed in Exhibit 3.4, were collected by all home visitors at baseline (initial home visit) and again at follow-up (i.e., at 6 months of child's age for NMHV; at case closure for ARHV). The results, compared to the Healthy People 2010 goals, show:

- While HDS children's health insurance rates fell short of the Healthy People 2010 goal of 100%, families served by NMHV and ARHV demonstrated high health insurance enrollment rates.
- The percentage of children reported to have a medical home continued to be high (92.5-94.5%), but dropped slightly below the Healthy People 2010 goal.
- In FY 2009-10, the rate of up-to-date immunizations at follow-up for both NMHV and ARHV exceeded the Healthy People goal by approximately 7%.

Exhibit 3.4 Children's Utilization of Healthcare, Results by Service Type

Health Resources	FY 2009-10			Healthy People 2010 Goal**	% Difference from Follow-Up to HP 2010 Goal
	Service Area	Baseline	Follow-Up*		
Children with Health Insurance	NMHV	96.1%	93.1%	100.0%	-6.9%
	ARHV	91.9%	96.9%		-3.1%
Children with a Medical Home	NMHV	99.4%	94.5%	97.0%	-2.5%
	ARHV	98.4%	92.5%		-4.5%
Children with Up-to-Date Immunization Status	NMHV	95.4%	97.2%	90.0%	+7.2%
	ARHV	96.0%	97.0%		+7.0%

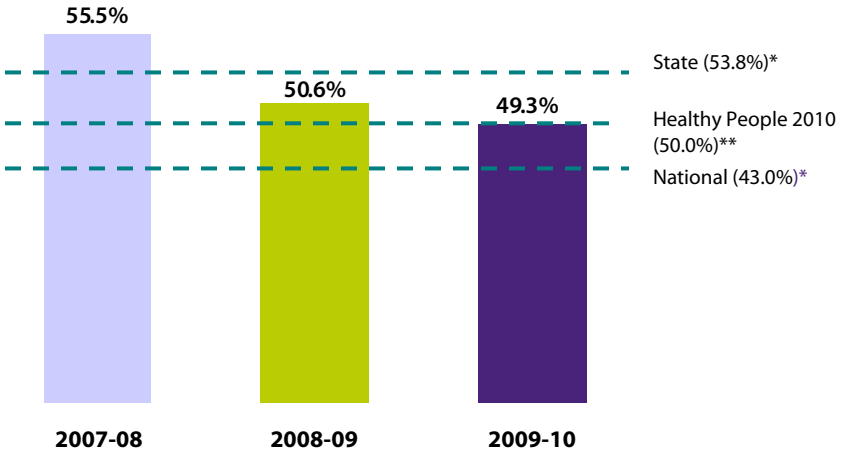
**Follow-up for NMHV is at 6 months and for ARHV is at case closure.*

***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>*

How did the program impact breastfeeding rates?

Research emphasizes the benefit of breastfeeding for babies' nutrition and health, as well as their immunological, developmental and psychological well-being.[10,11] Breastfeeding is heavily emphasized in home visitation, and thus a major indicator of home visitation's success. In FY 2009-10, there were slightly fewer children served by NMHV who were breastfeeding at 6 months of age when compared to FY 2008-09 (49.3% vs. 50.6%). However, the rate of breastfeeding was higher than the national rate and only dipped slightly below the Healthy People 2010 goal. The slight decrease in breastfeeding rates may be attributed to provider changes that occurred in some regions, which affected the availability of lactation support.

Exhibit 3.5 Breastfeeding Rates at Six Months of Age



** Centers for Disease Control and Prevention. National Immunization Survey. 2010. Accessed 23 September 2010. www.cdc.gov/breastfeeding/data/NIS_data/index.htm*

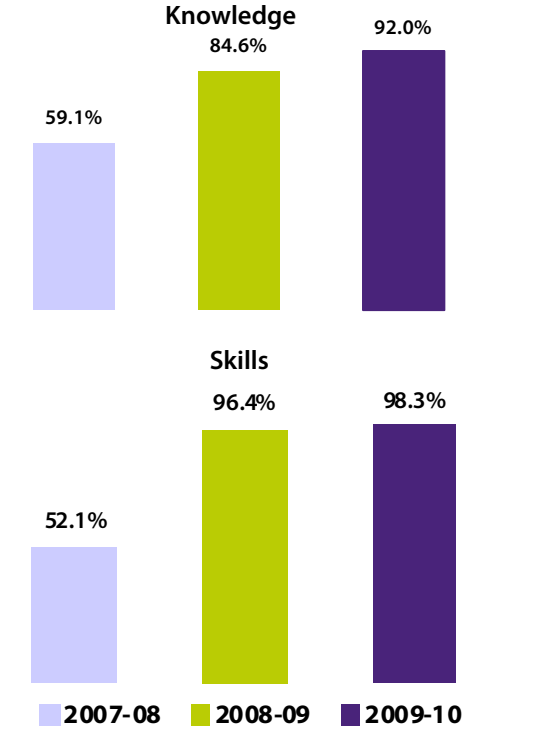
*** Office of Disease Prevention and Health Promotion, "Maternal, Infant and Child Health." Healthy People 2010: Volume II. Washington DC: U.S. Department of Health and Human Services, 2000. Accessed 23 September 2010.*

Did parents served by ARHV increase their knowledge and skills about their child's healthy development?

A core component of home visitation is to increase each family's ability to have the necessary knowledge and skills to obtain needed services and supports. This is particularly important for families with identified risk factors. Based on a survey parents completed before and after receiving ARHV services, the FY 2009-10 results show a continued increase in the percentage of parents with increased knowledge over the past three fiscal years.

Similarly, families must learn skills to promote their children's health and development. In ARHV, there were a higher percentage of parents reporting increased skills than in other HDS service areas (see comparative data in the following sections). FY 2009-10 also saw the largest percentage of parents reporting an increase in skills over the last 3 years.

Exhibit 3.6 Parents Reporting Increased Knowledge and Skills for ARHV by Fiscal Year



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

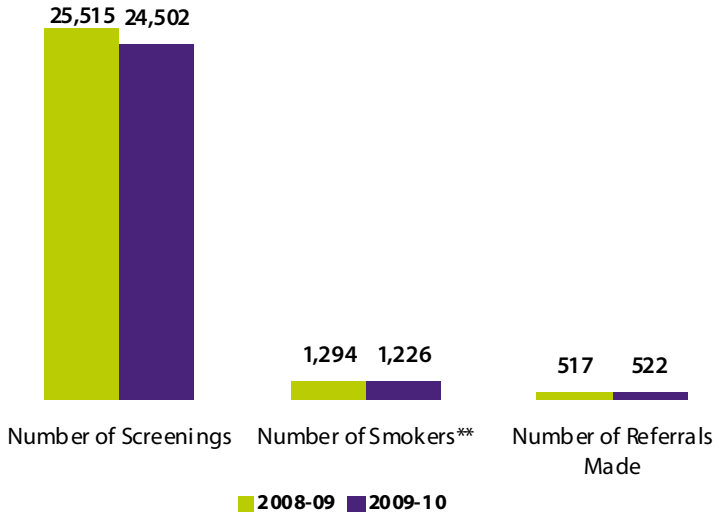
[11] American Academy of Pediatrics Work Group on Breastfeeding. "Breastfeeding and the Use of Human Milk." Pediatrics, 100 (1997): 1035-39.

Encouraging Healthy Homes: Smoking Cessation

Have smoking cessation activities decreased the levels of smoking in San Diego?

As a separate but integral part of HDS, the Partnership for Smoke-Free Families (PSF) is a nationally recognized, countywide, tobacco control program operated by Rady Children's Hospital and partially funded through First 5 San Diego. PSF trains clinicians and providers to identify tobacco use among pregnant women and families with young children through evidence-based practices. Smoking during pregnancy has been linked to slow fetal growth and nearly doubles a woman's risk of having a baby with low birth weight.[12] Additionally, the Surgeon General has stressed that secondhand smoke causes premature death and disease in children, including asthma and other respiratory ailments.[13]

Exhibit 3.7 Families Served through Smoking Cessation Activities by Fiscal Year



***For NMHV and ARHV, this is the number of households with smokers.*

PSF demonstrated the following results:

- PSF-trained providers conducted 24,502 tobacco screenings during FY 2009-10, almost half of which (46%) were conducted through NMHV and ARHV services.
- The total number of smokers was similar to the previous year, with a slight increase in the percentage of referrals made for smoking cessation (45.6% as opposed to 40.0%).

[12] March of Dimes. Smoking During Pregnancy Fact Sheet. Accessed 22 October 2009. <www.marchofdimes.com>

[13] 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>

Parent Support and Empowerment

Parents play an essential role in ensuring the key HDS goals of early identification and intervention are met. However, they often lack the knowledge and resources necessary to navigate the complex system of care and advocate for their child's needs. Parent Support and Empowerment (PS&E) services include parent education classes, workshops and one-on-one consultations to help parents promote their child's optimal development and connect to appropriate resources.

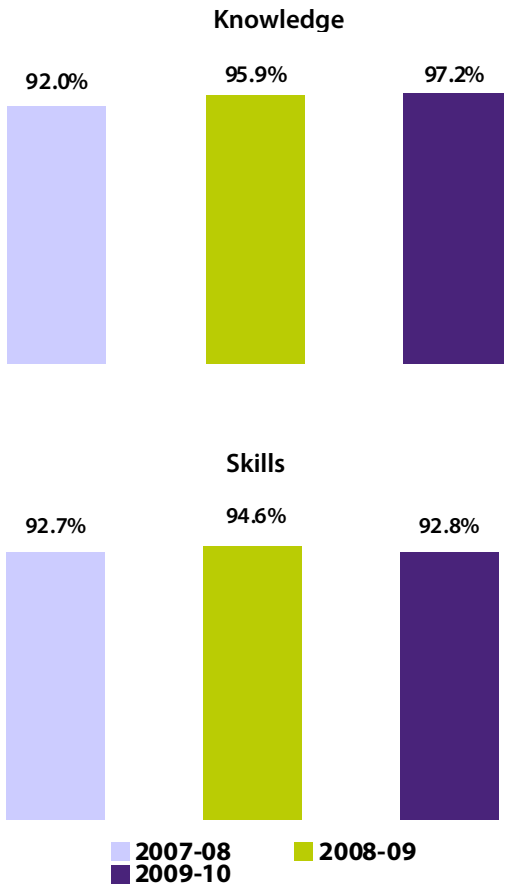
PS&E assessed its impact through basic knowledge and skills gains. Parents served in several service areas of HDS were assessed on their pre and post knowledge and skills regarding their child's development. In FY 2009-10, each provider utilized a different curriculum or approach, thus the initiative did not share a common measurement strategy. To provide an overall measure of impact, a uniform dichotomous result for each client, of "knowledge/skill gain" or "no knowledge/skill gain," was collected from all providers, regardless of the tool they used.[14]

Did parents served by PS&E increase their knowledge and skills?

Exhibit 3.8 summarizes trends in the percentage of gains in knowledge and skills made by parents who received PS&E services between FY 2007-08 and FY 2009-10. Similar to those parents receiving ARHV services, parents receiving PS&E services consistently reported that they have increased their knowledge regarding supporting their child's development.

Key to this program is assisting parents who often lack the skills to navigate complex health and social services systems or who may not feel empowered to advocate for their children. Though there was a slight decrease compared to last fiscal year, over 90% of parents served by PS&E in FY 2009-10 displayed a gain in the skills needed to advocate for their children's needs.

Exhibit 3.8 Parent Support and Empowerment Knowledge and Skill Gain by Fiscal Year



[14] AAP and Harder+Company are working to standardize HDS parent education components, which will in turn strengthen the measurement of its impact.

Early Identification of Developmental Delays

While an HDS screening is available to all children, the assessment and treatment services for children with an identified concern is targeted for children with mild to moderate needs. Children identified with more acute needs are referred outside of HDS to other services in the community, such as the San Diego Regional Center. HDS's focus on mild to moderate needs allows access to low or no cost services for families who might not otherwise be able afford these services and who are likely to leave these identified concerns unaddressed. In short, these critical services ensure that San Diego's young children have the opportunity to receive needed services and establish a strong foundation for entering school ready to learn.

What does the HDS system of care look like?

The HDS service system is complex; it seeks to build on existing services, fill in gaps, and strengthen connectivity between organizations that offer complementary services across a wide spectrum of development, from speech to behavior. Each service area has its own "service pathway," which the American Academy of Pediatrics (AAP) assisted in developing to clarify how clients move through the HDS system of care. While each service area is unique, with tools, processes and procedures to meet the needs of children and their families, the general pathway from screening and assessment to treatment is similar. Thus, for the purposes of a Commission level evaluation, we have distilled the existing pathways into the below diagram, demonstrating the progression from screening and assessment to treatment and the relative gains by service area.

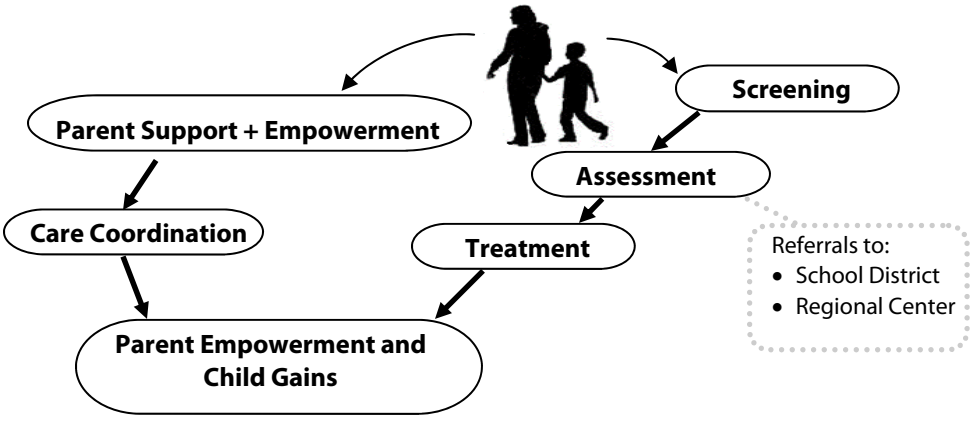
How Do Parents Find HDS?

There are a number of referral points for HDS. In addition to the outreach efforts of individual HDS contractors, Care Coordinators noted that pediatricians have become allies in referring families. Other services, such as local preschools and Head Starts, have also become referral points.

Source: Care Coordinator focus group

As Exhibit 3.9 shows, children typically advance from screening to assessment and treatment as needed. While many screenings are performed by HDS, it is a goal of the Commission to have all children screened at regular intervals throughout early childhood. Screenings can be performed by parents, pediatricians, early care and education settings and other community organizations. Broadening the variety of settings where children receive screenings will expand access to screenings and also allow more HDS funds to be used for treatment. A small number of children will skip assessments and move directly from screening to treatment. A third path for children is to be referred out of HDS to existing community services, such as Regional Center, depending on assessment results. In any of these cases, a developmental gain is the goal. Parents whose children receive HDS services also receive Parent Support and Empowerment to help them support and advocate for their child as well as care coordination if their child requires multiple services.

Exhibit 3.9 HDS Service Pathway Diagram



How did children move through the system and what were their gains?

The screening to treatment and gains results pathway data were assessed by service area. A review of these data (Exhibit 3.10) suggests trends that will be discussed in more detail in later sections of this chapter devoted to the context of each service area. Overall, the following general trends emerged:

- Behavioral services demonstrated the highest percentage of children (82.0%) receiving needed services (not counting vision, which is a low intensity treatment service area). This may be due to two factors. First, the service delivery modality meets parents where they are -- behavioral practitioners go to the family instead of the family coming to the provider. Second, First 5 San Diego approved additional funding to enhance behavioral services in FY 2009-10, which increased the capacity to serve more children through a greater number of treatment sessions and in a more intensive way. A more complete discussion of this is included in the following section.
- Developmental and speech and language services exhibited the largest gap between the number showing concern and the number and percent receiving treatment. This suggests that a relatively high percentage of children identified with developmental or speech/language concerns are not receiving the treatment needed from an HDS provider, though they may be receiving it elsewhere through insurance, the Regional Center or schools.
- Nearly all providers reported increases in the percentage of children receiving treatment who showed a gain. Future evaluation years will allow us to assess the magnitude of the change.

Exhibit 3.10 Early Identification and Treatment of Children in HDS

Service Area	Early Identification of Delays		Treatment and Results	
	# Screened or Assessed*	# Showed Concern**	% Received Treatment**	% Showed Gain**
Behavioral	1,270	1,361	82.0%	97.5%
Developmental	14,402	3,028	65.7%	90.5%
Speech/Language	N/A (included in Dev)	2,953	56.8%	91.5%
Hearing	4,547	--	--	--
Vision	4,441	318	100%	N/A

** Data source: CMEDS service list.*

*** Data source: Treatment Need/Results CMEDS assessment. Number who showed concern may include children who were screened or assessed outside of HDS and referred for treatment.*

What is the intensity of the treatment services provided by HDS?

Service intensity, as defined by the average number of sessions per client, varies by service area. To understand the dynamics of intensity, the average number of sessions children received, as well as the average duration of each session, was reviewed (Exhibit 3.11). From this brief analysis the following trends emerged:

- On average, children received twice as many behavioral treatment sessions (8.2) than developmental (3.9) or speech/language (3.3) sessions.
- The average duration of sessions was slightly briefer for behavioral treatment sessions than other sessions (45 minutes compared to one hour).

Exhibit 3.11 Treatment Service Intensity by Service Area

Treatment Service Area	Average # of sessions per client*	Average duration of sessions**
Behavioral	8.2	45 min
Developmental	3.9	1 hr
Speech/Language	3.3	1 hr

** Calculated by the number of unduplicated clients by number of service records.*

*** Calculated by the number of service records by service count recorded in 30 minute units. Durations of more than 4 hours were excluded from the analysis.*

A Focus on Behavioral Services

FY 2009-10 was the first complete fiscal year in which contractors utilized the additional funds approved by the Commission for enhanced behavioral services. In FY 2008-09, the Commission allocated an additional $2,496,000 for 18 months to support additional behavioral screenings and treatment services. This augmentation was based on First 5 San Diego's observation that behavioral services are not keeping pace with service demands. Behavioral services differ from other HDS service areas in that they routinely require a greater number of sessions, as seen in Exhibit 3.11. With the original funds allocated to behavioral services, this resulted in limited capacity to meet the unexpected demand for these services. The Commission assumed that as professional staff were added, behavioral services would "more than double" and waiting times for needed assessments and treatments would be significantly shortened.[15] Overall, the original intent of the augmentation was realized: in general, while the percentage of children receiving services dropped slightly from last fiscal year, the number of children receiving behavioral treatment and making gains increased from the previous year.

Did children needing behavioral treatment receive it?

Exhibit 3.12 shows the percentage of children who received recommended behavioral treatment for FY 2008-09 and FY 2009-10. While the percentage of children receiving recommended behavioral treatment is slightly lower in FY 2009-10, the actual number of children treated increased by 107. Two reasons may account for the percentage decrease from last fiscal year: family instability and remaining capacity issues.

For family instability, client level data reports show that the most common reason children did not receive behavioral treatment was the provider's inability to locate or contact the family (66.8%). Providers noted that this finding can be contextualized by the high level of household insecurity and mobility due to the poor economy.

Exhibit 3.12 Percentage of Children who Received Recommended Behavioral Treatment by Fiscal Year

Discussions with service providers indicated that capacity continued to be an issue, despite additional funding in FY 2009-10. Providers noted the following trends:

- In FY 2009-10, the HDS contract was coming to an end and was reissued. Contractors acted conservatively, ramping down services so as not to start services they would not be able finish if they were not awarded another contract;
- Contractors shifted from briefer services for a high number of children to deeper and more intensive series of services to ensure an enriched treatment. As shown in Exhibit 3.11, HDS provided an average of 8.2 behavioral treatment sessions per child; and
- Wait lists for behavioral one-on-one therapy remained high. However, providers offered classes to parents to address behavioral concerns while they awaited services.

[15] See Item 8-A, "Strengthening the Safety Net for Children Ages 0-5 and their Families" First 5 San Diego County Commission meeting notes, November 2008.

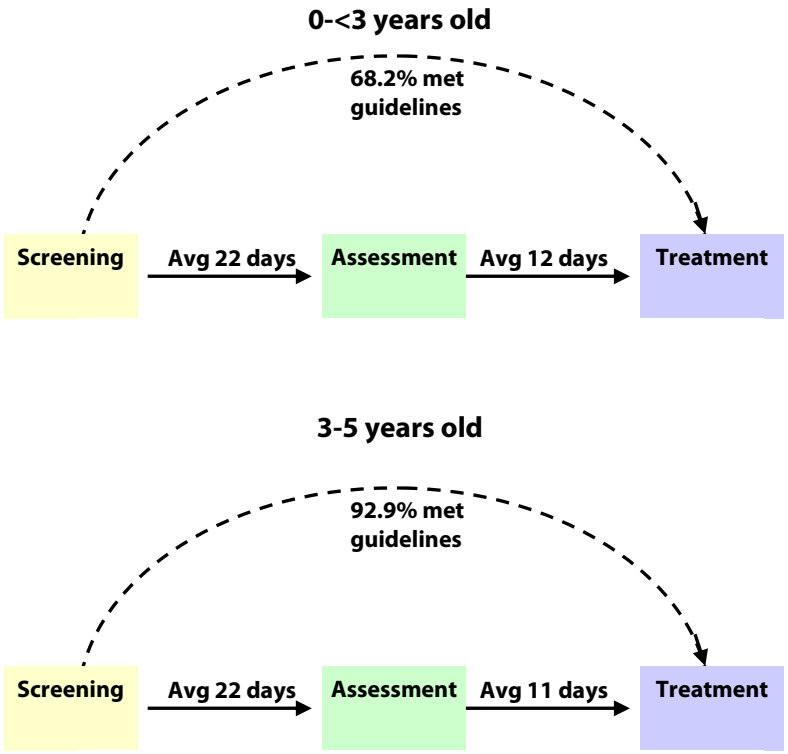
Did children needing behavioral treatment receive it in a timely manner?

Care coordinator and HDS parent focus group participants noted that wait lists are an ongoing issue. Studies of child and adolescent mental health services show that longer waiting times decrease clients' likeliness to attend appointments.[16] Long wait lists, especially for behavioral and Spanish language behavioral services, were concerning to care coordinators, as the child's identified issues may become more significant and families become frustrated. This waiting period is frequently when parents "drop out" of the service.

To better understand the issue of waitlists and if children are receiving treatment in a timely manner, a closer look was given to wait times between screening, assessment and treatment. The figures in Exhibit 3.13 show the process of how children typically move through the HDS system, from screening, to assessment, to treatment (or directly to treatment). Children who only received one of these services through HDS are not included in the analysis.

The average time in days between each of these services is presented in these figures. These data are then compared to recommended guidelines for treatment by age group and summarized below.

Exhibit 3.13 Average Wait Times between Behavioral Screenings, Assessments and Treatment by Days, Guidelines, and Age Group



Overall, 83.9% of children received behavioral treatment within the time guidelines recommended by California Early Start (i.e., this is defined as within 4 weeks [28 days] from identification of concern for children ages birth-<3 and within 6 weeks [42 days] for children ages 3-5). However, there was a marked difference between the age groups: 68.2% of birth-<3 year olds received treatment within the recommended timeframe whereas 92.9% of 3-5 year olds received timely treatment. Additionally, 9.7% of birth-<3 year olds received screening, assessment and treatment on the same day compared to 46.3% of 3-5 year olds.

The average wait times between screening and treatment (not shown) were 29 days for birth-<3 year olds and 18 days for 3-5 year olds. This suggests that treatment services for children birth-<3 are more overloaded than for 3-5 year olds.

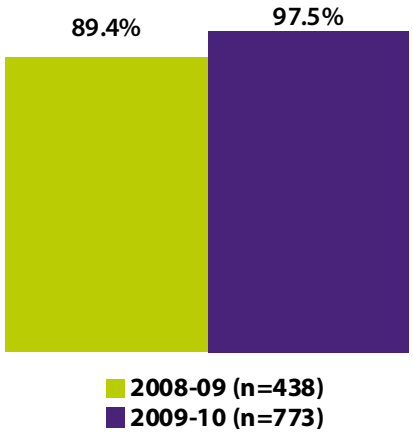
16 Hawker, David S.J. Increasing initial attendance at mental health out-patient clinics: opt-in systems and other interventions. Psychiatric Bulletin 2007 31: 179-182.

What is the impact of behavioral treatment?

Providers were asked to report on whether children who received behavioral treatment showed a gain as a result of this treatment, based on clinical assessment tools. While we do not know the magnitude of the increase, providers reported that almost all children (97.5%) receiving behavioral treatment showed gains. Furthermore, a higher percentage of children showed gains than in the previous fiscal year (see Exhibit 3.14). This gain may be attributable to two key contextual factors:

- The shift from briefer services to more intensive services is significant because the duration and number of services increased this fiscal year, presumably as a result of the additional funding.
- Client retention rate is improved due to experienced and specialized providers. Over three quarters of children (75.8%) who received treatment completed their treatment plan in FY 2009-10.

Exhibit 3.14 Percentage of Children who Showed Gains after Receiving Behavioral Treatment by Fiscal Year



What is the impact of HDS parent education on parent's knowledge and skills related to child behavior?

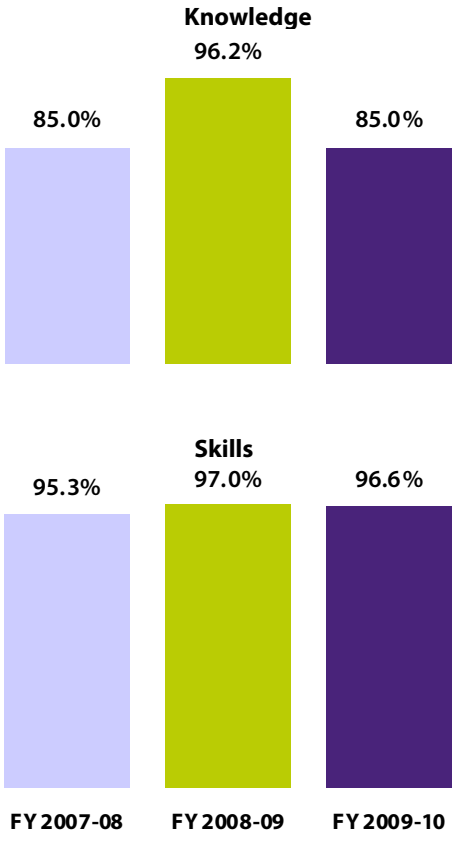
All parents who participate in HDS behavioral services receive education to support their child's social and emotional development. However, the intensity and the mode of service provision varies and is generally grouped into three types:[17]

- Group classes about child behavior
- One-on-one coaching in cases where parents needed more support than a group class, but the child's behavior did not reach the threshold for therapy
- Intensive child and parent-child therapy

For group classes, each provider utilized an evidence informed curriculum or approach, but the initiative did not share a common approach or measurement strategy. Thus, the evaluation received a simple dichotomous result for each client of "knowledge/skill gain" or "no knowledge/skill gain" based on the tool providers used. Exhibit 3.15 presents three years of trend data in gains made in knowledge and skills as a result of the HDS parenting education intervention. In all years, parents made significant gains of 85% or above in knowledge and 95% or more in skills following participation in these services. Providers shared the greater increase in skills may be because parent education for behavior is more skills based and hands on than education and knowledge focused.

For one-on-one coaching, 1,515 parents received behavioral consultations, an increase of 1,027 from FY 2008-09 to FY 2009-10. Providers attributed this increase to the dynamics of ending a contract: providers ramped down intensive and longer term treatment while increasing consultations to prepare parents to navigate the system and support their child's development during the change in contracts.

Exhibit 3.15 Percentage of Parents who Received Behavioral Services with Increases in Knowledge and Skills



[17] In preparation for the new HDS contract, AAP codified these types into three levels of behavioral services.

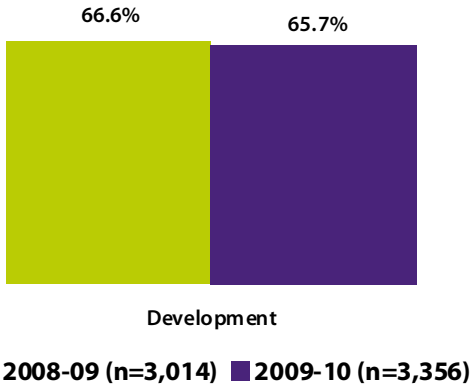
A Focus on Developmental Services

Developmental services in HDS are split into three key areas: development, speech/language, and hearing and vision. Each area is specific to a set of providers that specialize in their respective areas. However, service areas are frequently blended through a common screening and assessment process. For example, a child may receive one developmental screening that simultaneously identifies a gross motor skill delay (development service area) as well as a vision concern (vision service area). The child would then be referred to two different contractors (as opposed to behavioral, in which behavioral services can be addressed by one contractor). There are two variations on this general theme. First, speech/language is included as part of the developmental screen, and is only split out as its own area if treatment is necessary. Second, hearing and vision providers also conduct their own service area specific screenings that may not pick up on other developmental concerns. First 5 does not fund vision or hearing treatment, thus this section focuses on the gains of two funded developmental treatment services: developmental and speech/language.

Did children needing developmental treatment receive it?

As shown in Exhibit 3.16 the percentage of children who received developmental treatment fell slightly but the number of children served increased by about 200 children (2,205 in 2009-10 and 2,007 in 2008-09). Providers report they are more experienced at identifying those children who can benefit from HDS services, and make appropriate referrals for children who need a higher level of care.

Exhibit 3.16 Percentage of Children who Received Recommended Developmental Treatment by Fiscal

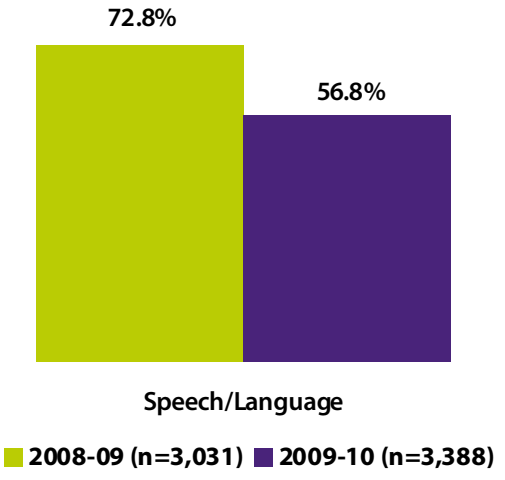


Did children needing speech/language treatment receive it?

Speech and language (Exhibit 3.17) exhibited a different trend than developmental in which both the percentage and number of children who received speech treatment decreased from FY 2008-09- to FY 2009-10 (from 72.8% to 56.8%). In reviewing these data with providers, they offered two explanations:

- Speech services are prevalent in the community either via the school system, which is mandated to serve children with identified speech/language concerns at age 3, or private practitioners whose services are frequently covered by private insurance. Consequently, providers report that children are frequently referred out to these existing services rather than initiating an HDS funded service.
- All regions report waitlists for speech due to the limited number of Speech/Language Pathologists. Children needing more intensive speech treatment could attend group classes (such as Hanen) to support their speech development while on a waitlist.

Exhibit 3.17 Percentage of Children who Received Recommended Speech and Language Treatment by Fiscal Year



- A closer look at the reasons for not receiving treatment suggests another dynamic. Speech treatment has the highest percentage of all service areas for families that "no show" or cancel their appointments (24.4%). These results can be explained in part by the order of services: speech treatment often follows developmental treatment. By the time families complete developmental treatment, they may no longer be interested in pursuing speech/language treatment as it is time intensive and families typically served by HDS have difficulty finding time for treatment. In the words of one care coordinator, "it's already hard for them to get to that first appointment and then they get out with five more classes to go to and they're overwhelmed."

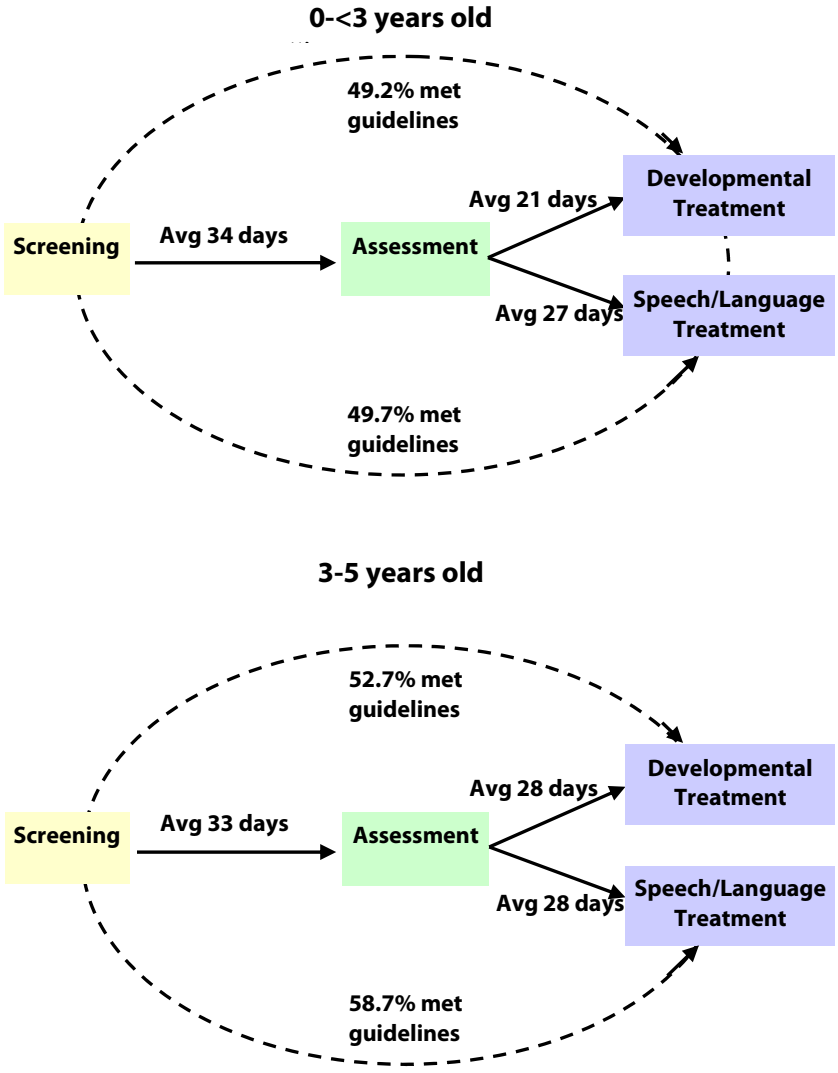
Did children needing developmental treatment receive it in a timely manner?

Exhibit 3.18 shows the average number of days that children wait between receiving developmental and speech/language screenings, assessments and treatment, as well as the percentage who met the time guidelines recommended by California Early Start (defined as within 4 weeks (28 days) from identification of concern for children under age3 and within 6 weeks (42 days) for children ages 3-5).

In FY 2009-10, 50.0% of children received developmental treatment and 51.8% received speech and language treatment within the recommended time guidelines. Unlike behavioral services, the difference between the age groups was not as large: 49.2%-49.7% of birth-<3 year olds received development or speech/language treatment within the recommended timeframe compared to 52.7%-58.7% of 3-5 year olds.

However, there was a larger percentage of birth-<3 children who received screening, assessment and treatment on the same day (35.0-44.3% of 0-<3 vs. 12.8-19.6% of 3-5), the reverse trend of behavioral services where more 3-5 year olds were receiving screening, assessment and treatment on the same day (9.7% of birth-<3 vs. 46.3% of 3-5). The average wait time between screening and developmental treatment was longer for 3-5 year olds (53 days) than for birth-<3 year olds (43 days). Average wait times between screening and speech and language treatment were longer than for behavioral or developmental, and ranged from 47-55 days depending on age.

Exhibit 3.18 Average Wait Times between Developmental Screenings, Assessments and Treatment by Days, Guidelines and Age Group



What was the impact of developmental treatment on developmental and speech/ language outcomes?

Providers were asked to report on whether children receiving developmental or speech/language treatment experienced a gain, based on clinical assessment tools. While we do not know the magnitude of these gains, providers reported that over 90% of children receiving developmental treatment showed gains and 91.5% of children receiving speech and language treatment showed gains in FY 2009-10. These gains are significantly higher than reported gains in FY 2008-09 and slightly lower than the average behavioral gains reported earlier. In addition to different treatment and measurement tools used in each of these services, behavioral services received additional funding to extend the length of the intervention with children, so these gains are not expected to be the same.

Exhibit 3.19 Percent of Children who Showed Gains after Receiving Developmental Treatment by Fiscal Year

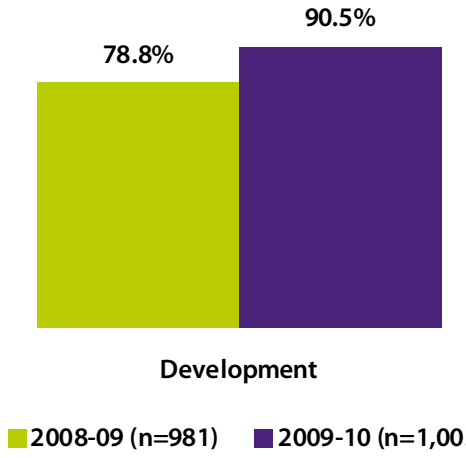
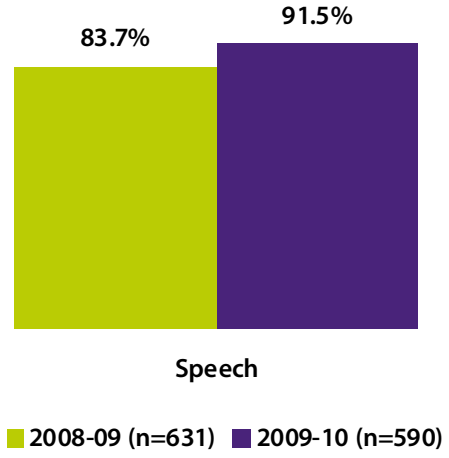


Exhibit 3.20 Percent of Children who Showed Gains after Receiving Speech and Language Treatment by Fiscal Year

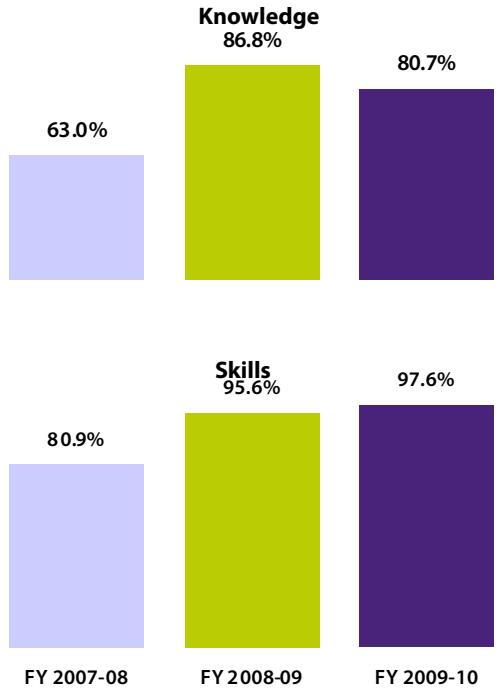


What is the impact of HDS parent education on parents' knowledge and skills related to child development?

All parents who participate in HDS developmental services are offered education. Both of the contractors who provided developmental services also provided education via classes, but with different curricula and associated tools. Thus, the evaluation received a simple dichotomous result of either "knowledge/skill gain" or "no knowledge/skill gain" based on the tool used. Similar to the results from behavioral services, it appears that parents exhibited a higher increase in skills than knowledge. Providers noted the same dynamic as behavioral: that the higher increase in skill compared to knowledge may be attributed to the hands-on skill building approach used in developmental parent education.

Note: The new HDS contract, which began in FY 2010-11, prescribed a standardized curriculum and tool to measure family empowerment which will be used across all six regions. There is also attention being given to using one standardized knowledge/skill gain tool. A standardized tool will allow a more meaningful comparison of parent outcomes in future years.

Exhibit 3.21 Percent of Parents Served by Development or Speech and Language with Increases in Knowledge and Skills by Fiscal Year



Care Coordination

What is care coordination?

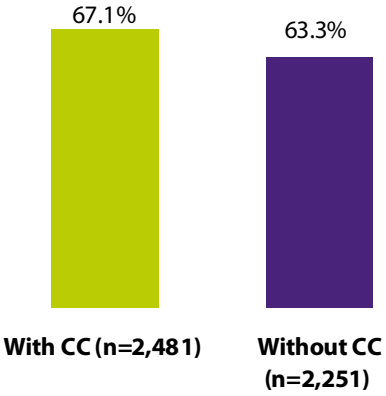
In November 2008, the Commission approved up to $2,496,000 for HDS care coordination. First 5 San Diego staff identified care coordination as critical for families whose children needed access to multiple services, both internal and external to HDS. Additional care coordination funding was granted to each HDS regional lead to provide families with needed support to ensure children receive the services they need and reduce the number of families who are lost to follow-up and miss appointments. First 5 San Diego anticipated this would improve the overall efficiency of HDS and reduce wait times.[18] The care coordinator works to connect children identified through screening and later assessments to the needed treatment. Once a child begins treatment, it becomes the treatment provider's responsibility to ensure the child receives all needed treatment. The care coordinator enters the picture again if the family drops out or needs further coordination of other services.

While each region has implemented different internal procedures, care coordination occurs primarily via phone consultations and, informed by screenings and assessment results, utilizes care coordinators' deep knowledge of community resources to link families to needed services. Most regions did not begin to utilize care coordination resources until July 2009.

What effect did care coordination have on success in initiating services?

Successful initiation of referred services data was reviewed by those families receiving care coordination and those who never received care coordination.[19] The populations compared were similar in the number of services to which they were referred. Data were also analyzed by clients with multiple referrals who were not served by care coordination but no significant differences were found. Care coordination appears to have a positive impact in the number of parents receiving services, but not dramatically so. Care coordinator focus group participants noted that budget cuts and changes to eligibility for services and insurance coverage has extended wait lists and made care coordination challenging.

Exhibit 3.22 Percentage of Referrals Resulting in Initiated Services



What are the challenges associated with successful care coordination?

Parents and care coordinator focus group participants shared similar reasons why families declined or neglected to connect to the services for which they were referred. Both listed the issue of stigma, in which parents declined or avoided treatment because of the pressure associated with having a child who is not developing typically. A number of parent participants also noted that they feared the results. Logistical concerns, such as parents balancing work and family schedules and the demands of multiple children in the household, and parents' lack of understanding of the services they were referred for were also common barriers that prevented parents from receiving care coordination services.

[18] Item 08-A - Descriptions of Safety Net Options Strengthening the Safety Net for Children Ages 0-5 and Their Families, Descriptions & Estimated Costs of Safety Net Options. Commission packet November 2008.

[19] Across the HDS initiative, the actual number of referrals to other providers within HDS dropped from FY 2008-09 to FY 2009-10 (from 4,732 to 4,212). This is primarily due to two regions not providing complete referral data.

Making the Connection

The initial contract for HDS services was broad and, consequently, service providers each made their own interpretation of the contract when providing appropriate services for their regions. Efforts in FY 2009-10 were directed toward the refinement and standardization of HDS services in preparation for the following contract. With the CMEDS data system fully functional, AAP and contractors spent significant time specifying what services were provided to whom. AAP led this process by developing "clinical pathways" for each service area in collaboration with the service area workgroups. These pathways clearly defined how clients move through the different service areas, and offered the opportunity for providers to clearly identify what components of the system they served and where a referral to another HDS or non-HDS provider would be better suited to a client's particular need. This process facilitated a clearer understanding of how to effectively and efficiently serve clients both within and across service areas and established a strong programmatic foundation for the next HDS contract. [20]

Each service area focused on specific issues that ultimately strengthened the HDS initiative. While each service area worked intensively throughout the year, the activities for the three largest service areas are the following:

- **Behavior:** Behavior workgroup members implemented a Behavior Framework that differentiates "levels" of services based on service mode and intensity (i.e., intensive behavioral modification therapy, one-on-one parenting support, group classes). The introduction of levels identified how each provider fit into the larger system, better integrated services, and set up the initiative to ensure appropriate referrals and the best service fit for a client's identified need.

- **Developmental:** Development workgroup members focused on establishing clinical pathways that outline how development service providers determine client need for services and referrals to other programs in San Diego County. This year introduced the additional challenge of changes in San Diego Regional Center's eligibility criteria. These changes resulted in fewer children being accepted at the Center, and, by provider accounts, increased the demand for HDS services. The Development workgroup members also focused on challenges with data quality and definitions related to the previous fiscal year.

- **Speech and Language:** Speech and Language, while technically a domain of development, was split out due to the significant demand for services. Speech and Language workgroup members focused on developing their pathways, which are markedly similar to development.

In general, the focus on the clinical pathway development appears to have led to three positive results. First, the pathways clarified providers' roles and responsibilities. Second, the pathways strengthened the overall HDS initiative, creating opportunities to clarify and then introduce best and promising practices for standardization. Third, the pathways provided a clear roadmap for new and continuing providers, creating minimal interruptions in services for clients.

While the main thrust of the year was clarifying how HDS services were provided, there were a number of other key activities the HDS initiative undertook to connect with other systems within San Diego County. These included:

- Training provided by AAP for Public Health Nurses on the use of the Ages and Stages Questionnaire (ASQ), a screening tool for developmental issues, as a standard, best practice for ensuring consistent screening for early intervention of needs: this training resulted in the full adoption of the ASQ screening for all Public Health nurses in FY 2010-11.

[20] It is of note that these programmatic standards and uniformity of services will provide a more robust evaluation of initiative-level results in subsequent fiscal years.

- Physician outreach to promote the use of routine developmental screenings at well child visits: AAP provided in-service trainings to over 140 physicians and 175 medical staff in FY 2009-10.
- Scholarship program for Alliant International University to increase capacity for mental health clinicians in San Diego to focus on the birth-5 year old population: this focus increased the number of providers qualified to address the needs of young children.

Over the past five years, HDS has made great strides in creating an unprecedented system of support and care for young children's development. The hard work of this past fiscal year has created stronger connections within and outside of the HDS system and better ensured that San Diego's young children receive the care needed to promote their readiness for school success.

Update on FY 2008-09 Recommendations

Last year's Recommendation	Update to Recommendation
Develop strategies to increase the rate of initiated services.	✚ Though the rate of initiated services decreased slightly, the actual number of children receiving behavioral and developmental treatment increased, indicating that providers are able to reach families but have a capacity issue. ✚ Care coordination services were funded to help families move through the system and receive needed services.
Use systems to examine waitlists and time elapsed to service delivery.	✚ Care coordination was utilized to connect families to treatment and identify waitlists and effects on treatment capacity. ✚ Average wait times between screening, assessment, and treatment were examined and gaps in HDS capacity were found for 0-<3 year olds in behavioral services and all children in developmental and speech/language services. ✚ Scholarship programs were developed to build the capacity of health professionals serving the 0-5 year old population in San Diego County.
Standardize, strengthen, and implement program models and measurement tools.	✚ Although providers continued to use different curricula models and measurement tools, this recommendation was taken into account for the new contract and program models and tools were standardized in the HDS contracts beginning in FY 2010-11.
Implement the revised evaluation framework.	✚ The revised evaluation framework guided the initiative during the final year of the contracts and allowed for a smoother transition to the new contracts. First 5 staff, Evaluation staff, and Program Coordinator staff, reviewed and refined the evaluation framework to align with First 5's Strategic Plan.

Recommendations

FY 2009-10 was the final year of the current HDS contract and served as a transition year to the more standardized requirements in the new contract beginning in FY 2010-11. The following recommendations for FY 2010-11 draw from lessons learned during the first five years of the HDS initiative.

- **Utilize standardized tools and curricula across regions and providers.** The broad range of service models and measurement tools used by providers in FY 2009-10 limited the initiative-wide evaluation. Standardized tools and curriculums will ensure that programs are using best practices and common results will facilitate initiative learning. Providers should continue to participate in on-going conversations to identify and administer the most effective tools under the new HDS contracts.

- **Increase capacity for the provision of behavioral, developmental, and speech/language treatment.** The data reported on wait times and the decreased percentage of children receiving needed services (see Exhibits 3.13 and 3.18) indicate a capacity issue in both behavioral and developmental service areas. Care coordinators expressed their concern about these issues, noting that children on wait lists may fall further behind developmentally, and that delays can frustrate families.

- **Continue to provide evidence-based interventions resulting in gains.** Over 90% of children receiving treatment through HDS services exhibited gains in all service areas (see Exhibit 3.10). This indicates that the quality of the treatment is high and children who receive services are showing improved outcomes.

- **Empower and educate families through care coordination.** Care coordination is an essential part of HDS services. During this first year of care coordination services, focus group participants identified barriers such as basic needs, fear, lack of information, and stigma. Care coordinators can learn from their experiences in FY 2009-10 to further empower and educate families to navigate the complex system of care and initiate needed services for children.

- **Promote the goals of HDS to expand the network of care:** HDS has made a great impact on San Diego and, in FY 2009-10, served 13.2% of the 0-5 year old children in the county. Promoting the goals of HDS to other providers of similar services across the county will expand the system of care for young children and make early identification and intervention a universal priority.

Black Infant Health

The Black Infant Health (BIH) program seeks to improve birth outcomes for African-American women of childbearing age and the health and well-being of their infants across the State of California. BIH is located in the seventeen health jurisdictions, including San Diego County, that account for 97% of California's African-American live births and infant deaths. In San Diego, BIH is administered by the Maternal, Child, and Families Health Services (MCFHS) Branch of the San Diego County Health and Human Services Agency. The program provides interventions such as prenatal care outreach and follow-up, case management, social support and empowerment, and health behavior modification in order to improve the birth outcomes of African-American infants.

Table 1.1 FY 2009-10 Black Infant Health Program Results	
Percent of clients in prenatal care within 30 days	96.0%
Percent of clients who quit or reduced the level of smoking during pregnancy	91.0%
Percent of infants born with normal birth weight	80.0%
Percent of SIDS related deaths	0.0%

In FY 2009-10, the Black Infant Health program in San Diego served over 300 clients, 77 of whom were new clients this fiscal year. Eligible clients are identified by outreach, street canvassing, and partnerships with other referral organizations. Key program outcomes are identified in Table 1.1. There were 50 births, and 40 of those infants were born with normal birth weights (weighing more than 5 pounds, 8 ounces), resulting in a low birth weight rate of 20% (or 16% when excluding a set of twins and births occurring to mothers who received no prenatal care until their third trimester). There were no BIH infant deaths and no SIDS related deaths in FY 2009-10.

BIH is also well integrated with other First 5 programs and services. It established a mutual referral agreement with First 5's Healthy Development Services (HDS) in FY 2009-10, and distributed First 5 Kits for New Parents. BIH staff also attended the "What to Do When Your Child Gets Sick" Train the Trainer Program.

"What to Do When Your Child Gets Sick" Training Program

In FY 2007-08, Community Health Improvement Partners (CHIP) began a training for trainers on a curriculum based on *What to Do When Your Child Gets Sick*, an easy-to-understand resource book for parents. The program trains "master trainers" from community based organizations throughout San Diego County to instruct parents and caregivers to utilize the book.

The project is expected to reduce the number of non-emergency uses of emergency departments and clinics, as well as the number of days parents miss work and children miss preschool or daycare. [1]

Table 1.2 "What to Do When Your Child Gets Sick" Program Results

Results	FY 2008-09	FY 2009-10
Number of active master trainers	125	125
Number of parent/caregiver trainings held by master trainers	41	12
Number of parents/caregivers trained	638	312
Number of active partner sites	26	26

In FY 2009-2010, 125 master trainers were active, 12 trainings were held and 312 parents/caregivers were trained. Most parents were Latino, between the ages of 25 and 44 and had less than a high school education. The total number of active partner sites was 26.

An external study performed found that:

- There was a positive relationship between education level and health knowledge scores.
- Health knowledge increased from 58% correct answers in the pre test to 72% in the post test.
- A survey was distributed to Master Trainers to solicit feedback about program benefits, and the results showed an overwhelmingly positive response to the "What to Do When Your Child Gets Sick" Program and Training-the-Trainer model.

[1] sdchip.org. 2008. 6 October 2009 <http://www.sdchip.org/B-4/index.html>.

Obesity Prevention

The First 5 Commission supports the County's Building Better Health Agenda in many direct and indirect ways, as noted throughout this report. One direct means of support is financial investment in the San Diego County Childhood Obesity Initiative. The San Diego County Childhood Obesity Initiative is a public/private partnership whose mission is to reduce and prevent childhood obesity in San Diego County by creating healthy environments for all children and families through advocacy, education, policy development, and environmental change. In FY 2009-10, First 5 invested $130,000 in staffing and program support to the San Diego county Childhood Obesity Initiative.

Learning

Goal: Support each child's development of communication, problem-solving, physical, social emotional and behavioral abilities, building on their natural readiness to learn.

Preschool for All
School Readiness
- Mi Escuelita
- Therapeutic Preschool
- Reach Out and Read
- American Academy of Pediatrics
- Preschool Learning Foundations
- CARES

First 5 San Diego

CHAPTER 4.

Preschool for All

2009/2010 Scorecard

Goals	Measures	Target	Actual	Performance
1. Quality preschool programs provided in 8 communities	Number of children enrolled / Total number of funded slots	3,000 / 3,000	3,906 / 3,608	●
2. Parent engagement	Percent of parents satisfied with the quality of parent engagement activities	80%	96.8%	●
3. Preschool Quality	Significant increase in review scores from previous year: ECERS-R FCCERS-R	 6.24* 6.01*	 6.43 6.57	●
4. Impact growth and development of children	Children improved in each developmental domain. Competence Learning Motor Skills Safety and Health	No target set	 1.15 1.24 0.96 1.12	●

● 90% or above target ● 75-89% of target ● <75% of target

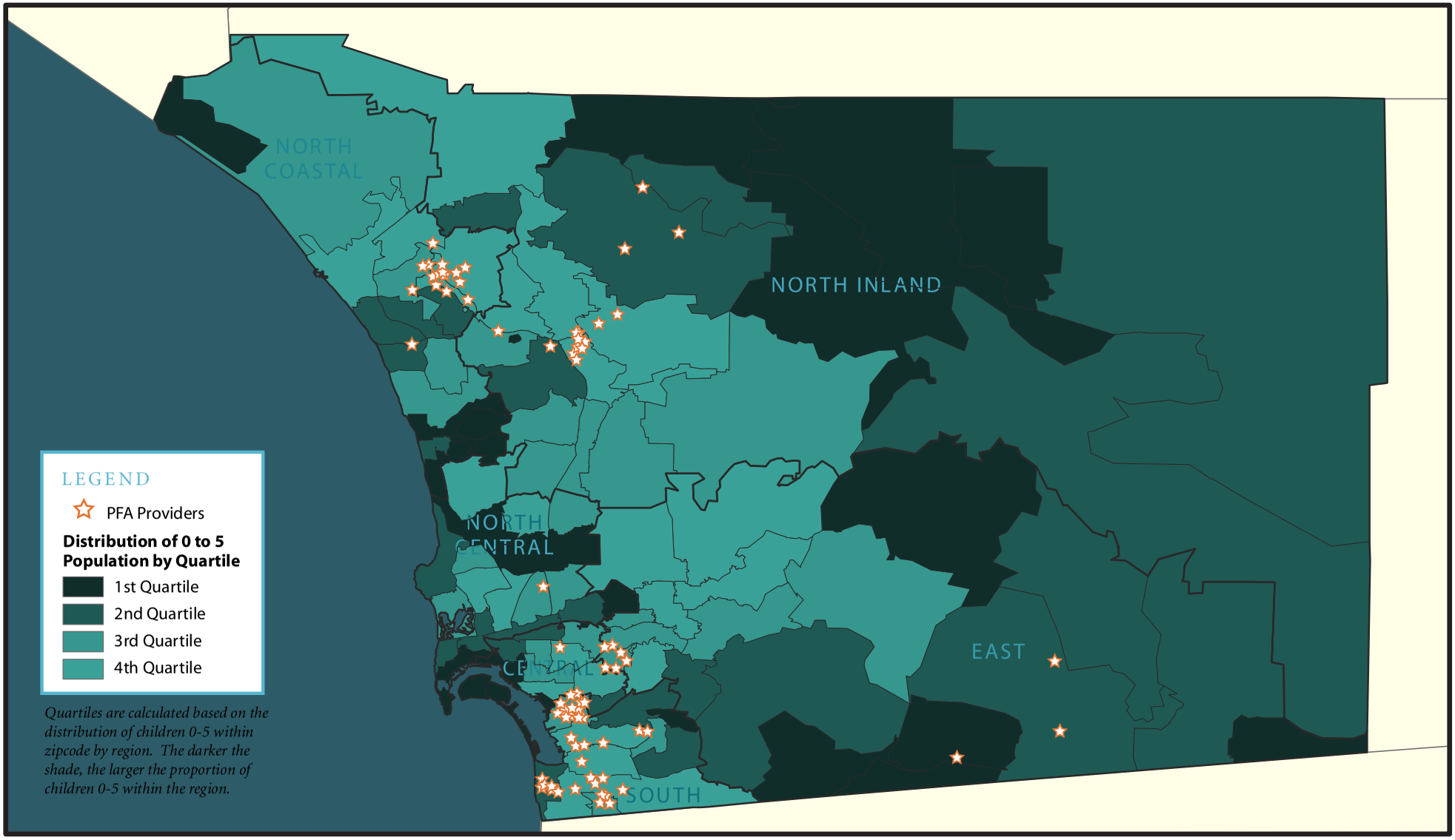
PFA 2009/2010 Scorecard, continued

Goals	Measures	Target	Actual	Performance
5. Developmental Screening	Percentage of PFA children who undergo the developmental screening process	80%	76.2%	
	Percentage of children enrolled in PFA who are identified with special needs.	10%	12.7%	
6. Professional development	Percentage of teachers participating in professional development	No target set	99.2%	

 90% or above target  75-89% of target  <75% of target

* No target was set for this measure so 2008-09 data were used for comparison purposes.

Preschool for All Providers



Introduction

"It's really incredible to see where [children] start and at the end of the year see how they have grown emotionally, academically, and socially."

- SDCPFA Director

Children who participate in high quality pre-kindergarten programs are shown to be less likely to repeat a grade, require fewer special education services, and are more likely to graduate from high school and attend college.[1] To improve access to quality early education opportunities for San Diego's young children and to prepare them to be successful in kindergarten, the First 5 Commission of San Diego County launched the San Diego County Preschool for All (SDCPFA) Demonstration Project in 2005. The Commission dedicated $30,000,000 to fund a five-year SDCPFA Demonstration Project, including $6,143,000 in FY 2009-10, the fourth year of the project. SDCPFA funded 28 agencies with preschool sites in eight priority communities throughout San Diego County: Escondido, Valley Center/Pauma, Vista, Lemon Grove, Mountain Empire, San Ysidro, South Bay, and National City.

Initiative Goals

- **Developmental progress** of children participating in SDCPFA programs
- **High quality preschool** programs provided in various settings (center-based and family care)
- **High parent satisfaction** regarding the programs and **parent involvement** activities
- **Early identification and intervention** of children with developmental delays
- **Professional development** of SDCPFA staff

Key Elements

The overarching goal of SDCPFA is to successfully enroll and serve 70% of four year olds located in all target communities by FY 2010-11. First 5 San Diego contracted with the San Diego County Office of Education (SDCOE) to coordinate the project and they, in turn, contracted with school-based, non-school-based (i.e., for-profit, private non-profit, faith-based, and Head Start), and family child care providers to provide quality preschool in each target community. Key elements of the initiative include:

+ **Classroom Quality:** Each session (or classroom) is assigned a tier level based on its external review scores and teacher education level. Coaching and training services are available for providers to help them improve their classroom quality. As their external review scores are directly related to their funding, providers are highly motivated to improve the quality of their classrooms, thereby inviting better outcomes for their young students.

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

- **Screening and Inclusion:** Providers offer screening and early identification of developmental delays, as well as ensure that services are provided for children with special needs. SDCPFA supports the larger First 5 goal of screening all children through schools and other community venues to encourage early identification and intervention of developmental concerns.

- **Parent Engagement:** Providers offer opportunities and support for families to be involved in their child's education to maximize each child's development and learning experiences. These opportunities encourage participation in the school environment, as well as interaction between the parent and child at home.

- **Professional Development**: Education and training are offered to teachers and administrators to develop a qualified workforce to meet the needs of their students. Professional development opportunities also encourage teacher retention and allow them to improve and expand their skills.

- **Collaboration with the Community:** To better serve families, providers build relationships with other agencies in San Diego County, referring families to these agencies as needed. SDCPFA is also playing a role in educating the public about the importance of quality preschool.

Summing It Up

"It's been really great to see from the beginning how PFA has changed and how they have listened."

- PFA Director

Fiscal year 2009-10 marks the fourth year of the SDCPFA Demonstration Project or PFA. This section includes key process data including the number of agencies, sessions, and slots by preschool setting. Note that a "slot" is a funded space that may serve more than one child throughout the year.

- **Agencies and sessions:** As shown in Exhibit 4.1, the total number of agencies participating in PFA increased to 28 in FY 2009-10, bringing the total number of sessions, or classrooms, to 242. Non school-based agencies continued to be the most common type (46.4%) and the majority of sessions (53.7%) were located in non school-based settings.
- **Children:** Exhibit 4.2 shows that the number of children enrolled in SDCPFA increased by 14.4% from last fiscal year. Enrollment in year 4 was 130% of the target enrollment of 3,000 children.
- **Slots**: The number of slots increased by 14.1% from last fiscal year (Exhibit 4.3). The majority of slots (51.5%) were located at school-based sites, while 61% of the pre-entry slots (meaning not of sufficient quality to be "entry level" and thus receiving preparatory support from SDCOE) were in non school-based sites. Most slots were enhanced (meaning that PFA funding was used to increase the quality of existing slots).

Exhibit 4.1 PFA Number of Agencies and Sessions

	06-07	07-08	08-09	09-10
Agencies	16	20	26	28
Sessions	103	142	213	242

Exhibit 4.2 Number of Children Served by PFA

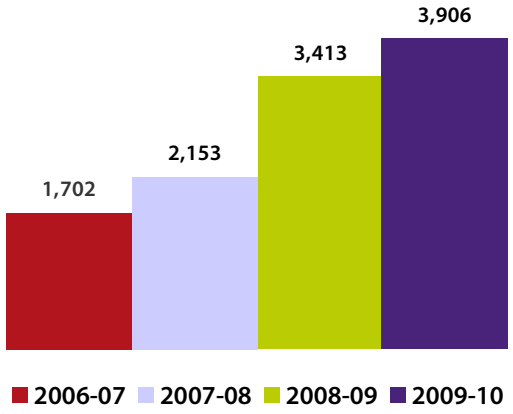
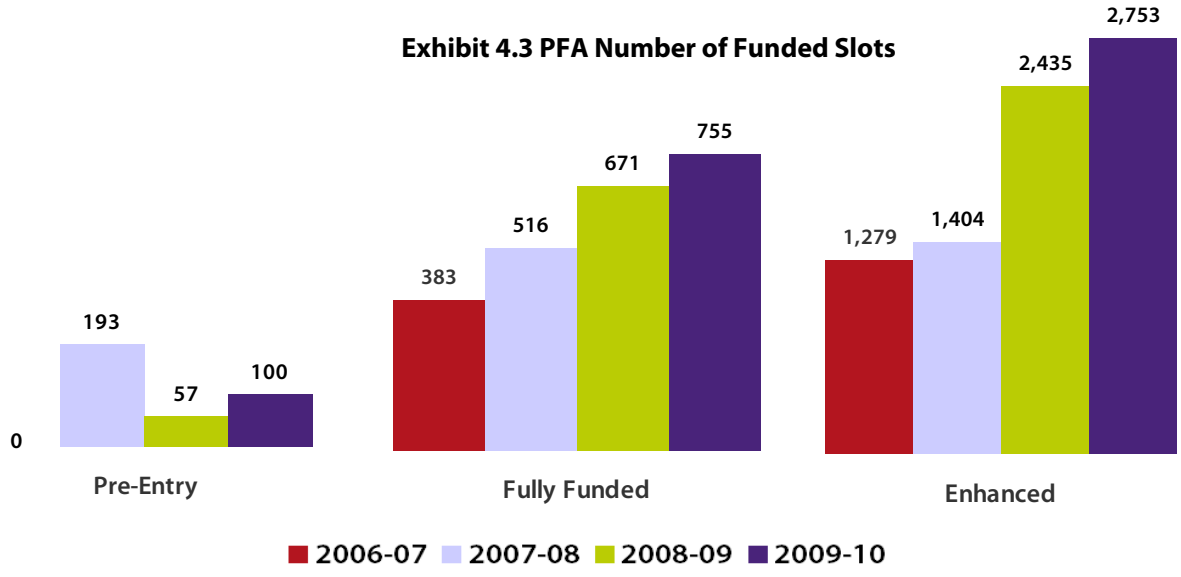


Exhibit 4.3 PFA Number of Funded Slots



Making a Difference

"The biggest success of PFA has been the change in the parents and how they understand the information they get."

-SDCPFA Director

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

Classroom Quality

SDCPFA uses three tools to evaluate preschool classroom quality, depending on the setting and tier level: 1) the Early Childhood Environment Rating Scale-Revised (ECERS-R) for classrooms; 2) the Family Child Care Environment Rating Scale-Revised (FCCERS-R) for family care centers; and 3) the Classroom Assessment Scoring System (CLASS) for the highest quality tier (Tier 3). Each session is assigned a tier level based on classroom quality and the teacher's education level. From lowest to highest, these tiers are Pre-Entry (Tier 0), Entry (Tier 1), Advancing (Tier 2), and Quality (Tier 3).

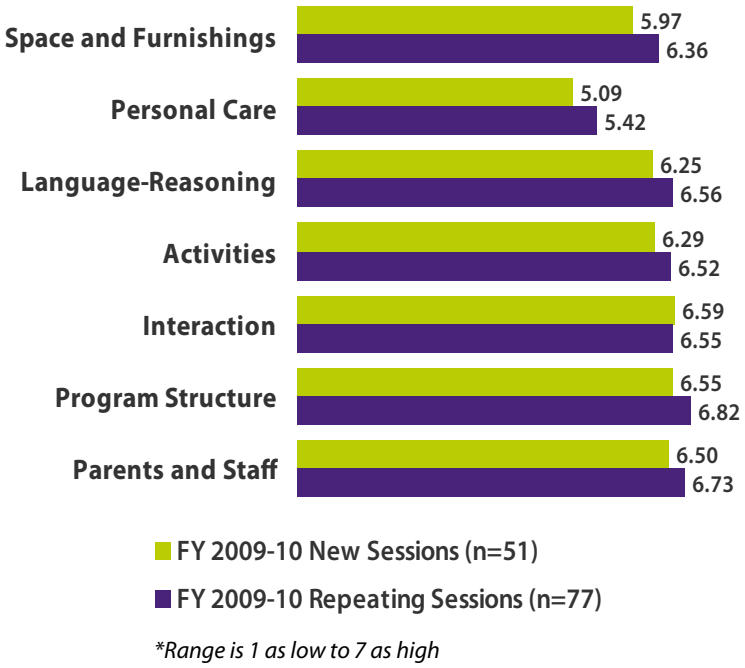
Did the quality of PFA funded classroom-based sites improve?

Overall, ECERS-R scores for SDCPFA sites were very high (see Exhibit 4.4), which is a positive result that may be related to the funding structure which provides incentives for improving classroom quality.

In FY 2009-10, ECERS-R scores for repeating sessions (sessions that have participated in SDCPFA for more than one year) were slightly higher than the scores for new sessions in every category except *Interaction*. This reflects SDCPFA's focus on classroom quality improvement. Sites that participate in SDCPFA are of relatively high quality to begin with, but continue to improve in quality as they receive coaching and professional development services through the program.

Personal Care, which consists of greeting, eating, napping, toileting, and health and safety, scored the lowest for all sessions and continues to be a challenging area for SDCPFA sessions.

Exhibit 4.4 Mean Early Childhood Environment Rating Scale - Revised (ECERS-R) Scores*

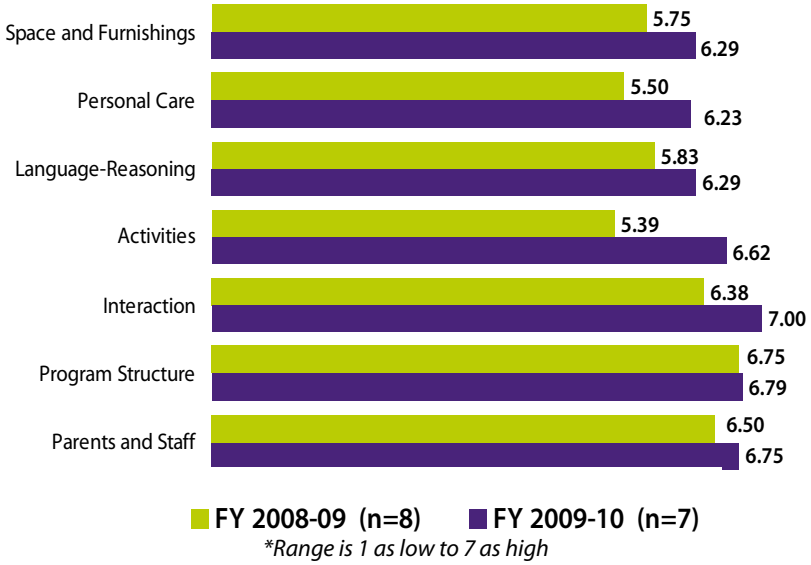


**Range is 1 as low to 7 as high*

Did the quality of PFA-Funded Family Child Care sites improve?

Family Child Care (FCC) sessions scored higher in FY 2009-10 than FY 2008-09 in all categories of the FCCERS-R, as displayed in Exhibit 4.5. Overall, scores were very high as all scores were over 6.2. FCCs scored a perfect 7.00 in *Interaction*, which involves both the interaction between providers and children as well as interaction among children. The greatest difference from FY 2008-09 to FY 2009-10 was in *Activities* and, similar to center-based sites, the lowest score in FY 2009-10 was in *Personal Care*.

Exhibit 4.5 Mean Family Child Care Environment Rating Scale–Revised (FCCERS-R) Scores



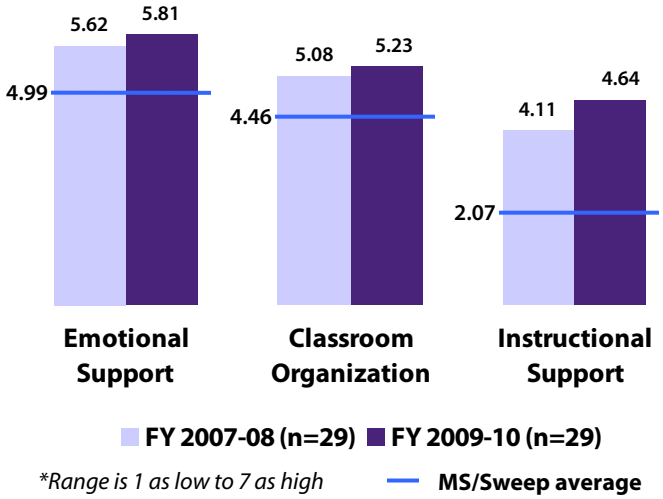
**Range is 1 as low to 7 as high*

Did SDCPFA's highest quality classrooms improve?

The CLASS is administered every two years to sessions at the highest tier level (Tier 3). Therefore, the sessions undergoing the CLASS review have already achieved high scores on the ECERS–R. Exhibit 4.6 shows that sessions reviewed in FY 2007-08 that were reviewed again in FY 2009-10 scored slightly higher this fiscal year for each domain.

Emotional Support, which measures a teacher's ability to support children's social and emotional functioning, was the highest scoring area. *Instructional Support* continued to be the lowest scoring area but had the most improvement over the two years.

Exhibit 4.6 Comparison of Mean Scores for Sessions Receiving Classroom Assessment Scoring System (CLASS) in FY 2007-08 and



**Range is 1 as low to 7 as high*

Research based on a similar population of predominantly low-income children served in state-funded preschools (MS/Sweep) showed average scores of 4.99 for *Emotional Support*, 4.46 for *Classroom Organization* and 2.07 for *Instructional Support*.[2] SDCPFA sessions scored higher in all three domains, especially in *Instructional Support*. For FY 2010-11, the SDCPFA Professional Development Management team is planning to improve *Instructional Support* scores further by providing trainings, monthly workshops and professional learning community modules specific to the CLASS.

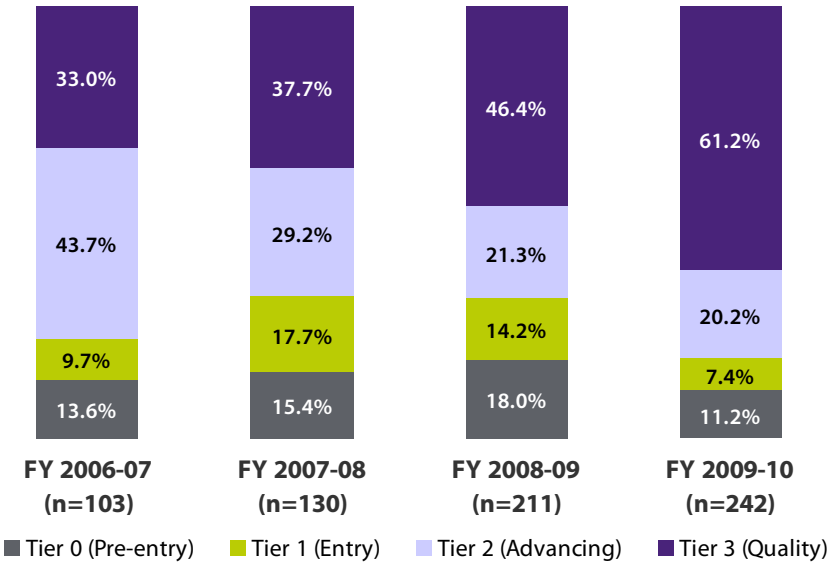
[2] Pianta, R. C., La Paro, K. M., & Hamre, B. K. (2008). *Classroom Assessment Scoring System (CLASS) Manual, Pre-K*. Baltimore, MD: Paul H. Brookes Pub. Co.

Overall Quality Improvements

Did the overall quality of SDCPFA sessions improve?

In FY 2009-10, there was an overall increase in the number of sessions (see Exhibit 4.7). In all four years, the majority of sessions reviewed were rated at either the Tier 2 (advancing) or Tier 3 (quality) level. Every year, the percentage of Tier 3 sessions has increased, and in FY 2009-10, almost two-thirds of sessions were Tier 3, exemplifying SDCPFA's commitment towards improving classroom quality.

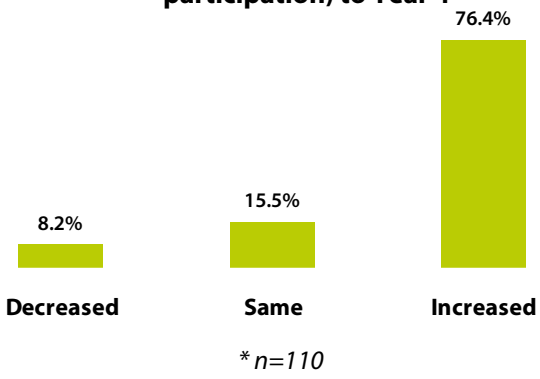
Exhibit 4.7 Percentage of Sessions at Each Review Tier Level by Year



Are SDCPFA sessions showing improvement after participating in PFA?

Exhibit 4.8 shows that almost 80% of sessions increased in tier level since their first year of participation in SDCPFA. About two-thirds of the sessions that remained at the same tier level were already at the highest tier level and 100% of the decreases in tier level are attributed to lower scores in *Personal Care*.

Exhibit 4.8 Tier Growth from Baseline (first year of participation) to Year 4*



** n=110*

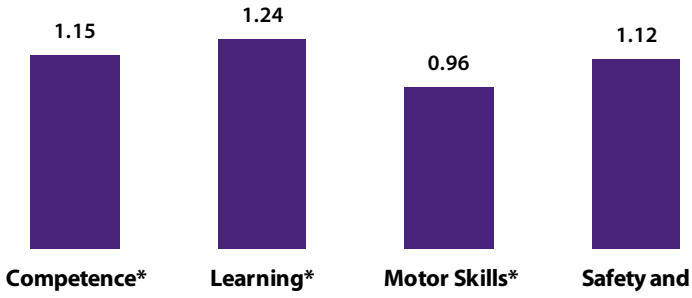
Developmental Gains for Children

Classroom-based child outcomes are measured through the Desired Results Developmental Profile-Revised (DRDP-R). Teachers assess children's competencies in four domains: competency, learning, motor skills, and safety and health. All data and findings are for children with both fall (pre) and spring (post) matched cases.

Are children making developmental progress towards school readiness?

The changes in the mean scores displayed in Exhibit 4.9 indicate that children participating in SDCPFA programs are making significant developmental progress from fall to spring. The greatest gain measured was in the *Learning* domain and the smallest gain was in the *Motor Skills* domain, though all changes were significantly positive.

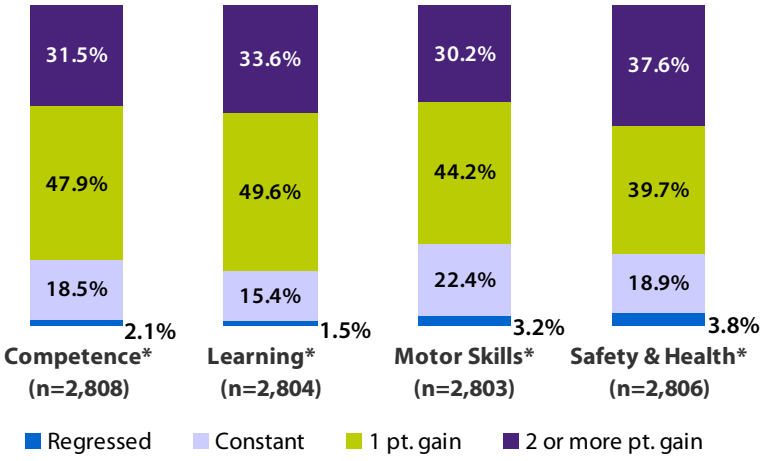
Exhibit 4.9 DRDP-R Developmental Area Mean Score Change (Fall to Spring, FY 2009-10)



**Statistically significant at p<0.001.*

In addition to the overall mean score improvements, Exhibit 4.10 shows the extent of developmental progress of children from fall to spring as described in the box below. Overall, more than 70% of children improved their scores from fall to spring in each of the four DRDP-R domains. The greatest improvement was within the *Learning* domain in which 83.2% of children gained at least one point. The *Safety & Health* domain had the highest percentage of children who regressed. The changes in all domains from fall to spring were statistically significant.

Exhibit 4.10 Children's Progress from Fall to Spring in Four Key DRDP-R Domains for FY 2009-10



**Statistically significant at p<0.001.*

- **Regressed:** children whose scores decreased from fall to spring.
- **Constant:** children whose scores were the same at both fall and spring.
- **1 pt. gain**: children whose scores increased 1 point from fall to spring.
- **2 or more pt. gain**: children whose scores increased 2 or more points from fall to spring.

Screenings and Special Needs

Are SDCPFA agencies identifying children with developmental delays?

Early identification and intervention for developmental delays is a key goal of all First 5 San Diego projects. Implementing appropriate treatment plans can dramatically improve a child's health, ability to learn, and social and emotional development.[3]

Almost 9 out of 10 children (86.6%) received a primary screening in FY 2009-10. Non school-based sites appear to be providing primary screenings to a higher percentage of students than school-based or family child care sites. As shown in Exhibit 4.12, the percentage of completed primary screenings has increased every fiscal year moving closer to the goal of screening every child before they enter kindergarten.

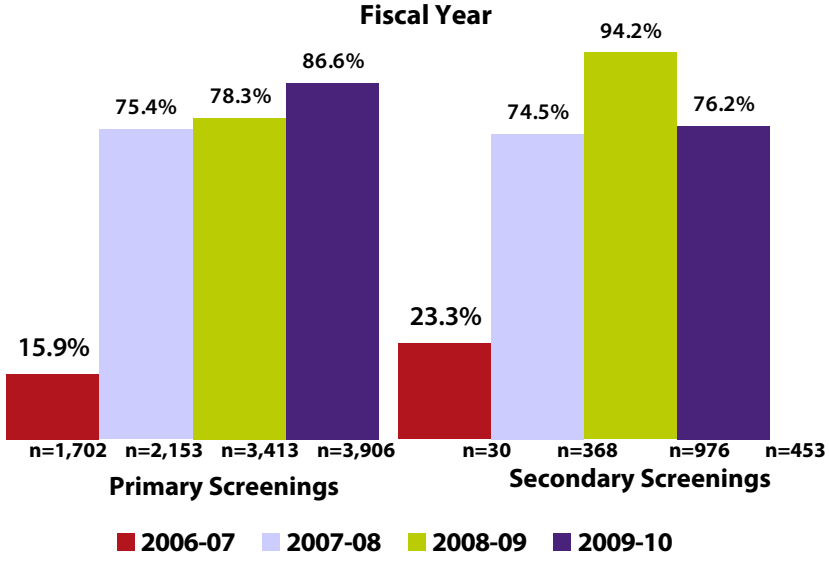
Despite the success in conducting primary screenings for children in early care environments, secondary screenings for children whose primary screenings indicate concern were less successful as only three quarters (76.2%) of children who show need completed a secondary screening. A possible explanation for this shortfall is that some children were referred to treatment immediately following their primary screening and completion of the secondary screening was not appropriate. Also, five agencies account for the majority (84.3%) of the incomplete secondary screenings indicating a capacity or procedural issue within those agencies.

Exhibit 4.11 Percentage of Children who Completed Primary and Secondary Screenings in FY 2009-10

	Children Served	Primary Screening	Secondary Screening*
School-Based	2,012	83.5%	60.3%
Non School-Based	1,795	90.5%	84.3%
Family Child Care	99	79.8%	90.0%
Total	**3,906**	**86.6%**	**76.2%**

***Note**: All children should receive primary screenings. Secondary screenings are provided if indicated (with the exception of three agencies that use the secondary screening tool as their primary screening).*
**This is the percentage of children who completed a secondary screening when a secondary screening was indicated. In FY 09-10, secondary screenings were indicated for 453 children*

Exhibit 4.12 Percentage of Children who Completed Primary or Secondary Developmental Screenings by Fiscal Year



[3] 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.

Are SDCPFA agencies identifying children with special needs and requiring Individualized Education Plans (IEPs)?

The percentage of SDCPFA children identified with special needs in FY 2009-10 was 12.7% (see Exhibit 4.13). Of the children with special needs, some are legally qualified for school services, which are documented in an Individualized Educational Plan (IEP). At the end of FY 2009-10, 7.6% of SDCPFA children had an IEP.

Trends in the percentage of children with IEPs over time are shown below (Exhibit 4.14). The percentage of children with special needs at the end of FY 2009-10 was lower than the percentage at the end of FY 2008-09. Contractors report that limited resources at the school districts led to delays in the completion of screenings and hearing assessments. Providers reported some cases in which children who were identified with special needs while enrolled in PFA were asked to wait until they entered Kindergarten to receive needed services.

Exhibit 4.13 Children with Special Needs and IEPs by Agency Type at Enrollment and at the End of FY 2009-10

	Children Served	IEPs		Special Needs	
		Upon Enrollmen	At End of Year	Upon Enrollmen	At End of Year
School-Based	2,012	5.0%	6.9%	5.8%	13.8%
Non School-Based	1,795	6.6%	8.1%	7.5%	11.1%
Family Child Care	99	7.1%	11.1%	14.1%	18.2%
Total	3,906	227	296	266	495
	100.0%	5.8%	7.6%	6.8%	12.7%

Exhibit 4.14 Percentage of Children with IEPs at Enrollment and at the End of the Year by Fiscal Year

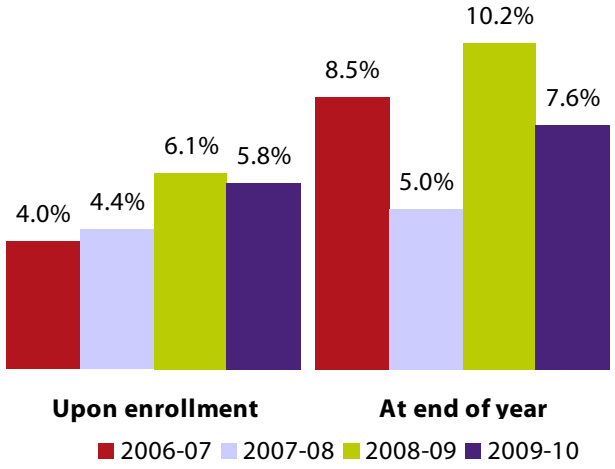
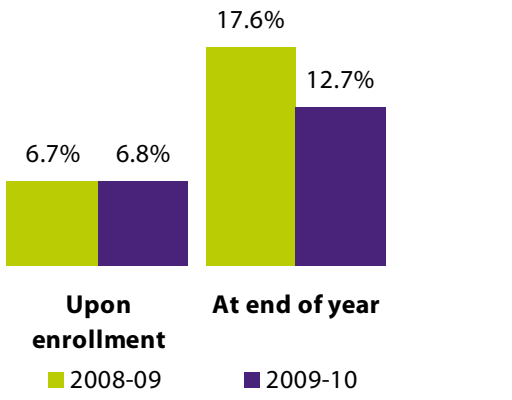


Exhibit 4.15 Percentage of Children with Special Needs at Enrollment and at the End of the Year by Fiscal Year

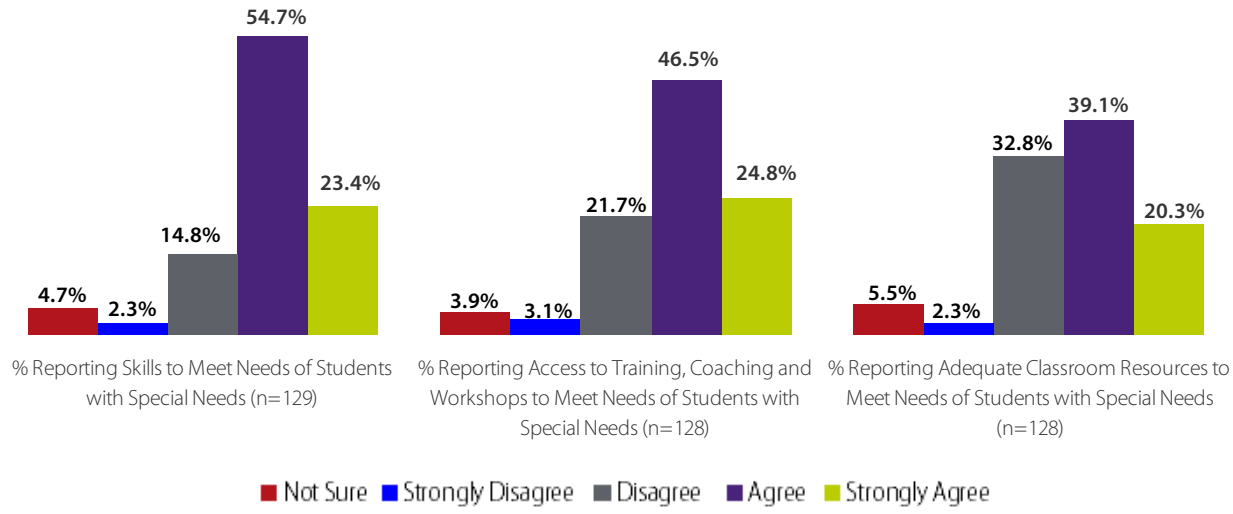


Are PFA teachers equipped to address the needs of students with special needs?

As shown in Exhibit 4.16, more than three-quarters (78.1%) of teachers surveyed agreed or strongly agreed with having the skills to meet the needs of students with special needs. Almost three-quarters (71.3%) of teachers agreed or strongly agreed with having access to training, coaching and workshops. However, over one-third (35.1%) disagreed or strongly disagreed with having adequate classroom resources to meet the needs of students with special needs. These findings indicate that most SDCPFA teachers are fairly confident in their ability to meet the needs of children with special needs but are lacking in classroom resources and some would like more training and coaching in this area.

Providers report that a number of factors, including the economy, stress at home, and the introduction of children to a new environment with more routine and structure, have resulted in an increase in the number of children with emotional and behavioral needs. These children do not always qualify for special needs but require extra attention from teachers. A number of seasoned preschool directors stated they are now seeing more young children with challenging behavioral issues, beyond what they have seen in their past experience. Providers feel this is an area where teachers could benefit from more assistance and directors report that teachers would like more training in this area.

Exhibit 4.16 Percentage of Teachers Reporting the Ability and Support Required to Meet the Needs of Students with Special Needs



Kindergarten Transition

How are PFA agencies helping children and families transition to kindergarten?

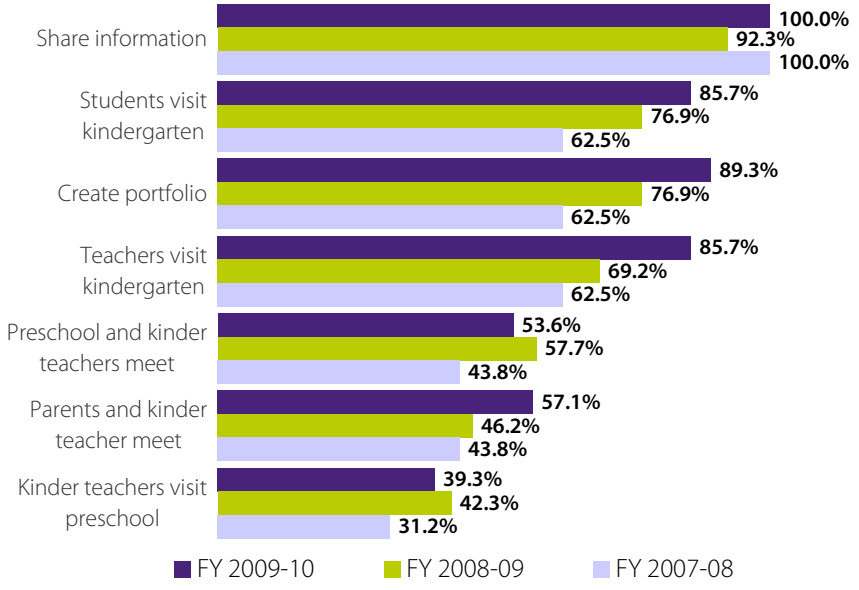
Exhibits 4.17 and 4.18 summarize the percentage of providers (by agency type and by fiscal year) who participated in various forms of kindergarten transition services. All agencies (100%) participated in some form of kindergarten transition activity in FY 2009-10. This is an increase from last fiscal year. The most common activity for all agency types was sharing information with parents. Directors reported information was shared in a variety of ways: at home visits, through informational packets, in group meetings, or through a DVD or video. Other kindergarten transition activities included creating portfolios for the kindergarten teachers and taking children to visit kindergarten campuses.

Exhibit 4.17 Percentage of Providers Participating in Kindergarten (K) Transition Services Activities by Agency Type

Transition Service	School-Based (N=7)	Non School-Based (N=13)	Family Child Care (N=8)	Total FY 09-10
Share information	100.0%	100.0%	100.0%	**100.0%**
Students visit K	85.7%	84.6%	87.5%	**85.7%**
Create portfolio	85.7%	84.6%	100.0%	**89.3%**
Teachers visits K	100.0%	84.6%	75.0%	**85.7%**
Pre-K and K teacher meet	57.1%	46..2%	62.5%	**53.6%**
Parents and K teachers meet	42.9%	61.5%	62.5%	**57.1%**

Some directors reported that their children would be attending various schools; thus, obtaining information from all of the possible schools and coordinating the process can be challenging. Interestingly, directors reported that school-based preschools may have more kindergarten transition activities since they are connected to a kindergarten through the school district or are on the same campus as the preschool, which facilitates the exchange of information. However, as shown in Exhibit 4.17, non school-based and family child care agencies participated in some activities more frequently than school-based agencies.

Exhibit 4.18 Percentage of Providers Participating in Kindergarten (K) Transition Services Activities by Fiscal Year



A Note about the Analysis

The data presented in the following sections are drawn from the results of two surveys and twelve interviews conducted near the end of FY 2009-10. The surveys were distributed to parents and teachers of all SDCPFA agencies that participated for the entire fiscal year. Over 2,800 parent surveys and 130 teacher surveys were completed, response rates of 72.2% and 63.4%, respectively. Both surveys were modified in FY 2009-10 to match with the Epstein parent involvement model so year to year comparison is not possible for all data but is presented when available. Qualitative data from one-on-one interviews with directors of twelve agencies are presented as appropriate throughout these sections.

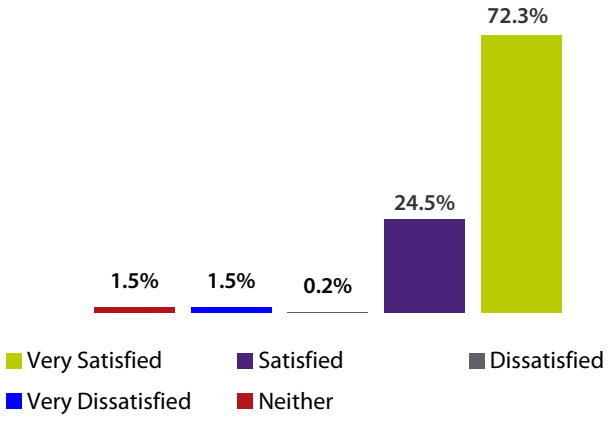
Parent Satisfaction, Involvement and Engagement

Parents play an essential role in children's development and success in the early care environment. This section focuses on parental satisfaction with their child's PFA funded program as well as parents' participation in the engagement and involvement activities and their subsequent development.

Are parents satisfied with the quality of PFA programs?

Exhibit 4.19 shows that the majority of parents (72.3%) were very satisfied with the overall quality of the program; in addition, 96.8% were either satisfied or very satisfied. Parents appeared to view SDCPFA as a high quality program.

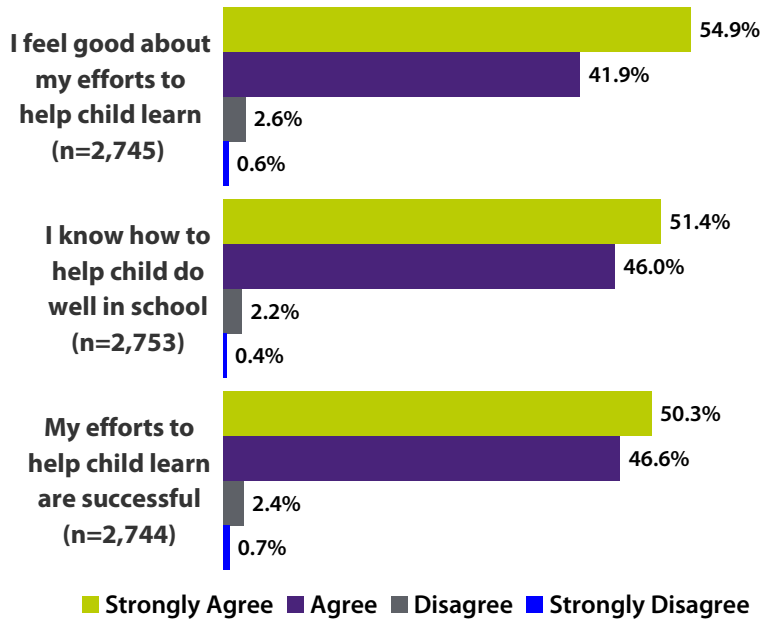
Exhibit 4.19 Parent Satisfaction with Overall Quality of PFA Programs (n=2,737)



Have parents increased their confidence in helping their children learn?

Almost all parents (at least 96.8%) agreed or strongly agreed that they knew how to help their child do well in school, that their efforts to help their child learn were successful, and that they felt good about these efforts, as displayed in Exhibit 4.20. Parents who reported taking a parenting class were slightly more likely to strongly agree with all of these statements compared to those who did not take a class.

Exhibit 4.20 Parent Knowledge and Confidence



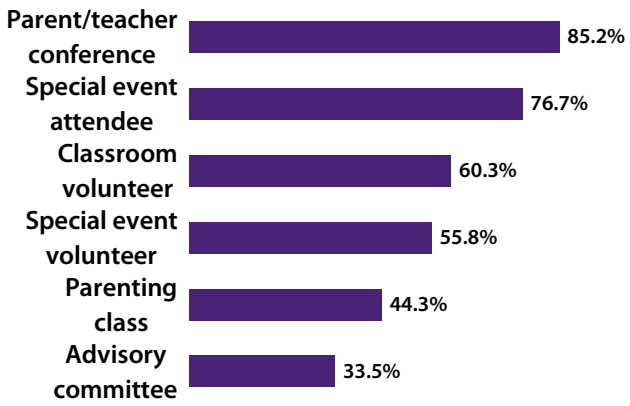
How are PFA agencies involving parents in their children's schools?

Parent involvement is a critical part of a child's early learning and development.[4] Both parents and teachers reported that parent/teacher conferences and special events or classroom volunteering were the most common involvement activities (Exhibit 4.21 and 4.22).

According to directors, parent participation varied greatly depending on the agency. Some agencies reported that only 20% of parents volunteer while at other agencies, up to 80% participate in some way. Directors reported that families from lower socio-economic status tended to volunteer less, especially if both parents worked. Therefore, they offer a variety of options for parent participation including parenting classes, parent nights, field trips, graduation, holiday events and home activities. The goal for most agencies is to make participation easy for parents. At one agency where fewer parents have the ability to volunteer, the director noted that they make information available to keep busy parents informed. There are also structural barriers to parent participation such as requirements for TB testing and background checks which parents must pay for at some agencies. All agencies recognize the importance of parent involvement.

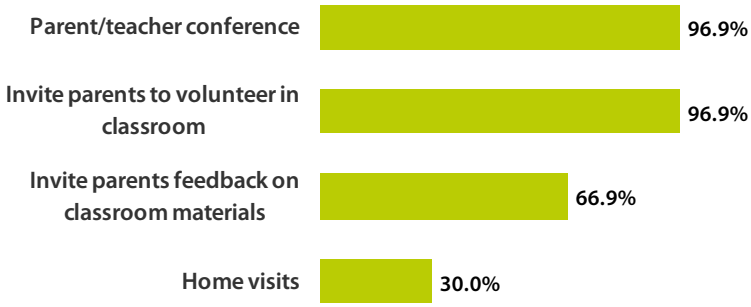
Exhibit 4.23 displays parent's participation in engagement activities at home with their children. These data show that almost all parents (97.6%) participated in helping their child learn letters, words and numbers. Engagement with children appeared high with over 80% of parents engaging in each activity. This is an important aspect of SDCPFA as it shows that the home environment and school environment are working together to improve outcomes for children.

Exhibit 4.21 Percentage of Parents Participating in Parent Involvement Activities in FY 2009-10*



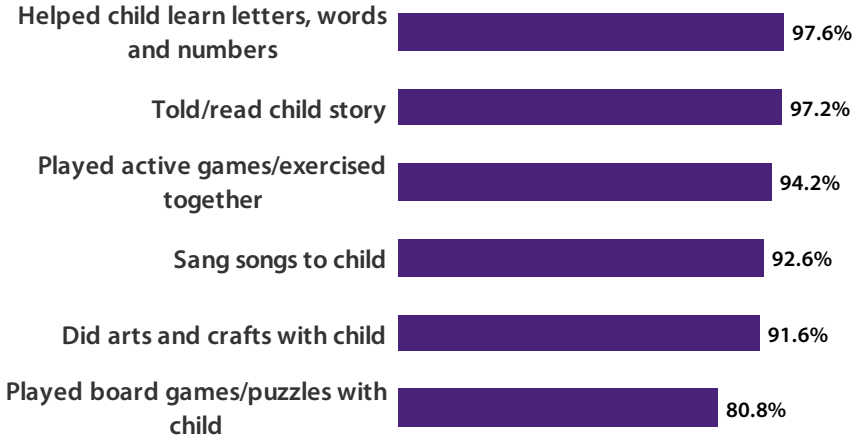
*n=2,682 parents

Exhibit 4.22 Percentage of Teachers Participating in Parent Involvement Activities in FY 2009-10*



*n=130 teachers

Exhibit 4.23 Percentage of Parents Participating in Parent/Child Engagement Activities in FY 2009-10*



*n=2,750 parents

[4] Children's Aid Society. (2003). *Fact sheet on parent involvement in children's education.* New York.

Do parents feel their child's school communicates with them?

Communication between schools and parents is an essential part of school readiness services for young children. Overall, as shown in Exhibit 4.24, parents surveyed reported high levels of communication between their families and their child's school. At least 90% of parents agreed or strongly agreed that teachers and programs provided information about their children and school, and invited them to participate in classroom activities. Parents most strongly agreed that programs sent home information. Fewer parents strongly agreed that programs provided opportunities to learn how to complete developmental screenings and serve on advisory councils or other decision-making boards. Directors agreed that relationships with families are important and one director stated that the teachers have a good bond with the families and another said they do their best to incorporate parent input. For example, parents wanted healthier lunches so the agency made changes to accommodate the family's requests.

Exhibit 4.24 Parents Perception of Program Communication and Impact

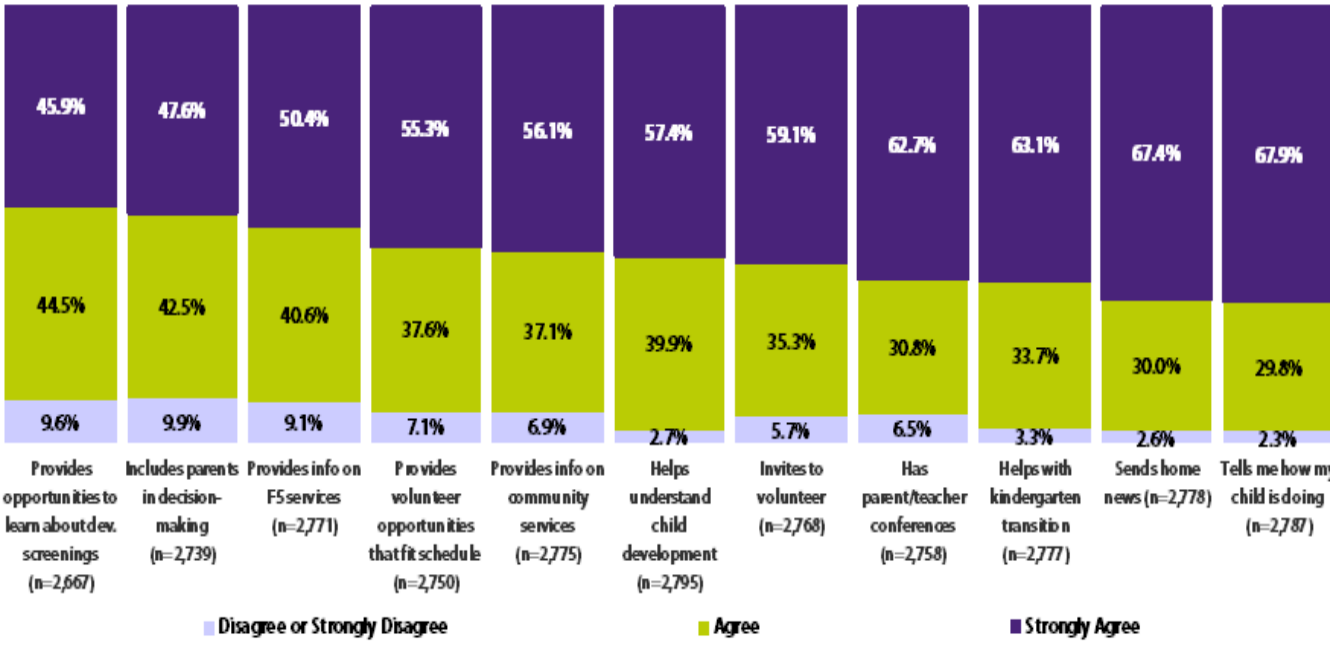


Exhibit 4.25 shows the type of information parents received and the greatest percentage of parents reported receiving information on how to help their child learn (94.0%) and how to get involved with the program (93.6%). The areas where the fewest parents reported receiving information were related to parenting skills (84.1%), the preschool staff's training and experience (84.3%), and where to report health and safety concerns (84.5%). Overall, SDCPFA sessions appear to have strong communication and relationships with their students' families.

Exhibit 4.25 Percentage of Parents Reporting that Program Provided Information on the following in FY 2009-10

What you can do to help your child learn (n=2,747)	94.0%
How you can get involved with the program (n=2,743)	93.6%
Schedule of daily activities (n=2,734)	92.5%
How your child is growing and developing (n=2,749)	89.9%
Discipline procedures (n=2,743)	88.4%
How to find services in the community (n=2,738)	86.9%
How children develop at different ages (n=2,745)	84.7%
Where to report health or safety concerns (n=2,732)	84.5%
Experience and training of preschool staff (n=2,728)	84.3%
Parenting Skills (n=2,729)	84.1%

Teaching Experience, Retention and Professional Development[5]

Are PFA teachers gaining experience and staying within the ECE field?

Teaching experience and retention are an essential part of quality preschool. More experience and stability among the staff usually results in a more stable learning environment for the children.

As shown in Exhibit 4.26, the percentage of teachers surveyed who have taught preschool for more than five years has remained fairly stable over the course of the demonstration project, even as the number of teachers has increased. The percentage of teachers who taught at the same school for more than five years also remained stable at around 50%.

Of teaching staff that participated in FY 2007-08, 90% of lead teachers and 69% of instructional assistants were still teaching at SDCPFA agencies in FY 2009-10.

Exhibit 4.26 Percentage of Teachers Who Have Taught Preschool for More Than Five Years

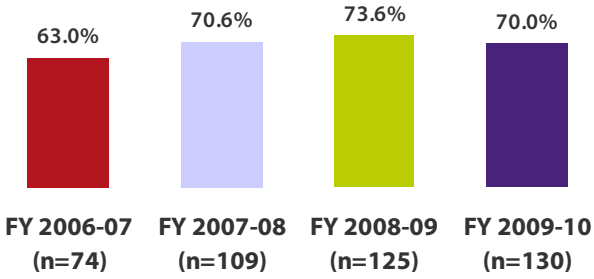
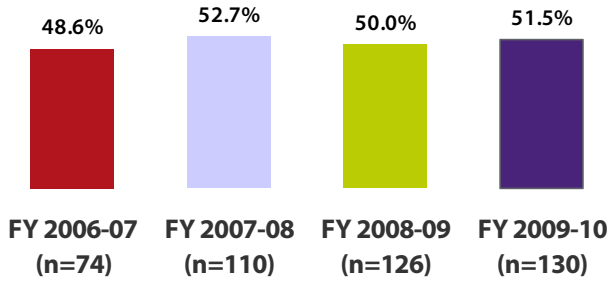


Exhibit 4.27 Percentage of Teachers Who Have Taught at the *Same* Preschool for More Than Five Years

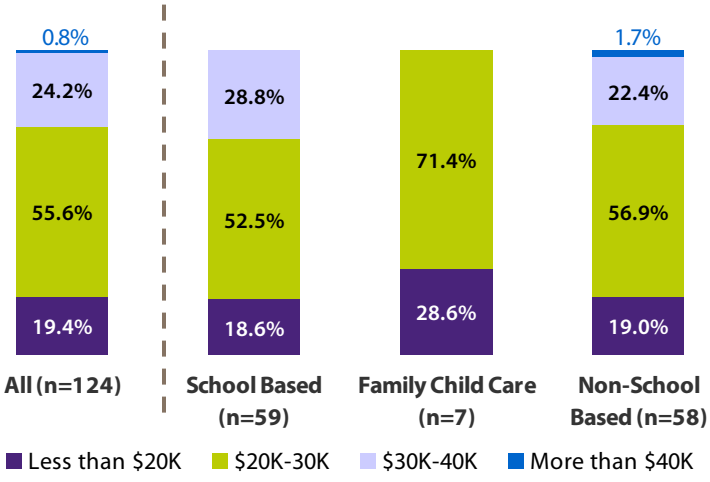


How much are PFA teachers earning?

SDCPFA teachers receive stipends based on their education and performance, an incentive which many program directors believe has a positive impact on classroom quality. Without this stipend, the majority of teachers (55.6%) earn between $20K and $30K and about 20% earn less than $20K (see Exhibit 4.28).

Salary and work setting play a role in teacher retention. Teachers working in family care setting received lower salaries. Teachers with more experience were more likely to earn higher salaries. No teachers with less than two years preschool teaching experience reported earning above $30K, while 31.8% of teachers with more than five years experience earned more than $30K.

Exhibit 4.28 SDCPFA Teacher Salaries (Excluding Stipend)

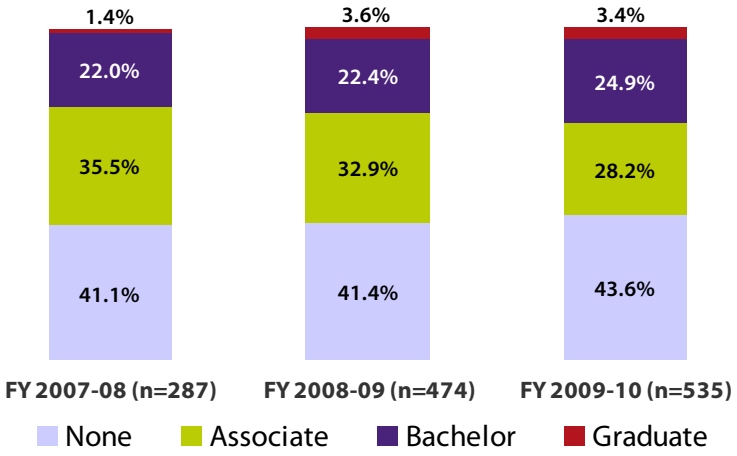


[5] Data provided by the San Diego County Office of Education on November 10, 2010.

What is the education level of the PFA workforce?

Workforce education level is a core component of SDCPFA quality. The data in Exhibit 4.29 show that from FY 2008-09 to 2009-10 there was an increase in the percentage of staff with a bachelor's degree. It should be noted that the addition of a large number of new staff to PFA has impacted the percentage of workforce with degrees. Of the lead teachers who have participated in SDCPFA since FY 2006-07, 85% have AA/AS, BA/BS or graduate degrees and 25 of the degrees were earned while the teacher was participating in SDCPFA. Since FY 2006-07, lead teachers and instructional assistants have earned 26 AA/AS degrees, 31 BA/BS degrees and 2 graduate degrees. The stipend program encourages staff to advance their education and permit level, further enhancing their knowledge and ability to educate young children.

Exhibit 4.29 Percentage of Workforce with Degrees

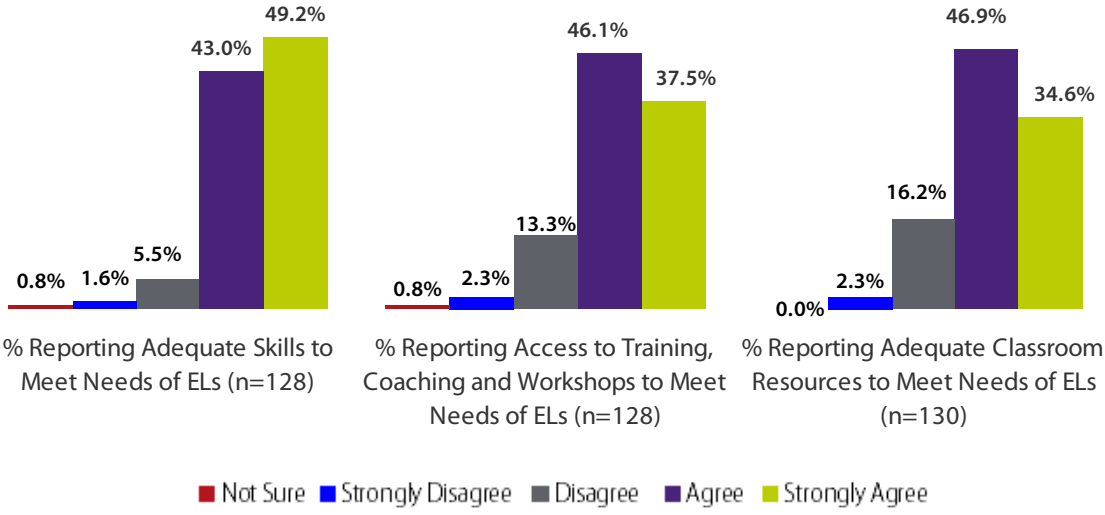


Are providers equipped to address the needs of English Learners?

Almost all teachers (93.0%) reported having English Learners (ELs) in their classrooms. Exhibit 4.30 below shows the percentage of teachers agreeing or disagreeing that they have adequate ability, access to training, and resources to meet the needs of English Learners.

More than 9 out of 10 teachers (92.2%) reported having adequate skills to meet the needs of English Learners in their classrooms; 83.6% reported having access to the training, coaching and workshops they needed; while 81.5% agreed that they had adequate classroom resources to help English Learners.

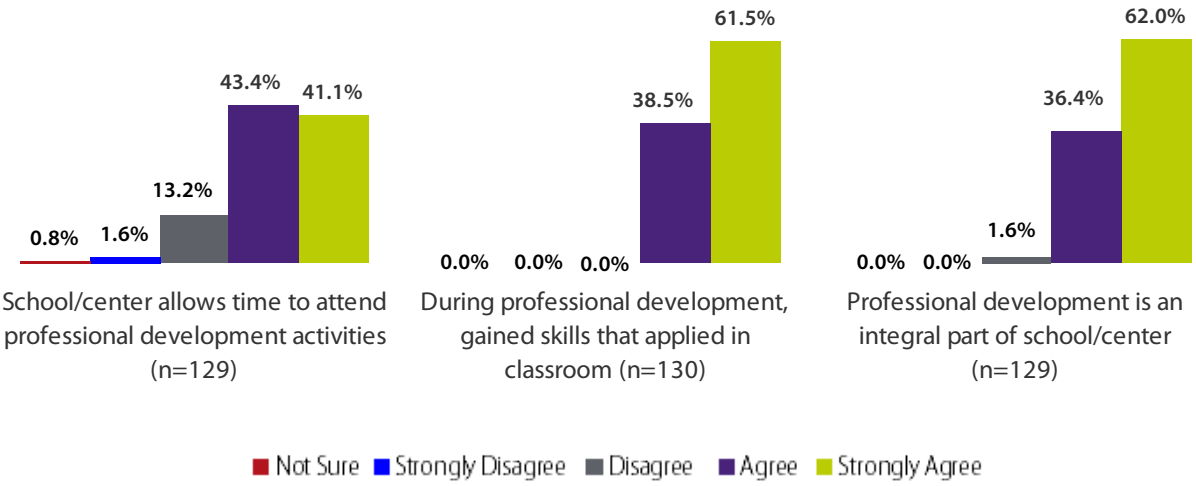
Exhibit 4.30 Percentage of Teachers Reporting Ability and Access to Training and Resources to Meet Needs of English Learners



What is the impact of participating in professional development on PFA providers?

As was the case last fiscal year, almost all teachers (98.5%) reported being offered the opportunity to attend professional development activities, and, of those, 99.2% reported participating in professional development activities. Almost all (98.4%) teachers additionally agreed or strongly agreed that professional development was an integral part of their school or center. Fewer teachers (84.5%) agreed that the school/center allowed time to attend professional development activities, however last fiscal year only 70.5% said that their school/centers offered enough time, indicating improvement in this area. All teachers agreed (100.0%) that they gained skills that they applied in the classroom during professional development activities.

Exhibit 4.31 Professional Development



Making the Connection

"I learn new things every year. I think the trainings and experiences you get along the way, clearly [they're] going to help you a lot"

-SDCPFA Provider

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 SDCPFA Year 4 included interviews with 12 SDCPFA program directors – six directors of non school-based agencies, three from FCC providers, and three from school-based agencies, as well as observations from the evaluation team throughout the year. The purpose of this section is to document the continuing and new successes and challenges of the project.

Successes

The fourth year of SDCPFA saw the addition of three new agencies for a total of 28 agencies in the eight designated areas of San Diego County. Directors from 12 SDCPFA sites were interviewed and continue to be excited about the successes of the project. Most identified successes this fiscal year that are similar to previous years' successes. Continuing achievements include increased access to quality preschool, educational advancement of teachers, and involvement of parents and the community.

- **Improved access to quality preschool.** As in past years, directors continued to praise SDCPFA's ability to provide quality preschool to a broad cross-section of children. Agencies utilized their SDCPFA funding in a variety of ways including improving their classroom quality environment (e.g., purchasing classroom materials) while other used it for professional development to enhance staff qualifications.

- **Professional coaching services and trainings provided by SDCOE.** SDCOE offered professional coaching services to SDCPFA teachers. The coaching was focused on a variety of topics including improving the classroom environment, behavioral and special needs issues, and language and writing. Most of the SDCPFA directors saw the professional coaching services as a tremendous benefit to their teachers, appreciating that the services were personalized and that the coaches were available. Although two directors noted that their teachers were resistant to the coaching, the majority of directors reported that the teachers appreciated the coaching. In one director's words, "[The teachers] felt supported. The [coach] was knowledgeable and supportive, and easy to talk to. She was really able to help them and give them guidance."

- **Integration of students with special needs.** Most directors reported that students with special needs are fully integrated into classrooms and are provided additional services either in the classroom or outside the classroom for a portion of the day if needed. Most agencies have only a few students with special needs and teachers and directors are familiar with the child's needs and the family. The SDCPFA inclusion specialist assists agencies with screening and referring children, as well as communicating with the family on the child's needs.

- **Encouraging educational advancement for teachers.** SDCPFA's structure and model encourages preschool teachers to further their education and advance in their careers. Even as new teachers join SDCPFA, the percentage of teachers with a bachelor's degree has continued to increase. Lead teachers and Instructional Assistants who have been participating in SDCPFA since inception of the demonstration project have earned 33 degrees since the project started and 85% of the original lead teachers from FY 2006-07 have an AA/AS, BA/BS or graduate degree.

- **Support from SDCOE.** In general, directors felt supported by SDCOE. They noted that SDCOE not only provided formal services, but they were also available as a "sounding board" and were always there when needed to help with issues. This was the case regardless of agency type – FCC providers felt supported, with one director saying SDCOE really understood her specific needs as an FCC provider. Directors most commonly reported using SDCOE support for staff training and development, professional development coaching, assistance with development screenings though the inclusion specialist, and budget support.

Challenges

In the fourth year of the demonstration project, many of the initial challenges identified in previous fiscal years have been overcome. However, there continue to be challenges in the areas of administrative requirements, workforce quality, classroom assessments and identification of students with special needs.

- **Administrative Requirements.** Similar to previous fiscal years, the biggest challenge appears to be the amount of paperwork and level of difficulty in understanding and finding time to complete the required reports. Still, most of the directors are now accustomed to the paperwork and find it easier with each year. Providers also reported delays in receiving review scores, such as the ECERS-R and the CLASS, which subsequently resulted in delays in receiving coaching services for the areas of improvement.

- **Workforce Quality.** Although many providers participate in professional development activities, directors reported that some teachers were resistant to them because they felt it was outside of their scope of work and did not understand the value of professional development plans.

- **Classroom Assessments.** There were delays in hiring a subcontractor to do classroom assessments. As a result, the ECERS, FCCERS and CLASS assessments were done late in the fiscal year and some sites did not receive coaching until FY 2010-11. Changes have been made to deter delays in this area in future years.

- **Screenings and Identification of Children with Special Needs.** There were lower rates reported for developmental screenings and children with special needs served by PFA. There was also a decline in the rate of children identified with special needs or referred for IEPs. The large increase in the total numbers of children served challenged the existing SDCPFA special needs support system. In addition, directors stated that there were fewer resources for children with special needs within school districts due to State budget cuts. Overall, the increase in children served by PFA and the impact of State budget cuts on school-based special needs services challenged the existing special needs services structure within SDPFA and likely contributed to these declines. Directors also stated that teachers would benefit from more training in special needs. One director said "we could be trained on that daily and it wouldn't be enough."

Update on FY 2008-09 Recommendations

Last Year's Recommendation	Update on Recommendation
Continue to increase classroom quality through professional development coaching.	+ Classroom quality continued to increase as the percentage of Tier 3 level classrooms increased each fiscal year and over half of SDCPFA sessions were rated as Quality level in FY 2009-10. + Coaching results will be reported in next year's report.
Explore strategies to increase parent involvement.	+ Though it varies by agency, parents of SDCPFA students generally had high levels of involvement with over half volunteering in classrooms or at special events and over 85% attending parent/teacher conferences. + Over 80% of parents participated in parent child engagement activities at home, such as helping their child learn letters or numbers, or reading or singing to their child.

Recommendations

The following recommendations are based on recommendations from FY 2008-09, the data in this report, interviews conducted with providers, and the SDCPFA quarterly reports.

- **Explore strategies to improve *Personal Care* scores for the ECERS-R and FCCERS-R.** Overall, ECERS-R and FCCERS-R scores are relatively high for SDCPFA sessions. However, *Personal Care*, which assesses greeting, eating, napping, toileting, health and safety continues to be the lowest area, particularly for center-based and family child care sites (see Exhibit 4.4 and 4.5). This accounts for the decrease in tier level for 8.2% of PFA sessions (see Exhibit 4.8).

- **Improved identification and inclusion of children with special needs.** There were fewer children with special needs or IEPs identified in FY 2009-10 than in previous years (see Exhibit 4.14). Fully implementing universal developmental screenings plus providing additional training and resources for teachers are recommended to help identify students with special needs and meet their needs in the classroom (see Exhibits 4.11, 4.12, 4.16). SDCOE has identified this as an area to focus on for FY 2010-11 and is implementing a plan to address this.

- **Address the decrease in completed secondary screenings.** Data submitted by PFA providers showed that nearly a quarter (23.8%) of children who showed concern on their primary screenings did not complete a secondary screening through SDCPFA (see Exhibit 4.11).[6] Though reasons may vary by provider, procedural and administrative issues that caused this discrepancy should be addressed to meet the goal of screening each child served by PFA and ensuring they are referred to needed services to address their delays. This may be related to the challenges in identifying children with special needs (see Exhibits 4.13-4.15) and suggests a pattern that should be further explored. In FY 2010-11, the ASQ will be used as the primary screening tool for all agencies and a target has been set to administer this tool to 100% of children enrolled in SDCPFA.

- **Create a culture that supports and encourages professional development.** 100% of teachers surveyed reported that they gained skills they applied in their classrooms during professional development activities. However, some teacher surveys noted that there are sites that do not allow sufficient time to attend professional development activities. Some responses in director interviews reported resistance from some teachers who do not want to participate in professional development. Encouraging teachers to participate in professional development will benefit both the teachers and the students in their classrooms.

[6] It was suggested that some agencies may have conducted their own secondary screenings which were not included in their reporting to SDCOE.

CHAPTER 5.

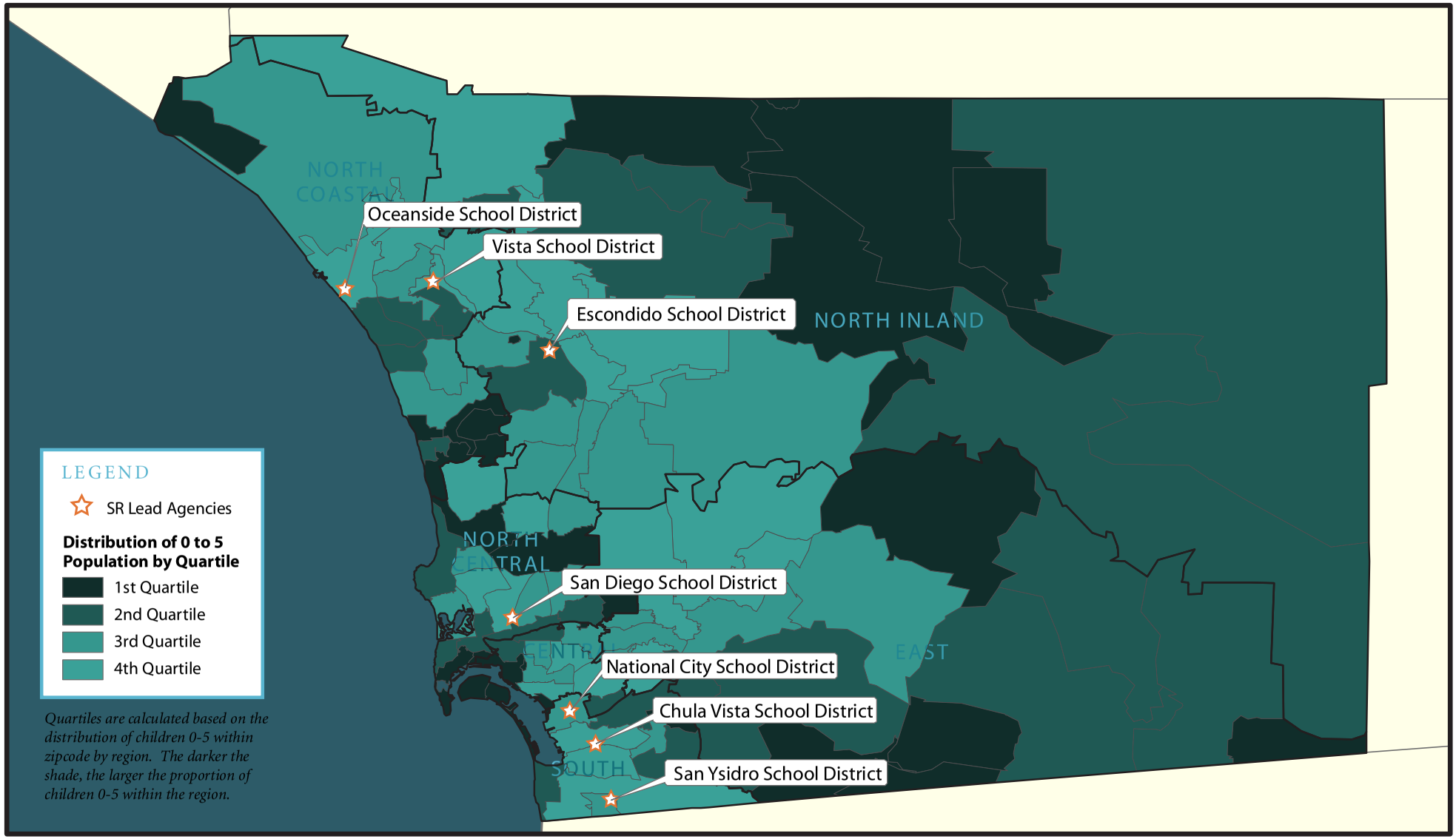
School Readiness

2009/2010 Scorecard

Goals	Measures	Target	Actual	Performance
1. Children 0-5 are making developmental progress toward School Readiness	Number of children receiving full or part-time early childhood education services.	610	947	
	Number of children receiving intensive education services at parent and child centers.	175	196	
	Children improved in each developmental domain: Competence Learning Motor Skills Safety and Health	No targets set	1.04 1.09 0.97 1.03	
2. Children are in home environments supportive of optimal cognitive development	Number of parents and caregivers participating in parenting and family support services.	4,392	7,559	
3. Children receive early and comprehensive screenings and intervention for developmental delays or other special needs	Number of children enrolled in early childhood services receiving a developmental screening.	3,937	3,879	
4. Schools and School Systems are ready for children	Number of children participating in kindergarten transition activities	3,458	5,353	

90% or above target 75-89% of target <75% of target

School Readiness Contractors



Introduction

"It is a great program for children to learn and enjoy school activities."

– F5 SR Parent

Nearly 40,000 children enter kindergarten in San Diego County each year.[1] While enrollment reaches record numbers, approximately 60.0% of these children perform at significantly lower levels than expected because they arrive without the necessary skills to learn.[2] Research has found that low performance in the early years can continue throughout their academic career. To address this gap, the School Readiness Initiative (SR) was launched in 2002 as a joint project between First 5 California and local county Commissions to help children living in school districts with low Academic Performance Indexes (API) enter kindergarten ready to succeed.

Initiative Goals

- Children 0-5 are making developmental progress toward School Readiness
- Children are in home environments supportive of optimal cognitive development
- Children receive early and comprehensive screenings and intervention for developmental delays or other special needs
- Schools and school systems are ready for children

The SR programs are based on the National Education Goals Panel's "Five Essential and Coordinated Elements" including: 1) early care and education, 2) parent and family support, 3) health and social services, and 4) schools' readiness for children (i.e., program infrastructure, administration and evaluation). Seven local school districts received $5.67 million in total in FY 2009-10 for this project (50.0% provided by the State Commission). SR has been funded at a total of $40.44 million since its inception.

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

A complementary component of the School Readiness Initiative is the Special Needs Demonstration Project (SNP). This pilot project was designed by First 5 California to enhance School Readiness services in a specific geographic area through early identification of children ages birth through 5 years with disabilities, developmental delays, and other special needs. Chula Vista Elementary School District was one of ten sites across the state selected by First 5 California to implement the Demonstration Project. First 5 San Diego matched their funds dollar-for-dollar for a total of $2,734,500 over five and a half years.

Both projects are discussed in this chapter. The participating school districts include Chula Vista Elementary, National Elementary, San Ysidro Elementary, Escondido Union Elementary, Oceanside Unified, San Diego Unified and Vista Unified School Districts (Cajon Valley School District concluded its contract after FY 2008-09). On June 30, 2010, the contracts for Chula Vista Elementary, National Elementary and San Ysidro Elementary School Districts concluded.

[1] California Department of Education, *California Public Schools - County Report.* 7 July 2009. Accessed 6 Nov. 2009. <http://dq.cde.ca.gov/dataquest/CoEnr.asp?cChoice=CoEnrGrd&cYear=2008-09&TheCounty=37%2CSAN^DIEGO&cLevel=County&cTopic=Enrollment&myTimeFrame=S&submit1=Submit>

[2] Child Trends Data Bank. Child Trends. 2003. Accessed 8 August 2008. <http://www.childtrendsdatabank.org/indicators/7EarlySchoolReadiness.cfm>

Contracts will conclude for the Escondido Union Elementary, Oceanside Unified, San Diego Unified and Vista Unified School Districts after FY 2010-11. The School Readiness Initiative is not included in the Commission's new Strategic Plan and will sunset next fiscal year.

Key Elements

School Readiness (SR) is the longest running Commission initiative. During its eight 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:

- *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, adapted from the National Education Goals Panel (NEGP).[3, 4, 5]
- *Variation in design*: Five districts are classroom-based programs and are located on elementary school sites, two are parent-child activity center programs located in neighborhoods. Data for SR are analyzed separately for classroom and center-based sites.
- *Multi-level*: SR programs focus on three target groups: children, families and schools.

[3] Early Connections: Technology in Early Child Development. Five Areas of Child Development. 2005. Accessed 17 August 2006. <http://www.netc.org./earlyconnections/index1.html>

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

[5] 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.

Summing It Up

"The staff is very professional and caring, providing many areas of growth and learning for my children."
– F5 SR Parent

Pre-kindergarten programs play a vital role in a child's social, emotional, and cognitive development.[6] SR supports full-time and part-time preschool, parent and child "drop in" activity centers, and service enhancements to children in State Preschool. Most children participating in SR activities were three years of age or older, of Hispanic/Latino descent, and primarily spoke Spanish in the home. The following sections provide the results of services provided to children, parents/caregivers, and staff/service providers. The decline in part-time preschool is because there is one less participating school district.

School Readiness Early Childhood Education (ECE)

How many children were provided early care and education services?

Exhibits 5.1 and 5.2 show over 1,143 children were intensively served by SR, including 437 (38.0%) children with special needs, in FY 2009-10. Additionally, 4,778 health and early education services were provided to other children in the community.

In comparison to FY 2008-09, the number of children attending full-time preschool has increased while the number of children served through part-time preschool decreased slightly. Fluctuations are due to changes in the number of classes offered in one or more districts. For example, San Ysidro's part-time toddler classes were cancelled in FY 2009-10.

Exhibit 5.1 Children Served through Early Care and Education

Services	FY 2007-08	FY 2008-09	FY 2009-10	Increase or Decrease from FY 08-09 to FY 09-10
Core Services				
Full-time Preschool	588	653	753	15.3% ⬆
Part-time Preschool	367	210	194	-7.6% ⬇
Parent & Child Activities	190	193	196	1.6% ⬆
Additional Services *				
Service Enhancements **	2,232	2,082	2,973	42.8% ⬆
"Light Touch" Services ***	1,675	1,743	1,805	3.6% ⬆

* *Represents a duplicated count of children who receive multiple services.*
** *Includes service enhancements such as curriculum and access to health, behavioral and social services.*
*** *Includes children who drop-in for services, those who do not consistently attend.*

Exhibit 5.2 Children with Special Needs Served through Early Care and Education

Services	FY 2009-10
Preschool Setting	348
Parent-Child Center	89
Total	**437**

Note: This year's data were recorded differently than previous fiscal years, therefore only FY 2009-10 data are presented.

[6] 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>

Making a Difference

"This is absolutely one of the best resources available to parents in developing their toddlers/preschoolers."

– F5 SR Parent

The overarching goal of SR is to increase the school readiness of children in low Academic Performance Index (API) performing schools. Programs utilize standardized tools to measure outcomes for children, families, and SR staff in four key domains: 1) Child Development, 2) Family Functioning, 3) Child Health, and 4) System of Care.

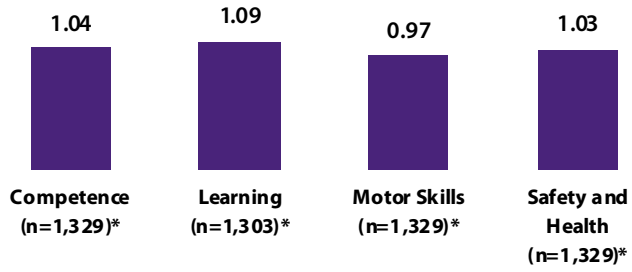
Improved Child Development

What is the impact of classroom-based programs on children's developmental progress towards school readiness?

The centerpiece of the SR Initiative is direct education services to children. Children were enrolled in full-time and part-time early learning programs and were also receiving service enhancements. The five classroom-based SR programs use the Desired Results Developmental Profile-Revised (DRDP-R), which is a teacher's observational assessment, to measure child outcomes in the fall and spring. Teachers assess children's competencies in four domains including competency, learning, motor skills, and safety and health. The data below represent children with matched pre and post scores in two ways: 1) overall mean scores for the four domains and 2) improvements from fall to spring.

The results, as displayed in Exhibit 5.3, indicate that children participating in ECE activities at classroom-based programs are increasing developmentally in all domains between fall and spring. All increases were found to be statistically significant.

Exhibit 5.3 DRDP-R Developmental Area Mean Score Change from Fall to Spring



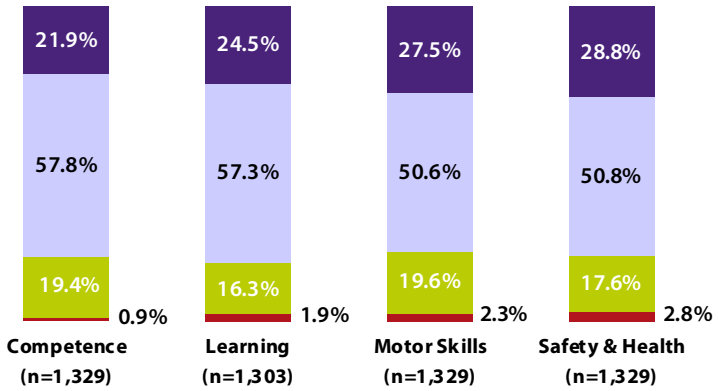
** Statistically significant at (p<.001)*
Note: Missing data and children considered unable to rate are not included in analysis resulting in the sample size variations across domains.
DRDP-R scores range from 0-4.00

In addition to the overall mean score improvements, Exhibit 5.4 shows the extent of developmental gains made from fall to spring on the DRDP-R four point scale, 1 being the lowest and 4 being the highest (see the Appendix for details on the analysis).

- **Regressed**: children whose scores decreased from fall to spring
- **Constant:** children whose scores were the same at both fall and spring
- **1 pt. gain**: children whose scores increased 1 point from fall to spring
- **2 or more pt. gain**: children whose scores increased 2 or more points from fall to spring

Results of progress from fall to spring indicate that approximately half of children within all four developmental domains improved by at least one point from fall to spring. Between 21.9% and 28.8% of children made a two or more point gain. Overall, the data demonstrate that nearly 80.0% of all children improved from fall to spring. Children improved the most within the *learning* domain.

Exhibit 5.4 Children's Progress from Fall to Spring in Four Key DRDP-R Domains for FY 2009-10



Note: Missing data and children considered unable to rate are not included in analysis causing discrepancy in the sample size across domains.

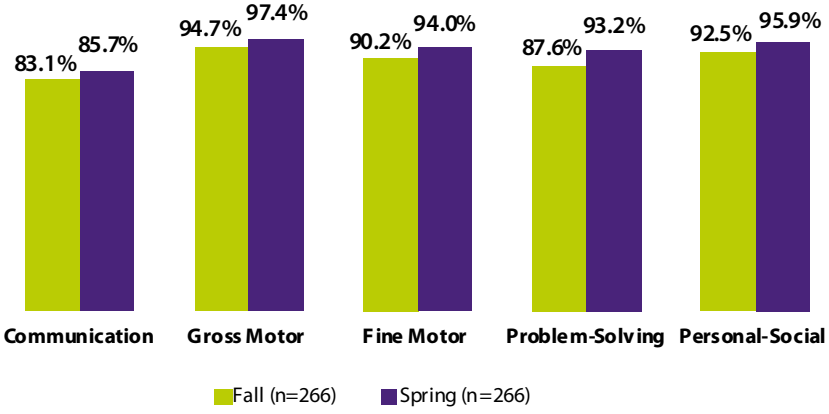
What is the impact of center-based programs on children's developmental progress towards school readiness?

The two parent-child center programs use the Ages and Stages Questionnaire (ASQ) to assess children's developmental progress in five skill areas including communication, gross motor, fine motor, personal-social and problem-solving. The analysis is presented using the scientifically set "cut-off" scores for the ASQ's age-specific instrument showing children's status "above" or "below" the age-specified boundary score at each point in time. Children assessed at being above the age-specified boundary indicate typical child development.

The results suggest evidence of age-appropriate developmental progress for the majority of children. Most children were assessed at being above the cut-off point and continued to be above the cut-off point in spring for all five domains. Similar to last fiscal year, the domain with the largest number of children below cut-off was *communication* skills. Children may need the most assistance in this area.

The two center-based programs reportedly have a high percentage (more than 50.0%) of children returning to their center each year. Consequently, these children receive the ASQ assessment each year which could cause high ASQ scores in fall.

Exhibit 5.5 Percent of Children At or Above Cut-off in Fall and Spring by Developmental Area in FY 2009-10



Improved Family Functioning

How many parents and caregivers received parent and family support?

The Parent and Family Support service element of the SR Initiative addresses the needs of families through parent education classes (e.g., sequential or single session), 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 on the developmental progress of children.[7]

Overall, 7,559 parents and caregivers received services through Parent and Family Support. The majority of these parents participated in single session parent classes (n=3,930) with the greatest increase in FY 2009-10 in the number of parents enrolled in sequential parent classes. This is due to more sequential parent classes being offered in FY 2009-10. For instance, San Diego Unified School District and Oceanside School District served more parents through literacy classes in FY 2009-10. The decrease in single session parent classes and home programs may be attributed to Cajon Valley Union School District no longer being a part of the SR Initiative.

Exhibit 5.6 Parents and Caregivers Served through Parent and Family Support

Services*	FY 2007-08	FY 2008-09	FY 2009-10	Increase or Decrease from FY 08-09 to FY 09-10
Sequential Parent Classes	1,869	1,891	2,981	57.6% ⬆
Single Session Parent Classes	4,043 **	4,436 ***	3,930 ****	-11.4% ⬇
Sequential Parent & Child Together (PACT)	274	251	241	-4.0% ⬇
Single Session Parent & Child Together (PACT)	107	108	123	13.9% ⬆
Home Programs	349	356	284	-20.2% ⬇
Total	**6,642**	**7,042**	**7,559**	**7.3%** ⬆

** May include duplicate counts within and between services.*
*** These parents and caregivers participated in approximately 543 classes.*
**** These parents and caregivers participated in approximately 452 classes.*
***** These parents and caregivers participated in approximately 500 classes.*

Are parents improving in key developmental areas?

Parents participating in Parent and Family Support services are administered the Parent Retrospective Survey designed to measure improved parent outcomes. The Parent Retrospective Survey is comprised of two components: a modified "Survey of Parenting Practice" and a modified "Desired Results for Children and Families- Parent Survey" (see Methods appendix for details). Parents are asked whether their knowledge, confidence, ability, and behaviors have changed due to parent development activities, comparing before the program (then) to after the program (now).

Similar to FY 2007-08 and FY 2008-09, parents attending sequential parent and child together (PACT) classes and home visitation programs consistently demonstrated the greatest increases within all four domains. However, unlike last fiscal year, the mean differences between "then" and "now" were greater in center-based sites than classroom-based sites, although these differences were only statistically significant for one of the items. This shift may be attributed to National and San Ysidro (two classroom-based programs) not being required to participate in the SR parent retrospective survey in FY 2009-10.[8]

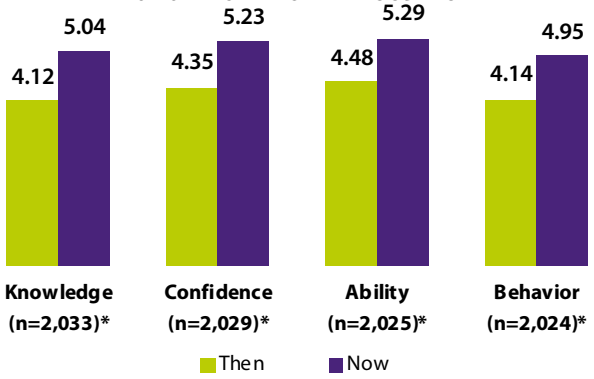
[7] U.S. Department of Education. No Child Left Behind: What Parents Need to Know. Accessed 15 December 2005. <http://www.ed.gov/nclb/overview/intro/parents/nclb_pg5.html>

[8] National and San Ysidro were dually funded by SR and Preschool for All (PFA); therefore data were reported for PFA and not SR to avoid duplicating results.

Results presented in Exhibit 5.7 indicate that parents are learning from the classes and workshops they attend. Within all four developmental areas, statistically significant increases were reported. Similar to last fiscal year, parents increased their ratings on all twelve parenting practice survey items measured. Improvement in parenting "knowledge" showed the greatest gains from before the program to after the program.

When looking at individual items within the four developmental areas, parents responded that their greatest *knowledge* gains were in learning about, "how my child's brain is growing and developing." Parents were most *confident* in "helping their child learn at this age." Within the *ability* area, the item that parents showed the most improvement was in "their ability to identify what their child needs," and within the *behavior* area the item that showed the most improvement was, "the amount I read to my child."

Exhibit 5.7 Mean Parent Development Scores at "Then" and "Now" for FY 2009-10



** Statistically significant at (p<.001). Scores range from 0-6.00*

Are parents satisfied with key program elements?

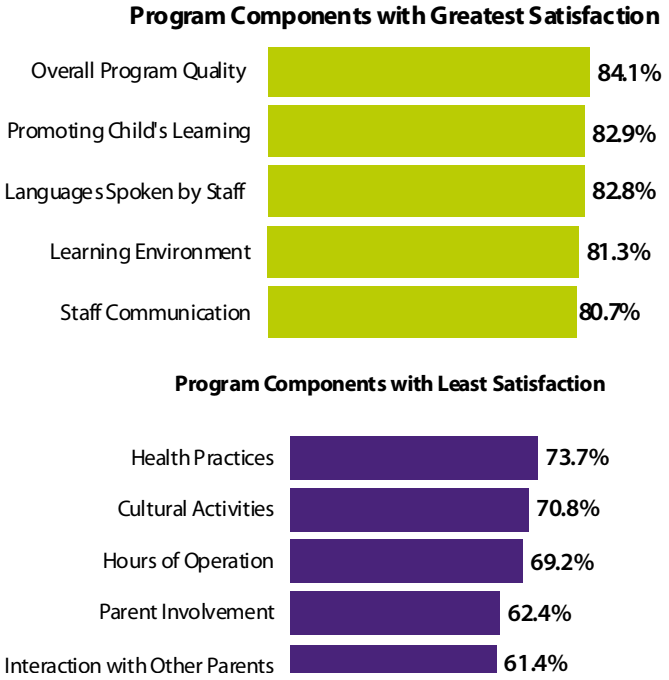
To measure parent satisfaction, SR providers implemented the "Desired Results for Children and Families-Parent Survey." The survey is a series of satisfaction questions about 18 components typically included in early care and education programs. Reported below are the components parents rated as most and least satisfied with.

The majority of parents were "very satisfied" with all items on the survey. The highest percentage of parents indicated that they were "very satisfied" with the *overall program quality* (84.1%) and *promoting child's learning* (82.9%).

Interaction with parents and *parent involvement* received the lowest satisfaction ratings, although still high, for the fourth consecutive year.

Satisfaction ratings remained fairly similar to those in past years. Similar to last fiscal year, parents participating in sequential PACT classes and classroom-based programs had the highest levels of satisfaction (data not shown).

Exhibit 5.8 Percentage of Parents Who Reported Being "Very Satisfied," by Component, for FY 2009-10

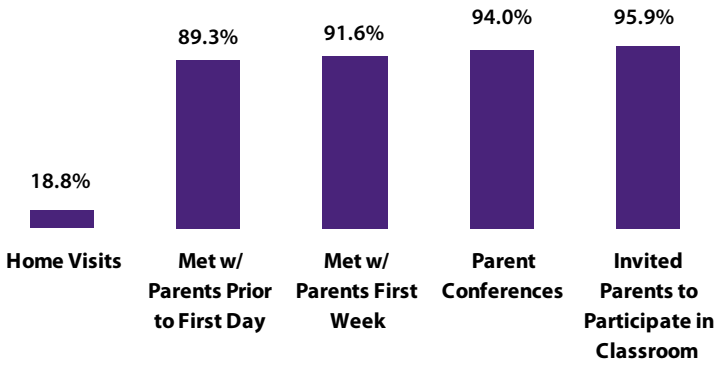


Valid Ns vary by item and range from 1,916-2,034

Are opportunities being provided for parents to be involved with their child's school?

Parent involvement in the learning environment is vital to a student's success. School Readiness preschool teachers completed staff surveys that gathered information about their interaction with parents. The most common on-going parent involvement activity reported during the school year was to *invite parents to participate in the classroom*. In addition, almost every SR preschool teacher indicated that they *met with parents during the first week of school* (91.6%) and held *parent/teacher conferences* (94.0%).

Exhibit 5.9 Activities Involving Parents



Improved Child Health

Are children receiving early and comprehensive screenings and intervention for developmental delays or other special needs?

The School Readiness Initiative provides a variety of health and social services to participating children and families. Health services include screenings (i.e., behavioral, dental, hearing, language and speech, and vision), health plan enrollment, health education, referrals for basic healthcare needs, mental health counseling, and specialized services for children with disabilities and other special needs. Together with early care and education programs and parent and family support programs, these services address the cognitive, physical, and social-emotional development of children.

As shown in Exhibit 5.10, in FY 2009-10, a total of 9,889 health and social services were provided to children. To promote early identification of children with developmental delays, all children intensively served through SR programs are required to have a developmental screening. Screenings are provided in-house by the SR Program, or provided by contract by outside health service providers, such as First 5 San Diego's Healthy Development Services Initiative (HDS). Children identified with delays are referred to either district services or external services, such as HDS.

Exhibit 5.10 Children Served through Health and Social Services

Services *	FY 2007-08	FY 2008-09	FY 2009-10	Increase or Decrease from FY 08-09 to FY 09-10
Developmental Screenings	1,778 **	1,450 ***	3,879	167.5% ↑
Health Screenings ****	2,489	4,010	4,249	6.0% ↑
Behavioral Services	160	169	106	-37.3% ↓
Referrals/ Case Management *****	2,106	1,345	1,655	23.0% ↑
Total	**6,533**	**6,974**	**9,889**	**41.8%** ↑

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

** *For FY 2007-08, an additional 840 developmental screenings were completed by HDS and not included here.*

*** *FY 2008-09, an additional 1,002 developmental screenings were completed by HDS and not included here.*

**** *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.*

A total of 3,879 children enrolled in Early Care and Education services received a developmental screening and were given referrals as appropriate (for further assessments and/or services). Of the children enrolled in the classroom-based programs, 88.6% received a developmental screening compared to 72.6% in FY 2008-09. Additionally, 443 children in parent-child center programs received a developmental screening compared to 412 children in FY 2008-09.

Improved Systems of Care

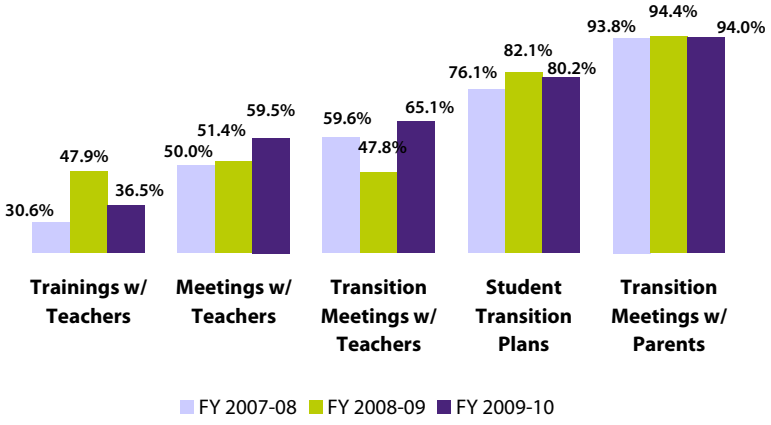
Are school and school systems helping parents and children transition to kindergarten?

Perhaps one of the most important components of SR systems improvement is enhancing communication between the SR programs, elementary schools, and parents. During FY 2009-10, 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, 5,353 children participated in kindergarten transition activities, such as Kinder Camp, kindergarten visitation, and kinder-readiness assessments. A total of 1,361 preschool parents participated in school-based activities and 134 SR staff participated in kindergarten articulation meetings with elementary staff.

Are preschool teachers effectively communicating with elementary schools and parents?

A total of 87 SR Preschool Teachers completed surveys gathering information regarding kindergarten transition activities, school readiness awareness, and professional development. Survey responses show that preschool teachers' interaction with kindergarten teachers varied in some categories compared to previous fiscal years. One of the most notable increases was in the number of transition meetings with kindergarten teachers (47.8% in FY 2008-09 compared to 65.1% in FY 2009-10). Trainings with kindergarten teachers, however, dropped nearly 12.0%. Fewer trainings were offered due to budget cuts. As a result, teachers scheduled more transition meetings to continue communications with kindergarten staff.

Exhibit 5.11 Preschool Teachers' Activities Involving Kindergartens FY 2007-08- FY 2009-10

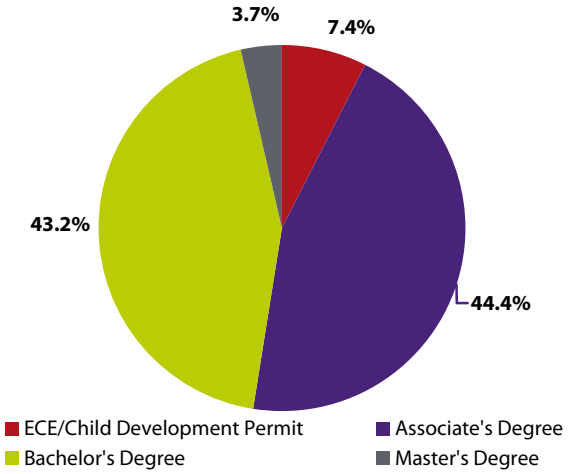


In addition to the transition meetings, preschool teachers also have formal transition plans for students entering kindergarten. Over three-fourths of preschool teachers (80.2%) reported having formal transition plans for students entering kindergarten, however, only 59.7% of preschool teachers created transition files for students. Transition files help kindergarten teachers obtain preparatory information about children coming into their classes. Information provided in these transition files include: 1) children's and families' strengths and weaknesses; 2) children's basic skills levels (e.g., DRDP-R data, behavioral, speech/language/hearing, literacy); and 3) prior intervention history (e.g., individualized education plans [IEP] and referrals). The kindergarten transition files were identified in the learning community as an area for improvement.

Are preschool teachers enhancing their education and professional development levels?

Survey results show that 91.3% of preschool teachers were educated at or past the Associate's level in FY 2009-10, with many SR staff also pursuing additional higher education (e.g., 43.2% obtaining a Bachelor's degree and 3.7% obtaining a Master's degree).

Exhibit 5.12 Preschool Teachers' Level of Education



Making the Connection

"It's a great resource in the community."

– F5 SR Parent

Systems integration and improvement are core components of the SR Initiative. The systems-level evaluation for School Readiness includes several components, such as inter-school readiness networking, connecting with other First 5 funded agencies, developing collaborative partnerships with community agencies, and providing venues for more effective articulation between public, private, and community-based preschools and elementary schools. The systems-level evaluation includes data collected through surveys with seven SR Coordinators and one Special Needs Demonstration Project Coordinator reflecting on the last eight years of the SR Initiative.

A Reflection on the School Readiness Initiative

As the Commission's longest running Initiative, the School Readiness Initiative can best inform the First 5 San Diego Commission of some of the successes and challenges this Initiative has faced. Through an online questionnaire, School Readiness Coordinators were asked about how being part of the SR Initiative has changed the early education practices in their district and how, if at all, they are continuing aspects of their program beyond their First 5 San Diego contract. The responses to the survey are summarized below.

What is the legacy of the School Readiness Initiative?

The School Readiness Initiative will sunset at the end of FY 2010-11. First 5 San Diego funding was used differently by each district, but in each, there will be a legacy of the difference it made.

- Professional–level staff (including speech and language therapists, behavioral specialists, mental health specialists, and others) were hired to conduct screenings and assessments. These provided needed services to children and families, especially those children with special needs.
- School districts provided workshops and trainings to enhance parent education and support and additional instructional materials were purchased to enhance school curricula. These materials will continue to bring benefit to these programs.
- The knowledge and skills of teachers and other instructional staff were improved through intensive professional development opportunities selected to enhance "the rigor of their instructional programs."
- Instruction, along with classroom curricula, became more intentional and differentiated to meet specific, individual child needs.
- Children and families benefitted from kindergarten transition activities aligned to provide direction and support. School districts were able to provide community outreach to bring more of an awareness of the needs of children and help link families to needed services.

> "The educational needs of young children exist even before they enter preschool, and without School Readiness we have no means to reach the child's first and best teacher: their parent."
>
> - School Readiness Coordinator

- Preschool staff, in some districts, are now being included in district wide decisions and have been formally invited to attend district leadership meetings.

- One SR Coordinator reported two of their elementary schools have been named Distinguished California schools of 2010 and that quality early education is part of that success.

Which components of SR Programs will be sustained?

In response to the survey, four out of the seven school districts identified components of the SR program that are likely to continue after FY 2010-11. Districts will continue some professional development. Parent education programs curricula will continue on a smaller scale, more focused on parents of children with behavioral challenges. Some districts will retain professional support staff such as Behavioral Specialists on a part-time basis. Community outreach will continue on a more limited basis. Finally, school districts plan to continue to use the strategies and best practices acquired during staff trainings when working with young children and families. The districts described plans to leverage resources (Title I funding, collaborating with Head Start and other First 5 San Diego funded initiatives) to continue aspects of their programs. Others are looking for grants. The majority of SR funded districts are located in areas served by the Commission's Preschool for All Initiative and will receive some support through that effort.

Update on Recommendations from FY 2008-09

Last Year's Recommendation	Update on Recommendation
Explore reasons for and ways to overcome consistently low parent engagement.	+ Parent participation was similar to last year and appeared low, especially for classroom activities, volunteering in the classroom, and attending classes. This may be due to changing requirements for classroom volunteers. Parents now need to pass a TB screening and a background check – which may intimidate and discourage some from volunteering. Not all districts pay for these processes so cost is likely a barrier to some parents.
Work to retain past improvements.	+ Overall, programs have retained and slightly improved most results.
Continue collaboration between SR providers, other First 5 San Diego Initiatives, and community agencies.	+ Many SR programs successfully partnered with other First 5 San Diego agencies and some made connections beyond First 5 San Diego (e.g., Head Start). In several cases, community agencies reached out to SR programs for collaboration.
Sustain programs over time.	+ Four of the eight SR contracts ended in FY 2009-10 and the other four programs will end by June 30, 2011. Per the Commission's new strategic plan, the SR initiative will sunset. At this time, the remaining First 5 San Diego SR programs have not yet secured continuation funding from other sources. School districts should actively seek additional funding and/or examine shifting existing district funds (e.g., Title I funding) to sustain their programs. First 5 San Diego can support these activities when appropriate. It is likely that some, but not all elements of the SR program will continue.

Special Needs Demonstration Project

In 2005, the Chula Vista Elementary School District (CVESD) was one of ten sites across the state selected for 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 $2,734,500 over five and a half years. The project is designed in three areas: Screening and Assessment, Access to Service, and Community Participation and Inclusion.

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

- 636 children screened received a health survey, completed by a parent or guardian.[9]
- 637 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.
- 635 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 (82.9%).

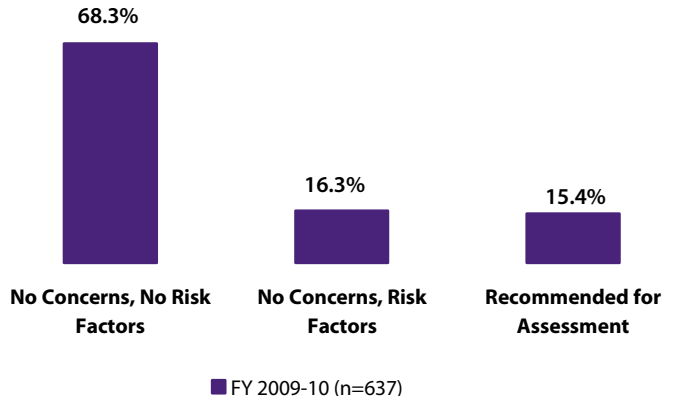
Screening and Assessment

The Kids on TRACK program promotes early childhood development and school readiness through proactively identifying children with, or at-risk of having, a disability, developmental delay, or special need. The program provides services to these children identified with mild to moderate developmental delays or special needs, or who evidence risk factors based on screening outcome. The percentage of children recommended for screening and assessment in this fiscal year is similar to last fiscal year and closely matches with statewide percentages. Thus, this section only includes results from this fiscal year.

Are children being screened for early identification of physical and developmental issues?

Exhibit 5.13 displays the results of all 637 screenings this year. The majority of children screened had no concerns, no risk factors (68.3%). In addition to first-time screenings, Kids on TRACK staff also aim to rescreen as many children as possible. This year, 197 children were rescreened using the SNP screening protocol. The majority of children rescreened had no concerns or risk factors (68.5%), 16.8% had no concerns but risk factors were present, and 14.7% of children rescreened were recommended for assessment (not shown).

Exhibit 5.13 First-Time Screening Results in FY 2009-10



[9] 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.

Mi Escuelita Therapeutic Preschool

Mi Escuelita is a therapeutic preschool program for children ages 3 through 5 who have been exposed to domestic violence, abuse, and/or homelessness. Through $284,092 of First 5 San Diego's Responsive Funding and other financial support, the school provides free bilingual services for children and their families including developmental screenings, parenting classes, counseling, teacher/caregiver training, and educational activities in a safe, healthy environment.[1]

Table 3.1 Mi Escuelita Program Results for FY 2009-10

Types of Services	Numbers Served
Number of children referred to Community Services for Families (CSF)	10
Number of children attending therapeutic preschool	36
Number of parents attending parenting classes/workshops	45
Number of parents attending parent-teacher conferences	36
Number of individual counseling sessions	152
Number of group counseling sessions	182
Number of occupational and/or physical therapy sessions	145
Number of speech classes provided	125

Mi Escuelita is the only school of its kind in Southern California and provides specialized age-appropriate care to a unique population in San Diego County.[2] In FY 2009-2010, Mi Escuelita used First 5 San Diego funds to serve a target 45 children and their parents with comprehensive education, parenting classes and developmental assessments. The data in Table 3.1 display the types and numbers of services provided through Mi Escuelita. Mi Escuelita generally operates at a full capacity of 45 children, but many children do not stay the entire year due to their families' transitory lives. Overall, 36 children were enrolled in Mi Escuelita for the full year. Among the children who attended the school, most parents attended classes/workshops (n=45) and parent-teacher conferences (n=36). Participation in individual and group counseling sessions was also universal, with an average of 34 to 42 children participating in individual counseling, and 40-55 participating in groups each quarter (the figures in Exhibit 3.1 total these sessions for the school year).

Table 3.2 Mi Escuelita Screening and Referrals for FY 2009-10

Types of Screening and Referrals	Numbers Served
Number of children who received a Vision Screening	28
Number of children who received a Hearing Screening	45
Number of children referred to HDS Services	29
Number of children referred to Community Services for Families (CSF)	10

[1] Southbaycommunityservices.org. 2009. 25 September 2009 < http://www.southbaycommunityservices.org/child-well-being.php>.
[2] Ibid.

Mi Escuelita Therapeutic Preschool, continued

The data in Table 3.2 summarize the screenings provided and referrals made for children at Mi Escuelita. A total of 28 children received a vision screen and 45 received a hearing screen. Of those identified as needing treatment, 29 were referred to HDS and 10 were referred to Community Services for Families (CSF).

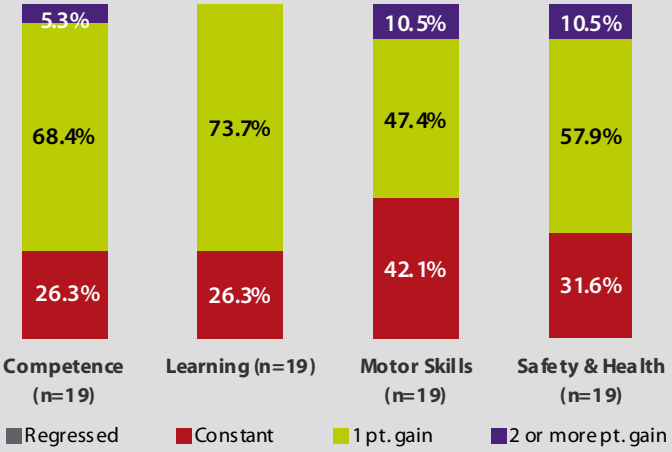
- **Regressed**: children whose scores decreased from fall to spring.
- **Constant:** children whose scores were the same at both fall and spring.
- **1 pt. gain**: children whose scores increased 1 point from fall to spring.
- **2 or more pt. gain**: children whose scores increased 2 or more points from fall to spring.

In addition to these screenings, participating children are assessed using the ASQ and the DRDP-R (instruments described in the School Readiness section). The following figures show the results of the DRDP-R administered at entry into the school and at the end of the school year. Data are presented for those children who attended at least 6 months of school and attended at least 75% of classes (n=19). Using the DRDP-R, a teacher rates a child's developmental status in each of four domains using a four point scale where 0=not yet at first level, 1=exploring, 2=developing, 3=building, and 4=integrating. Exhibit 3.3 shows the extent of developmental gains made from fall to spring on the DRDP-R four point scale, 1 being the lowest and 4 being the highest (see the Methods appendix for details on the analysis).

Results indicate that over half of the children improved by one or more points from fall to spring within all four developmental domains. Children improved the most within the competence and learning domains.

Overall, the Mi Escuelita appears to be having a significant positive impact on the children and families it serves.

Table 3.3 Children's Progress from Fall to Spring in Four Key DRDP-R Domains for FY 2009-10



Reach Out and Read

Reach Out and Read (ROR) is a pediatrician-developed program that uses regularly scheduled doctor's visits to encourage parents to read frequently to their children.[3] The goal of this national, evidence-based program is to make literacy promotion a standard part of pediatric primary care so that children grow up with books and the love of reading. ROR provides books for children birth to 5 via their health providers as a part of the "well child visit" and trains local community clinics and health providers to implement practices that promote early literacy.

In FY 2009-10, ROR expanded to eight new sites. Most of the First 5 San Diego funds received in FY 2009-2010 ($89,934) were used to purchase books and leverage other funding sources to provide the staffing and infrastructure for ROR. The data in Table 3.4 show that a total of 4,375 new books were purchased for this program and the total number of children served was 2,187.

Table 3.4 ROR Program Results for FY 2009-10

Results	FY 2007-08	FY 2008-09	FY 2009-10
Number of new sites	7	4	8
Number of new books purchased	8,329	8,267	4,375
Number of children served	4,164	4,133	2,187

The contract between ROR and First 5 San Diego expired at the end of the 2009 calendar year, which accounts for the decrease in new books purchased and children served in FY 2009-10.

Preschool Learning Foundations

The cornerstone of Preschool Learning Foundations (PLF) is to provide early childhood educators with the knowledge of what children should know before entering kindergarten. This project aims to provide culturally-responsive and effective professional development and outreach for preschool providers who do not receive the support through state-funded efforts. In FY 2009-2010, First 5 San Diego invested $334,702 in this program through its Responsive Fund program.

[3] Reachoutandread.org. 2003-2006. 25 September 2009 <http://www.reachoutandread.org/about.html>.

Preschool Learning Foundations, continued

In FY 2009-10, Preschool Learning Foundations (PLF) classes had a total of over 300 attendees (some duplication). Classes covered the following PLF domains: Social-Emotional Development, Language and Literacy, English Language Development, and Mathematics. Future workshops will be available in Visual and Performing Arts, Science, Social Studies, Physical Development, and Health.

Coaching services were offered to up to 10 participants of each class. Surveys were distributed to 50 teachers and providers who received PLF coaching services to rate the level of satisfaction with the services provided, and it achieved a 44% response rate (n=22).

Table 3.5 PLF Coaching Survey Results for FY 2009-10 (n=22)

Results	Agree	Strongly Agree
Percent of participants who agreed or strongly agreed that the experience was a valuable tool in helping them improve their teaching style and program's environment	40.9%	59.1%
Percent of participants who agreed or strongly agreed that they plan to implement what they learned into their program	27.3%	72.7%
Percent of participants who agreed or strongly agreed that the PLF services improved their classroom environment	31.8%	68.2%
Percent of participants who agreed or strongly agreed that the PLF services will improve their interactions with children	22.7%	77.3%
Percent of participants who agreed or strongly agreed that they would recommend the PLF workshops to other teachers.	27.3%	72.7%

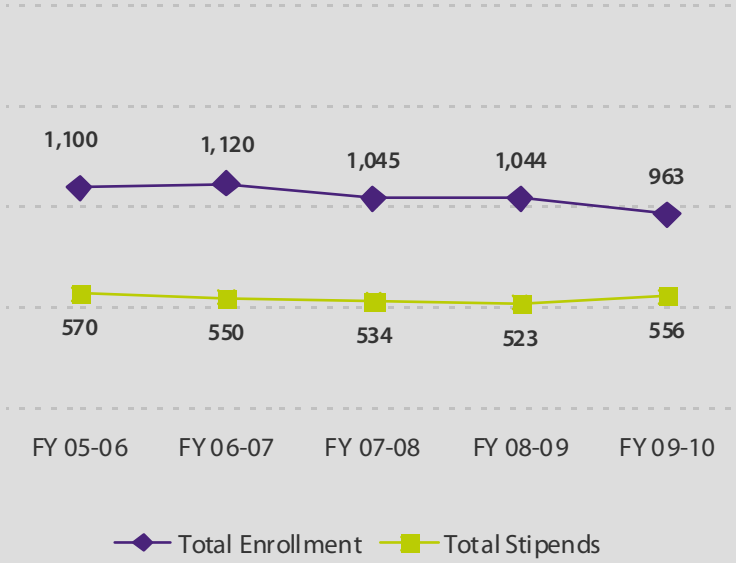
Key results from the survey are illustrated in Table 3.5. The data show that, among the teachers who responded to the survey, teachers were overwhelmingly positive about the value of the coaching program and how it had improved their classroom environment. All who responded planned to implement what they learned and believed that it would improve their interactions with their students. All respondents participated in the full 15-hour coaching program and would recommend it to other teachers.

San Diego CARES

The San Diego CARES (Comprehensive Approaches to Raising Educational Standards) program seeks to improve the quality of local childcare by offering stipends to childcare providers who attend early care and education classes. This program is administered by the YMCA-Childcare Resource Services. CARES was launched in FY 2001-02 by First 5 California, which provides 20.0% of the funds; the remainder is supplied by First 5 San Diego. In FY 2009-2010, First 5 San Diego invested $2,000,000 in the CARES program.

Table 3.6 San Diego CARES Participants

For the first 4 years of the CARES program, participants were able to receive stipends by taking child development courses. In year 5, participants were only eligible for stipends if they were working to complete California Child Development Permits or related degrees. Exhibit 3.6 presents the total enrollment and total number of stipends provided over the last 5 years of the CARES program.



FY 2009-10 saw the lowest number of CARES enrollees (963) since the program's first year, and participation has dropped 12.5% overall since FY 2005-06 when CARES changed its participation rules. There was an increase in the number of participants who received stipends (556), which accounts for more than half (57.7%) of all enrolled participants for this year. FY 2009-10 was the last year of the 9-year CARES program.

Family

Goal: Strengthen each family's ability to provide nurturing, safe and stable environments.

First 5 For Parents
Child Welfare Services Projects (includes Foster Care Respite)
- Horn of Africa
- Kit for New Parents
- SANDAPP

First 5 San Diego

CHAPTER 6.

First 5 For Parents

2009/2010 Scorecard

Goals	Measures	Target	Actual	Performance
1. Provide parent education services to families	Number of children of parents served	9075	17,188	
	Number of parents/ caregivers served	4319	3,790	
	Number of home visits	7290	5,343	
	Number of classes	2766	4,067	
2. Increase parent knowledge and confidence regarding child development	Mean parent confidence scores after participation in program	No target set	5.39	
	Percent of parents with knowledge of peer socialization, early learning, and parent-child interaction after participation in program	No target set	86.4%	
3. Increase parent involvement in child's early learning and literacy development	Percent of parents reading to their children three or more days per week.	89.7%	88.3%	
	Percent of parents playing with children three or more days a per week	No target set	92.5%	

90% or above target 75-89% of target <75% of target

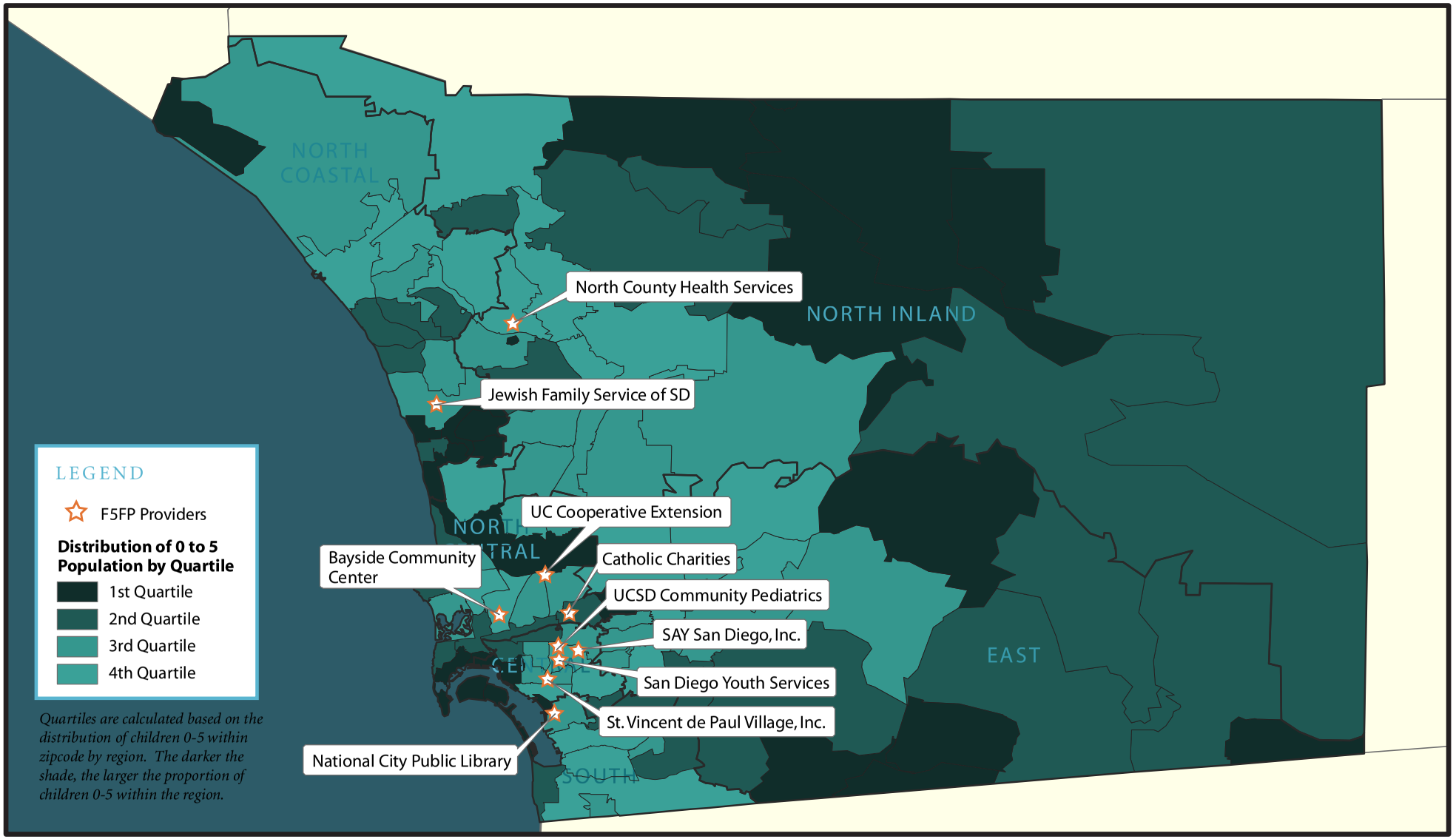
2009/2010 Scorecard

Goals	Measures	Target	Actual	Performance
4. Increase healthy behaviors in families	Percent of parents with knowledge of healthy behaviors related to nutrition and exercise	96.5%*	96.8%	
	Percent of families eating at least one meal at fast food restaurant at least one day per week	69.8%*	70.5%	
	Mean number of days parents engage in at least 20 minutes of physical activity	3.83*	4.08	
	Mean number of days children engage in at least 10 minutes of physical activities	6.10*	6.47	
	Mean number of hours children watch television, play video games and/or use computer on weekdays.	2.41*	2.17 hrs	

 90% or above target  75-89% of target  <75% of target

* No target set but 2008-2009 post data are presented as a comparisons to show gains made over last year.

First 5 for Parents Providers



Introduction

"I like this program very much because even though we know that we are the first teachers of our children, sometimes we don't know how to do it and with this program we learn."

- F5FP Parent

Research shows 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."[1] A child's first exposure to language, attitudes, behaviors, and socialization occurs in the home. Parents and caregivers are a child's first and most important teachers, and the First 5 for Parents project (F5FP) provided parent education to parents and caregivers through classes, workshops, and home visits to support them in their important role.

In FY 2009-10, the Commission funded F5FP at $3,427,128 for a cumulative total investment in this program of $12,591,593 over four years. Although FY 2009-10 was the last year of the F5FP initiative, parent education will continue to be provided through other initiatives including Preschool for All (PFA) and Healthy Development Services (HDS).

Initiative Goals

- Provide parent education services to families
- Increase parent knowledge and confidence regarding child development
- Increase parent involvement in child's early learning and literacy development
- Increase healthy behaviors in families

Key Elements

F5FP seeks to strengthen parents' knowledge and encourage positive behavior change. The First 5 Commission identified three Service Focus Area(s) for program funding. These Service Focus Areas included:

1) developing more effective parenting skills,
2) promoting children's early learning and early literacy development, and
3) fostering healthier behaviors with proper nutrition and exercise.

Contractors chose the focus area(s) in which they believed they could most effectively support parents and caregivers as well as the populations they could best reach with these services. Populations served by F5FP contractors included single parents, fathers, parents in immigrant families, and pregnant and parenting teens. Contractors also identified their service approaches (e.g., classes, workshops, and home visits) and their evidence-based parent education curricula. As a result, there are important variations in service delivery across F5FP contractors that should be kept in mind when reading this chapter.

The evaluation findings in this chapter are organized by the F5FP goals identified in the text box above.

[1] 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.

F5FP Contractors and Services

Exhibit 6.1 lists the F5FP providers in FY 2009-10 and identifies the service areas, service approaches, and goals addressed by each. The Exhibit also shows how the F5FP goals are addressed by each service focus area and approach.

Exhibit 6.1 F5FP Programs by Service Areas, Service Methods, and Goals

Contractor	Service Areas (Goal)			Service Approaches(Goal)		
	Parenting Skills (Goal 2)	Early Learning (Goals 2, 3)	Healthy Behaviors (Goal 4)	Classes (Goal 1)	Workshops (Goal 1)	Home Visits (Goal 1)
Bayside Community Center	X	X	X	X	X	X
Catholic Charities	X	X			X	X
Jewish Family Service of San Diego	X	X		X		X
National City Public Library		X			X	
North County Health Services	X			X	X	
SAY San Diego, Inc.	X	X	X	X	X	X
St. Vincent De Paul Village, Inc.		X		X		X
San Diego Youth Services			X	X	X	
UC Cooperative Extension	X	X			X	
UCSD Community Pediatrics			X	X		X

Summing it Up

"We actually really got to impact a lot of the families and then they would go out and seek other community resources and opportunities. I saw a lot of growth in families."

- F5FP Provider

Fiscal Year 2009-10 marked the fourth and final year of F5FP. This section includes the key measures from Goal 1-- providing parent education services to families. Data include the number and types of participants and the number and types of services.

Provide Parent Education Services to Families

Overall, there were decreases in the numbers of parents/caregivers and children served as well as the number of services provided by the initiative. Agencies reported that recruitment was one of the main challenges this year, with one agency noting, "Recruiting new families was a constant challenge for us." In addition to recruitment challenges, agencies felt retention was also a challenge, noting high drop-out rates due to caregivers' busy schedules and challenges with childcare. In addition, given that the program was in its final year, some contractors decreased outreach efforts, which likely decreased participation.

How many parents/caregivers and children received services?

- **Parents/caregivers**. Exhibit 6.2 displays four years of data on the number of participants served by F5FP. 3,790 parents and caregivers were served by F5FP contractors during FY 2009-10. This number represents a 19.7% decrease from FY 2008-09. With the exception of one contractor, every agency served fewer parents in FY 2009-10, despite upward trends in all earlier years.

- **Children of parents served intensively.** From the previous fiscal year there was a slight decrease (4.0%) in children of parents served intensively despite the upward trend in previous fiscal years. Although there was a decrease this fiscal year, the number was higher than in FY 2006-07 and FY 2007-08.

- **Children served: "light touch."** There was a larger decrease (30.4%) in the percentage of children served through "light touch" services. Light touch services are defined as programs that did not have regular contact with parents (including two literacy programs). The decrease was due to a decrease in participation for a reading program involving senior volunteers. Fewer seniors participated in this program as well, which likely contributed to the lower number of children served.

Exhibit 6.2 Number of Participants*

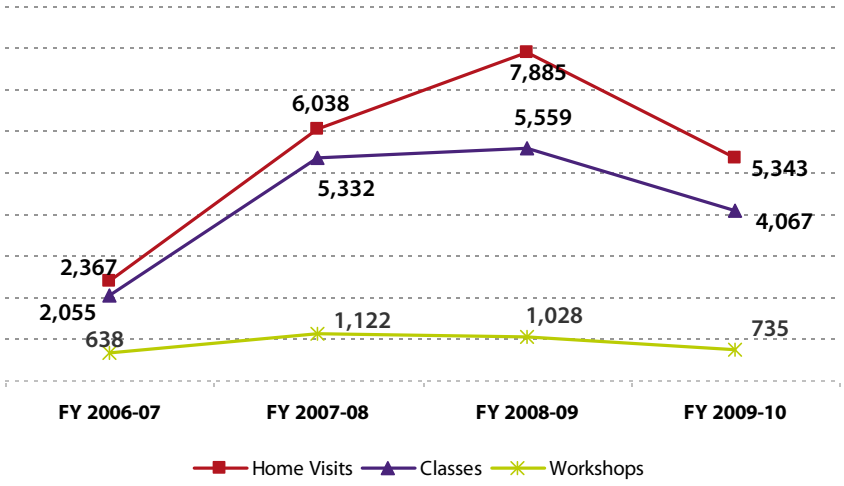
	FY 06-07	FY 07-08	FY 08-09	FY 09-10
Parents/Caregivers	3,381	4,662	4,720	3,790
Children of Parents Served: Intensively	3,837	5,363	5,440	5,224
Children Served: "Light Touch"	6,053	11,871	17,193	11, 964

**In some cases, parents participated in multiple programs at the same agency, and thus there may be some duplication in the child and parent counts.*

How many and what types of services did families receive?

The data in Exhibit 6.3 show the number and types of services delivered through First 5 for Parents. Overall, agencies more frequently provided home visits, followed by classes and then workshops. This was the case each fiscal year. From last fiscal year there was a 32.2% decrease in home visits, a 26.8% decrease in classes, and a 28.5% decrease in workshops.

Exhibit 6.3 Number and Types of Services



Making a Difference

"I cook healthier meals when I'm at home because we have had cooking classes that teach us how."

-F5FP Parent

Although each F5FP program is different, every program administers a survey comprised of common items that address the specific outcomes and result areas the initiative addresses as a whole. This survey is administered to parents at the beginning and end of their program participation. The outcomes for those questions with the most significant results are presented in this section. Key outcomes are highlighted with circles and, where possible, county and State comparison data is also presented. Data was only analyzed for matched cases where parents completed both a pre-test and a post-test. For FY 2009-10, there was a total of 1,335 matched cases where both the pre and post surveys were completed.

Increase Parent Knowledge and Confidence Regarding Child Development

F5FP projects working towards goal 2 aim to increase parent knowledge and confidence in a variety of topics including the importance of peer socialization, parent-child interaction, and early learning. For knowledge and confidence, scores for FY 2009-10 were similar to those from FY 2008-09. Parents had high levels of knowledge upon entering programs and increases over time were small. Thus, this section only includes scores from this fiscal year.

Did F5FP increase parents' confidence in their parenting skills?

Although parents reported fairly high confidence levels upon entering the program, they demonstrated statistically significant ($p<0.001$) increases in confidence after participation. Parents showed the greatest increase in reported ability to discipline their child. This was also the area with the lowest "then" score, allowing the most room for improvement. After completing the program, parents, on average, reported the highest confidence in their ability to help their child learn and their ability to make decisions about services their child needs.

Exhibit 6.4 Mean Parent Confidence Scores (range from 0 as low to 6 as high)

	Then (before)	Now (after)	Mean Difference
Ability to make decisions about the services my child needs (n=900)	4.02	5.47	1.45*
Ability to help my child learn (n=894)	3.98	5.49	1.51*
Knowing what is right for my child (n=915)	3.77	5.38	1.61*
Ability to handle the day-to-day challenges of raising my child (n=902)	3.73	5.32	1.60*
Ability to discipline my child (n=884)	3.66	5.33	1.67*

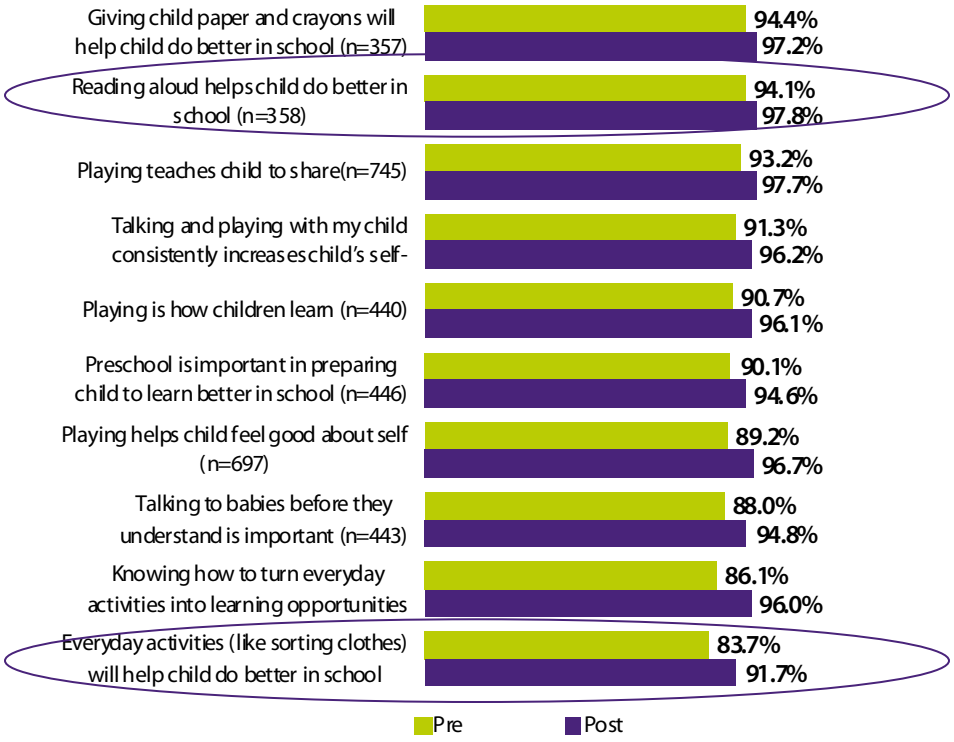
**Statistically significant at p<0.001*

Note: Questions were administered retrospectively. They were asked at post-test only, and parents were asked to rate themselves "before" and "after" program participation.

Did F5FP participants increase their knowledge of child development?

Overall, parents had high levels of knowledge at baseline and increases over time were small. The largest increase (9.9%) was in knowing how to turn everyday activities into learning opportunities. This item was also one of the areas where the fewest parents had knowledge at the pre-test, allowing more room for improvement. At post-test, the greatest percentage of parents reported knowing that reading aloud helps their child to better in school.

Exhibit 6.5 Parents Responding Correctly to Statements Related to Peer Socialization, Early Learning, and Parent-Child Interaction



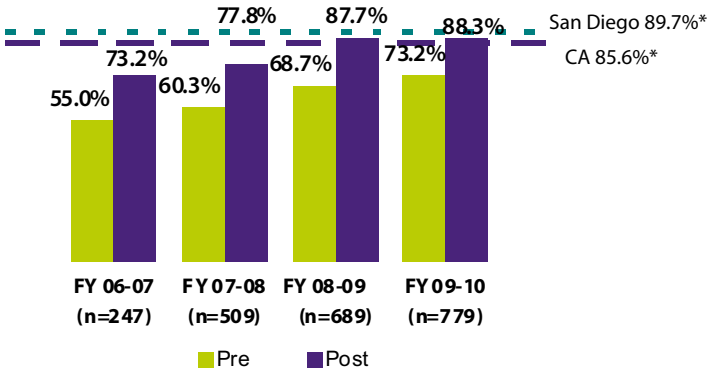
Increase Parent Involvement in Child's Early Learning and Literacy Development

Three key activities measured parent involvement in child's early learning and literacy development: 1) reading to their children, 2) telling stories or singing songs to their children, and 3) playing with their children. Results are reported for FY 2006-07 through 2009-10.

Were more parents reading to their children?

Since FY 2006-07, the percentage of parents reading to their children has increased at both pre- and post-test. This fiscal year, there was a 15.1% increase from pre-test to post-test with 88.3% of parents reading to their children after program participation. Reading frequency exceeded the statewide figure and was less than 2.0% below the countywide reading rate.

Exhibit 6.6 Parents Reading to Their Children 3 or More Days Per Week

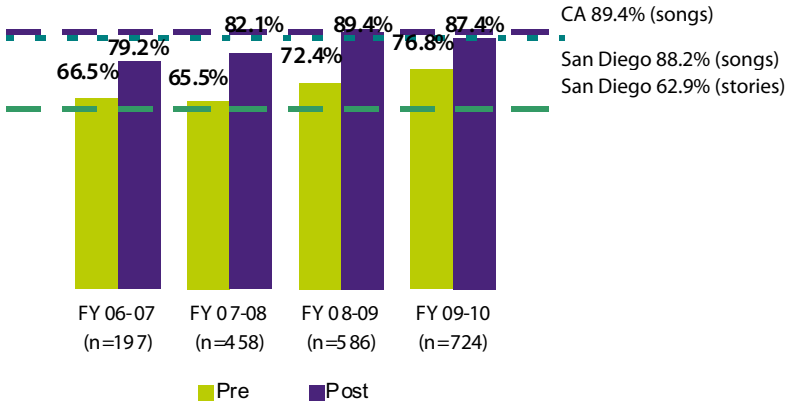


**Source: California Health Interview Survey, 2007 (SD and CA).*

Did more parents sing songs and/or tell stories to their children after F5FP Participation?

In FY 2009-10, there was a 10.6% increase in parents who reported telling stories or singing songs from pre-test to post-test, with 87.4% of parents engaging in these activities at post-test. However, slightly fewer (2.0%) parents reported engaging in these activities at post-test this fiscal year compared to last fiscal year. The frequency of telling stories and singing songs exceeded the countywide frequency of telling stories at both pre- and post-test and was just below the state and countywide rates for singing songs at post-test.

Exhibit 6.7 Parents Telling Stories or Singing Songs 3 or More Days Per Week

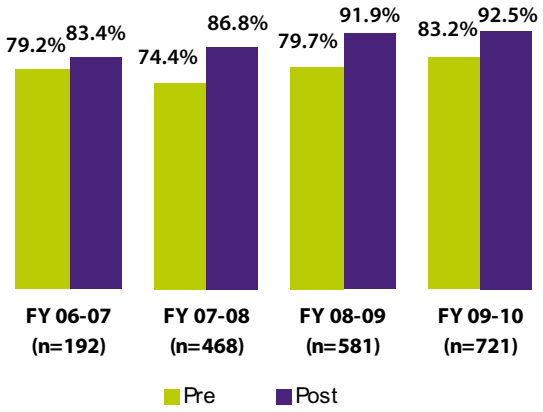


Sources for comparison data: California Health Interview Survey, 2007 (CA data). First 5 Family Survey, 2005 (SD data)
Note: Questions varied between CHIS, F5 Family Survey and F5FP Survey.

Did more parents play with their children after F5FP Participation?

There was a 9.3% increase in the percentage of parents who reported playing with their children from pre-test to post-test, with 92.5% playing with their children after program participation. Over time, the percentage of parents playing with their children at post-test has steadily increased from FY 2006-07 through FY 2009-10, suggesting either program improvement or changes in the population of parents participating in the program from year to year.

Exhibit 6.8 Parents Playing with Children 3 or More Days per Week



For measures related to goal 3, data indicates that parent engagement in reading to, singing songs/telling stories to, and playing with children increased from pre-test to post-test. Additionally, parent engagement in these activities has increased since FY 2006-07.

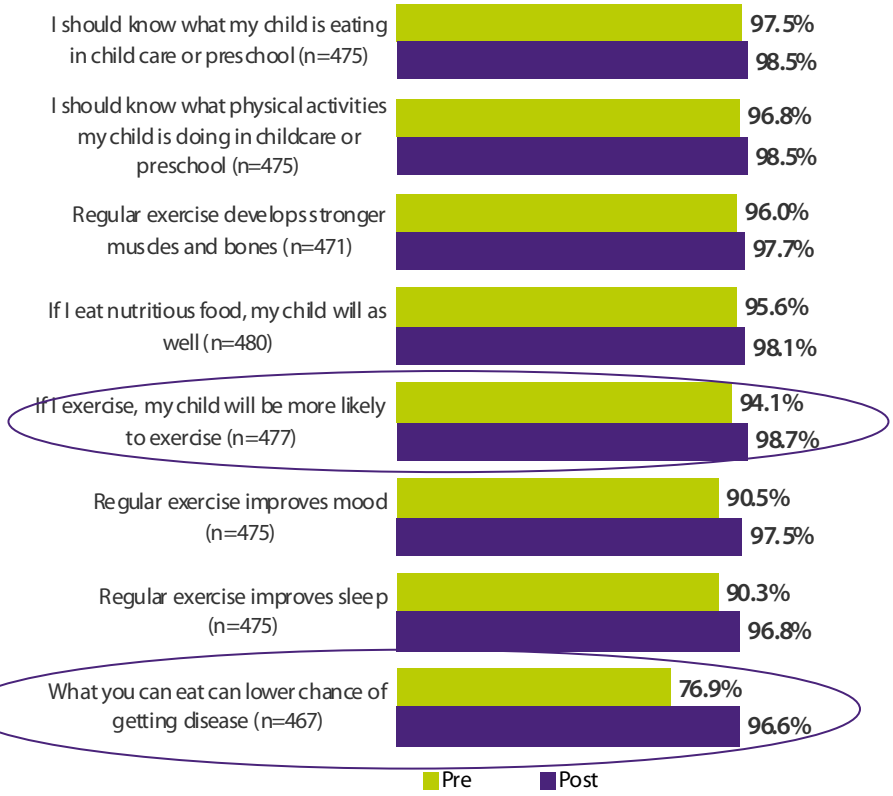
Increase in Family Healthy Behaviors

The following results are for F5FP projects that focused on healthy behaviors, with a goal of improving parent knowledge about nutrition and exercise, as well as fostering healthy behaviors. F5FP programs working to foster healthy behaviors aimed to improve parenting knowledge about the importance of nutrition and regular exercise, the relationship between diet and disease, and the importance of family participation in activities that promote a healthy lifestyle. Additionally these agencies aimed to change family behaviors by decreasing fast food consumption, increasing physical activity, and decreasing screen time.

Do more parents have knowledge of health behaviors related to nutrition and exercise?

Knowledge scores for FY 2009-10 were similar to FY 2008-09 , with parents having high levels of knowledge of health behaviors upon entering programs and increases over time being small. Thus, this section includes scores from this fiscal year only.

Exhibit 6.9 Parents Responding Correctly to Statements Related to Nutrition and Exercise

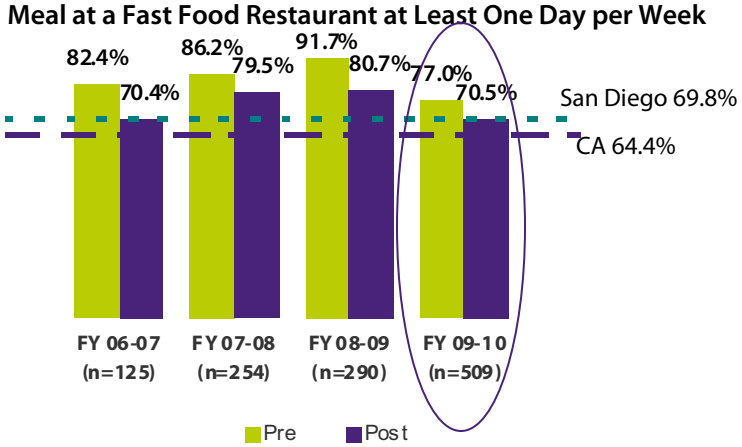


At post-test, the most parents reported knowing that their exercise habits influence their child's habits. The largest increase (19.7%) was in reported knowledge about the relationships between food and health. This was also the area in which the fewest parents had knowledge at pre-test, allowing the most room for improvement. Other areas that showed larger increases were the relationship between regular exercise and mood (7.0% increase from pre to post) and the relationship between regular exercise and sleep (6.5% increase from pre to post). These were also areas where parents had the least knowledge at pre-test.

Did participating families reduce their consumption of fast food ?

In FY 2009-10 , fast food consumption decreased 6.5% from 77.0% at pre-test to 70.5% at post-test. Consumption at post-test was lowest in FY 2006-07, but increased in FY 2007-09 and FY 2008-09. Although fast food consumption was higher among the F5FP population compared to State comparison data, it was comparable to the countywide comparison. Analysis of the data by program indicated that a program with intensive services (long-term classes) yielded better knowledge gains and behavior change among participants.

Exhibit 6.10 Parents Reporting that Families Eat at Least One Meal at a Fast Food Restaurant at Least One Day per Week

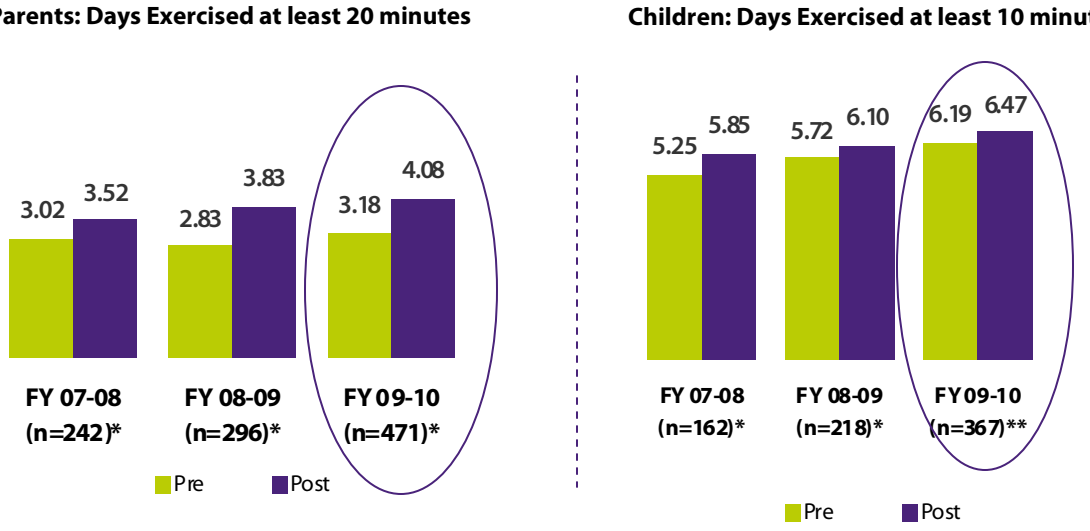


Sources for comparison data: California Health Interview Survey, 2007 (CA data). First 5 Family Survey, 2005 (SD data).
Note: Questions varied between CHIS, F5 Family Survey and F5FP Survey.

Did families in F5FP increase their physical activity?

After participation in F5FP classes, parents and children engaged in physical activity more frequently. During FY 2009-10, parents increased their activity by an average of 1.10 days per week, from 3.18 days to 4.08 days. Post-test activity for parents was higher this fiscal year than it has been in past fiscal years. This fiscal year children were active almost every day (6.19 days) before program participation, but they also increased their activity to 6.47 days at post-test, which is the highest it has been in all years of the program.

Exhibit 6.11 Mean Number of Days Per Week Parents and Children (ages 2-5) Engaged in Physical Activity

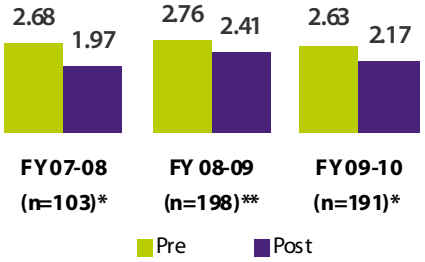


**Difference statistically significant at p<0.001*
***Difference statistically significant at p<0.05*

Did families reduce screen time for children?

In FY 2009-10, children spent an average of 2.63 hours of time watching television, playing video games, or being on the computer before program participation. After participation in F5FP, screen time decreased by almost half an hour at post-test, falling to 2.17 hours per day. Although post-test screen time decreased this fiscal year compared to last fiscal year, it was higher than in FY 2007-08. This may be due to the increased use of computers. It may also be that families relied on television for low-cost family entertainment.

Exhibit 6.12 Mean Number of Hours Children (ages 3-5) Watch Television, Play Video Games and/or Spend Time on the Computer on a Weekday



**Difference statistically significant at p<0.001.*
***Difference statistically significant at p<0.05.*

Lessons Learned

FY 2009-10 was the final year of the F5FP Initiative. First 5 San Diego is now implementing parent education programs through Preschool for All (PFA) and Healthy Development Services (HDS). Thus, this section focuses on lessons learned over the past four years of F5FP. These lessons are meant to assist First 5 San Diego in refining its parent education program(s) in the future, and are based on the quantitative data collected as well as feedback from contractors.

- **F5FP programs decreased social isolation and empowered parents.** Many of the families served by F5FP were new to the area and/or did not speak English fluently. The workshop/class structure of the program allowed parents to interact socially with other families. This was not only beneficial for parents, but also for children as it gave them the opportunity to interact with other children before kindergarten. Parents were also introduced to other community services, such as the library or health services. In one contractor's words, "Even though they are far away from home they now are meeting other moms, talking [to], or meeting other dads, and have a place for their kids to hang out."

- **F5FP programs succeeded in increasing parent knowledge and confidence (goal 2), parent involvement (goal 3) and healthy behaviors (goal 4).** Parents reported an increase in confidence and knowledge related to child development after program participation. Parents also reported interacting more with their children through reading, singing songs/telling stories, and playing. Additionally, families reported increasing physical activity, decreased screen time, and decreased fast food consumption after program participation.

- **Explore and implement strategies to increase program retention.** Many agencies reported a high drop-out rate. They noted the importance of offering incentives such as having food available at the sessions or having a raffle at the end of the workshop series. Providing childcare was also key to increasing retention. Some agencies noted that they provided transportation vouchers based on parent feedback, but that this strategy was not successful.

- **Future parent education programming should narrow the focus and utilize a single evidence-based curriculum.** One of the challenges in understanding the effectiveness of F5FP is that each agency used a different curriculum. Contractors noted that using evidence-based curricula was valuable because there was national recognition as well as support for their staff. When selecting the curriculum, the training opportunities and requirements should be assessed to ensure that agencies have the capacity to train staff. If staff turnover is high and training opportunities are few, new staff members may have to wait months to attend a national training for a particular curriculum.

CHAPTER 7.

Child Welfare Services

2009/2010 Scorecard

Goals	Measures	Target	Actual	Performance
1. Ensure the implementation of the ICP.	Number of children 0-5 in foster care receiving an Individualized Care Plan (ICP)	1,004	964	
2. Promote socio-emotional development of children 0-5 in foster care	Number of children 0-5 in foster care identified with needs that received case management	524	524	
3. Improve the long-term relationship between teen parents in residence at Polinsky Children's Center and their children.	Percent of teen parents residing at the Polinsky Center that received coaching.	100%	100%	
4. Support children to exhibit age-appropriate behavioral and developmental skills that will facilitate stable placements while in foster care and reunification with their families when appropriate.	Percent of children 0-5 years reunified with their parents within 12 months	58%	59.6%	
	Percent of children 0-5 years in foster care for less than 12 months who will have two or fewer replacements	83%	83.1%	

90% or above target 75-89% of target <75% of target

Introduction

"When children are provided early intervention services, they are more likely to have better developmental outcomes; at times, being able to become developmentally on-track for their age group."

– CWS Supervisor

Maltreatment and child neglect adversely affects a child's physical/social-emotional development, particularly in the early years of life. Young children who are placed in care outside of the home are more likely to exhibit mental health concerns than those who have a stable home environment. Studies indicate that 50.0% to 75.0% of children entering foster care exhibit behavioral and social competency problems warranting mental health services.[1] These concerns are exacerbated with multiple placements and low stability within the home environment. To address these concerns, the First 5 Commission of San Diego County invested a total of $6.36 million in three early intervention programs to support young children in foster care:

Project's Goals

- Increase the continuity of care for children in the foster care system
- Decrease the number of placements children experience while under the care of Child Welfare Services

+ ***CWS Developmental Screening and Enhancement Program Project (CWS DSEP)***: This program has three core components related to children in foster care and their foster and kinship caregivers. These include: 1) enhance existing developmental and behavioral assessments and care coordination for children at the Polinsky Children's Center (PCC) and in foster care settings, 2) provide interventions to support foster and kinship caregivers via coaching, and 3) provide intensive behavioral interventions for identified children and caretakers. A final component of the program is to provide specialized training and coaching to PCC staff on supporting the developmental challenges of young children in foster care.

+ ***Child Welfare Services Early Childhood Services Project (CWS ECS)***: This program supports additional social worker staff and supervisors (i.e., 39 full-time equivalent Early Childhood Specialist social workers and 5 Early Childhood Specialist supervisors) to receive specialized training in early childhood development, screening and evaluations, accessing developmental resources in the community, and other topics to support and address the unique needs of young children ages 0-5 years in foster care and provide support for their caregivers. These early care specialists work in tandem with the CWS DSEP project.

+ ***Foster Care Respite***: A project that seeks to offer support and reduce stress for foster parents and kinship caregivers by providing respite care. Through this program, caregivers can attend trainings, appointments, and other personal obligations while the children receive professional care.

Due to the interconnectivity of the elements of these three projects, they are being evaluated as an integrated set of services and reported together.

[1] Stahmer, A. Leslie, Hurlburt, m. Barth, R, Webb, M, Landsverk, J & Zhang, J, (2005). Developmental and Behavioral Needs and Service Use for Young Children in Child Welfare, Pediatrics, 891.

Key Elements

The CWS Projects' "System of Care" consists of the following key elements:

- *Systems Change- Professional Development & Individual Care Plan (ICP) Implementation*: Develop specially trained social workers and PCC cottage workers to 1) address the needs of children age birth through 5, and 2) implement and monitor the use of the Individual Care Plan (ICP), a document that provides recommendations to support a child's developmental needs and is a resource for the developmental information provided in the court report.
- *Improved Child Development- Developmental Services*: Promote social-emotional development through expansion of developmental services (including a new component of addressing the needs of children birth to 3 months).
- *Improved Family Functioning- Caregiver Support Services*: Improve the long-term relationship between caregivers (including teen parents in residence at PCC) through the delivery of expanded services for caregivers.
- *Placement and Reunification Support Services*: Children exhibit age appropriate behavioral and developmental skills that will facilitate stable placements while in foster care and reunification with their families when appropriate.

Summing It Up

Fiscal Year 2009-10 marks the first full year of this project. This section includes an overall picture of the "System of Care" that was built for the children and families served. Because this project is still in its early implementation stages, this year's report includes mainly process numbers. Assessment outcomes will be reported in upcoming years.

The development and integration of CWS-DSEP and CWS-ECS, as part of the innovative Early Childhood Services Initiative, marks a new direction for Child Welfare Services in supporting the healthy development of young children in foster care.

The diagram in Exhibit 7.1 is a general overview of how the project functions, from a child's entrance into the Child Welfare Services system to the interventions that children and caregivers receive. The diagram also includes the number of children served at each programmatic step. As displayed in the exhibit, the core component is the CWS-DSEP Project which complements the assessments funded through HDS by expanding assessments to young infants and by providing new innovative services such as an Individual Care Plan for each child (with assessment results and recommendations for enhancing development), customized developmental/behavioral coaching and training for Polinsky Children's Center staff, specialized support for teen parents placed at Polinsky Children's Center (PCC) and placement transition support for caregivers to support continuity of care when children

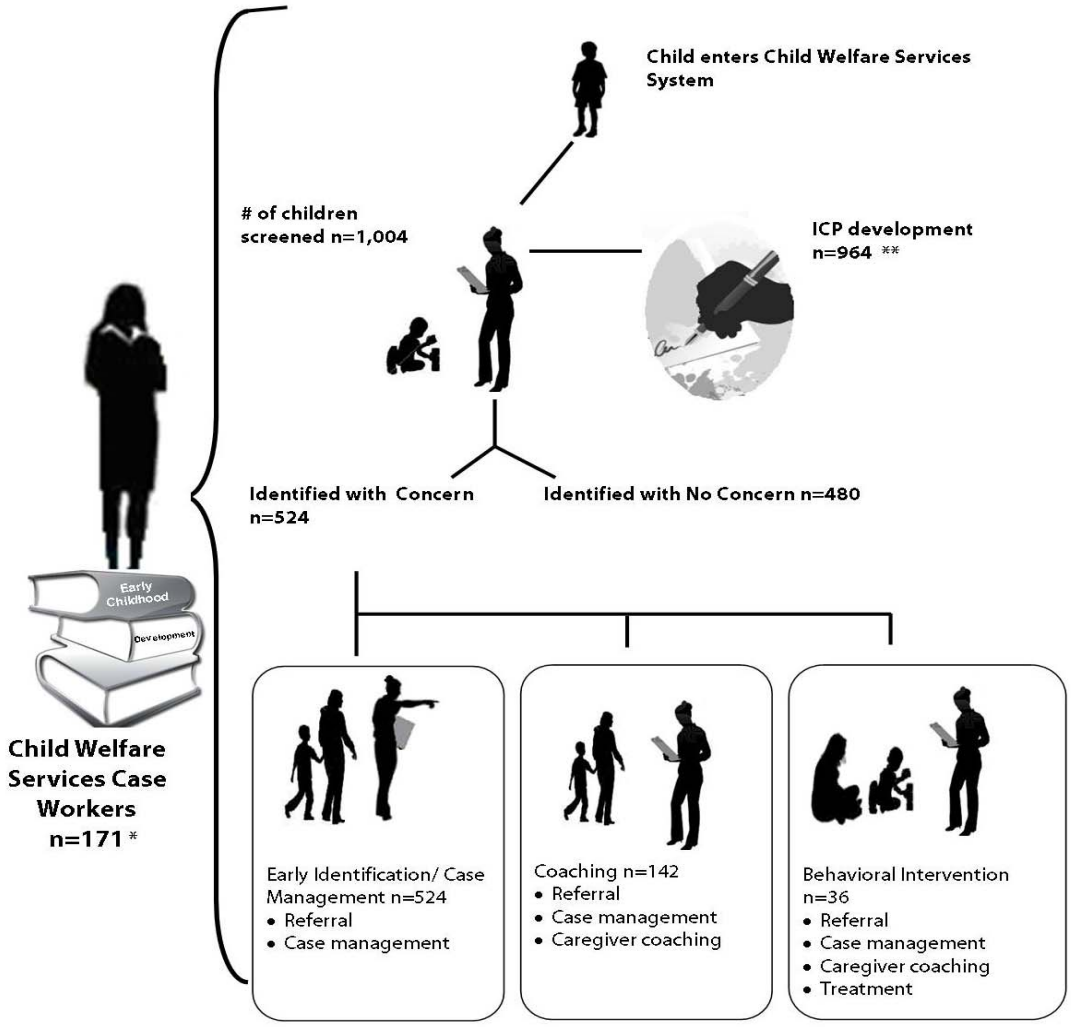
A Note about the Partners

Both CWS DSEP and CWS ECS are led by Child Welfare Services with a subcontract to the Developmental Screening and Enhancement Project (DSEP). DSEP is housed in Rady's Children's Hospital and is focused on addressing the developmental and behavioral needs of children ages 0 to 5 years in the foster care system. DSEP has a team of professionals at Polinsky Children's Center, as well as a team of developmental specialists that visit the homes of those children placed directly with foster families and/or relatives. Through this project, DSEP trains social workers and PCC staff on the latest research in working with children ages 0-5. This project expanded both CWS and DSEP's ability to meet the needs of this vulnerable population.

move from PCC to a relative or foster home. Caregivers are supported through one or more of the following interventions: case management and linkages to services, developmental coaching, and behavioral intervention and coaching.

To complement the CWS-DSEP project, CWS-ECS is providing social workers with specialized training to address the needs of children age birth to five. Workers receive training in understanding and supporting early childhood development and in understanding existing systems and community resources. These workers also support the implementation of the ICP recommendations by informing the Court of recommendations and progress and by working with caregivers to implement daily activities that further the children's healthy development.

Exhibit 7.1 CWS ECS and CWS DSEP "System of Care"



** Trained CWS ECS Social Workers support all stages of the DSEP Component, particularly the implementation and usage of the Individual Care Plan (ICP).*

*** Reasons children did not receive an ICP are discussed later in this section.*

Making a Difference

"I have learned different techniques to stimulate child development and growth."
– PCC Cottage Staff Worker

The overarching goal of this project is to strengthen the "system of care" for children ages 0-5 years who enter PCC or are placed in out-of-home foster care. This system will create and maintain a nurturing environment that enables and encourages each child's readiness to enter school ready to succeed. This section presents process and outcome data associated with three key elements: systems change, child development, and family functioning. FY 2009-10 was a baseline year. Future years will include outcome data on the full project.

Systems Change: Professional Development and Individual Care Plan Implementation (ICP)

The Systems Change element consists of: 1) developing specially trained CWS social workers and PCC cottage workers attuned to addressing the needs of children age birth through 5, and 2) implementing and monitoring the use of the Individual Care Plan (ICP) for each child who receives CWS DSEP services to document child developmental needs and progress.

Are Social Workers receiving professional staff development?

First 5 San Diego provides funding for the equivalent of 39 full-time equivalent early childhood social workers and 5 early childhood supervisor positions. As part of this project, staff receives specialized training in early childhood development, screening and evaluations, accessing the developmental resources available in their community, and other topics to support the early developmental needs of children in out-of-home care.

DSEP provided four different trainings on early childhood topics to CWS social workers and supervisors. DSEP trained 171 social workers and supervisors in an introduction to the project through topics including: early/intermediate child development; developmental delays; and available community resources critical for developmental and behavioral needs. The trainings provided social workers with a solid foundation for understanding developmental screenings and evaluations, which will help them to reinforce results and recommendations with caregivers. Overall, DSEP contractors reported that 68.0% of all ECS staff showed gains in knowledge between pre and post test results at each training.

Are PCC Cottage Staff receiving professional staff development?

DSEP staff also provided training, modeling, and coaching to PCC Residential Care Workers. Nineteen (19) DSEP trainings, totaling 42.5 hours of instruction encompassing 13 topics, were provided to PCC cottage staff in FY 2009-10. A total of 68 PCC staff attended at least one of these trainings. The training subject matter focused on early child development concepts including: behavioral, social-emotional, fine motor, gross motor, cognition and speech and language skills to enhance staff expertise in identifying and meeting the specific needs of children. Nearly three quarters of all staff (72.1%) demonstrated knowledge gains; meaning an increase in their scores from pre to post tests at each training offered. Also, 98 PCC staff received a total of 1,228 coaching hours while working in the PCC infant and toddler cottages.

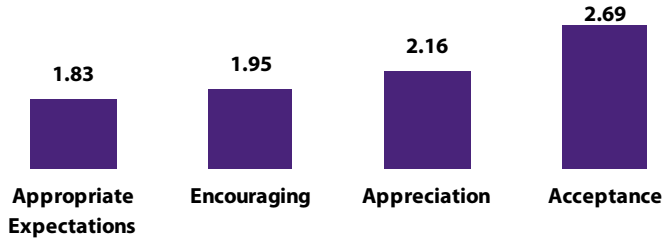
What was the impact of training participation on PCC Cottage Staff knowledge?

DSEP trainings emphasized a highly sensitive and responsive approach to care giving. Research demonstrates that children who engage with these types of caregivers in early childhood have greater social competency, fewer behavioral problems, higher levels of language development, and higher performance on all school subjects in elementary school than those without this exposure[2].

Baseline data were collected on 23 "core" PCC cottage staff from two early childhood classrooms (e.g., Infant/Toddler and Preschool) from March-May 2010 to assess the quality of interactions between the caregivers and the children in care at PCC. The Arnett Caregiver Interaction Scale (CIS)[3] was implemented by an external rater to measure caregiver-child interaction. The CIS consists of 26 items that measure four dimensions of interaction, which are renamed here to more accurately and objectively assess the four dimensions of interaction. The data presented are the baseline to which subsequent years will be compared.

The average score for all 23 caregivers at baseline was a 2.23 out of a possible score of 4.00, indicating that caregivers performed at an average to slightly above average level. As shown on Exhibit 7. 2, caregivers generally scored lowest on "providing appropriate expectations for children" and highest on "acceptance and respect for children." Scores indicate that PCC caregivers score lower on items related to punitive and critical interactions, however caregivers still score high in areas related to discipline and limit-setting.

Exhibit 7.2 Baseline Average Scores for Four Indicators of the Arnett CIS*



(n=23 cottage staff)

**Results are based on the assessments performed by an external rater. See Methods appendix for details.*

Future training, coaching and modeling activities with PCC caregivers will use the CIS results to target areas where improvement is needed.

[2] Mitchell, Sascha, PhD. (2010). PCC Caregiver Interaction Scale. San Diego, CA: Rady's Children's Hospital.

[3] Arnett, J. (1989). Caregivers in day-care centers: Does training matter? Journal of Applied Developmental Psychology, 10, 541-552.

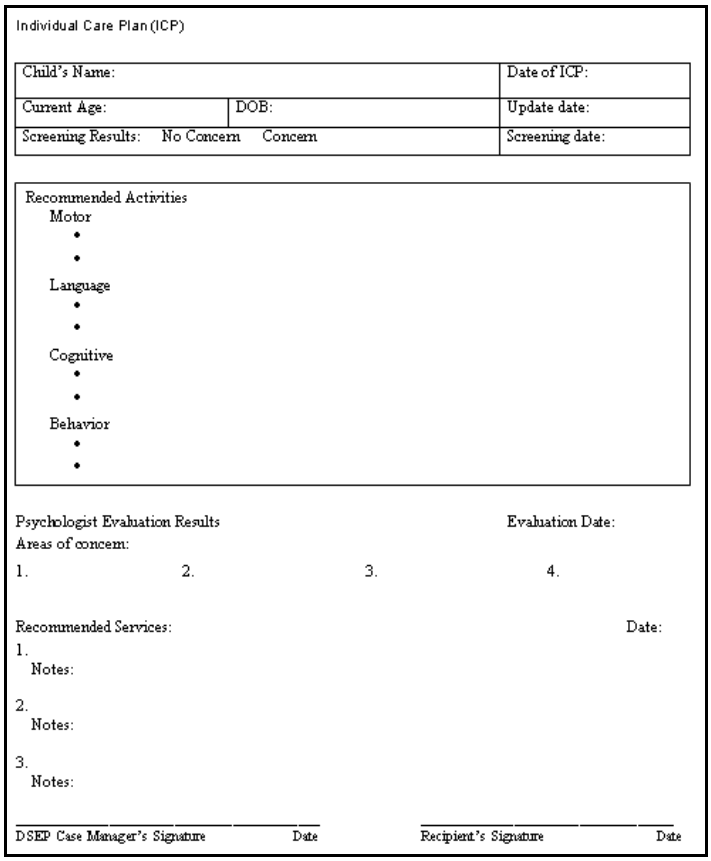
Are PCC cottage staff utilizing the Individual Care Plan (ICP) and are CWS staff ensuring the ICP plan is being followed and is included in court records?

As part of this project, DSEP's protocol is to develop an ICP within 48 hours of screening for children at PCC and within one week of screening for children bypassing PCC ("Off Site"). The ICP document results from the screening data, areas of concern, and provides information on recommended activities and needed services. The ICP informs both the primary caregiver and/or social worker about each child's progress and the follow-up required to help each child reach critical developmental milestones.

In FY 2009-10, 96.0% of children screened received an ICP. The difference between the number screened and the number of ICP's developed is explained in three ways. First, because this is a new project, it took a few months to achieve full implementation in which all staff was trained to utilize the ICP. Second, children screened during the last week of June will not have an ICP counted in this FY because it takes up to a week to fully complete an ICP. Third, children may enter PCC and receive a screening but be discharged (within two business days) before an ICP has been completed.

The ICP is a living document that is updated throughout a child's inclusion in the CWS DSEP Project (see Exhibit 7.3 for sample ICP). Social workers use it to help overcome potential barriers related to service access such as foster parent/caregiver's refusal to cooperate with recommended services; consent; reporting to the court; and, efforts made to bridge to the biological parents as needed. Social workers are instructed to use the document to update developmental information in reports to the Court. In addition, Public Health Nurses enter the information into the Child's Health and Education Passport.

Exhibit 7.3 Sample ICP



Individual Care Plan (ICP)

Child's Name:		Date of ICP:
Current Age:	DOB:	Update date:
Screening Results: No Concern Concern		Screening date:

Recommended Activities
- Motor
  - •
  - •
- Language
  - •
  - •
- Cognitive
  - •
  - •
- Behavior
  - •
  - •

Psychologist Evaluation Results — Evaluation Date:

Areas of concern:

1. 2. 3. 4.

Recommended Services: — Date:

1. Notes:
2. Notes:
3. Notes:

DSEP Case Manager's Signature — Date — Recipient's Signature — Date

The Value of Training to Social Workers and Polinsky Center Staff

The CWS Projects' focus on improved Professional Development Training services is a critical element for ensuring program improvement. Telephone interviews were completed by Harder+Company staff with PCC staff (4 cottage staff and 2 cottage staff supervisors) and CWS social workers (6 social workers and 2 social worker supervisors) to understand the value and benefit of DSEP trainings and ICP implementation. The results show positive feedback in regards to the trainings as well as the implementation of the ICP and are summarized below.

What is the value and benefit to participating in the DSEP trainings?

All interviewees reported that their knowledge of basic child development increased because of the trainings. They reported that the trainings were valuable in enhancing staff expertise and knowledge of early childhood development, particularly the detailed information on children ages 0-5 and their developmental milestones. As one social worker reported, "I am able to more quickly identify age appropriate developmental levels of children and discuss these stages with their parents." Many staff reported trainings to be a great refresher course, identifying child and family support resources and service providers.

The DSEP trainings stressed the importance of treatment services for young children and provided information on available early care services. Supervisors reported that their staff are now more in-tune with children's needs. Social Workers now provide more detailed information to caregivers on how to work with children with developmental needs, including recommending specific activities and exercises. There is more accountability by staff to use the recommended activities in the ICP and to inform and help the caregivers implement these activities. As one social worker supervisor stated, "Especially when working with the caregivers, my staff are more likely now to pay particular attention to whether or not parents are actually getting their children into services. There is more follow-up with caregivers and more of a push to get caregivers involved in the process and aware of their child's needs. There is an increase in staff who provide caregivers with referral information and stress the importance of getting their children into the needed services."

What is the value of the implementation of the ICP?

All interviewees reported that they were familiar with the ICP and use the document as children enter and are screened at PCC. All interviewees reported that the activities recommended in the ICP are useful for engaging caregivers in developmentally appropriate activities with their children. "The ICP provides, at a quick glance, a synopsis of the child's behavioral and developmental state. Particularly, during home visits, I use this document to be able to determine whether or not the child is improving, staying the same, or decreasing in certain areas. I can then gauge my conversations and provide caregivers with some helpful tips." Interviewees reported two key barriers to fully utilizing the ICP's. First, is that the implementation of ICP's has increased demand for services which has resulted in wait lists for needed services. Secondly, some caregivers are reluctant to follow through on ICP recommendations. As one social worker supervisor noted, "My staff can follow-up but in the end, the caregiver has to make it happen. There are transportation barriers for some of our caregivers, other childcare constraints, etc. I recommend offering foster parent meetings/support groups to inform these parents of why the social workers are asking and pushing the services onto the parents."

Improved Child Development

Are children in placement receiving the appropriate and timely developmental services determined by their ICP?

As previously stated, only process numbers are being reported for FY 2009-10 because the projects are in the early phase of implementation. Outcomes for the "Improved Child Development" and "Improved Family Functioning" elements will be reported in subsequent years.

In FY 2009-10, a total of 1,004 children 0-5 years were screened (70 were birth-3 months). Of the children screened, 524 (52.5%) showed concerns. All 524 children received case management with 85.0% of these children linked to a service when appropriate. In addition to case management, 36 children also received a behavioral intervention. These children were identified with more severe social/emotional and/or behavioral concerns. These behavioral services are very narrowly focused including techniques to enhance secure attachment, self-regulation, and caregiver attunement and nurturing. In addition to the behavioral services provided at PCC, DSEP's Behavioral Specialist provided in-home interventions to families or referred children to needed services.

Exhibit 7.4 Children 0-5 years Receiving Screening, Intervention or Coaching

Service	
Screenings Conducted*	1,004
Of Children Screened, number identified with Concerns	524
Early Identification/Case Management received	524
Behavioral Intervention	36

**Includes 934 children who received an HDS developmental and/or behavioral screening plus 70 children who received DSEP 0-3 month screenings.*

Of note is the special attention DSEP gave to implementing a new clinical assessment protocol for infants ages birth to three months. Prior to this project, assessments were only provided to children ages 3 months or older. Young infants are difficult to assess because they have a more limited capacity to respond and the instruments available lack specific cut-points. However, early identification can make a world of difference to these young children. In FY 2009-10, 16 children under 3 months of age (22.9%) were identified as needing further evaluation and possible treatment. Without the funding to provide screening for infants, the needs of these children most likely would not have been identified until a later age.

Are children in placement receiving early care and education services?

Research shows that a quality early care and education experience can improve a child's chances of entering school ready to succeed. Through this project, all children screened are assessed for referral to specific early childhood education services. Of the 339 children identified as having a need for a referral, 23.0% were actively enrolled in early care and education services. The remaining 77.0% of children were referred out and were awaiting enrollment due to the following reasons: caregiver refusal, child was ineligible, similar service was already being utilized, or the child was already in the process of enrollment.

Exhibit 7.5 Children (0-5 years) Receiving Early Care and Education (ECE) Services

Service	
Children Identified as having a need for a referral to ECE	339
Children Referred to and Awaiting Enrollment into ECE Services	261
Children Enrolled in ECE Services	78

Improved Family Functioning

Are caregivers, including teen parents, receiving support services?

DSEP Early Childhood Specialists provide caregivers with support to maintain child placements and assistance in supporting the developmental recommendations in the child's ICP. During FY 2009-10, 142 caregivers and biological parents received coaching regarding how to implement the ICP recommendations and any behavioral interventions needed. DSEP case managers indicated that some caregivers offered the following reasons for refusing coaching: not enough time to participate (e.g., work full-time), feel coaching is not needed either for themselves or the child, or child was already involved in similar services.

Exhibit 7.6 Caregivers Receiving DSEP Intervention or Coaching

Service	
Number of Families Served by DSEP	432
Number of Caregivers and Biological Parents Receiving Coaching	142
Number of Teen Parents who Received Coaching	12

DSEP Developmental Specialists also provide parent education services to teen parents at PCC and other placement settings. In FY 2009-10, 12 teen parents received expanded support services while at PCC; such as child development education and modeling of developmental play activities. Seven teen parents were referred to community-based services with First 5 Healthy Development Services (HDS). PCC managers arranged for teen moms to receive an education credit for these sessions so they could participate during school hours.

Foster Care Respite

Background

Foster Care Respite seeks to offer support to reduce stress for foster parents and kinship caregivers by providing respite care. Through this program, caregivers of foster children can attend trainings, appointments, and other personal obligations while their children receive professional care. In FY 2009-10, 527 foster children age birth-5 years and 243 parents caring for these children were served by CWS Respite.

CWS Respite conducted a survey via the telephone in May of 2010 with 101 recipients of CWS Respite services. The aim of the survey was to assess the impact of respite services on foster parents and caregivers who care for children ages 0 to 5. Results of the survey are reported below.

Respondent Characteristics

- Most survey respondents (70.0%) reported receiving respite services from County Child Welfare Services for one year or longer.
- Eight out of 10 respondents (81.0%) had one or two foster children under age six enrolled in respite care services with the remaining two families having between 3 to 5 children under age six in respite care.

Amount of Services Received

- 91.0% of respondents reported receiving approximately 24.3 hours of respite services each quarter (range 10-25 hours). However, 77.0% of respondents did not find this amount of time for respite services to be adequate and desired to have an average of 52.55 hours per quarter (range was 25- 150 hours).

Impact of Services on Family Functioning

- 88.0% of respondents reported a decrease in the amount of stress they were feeling after receiving respite care services.
- 92.0% reported feeling less overwhelmed after receiving respite care services.
- If respite care services were to end, 62% of respondents would feel extremely stressed.
- Over half of respondents (62%) reported an improvement in relationships with the children under their care after receiving respite care services.
- Since receiving respite care services, three out of four respondents (73%) reported that their foster care child(ren) had not been placed in another foster care or institutional care.
- Three out of four respondents (72%) reported that respite care services had assisted in maintaining child placement in their home.

Making the Connection

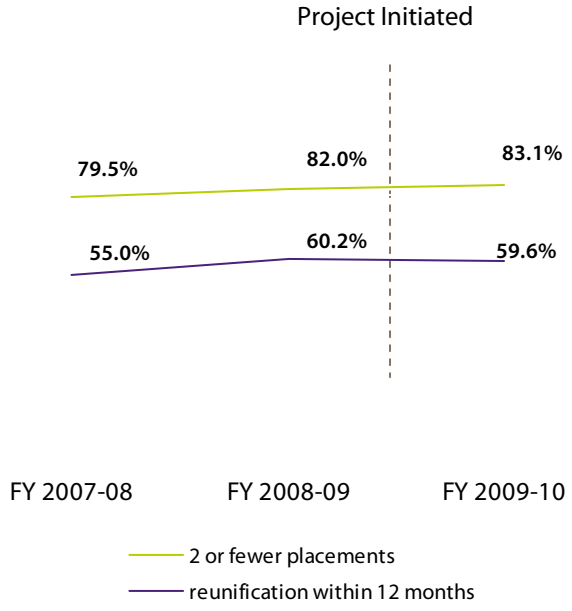
"These services support the CWS Mission of protecting children and preserving families."
– CWS Supervisor

These three CWS projects represent First 5 San Diego's significant investment in the well being of San Diego's most vulnerable children. During the current economic recession, this investment was more important than ever because the State cut $80,000,000 from the Child Welfare budget statewide. The funding from First 5 San Diego enabled the County to leverage an estimated $358,000 in federal funds (a 32% match from Title IV-E) to serve the youngest in the child welfare system.

With the creation of these projects, DSEP has worked closely with other providers to ensure that critical services are being coordinated to meet the developmental needs of young foster children and families. More specifically, DSEP has organized planning meetings with other community providers, defined roles and gaps, and established a cross-referral protocol. DSEP began producing and distributing a bi-monthly newsletter that is shared with social worker staff in all regions and provides regular reminders to workers about the importance of young children's developmental needs and the availability of DSEP services. In addition, DSEP has established a DSEP Liaison in each region to facilitate communication with regional social workers and provide expertise on regional community resources.

More importantly, at a macro level, these CWS foster care projects are intended to impact the placement and stability rates for San Diego's young children in out-of-home placement. Research shows that multiple foster care placements can have a deep and detrimental effect on children's social-emotional development as well as their bonding and attachment to caregivers. DSEP Early Childhood Specialists provide caregivers with support needed to maintain child placements and assistance in supporting the developmental recommendations in each child's ICP.

Exhibit 7.7 Placement and Stability Trends, Baseline



At the initiation of this project in FY 2009-10, baseline data show that 59.6% of children ages 0-5 who were reunified did so within 12 months of removal (see Exhibit 7.7). In addition, 83.1% of children ages 0-5 who were in care for less than 12 months had two or fewer out-of-home placements. These numbers exceeded the FY 2009-10 target goals of 58.0% for reunification within one year and 83.0% for two or fewer placements and closely match national (75.2% and 86.0%) and California statewide (67.6% and 85.5%) percentages.

Future evaluation years will track the progress of placement and reunification trends to provide suggestive evidence of the impact of this project.

Recommendations

The following recommendations were developed based on FY 2009-10 data and evaluation findings.

- **Explore reasons for and ways to increase quality improvement in the child care setting.** Based on the results of the Arnett Caregiver Interaction Scale (CIS), DSEP plans to follow-up and target PCC for further staff trainings that address the recommendations of the external rater.
- **Increase caregiver participation in the coaching services offered through these programs and follow-up on identified child needs.** DSEP is developing a curricula for foster parent groups that will continue to educate parents on the importance of following up on the needs and recommendations identified in the ICP. In FY 2010-11, DSEP and CWS will also discuss the potential of using incentives or other means to encourage caregivers to participate in follow-up appointments.

The Story of "Sophie"

"Sophie"* entered the Polinsky Children's Center due to allegations of physical abuse, severe neglect, and child endangerment in her home. Sophie is 3 years old and is the second oldest of four siblings. Upon entry, Sophie was screened and found to be suspect for developmental delays. She was then referred for a full developmental evaluation that was conducted by a psychologist from Rady Children's Hospital Developmental Evaluation Clinic. The outcome of the evaluation indicated that Sophie was substantially delayed (within the developmentally disabled range).

Based on the results of the evaluation, Sophie was referred for speech and language services at the San Diego Regional Center. Concurrently, throughout her first few days at Polinsky Children's Center, Sophie demonstrated behaviors that were difficult for the residential childcare staff to manage. She attempted to injure herself, was non-verbal, and destroyed physical property. To address these negative behaviors, Developmental and Behavioral Specialist services were immediately initiated and an ICP, based on her developmental level and individual needs, was created to provide her caregivers with the tools, activities, and recommended services that would be needed to promote Sophie's development and well-being. The recommended services included: an individual intervention with developmental enrichment activities; intervention within a larger group setting; facilitated sibling visitation; and daily communication and collaborative exploration with childcare staff regarding Sophie's individual needs. Sophie received these services throughout her 20 day stay at Polinsky, and the ICP was regularly updated to reflect progress toward goals. She was then discharged to a licensed foster home with her younger sister.

A transitional home visit was arranged between the Developmental Specialist and Sophie's foster mother and conducted three days after discharge from Polinsky. At this point, the foster mother was provided with the ICP for both siblings and DSEP's packet of community resources available to foster parents and information about child development.

Through the culmination of DSEP services and the consistent, nurturing care of primary caregivers, Sophie has and will continue to make substantial developmental and behavioral progress. She no longer exhibits self-injurious behavior or physical property destruction, is communicating through several signs and a few words, has increased self-regulatory and self soothing capacities, has enhanced pro-social abilities, and has established a connection and ability to seek comfort and reassurance from her primary caregivers. DSEP will continue to monitor Sophie's progress by re-screening her every 6 months. In sum, Sophie's case exemplifies the poignant and powerful potential impact of DSEP services at Polinsky.

* Names have been changed to protect confidentiality.

Horn of Africa - Families Together Program

Horn of Africa (HOA) is a non-profit community-based organization in San Diego that primarily serves East African immigrants and refugees. First 5 San Diego provides partial funding of their Families Together Program (FTP). The FTP program design follows the evidence-based Healthy Families America (HFA) model. FTP staff members work with pregnant women and their families to ensure that their infants and children have appropriate healthcare, education, and advocates that support them. The program focuses on East African families with children ages 0-5. A comprehensive assessment of the family is completed, and weekly home visits are provided to implement individualized care plans, and FTP ensures that children and mothers have a medical home and are linked to other needed services. FTP also supports positive parent-child interaction, bonding, and family well-being. Table 8.1 demonstrates the positive outcomes of the program for infants, children and families.

First 5 invested $109,940 in FTP in FY 2009-10 as part of a three year contract which began in FY 2008-09. With this investment, FTP enrolled 12 new families, which included 37 infants and children. When added to the number of continuing families, a total of approximately150 individuals (children and parents) were served in FY 2009-10.

Table 8.1 Horn of Africa Program Results

Results	FY 2009-10
Percent of infants linked to a medical provider within 3 months of enrollment	100.0%
Percent of parents linked to a medical provider within 3 months of service initiation	100.0%
Percent of children screened for developmental delays at regular intervals	100.0%
Percent of families who did not receive a CPS referral during participation	99.3%
Percent of families who showed improvement in parent-child interaction within 18 months of initiating services	90.0%

Kit for New Parents

The Kit for New Parents (Kit) has been an integral part of First 5 California and County Commissions such as the First 5 Commission of San Diego County since its inception in 2001. The Kit, which is offered to parents at no cost, contains books, DVDs, and other resources that provide information on parenting and children's development. In San Diego, the Kit is distributed by UCSD Regional Perinatal System's Welcome Baby Program, which enhances the Kit by including San Diego specific resources.

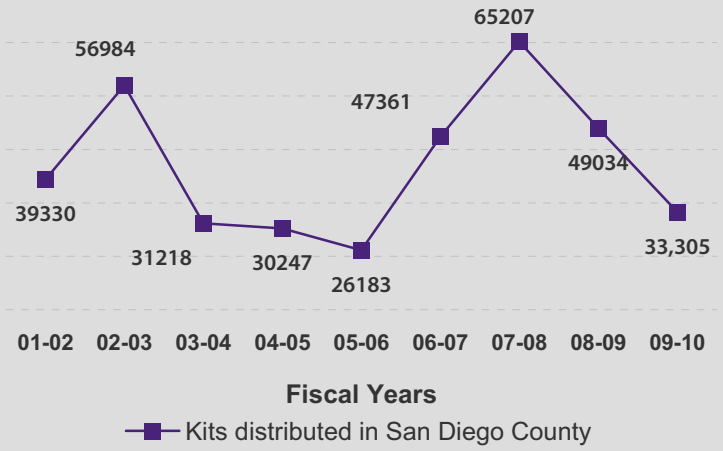
Table 9.1 Kits Distributed in San Diego County by Language in FY 2009-10

Language of Kit	Number of Kits	Percentage of Total Kits
English	20,621	61.3%
Spanish	11,958	35.5%
Vietnamese	321	1.0%
Mandarin	165	0.5%
Cantonese	129	0.4%
Korean	111	0.3%
Total	**33, 305**	**100.0%**

The total number of Kits distributed over the past five years of the program is displayed in Table 9.1. In FY 2007-08, the kits became available in DVD format, resulting in an overall increase in the number of kits distributed. The decrease noted for FY 2009-10 was due to contracting and funding delays at the State Commission which have been resolved. A newly revised version of the Kit is expected to be available from First 5 California in early 2011.

There has been growth in the number of languages in which it is offered. Originally only offered in English and Spanish, parents can now also receive Kits in Vietnamese, Mandarin, Cantonese, and Korean.

Table 9.2 Kits Distributed in San Diego County by Fiscal Year



San Diego Adolescent Pregnancy Prevention (SANDAPP)

San Diego Adolescent Pregnancy Prevention (SANDAPP) is a county-wide program operated by San Diego Unified School District since 1985. SANDAPP provides home-based case management, counseling and support services to pregnant and parenting youth throughout the county. The specific purpose of the SANDAPP program is, "to enhance the health, educational potential, and healthy relationships of pregnant and parenting adolescents, their children, siblings, and parents by promoting a collaborative, integrated support system." FY 2009-2010 was the first year of First 5's investment in SANDAPP, a total of $720,000.

In FY 2009-10, SANDAPP served 424 pregnant or parenting teens with First 5 funds. (The program served additional teens with other funding sources). The key results of the program are identified in Table 10.1. Of particular note is that of those served, only one client had a repeat pregnancy (0.2%), compared to the national repeat teen pregnancy rate of 17.5%. SANDAPP also engaged with other First 5 San Diego programs, as they distributed Kits for New Parents, and referred clients to Healthy Development Services (HDS) and 211 San Diego.

While their first year outcomes are noteworthy, SANDAPP hopes to further their positive impact on youth in FY 2010-11. One goal is to increase the number of young families that are enrolled in and complete Parent Child Attunement/Interaction Therapy (PCAT/PCIT) services. The contractor noted that challenges in providing these services included possessing the appropriate staff to facilitate the sessions and the fact that the therapy is intensive and long-term.

Table 10.1 SANDAPP Key Results

Results	FY 2009-10
Percent of clients with repeat pregnancy	0.2%
Percent of clients who achieved individual education goals	100%
Percent of clients who developed an active pregnancy plan	100%
Percent of clients who received parenting skills education	100%

Community

Goal: Build each community's capacity to sustain healthy social relationships and support families and children.

Parent and Public Education
211 San Diego
Innovative and Capital Grants

First 5 San Diego

CHAPTER 8
Community, Innovative and Capitol Projects

The First 5 commission is dedicated to building the community's capacity to serve families and young children. The strategic plan objectives related to this goal include increasing the public's commitment to investing in services that support the healthy development of children 0 through 5 and increasing community capacity to identify, treat and support the needs of young children and pregnant women.

In FY2009-2010, First 5 invested in a comprehensive media campaign to educate the public about the First 5 programs and services, supported San Diego 211 information and referral line, and invested in a range of innovative and capital projects. These programs and investments are summarized below.

First 5 San Diego Parent and Public Education Campaign

In FY 2007-08 the Commission contracted with MJE Marketing Services, Inc. (MJE) to develop and implement a strategic communications plan for First 5 San Diego. The communications plan, developed in collaboration with staff, and approved by the Commission in May 2008, was designed to increase awareness of the importance of children's early development, educate parents, and increase awareness of Commission-funded services and programs available to children and families.

Phase 1 of the First 5 San Diego "Good Start" campaign was conducted from August 2009 to November 2009, with a focus on healthy development checkups and the Commission's Healthy Development Services (HDS) Initiative. Phase 2 of the campaign ran from November 2009 to May 2010, and continued with the same focus and key messages stressing the importance of a child's first five years of life, the critical role of parents and other early care providers in a child's life, and the services offered to children ages 0 through 5 and their families by First 5 San Diego.

MJE reported the following accomplishments for Phase 2 of the Good Start campaign:

- Approximately 75,000 newly designed developmental pocket guides were distributed to young parents in San Diego.
- Leveraged $4.85 dollars for every $1 spent on broadcast media by negotiating $1.2 million dollars in bonus media.

The returns on the media investments include the following:

- Website visits to the First 5 San Diego website increased 95% from a low of 6,400 to a high of 12,500 per month.
- Achieved more than 414 million gross impressions at a cost of less than one-tenth of a cent per impression. (Gross impressions are the number of times elements from the campaign were seen.)
- First 5 San Diego warm line calls (1-888-5 FIRST 5) calls increased 161% from 144 per month to 376 per month.
- Referrals to First 5 San Diego programs and services increased 120% from 92 per month to 203 per month.

2-1-1 San Diego

211 is the free national dialing code for information about community, health and disaster services. Locally, 211 San Diego provides live information and referral specialists who offer personalized information to callers seeking services in San Diego County. The First 5 "Warm Line" (1-888-5-First5) was established within the 211 network in early FY 2008-09 in conjunction with the launch of First San Diego's initial public education campaign. The Warm Line is promoted through various media and outreach activities as the number to call for information about and referral to First 5 services.

In FY 2009-2010 First 5 San Diego invested $1,040,000 for 211 San Diego operations and Warm Line enhancements, and an additional $529,452 for capacity building and systems improvements.

Exhibit 12.1 211 San Diego Callers and Referrals by Year*

	FY 07/08	FY 08-09	FY 09-10
Total 0 - 5 Calls	19,980	26,866	37,385
Total Referrals provided to 0-5 callers	33,206	48,080	70,349
Total Referrals to First 5 programs	539	2,384	2,166

During FY 2009-10, 211 San Diego answered a total of 186,097 calls, which was a 13% increase from the previous year. Twenty percent of those calls were from families with children 0-5, which resulted in 2,166 referrals to First 5 San Diego programs. Although the number of calls from families with children 0 to 5 increased in FY 2009-10, increases in call wait times and abandonment rates raised concerns about how effectively families were able to access services through 211. This led to the Commission's restructuring of the contract payment methodology with a focus on improved customer service.

Improving Services

211 San Diego faced challenges in FY 2009-10 with increased call volume, the H1N1 outbreak and staff vacancies. To address these challenges, 211 took the follow steps to improve its processes: all phone center staff members were re-trained on the First 5 warm line protocols and procedures; 211 held numerous trainings on the distinctions among the various First 5 San Diego programs; and 211 trained all call specialists on protocol to reduce their call talk times, while still providing quality service. In addition, a Quality Assurance Coordinator reviewed calls daily to check the appropriateness of referrals and the accuracy of information distributed. These efforts seem to be successful, as abandonment rates on the Warm Line dropped 12% from March to June, and wait time on the Warm Line decreased by an average of 2 minutes from March to June. 211 is poised to continue these efforts to provide quality information and referral services in FY 2010-11.

**Note: The FY 07-08 data has been revised since FY 07-08's Annual Evaluation Report to address inconsistencies in data reporting.*

Table 13.1 Innovative Projects			
Grantee/Program	**Children Served**	**Adults/ Families Served**	**Description of Project/Services**
Alliance for African Assistance *Parent Play Group for Burmese Refugees*	124	96	Provide school readiness playgroups for Burmese refugee parents and children.
Hearts and Hands Working Together *High Conflict Diversion Program (Spanish)*	Parents Served 167		A 12-week class for parents to reduce tension in high conflict divorces and custody battles. These conflicts often have profound effects on young children.
Jewish Family Service of San Diego *Preschool in the Park (PIP)*	50	38	Parenting instruction, community-based early learning preparation, medical access and play for children ages 1-5 and their parents.
Nile Sisters Development Initiative *Circle One Literacy*	130	104	Training for first generation college students from SDSU to provide home-based tutoring services to refugee families with children birth to 5 living in Central San Diego.
Resounding Joy *Sound Minds: An Early Intervention Music Program for Children and Teenage Parents*	Families Served 1,205		Builds attachment between teen mothers and their babies through the use of music therapy.
REINS Occupational and Physical Therapy Program	80	74	REINS (Riding Emphasizing Individual Needs and Strengths) Therapeutic Horsemanship Program provides physical and emotional therapy to disabled children and adults through supervised horseback riding. The riding instructors received additional training by the occupational and physical therapists to improve the therapeutic aspects of their riding lessons.
San Diego Symphony Orchestra Association Words and Music: Music and Words	Families Served 744		Conducts performances with ensemble orchestra (nine musicians) at venues located in geographically diverse locations, followed by a parent/caregiver workshop that offers activities to promote reading with children and to foster an interest in using music as a tool to promote school-readiness.
Vista Community Clinic Dad to Dad Connection	Teen Parents Served 36		Provides outreach, parenting education, case management, and family activities designed to increase the involvement of young fathers in their children's health, development and school readiness.

Innovative Grants

First 5 San Diego supports innovative practices and new approaches or techniques that encourage the healthy development of children ages 0-5 and their families in San Diego County. Through one-year Innovative Grants for up to $75,000, the Commission enables organizations in the community to demonstrate unique approaches or expand successful strategies in different ways or to underserved populations. Table 13.1 describes the Innovative Grants that received funding during FY 2009-10 and all closed at the end of the year. The Innovative Grant program was suspended in FY 2008-09.

Capital and Equipment Projects

In FY 2004-05 the Commission approved a one-time expenditure of $60 million to invest in the physical infrastructure of programs that support children 0-5. The funds were released in three phases. In the first two phases applicants could request up to $12,000,000 to fund both construction and major and/or minor equipment. In the third phase, the maximum request was up to $50,000. A total of 47 projects were funded as a result of these funds. Listed are the projects that are still not completed. These were the active projects during FY 2009-10. All capital projects were completed except San Diego Public Library, St. Vincent de Paul, and the U.S. Department of the Navy. At the time of publication: the San Diego Public Library had 3 of 4 projects completed; the St. Vincent de Paul project is under construction; and the U.S. Department of the Navy completed 1 of 2 projects.

Table 13.1
Capital Project and Equipment Projects

Capital Improvements	Use of Funds
Cajon Valley Union School District	Toddler/preschool play structure at Kennedy Park. Project period: 4/1/08 - 3/31/11 FY 2009-2010 Investment: $50,000.
Chicano Federation of San Diego County, Inc.	Improve the current child development facility, which includes: building three enclosed classrooms, building an inside gym, remodeling the center's kitchen and replacing the existing carpet throughout the center. FY 2009-2010 Investment: $50,000. Project period: 10/15/08-10/14/09.
Grossmont Cuyamaca Community College District	Improve the playground at the Child Development Center. FY 2009-2010 Investment: $50,000. Project period: 5/1/08-4/30/10.
Rady Children's Hospital of San Diego	Improve the playground at the Oceanside Developmental Services Center (ODSC) and Children's Toddler School (CTS), and behavior treatment/observation rooms of the new Autism Discovery Institute (ADI). Project period: 4/1/08 - 11/30/10. FY 2009-2010 Investment: $47,186.
San Diego Public Library	Add a preschool area in four new libraries to promote school readiness. Project period: 11/30/04 - 11/29/12. FY 2009-10 Investment: $4,000,000.
San Diego Unified School District	Restructure, renovate, replace, and enhance the facility at Garfield Children's Center and at Rowan Children's Center. Also, update the playground at Garfield. FY 2009-2010 Investment: $1,024,508. Project period: 9/10/08-10/31/10.
St. Vincent de Paul / Father Joe's Villages	Construct a new facility to house St. Vincent de Paul Village's therapeutic childcare services. Project period: 5/20/05 - 11/19/12. FY 2009-2010 Investment: $6,968,025.
U.S. Department of the Navy, Navy Region Southwest	Construct two new Child Development Centers in the Murphy Canyon and Coronado Naval Air Station communities. Project period: 3/31/06 - 3/30/11. FY 2009-2010 Investment: $10,803,043.

*All capital projects are multiyear contracts with specific project length budgeting allowed.

Data and Methods Appendix: FY 2009-10

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 and program staff to broadly define objectives and indicators of success. Using this Framework as a road map, the Commission selects from the frameworks' indicators when developing new initiatives. These indicators are then refined by Harder+Company and the First 5 staff in the context of the particular initiative.

The following is a description of the methods used by each initiative. Each section also contains additional data elements that were not included in the report chapter for funded programs to use for program improvement efforts. Individuals desiring additional information about the evaluation's methodology are invited to contact Harder+Company Community Research directly at (619) 398-1980.

Initiative-Specific Data Collection Strategies

Each initiative has its own evaluation design, derived from the key goal areas listed in the Commission's 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 involves 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.

This Appendix summarizes the goals that guide the evaluation of each First 5 initiative, as well as the data sources and analytic approaches, when non-standard approaches were used, for each initiative.

Healthcare Access Initiative

Each Healthcare Access contractor engages in the same types of activities to achieve three goals:

1. Increase and sustain enrollment of eligible children ages 0-5 and pregnant women in existing health plans (Medi-Cal, Healthy Families, AIM);
2. Link enrollees to a medical home;
3. Support the appropriate utilization of services ensuring that children and pregnant women receive preventative health services and families get the help they need to navigate the healthcare system.

Methods

All contractors collect and report on the same process data and utilize the same follow up survey to collect outcomes data. All data is entered into and tracked by First 5's database known as the Contract Management and Evaluation Data System (CMEDS). Process numbers are reported quarterly by each contractor. Outcome data is designed to collect client enrollment and health utilization status. Exhibit A.1 provides an outline of the data collected in the quarterly reports and by the follow-up surveys.

Exhibit A.1 Healthcare Access Initiative Evaluation Table

Data Elements	Related Goal(s)	Method of Collection
Demographic Data		
Children ages 0-5: ethnicity, language, age, special needs	Goals 1-3	CMEDS Performance Measures
Process measures data		
Number of children 0 to 5 assisted and enrolled in Medi-Cal/Healthy Families	Goal 1	CMEDS Performance Measures
Number of children ages 0-5 assisted and enrolled in Medi-Cal/Healthy Families	Goal 1	
Number of pregnant women who are enrolled in Medi-Cal/AIM.	Goal 1	
Number of children ages 0-5 linked to a medical home	Goal 2	
Number of children ages 0-5 linked to a medical home	Goal 2	
Number of families reached through outreach and in-reach activities.	Goal 1	
Number of Welcome Baby Kits distributed to new parents.	Goal 3	
Number of children ages 0-5 assisted with reactivation and renewal of insurance enrollment	Goal 1	

Exhibit A.1 Healthcare Access Initiative Evaluation Table, continued

Data Elements	Related Goal(s)	Method of Collection
Outcomes data		
Increase health insurance enrollment of eligible children 0 to 5 and pregnant women	Goal 1	Survey Administered at 6, 12, and 18 month intervals
Increase the number of children 0 to 5 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	

Quarterly Reports

Each region utilizes CMEDS to enter their process numbers quarterly in what is referred to as Performance Measures. These measures track the number of assisted/confirmed enrollments, outreach activities, retention, etc., as well as the demographics of the population. Providers also provide narrative about their quarterly successes and challenges.

Outcome Follow-Up Survey

Contractors collectively developed a follow-up 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; and 5) utilization of the emergency room. The follow-up survey consists of 12 questions that were reformatted for CMEDS adaptation and translated into Spanish. The follow-up survey is conducted at six, 12, and 18 months after health insurance enrollment by the contractors' line staff during normally scheduled follow-up calls to families. In order to reduce the number of completed surveys but maintain a representative sample for evaluation, the survey is only collected during quarters 1 and 3 during the fiscal year. All six providers utilize CMEDS to enter survey responses at the client level.

The follow-up surveys for individual children are designed to be tracked and matched using unique identifier codes, automatically generated by CMEDS, rather than identifying information so that outcomes can be analyzed over time. Families that did not sign a consent form, could not be contacted by agencies during data collection, or were only contacted once by contractors were excluded from the analysis. The survey analysis includes a total of 1,309 children from three follow-ups:

- *Follow-up 6-12:* 1,085 children had completed matched surveys for 6 and 12 month follow-ups.
- *Follow-up 12-18:* 723 children had completed matched surveys for 12 and 18 month follow-ups.
- *Follow-up 6-12-18:* 499 children had completed matched surveys for 6, 12, and 18 month follow-ups.

Results only include Follow-up 6-12 and Follow-up 12-18 because these groups are larger than follow-up 6-12-18. This is due, in part, because many children have not been enrolled long enough to receive the 18-month follow-up survey. FY 2009-10 is the third year where outcomes are presented for matched cases. Only direct comparisons could be made to last year's (FY 2008-09) results.

Frequencies for retention, 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 clients were noted as being enrolled in a health insurance program at both time points. Similarly, frequencies for reasons for health care and dental care utilization were based on surveys where children had reportedly visited the doctor and/or dentist and where the questions had valid answers at both time points. Dental care utilization analysis excluded children less than 1 years of age that do not visit the dentist. Frequencies for reasons for emergency room utilization were based on all children who had reported visiting the emergency room at any time point. The same is true of frequencies of reasons that children were no longer enrolled.

Contractor Interviews

Six of the providers participated in phone interviews to provide their feedback about the HCA Initiative and their partnerships.

Line Staff On-Line Survey

Line staff provided their feedback through an on-line survey.

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 seven program areas:

1. Oral health screenings coupled with education for children ages 1-5 years and pregnant women in the clinical setting;
2. Dental examinations coupled with education for children ages 1-5 years and pregnant women;
3. Begin dental treatment plan for children ages 1-5 years and pregnant women and tertiary/specialty treatment for children ages 1-5 years;
4. Care coordination services for high risk children ages 1-5 years and pregnant women;
5. Oral health education for parents and caregivers of children ages 1-5 years, pregnant women, child care providers and staff at community-based organizations (CBOs) in the community setting;
6. Training for prenatal care providers, general dentists, primary care providers, and ancillary clinic staff; and
7. Oral health screenings coupled with education for children ages 1-5 years and pregnant women in the community setting.

Methods

All data is collected through First 5's database (CMEDS). Process and outcomes data are reported monthly by each contractor. Outcome data is collected through the Caries Risk Assessment (CRA) utilized by each agency for identifying high-risk children ages 1-5 years and pregnant women for care coordination. The following table (Exhibit A.2) summarizes the data collected, related goals and method of collection for the Oral Health Initiative.

Exhibit A.2 Oral Health Initiative Evaluation Table		
Data Elements	**Related Goal(s)**	**Method of Collection**
Demographic data		
Children ages 1-5 years: ethnicity, language, age, special needs; Pregnant women: ethnicity, language	Goals 1-4, 7	CMEDS
Process measures data		
Number of children ages 1-5 years and pregnant women who receive oral health screenings in the clinic setting	Goal 1	CMEDS
Number of children ages 1-5 years and pregnant women who receive dental exams	Goal 2	
Number of children ages 1-5 years who receive routine/specialty treatment	Goal 3	
Number of high-risk children ages 1-5 years and pregnant women who receive care coordination services	Goal 4	
Number of children ages 1-5 years and pregnant women who receive educational messages *	Goal 5	
Number of providers trained in relevant maternal & child oral health topics	Goal 6	
Number of screenings and type of preventive services (fluoride varnishes and sealants) delivered to children ages 1-5 years and pregnant women in community setting.	Goal 7	
Number and type of treatment and education services provided to children ages 1-5 years and pregnant women receiving care coordination.	Goal 4	
Number of children ages 1-5 years and pregnant women who receive oral health screenings in the community setting	Goal 7	
Outcomes data		
Identify previously unidentified oral health concerns in children ages 1-5 years and pregnant women	Goals 1-2, 7	CMEDS
Reduce the proportion of children ages 1-5 years and pregnant women with untreated dental decay	Goal 3	
Increase the proportion of children ages 1-5 years and pregnant women who have visited a dentist in the past year	Goal 3	
Connect children ages 1-5 years and pregnant women with needed oral health services (exams, treatment, etc.)	Goal 4	
Increase providers' knowledge of how to promote the oral health of children ages 1-5 years	Goal 6	

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

Monthly Reports

All of OHI's service areas, with the exception of care coordination, are expressed as a series of process measures and outcomes. Each month, OHI programs report these data elements in aggregate. Care coordination is the only area where client level outcome data is collected. The evaluation centers on understanding how many children ages 1-5 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 the education and trainings directed to oral health providers.[1]

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.[2] All programs then report their aggregated monthly data as well as their client level care coordination data in the CMEDS database.

Outcome Data

The Caries Risk Assessment (CRA) was designed to be completed on all clients at the time of their exam and care coordination was to be provided for those deemed "high risk" for dental disease. The CRA is a two pronged assessment composed of a patient interview followed by a clinical exam. FY 2009-10 is the second year where the results from the CRA were analyzed and reported as outcomes data for OHI. Clients were asked to consent for their CRA results to be included in the analysis; only CRA outcomes where consent was obtained were included in the analysis. Frequencies were conducted on each of the risk indicators, protective factors, and clinical exam questions.

Assessments

Aside from the CRA, additional assessments were created to better track services rendered. Treatment/ prevention and education/assistance assessments were completed for high risk clients. The treatment and education services provided to these clients were reported in aggregate. Frequencies were conducted for on the total number of services provided to clients. Services are not mutually exclusive; therefore, clients may receive more than one service.

Conference Evaluation

The 5th annual OHI conference took place in April 2010 and focused on oral health treatment for pregnant women. At the end of the conference, a total of 88 participants ranging from dentists, dental assistants and hygienists, doctors, health professionals, and management staff completed an evaluation survey of the conference.

Provider Survey

A total of 21 dental providers completed an online survey assessing their perspectives on treating pregnant women after attending the OHI sponsored training conference.

Qualitative Data Collection

Qualitative methods complement numeric data in the evaluation design: a telephone interview with the lead contractor. The findings of all of these methods are interwoven throughout the chapter.

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[1] "Providers" refers to prenatal care providers, general dentists, and other primary care providers.

[2] 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.

Healthy Development Services Initiative

The Healthy Development Services Initiative (HDS) is a comprehensive system of care with four key goals:

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

Methods

The evaluation relies upon quarterly progress reports (Performance Measures) of HDS contractors for demographic data and process data elements for each service category collected in the First 5 San Diego Contract Monitoring and Evaluation Data System (CMEDS). Outcome data is collected at the client level on all clients receiving core services.

Exhibit A.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	CMEDS Performance Measures
Process measures data	
Number of screenings	CMEDS Performance Measures
Households in which someone smokes	
Number of assessments and treatment units	
Number of parent education classes, workshops and home visits	CMEDS Client Records
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	
Average number and duration of treatment sessions	
Average wait times between screenings, assessment and treatment	
Child Outcomes	CMEDS Client Records
Breastfeeding at 6 weeks and 6 months	
Children identified as needing treatment who receive treatment	
Children receiving treatment who demonstrate gains related to the service received	
Parent Outcomes	
Increased knowledge of how to promote 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. The programs often 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.[3] Given the variety of instruments used, it would be a misrepresentation to collapse or compare data across agencies.

Data reported in the HDS chapter presents a comprehensive review of outcomes for the fiscal year; however, comparisons between service categories should be made with caution, as each service is unique in its service delivery, challenges, and capacity. FY 2008-09 was the first year that client-level outcome data analysis was possible for HDS, as a result of implementation of the First 5 San Diego Contract Monitoring and Evaluation Data System (CMEDS). In FY 2009-10, data collected at the individual client level was reported whenever possible as improved data quality enhanced the utilization of the data. Additionally, service areas continue to meet to discuss the standardization of outcome measures and potential data sharing across regions in FY 2010-11.

The method for collecting process data changed in FY 2009-10. Therefore, trend data from previous fiscal years are excluded when they are not comparable.

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;
- First 5 San Diego evaluation efforts to learn about the impact of the First 5 San Diego Preschool for All Demonstration Project at the eight San Diego Communities; and
- The SDCPFA Master Plan Evaluation to inform the update and expansion of the PFA.

Methods

All data included in the report was collected through CMEDS, the tracking tool used by the San Diego County Office of Education (SDCOE), interviews with agency directors, surveys completed by parents or teachers, and/or quarterly reports. Numerous data collection tools were used to collect the data. These are summarized in Exhibit A.4.

[3] 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. Standardized instruments have been put in place for FY 2010-11.

Exhibit A.4 Data Collection Tools	
Process Numbers	**Tool (if applicable)**
Number of agencies, sessions, slots, and children	SDCOE Database
Number of parent activities	SDCOE Database
Number of children receiving primary and secondary screenings	SDCOE Database, Parents Evaluation of Developmental Status (PEDS); Ages & Stages Questionnaire (ASQ); Acuscreen
Number of children with special needs and IEPs	SDCOE Database
Number of agencies providing Kindergarten transition activities	SDCOE Database
Outcome data	
Classroom quality scores and changes over time	Classroom quality was measured through the Early Childhood Environment Rating Scale – Revised Edition (ECERS-R), the Family Child Care Environment Rating Scale – Revised Edition (FCCERS-R), the Classroom Assessment Scoring System (CLASS), and the Program Administration Scale (PAS).
Children making developmental progress from Fall to Spring	Desired Results Developmental Profile – Revised (DRDP-R)
Parents demonstrating increased knowledge (confidence and competence) to promote child's optimal development and school readiness	First 5 Parent Survey
Parents engaged in activities	
Parents reporting satisfaction with PFA programs	
Parents perception of program communication and impact	
Teachers offering parents involvement opportunities	PFA Preschool Teacher Survey
Teachers ability and support to meet needs of students with special needs and English learners	
Teachers participating in professional development	
Teachers retention, experience, salary and education level	

Classroom Quality

The ECERS-R, FCCERS-R, CLASS, and PAS were used to evaluate site and session quality. The ECERS-R consists of 43 items and is reliable at the item, indicator, and scale level, with 86.1% agreement across all items. Additionally, there is a high level of inter-rater reliability (.921 Pearson correlation).[4] The FCCERS-R is a 38-item tool and is also reliable at the item, indicator and scale level with 88.4% agreement across all items.[5] The CLASS consists of 10 dimensions, and its scores are stable across time. Additionally, the tool has a high level of inter-rater reliability with 78.8% – 96.9% inter-rater agreement.[6] All three of these tools have scores ranging from 1 as low to 7 as high, and all are among the nationally recognized instruments designed to measure various aspects of classroom and child care site quality. Similarly, the PAS is a valid and reliable instrument that solely measures the administrative practices of an early childhood program.[7] It has scores ranging from 1 as low to 7 as high, and consists of 25 items.

Mean scores, by year, for each of these tools were reported for all sessions that received the review. The analysis of tier growth is based on the review tier, which is the tier level assigned based on the ECERS-R and FCCERS-R scores.

Child's Development

PFA uses the DRDP-R, the PEDS, and the ASQ or Acuscreen to assess a child's development. Providers administered the DRDP-R to all children in PFA programs in the fall and spring. The tier level analysis of the DRDP-R was completed based on the fund tier, which is a combination of the session's external review and the teacher's educational level. The DRDP-R consists of 39 questions and measures development in four domains: competency, learning, motor skills and safety and health. 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; and 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. The developmental progress of children from fall to spring was calculated by determining the point gain between pre and post mean scores which were ranked into four categories as regressed (children whose mean scores decreased from fall to spring), constant (children whose mean scores were the same at both fall and spring), 1 pt. gain (children whose mean scores increased 1 point from fall to spring, and 2 or more pt. gain (children whose mean scores increased 2 or more points from fall to spring).

[4] 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.

[5] 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.

[6] Hamre, Bridget, Karen M. La Paro, Robert C. Pianta. Classroom Assessment Scoring System Manual: Pre-K. Paul H. Brookes Publishing Co, Inc. Baltimore, 2008.

[7] Talan, Teri N, Paula Jorde Bloom. Program Administration Scale: Measuring Early Childhood Leadership and Management. Teachers College Press. New York, 2004.

Exhibit A.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

To further understand the impact of the PFA and School Readiness programs on the development of children, as measured by the DRDP-R, additional analysis was completed to control for the impact of children aging on DRDP-R scores. To accomplish this, DRDP-R data were pooled across years and standardized scores were calculated within 5 age groupings (based on age in weeks, in roughly equivalent age groupings). These data showed mean increases of 7 points or more in all domains between pre and post-test scores (standardized scores have an overall mean of 50 and a standard deviation of 10). Analysis of the pre and post-test paired scores were completed using a paired-samples t-test. The results showed significant gains in all four domains of the DRDP-R at $p<.001$, even after controlling for age. This analysis suggests that the gains achieved between the pre and post-test DRDP-R for children in PFA are not just the result of children aging, but also reflect program impact. [Note that the DRDP-R is used by the California Department of Education, but it is not a normed and validated instrument.]

The PEDS is used as a primary screening tool and is intended to be administered to all children. The ASQ and Acuscreen are secondary tools and administered to children if the PEDS indicates a need (with the exception of three providers who administered secondary screenings to all children). The PEDS and ASQ are recognized by the American Academy of Pediatrics as reliable and valid tools for children ages 0-5, and the Acuscreen fulfills First 5 San Diego's requirements of early childhood screening.[8] [9]

First 5 Parent Survey

The First 5 Parent Survey is comprised of two components: a modified "Survey of Parenting Practice" developed by the University of Idaho[10] and a modified "Desired Results for Children and Families-Parent Survey" developed by the California Department of Education.[11] The survey was slightly modified in FY 2009-10 to correspond with the Epstein parent involvement model so year to year comparison is not possible for all data but is presented when available. The response rate was approximately 72% (approximate because it is calculated based on the number of children as the number of parents is unknown).

[8] 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>.

[9] 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>.

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

[11] 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>

PFA Provider Teacher Survey

The PFA Provider Teacher Survey was distributed to Directors who then distributed the surveys to their lead teachers. The survey was slightly modified in FY 2009-10 to correspond with the Epstein parent involvement model so year to year comparison is not possible for all data but is presented when available. The response rate was 63.4%.

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 child development;
2. Improved family functioning;
3. Improved child health; and
4. Improved system of care.

Methods

The table below lists the indicators and data sources selected by First 5 San Diego's School Readiness Initiative Coordinators. For the FY 2009-10 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. In addition, contractors submitted quarterly progress reports to the Commission outlining numbers served, demographics, and narrative updates. All data is entered and tracked in CMEDS.

Exhibit A.6 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	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. For additional details on the DRDP-R analysis, please see the Preschool for All section.

The Ages and Stages Questionnaire (ASQ) has been identified as an appropriate tool for center-based interventions that can map to the DRDP-R. The ASQ system is composed of nineteen age-appropriate questionnaires and is designed to be completed by parents or primary caregivers.[12] 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 utilized the scientifically set cut-off scores for the ASQ's age-specific instrument, preserving the design of the tool.

Parent Retrospective Survey

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 districts except National and San Ysidro school district completed the Parent Retrospective Survey. National and San Ysidro were dually funded by SR and PFA; therefore data were collected and reported for PFA and not SR to avoid duplicating results. In FY 2009-10, 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.[13]

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.[14] 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.

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[12] 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>

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

[14] "Bonferroni." Simply Interactive Statistical Analysis. Quantitative Skills Consultancy for Research and Skills. Accessed 6 August 2007. http://home.clara.net/sisa/bonhlp.htm

SR Teacher Survey

The SR Teacher Survey was distributed to SR Coordinators who then distributed the surveys to their lead teachers.

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); and
3. Fostering healthier behaviors with proper nutrition and exercise (Service Focus Area 3).

Methods

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. All data is collected through First 5's database known as the Contract Management and Evaluation Data System (CMEDS). Process numbers are reported by each contractor and reported aggregately. Outcome data is collected through each agency's individualized surveys, which have common questions. These common questions are referred to as the Common Survey.

Exhibit A.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)	
Outcome measures data	
Common Survey : Includes knowledge outcomes (ex: how to promote child's cognitive development) and behavior outcomes (ex: exercise and healthy eating habits)	Pre-Post Test

Common Survey

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).

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. In FY 2007-08, 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 FY 2007-08. This fiscal year, the same outcomes were presented for comparability across years.

It is important to note the following:

- 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.
- Common Survey was revised at the end of FY 2006-07 to strengthen the design after several months of implementation. As a result, data is not available for all program years.
- The Common Survey is generally self-administered. However, 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.
- Valid percents are presented, and as a result, the total number of respondents varies by question.
- Attendance data was not available for analysis. Therefore, the evaluation team assumed that matched pre- and post-test surveys indicated that a participant completed the program.

Analysis of the Common Survey

To facilitate comparison of outcomes between years, 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 differences between programs, including parents' exposure to dissimilar curriculum content and varying service intensity and different follow-up periods, a discussion of trends between pre-test and post-test assessments in each fiscal year is more appropriate than presentation of statistical tests of significance. For some items, 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.

Some contractors have more than one program that parents may enroll in. As a result, some parents have more than one pre- and post-test with overlapping questions. This year, the implementation of CMEDS allowed duplicated cases to be identified. Duplicated matched cases were deleted this year whereas in previous years they were included.

Source of Indicators

SDF5 2005 Family Survey and California Health Interview (CHIS) County and State comparison data were presented in the report to provide context to the F5FP survey findings. The comparison data and survey questions have some variations which are discussed below in Exhibit A.7:

Exhibit A.8 Comparison of F5FP Common Survey Questions and Other Surveys

Topic	F5FP Common Survey	SDF5 2005 Family Survey	California Health Interview Survey
Reading	In a typical week, how many days do you read to your child?		In a usual week, about how many days do you or any other family members read stories or look at picture books with (CHILD)?
Stories/Songs	In a typical week, how many days do you tell your child stories/sing songs?	In a typical week, how often do you, other people in the household, or other family members not living in the household sing songs to this child?	In a usual week, about how many days do you or any other family members play music or sing songs with (CHILD)?
		In a typical week, how often do you, other people in the household, or other family members not living in the household tell stories to this child?	
Fast Food	In a typical WEEK, how often does your family eat the following meals out a fast food restaurants (for example, Mc Donalds, Wendy's, etc.), including take-out?		In the past 7 days, how many times did {you/he/she} eat fast food? Include fast food meals eaten at work {school}, at home, or at fast food restaurants, carryout or drive thru
Television, Video Game, and Computer Time	On a typical WEEKDAY (Monday – Friday), does your child watch television, play video games and/or spend time on the computer		Thinking about [your/CHILD's] free time on MONDAY THROUGH FRIDAY, on a typical day, about how many hours do you usually watch TV or play video games (such as Playstation)?

CWS Inititative

The CWS Projects' "System of Care" consists of the following key elements:

- Systems Change- Professional Development & Individual Care Plan (ICP) Implementation;
- Improved Child Development- Developmental Services;
- Improved Family Functioning- Caregiver Support Services; and
- Placement and Reunification Support Services.

Methods

Arnett Caregiver Interaction Scale

The Arnett Caregiver Interaction Scale (CIS) (Arnett, 1989) was used to measure caregiver-child interaction with 23 Polinsky Children's Center (PCC) cottage "core" staff. The CIS consists of 26 items that measure four dimensions of interaction: Sensitivity (meaning caregivers are using a positive tone of voice and giving encouragement and positive attention to children), Harshness (caregivers are accepting and use positive guidance techniques), Detachment (caregiver supervises children closely), and Permissiveness (caregiver has high but developmentally appropriate expectations for children). The Arnett Caregiver Interaction Scale uses a four-point likert scale (1= "not at all" to 4="very much"). The evaluator, Dr. Sascha Mitchell, PhD, conducted an hour and a half classroom observation for each of the 23 caregivers from two early childhood classrooms from March through May 2010. In order to more accurately and objectively assess the four dimensions of interaction, specific indicators are used to describe these dimensions (e.g., Sensitivity= Encouraging, Harshness= Acceptance, Detachment= Appreciation, and Permissiveness= Appropriate Expectations). Over the next two years, the CIS will be administered 3 additional times at 6-month intervals to determine the impact of services delivered by DSEP.


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