First 5 Commission of San Diego

Annual Evaluation Report FY 2010–2011

Improving the Lives of Children 0–5

January 2012

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 communitydevelopment 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

The evaluation of the process and impact of the First 5 program activities is an effort that requires the cooperation and work of hundreds of individuals and agencies all year long, from contract development and evaluation planning to daily data collection and reporting, discussions and agreements regarding evaluation data are integrated into all First 5 program operations. This on-going collection and reporting of evaluation data is required to provide the First 5 Commission with the most current and accurate information for their monitoring of program services and outcomes.

The First 5 evaluation team at Harder + Company Community Research is grateful to all of the children and families who participated in evaluation activities, all contractors and evaluation staff who collected and entered data, and the program managers and First 5 staff who helped to oversee the collection of evaluation data presented in this report. In addition, we 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 improving the health and well-being of children ages 0-5 and their families: Supervisor Pam Slater-Price (Chair), Carol Skiljan (Vice-Chair), Nick Macchione, Sandra McBrayer and Dr. Wilma J. Wooten, M.D.

- The First 5 San Diego staff who provided critical leadership and collaboration with the evaluation team: Barbara Jimenez (Executive Director), Dr. Lynn Eldred (Program and Evaluation Manager), Grace Young (Contracts and School Readiness Program Manager), Eve Leon-Torres, Randall Marks, Nancy Page, Troy Rippengale, Steven Smith and the rest of the First 5 staff who support the Commission.

- All of the First 5 contractors and evaluation staff who collect and enter program data for the evaluation.

- The CMEDS team members at Persimmony International, Harder + Company and First 5 San Diego for their management of the Commission's contract and evaluation database.

TABLE OF CONTENTS

Executive Summary

The first five years of life are critical for healthy brain development and social emotional well-being. Early childhood experiences have a vital impact on the development of a child's brain. Recent research studies have demonstrated the importance of providing stimulation, nurture, and nutrients to young children to foster healthy brain development and allow them to grow and develop to their potential.[1] Nobel economist James Heckman has found that early interventions that focus on cognitive ability, socio-emotional skills, physical and mental health, perseverance, attention, motivation and self-confidence have a high cost benefit ratio and can produce a rate of return of between 6-10% annually. The largest return on investment is produced in the first three years, followed by ages four and five. Delaying interventions until later in life will increase service costs.[2]

This is why First 5 San Diego invests in projects that support the health, developmental, behavioral and educational needs of San Diego County's children, ages 0 through 5, and their families. Through 55 contracts with nonprofit and governmental agencies totaling over $61 million in FY 2010-11, First 5 San Diego provides child and family-centered services in all regions of the county. In line with its strategic plan, First 5 San Diego has knit a comprehensive network of health, learning, family involvement and community awareness services with the goal of producing generations of healthy, nurtured children who are ready to succeed.

This evaluation report summarizes the findings of the Commission's larger-scale initiatives and special projects for Fiscal Year 2010-11. The data for this report are collected and reported by 142 active contractors and subcontractors and analyzed by Harder+Company Community Research. The Commission's robust evaluation design springs from the outcomes and indicators of its five-year strategic plan and operationalized into 817 different performance measures and 114 different client assessments collected among 164 different services. In all, data on 233,372 client records were analyzed for this report.[3]

First 5 San Diego's Vision and Mission

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.

Fiscal Investment

During Fiscal Year 2010-11, First 5 San Diego invested a total of $61,653,380 in direct client services, parent and public education, as well as support for systems of care and capital projects. First 5 San Diego projects also leveraged an additional $9,238,963. In addition to its vital impact on children, the First 5 investment in services for children in San Diego provide employment to thousands of residents and support for the non-profit organizations that serve vulnerable families. The comprehensive impact of these investments on the community is significant, though challenging to measure. Going forward, the Commission has had to reduce its investments in community projects. This reduction was triggered by recent State legislation that could reduce First 5 San Diego assets by over $88 million.[4]

First 5 San Diego Investments

Amount Invested in FY 2010-11: $61,653,380

Number of Contracts: 55

Organizations Providing Funded Services: 31

Funds Leveraged: $9,238,963

[1] Hawley, T. "Starting Smart: How Early Childhood Experiences Affect the Brain." Ounce of Prevention Fund and Zero to Three. 2000.

[2] Heckman, James J. & Masterove, D. *The Productivity Argument for Investing in Young Children*, University of Chicago. From www.ced.org/docs/report/ report_ivk_heckman_2004.pdf.

[3] The number of client records is represents the total of unique client records by service area. It is not the number of unique / unduplicated individuals served by First 5 San Diego programs. (See Exhibit A.1.)

Initiative Goals and Impact

During this fiscal year, First 5 San Diego funded seven major initiatives – Healthy Development Services (HDS), Healthcare Access (HCA), Oral Health (OHI), KidSTART, Preschool for All (PFA), School Readiness (SR), and Child Welfare Services (CWS). It was the first year for KidSTART and the concluding year for SR. In addition, the Commission continued its support of a variety of special and capital projects. A summary of key findings for each of the initiatives is presented below and a detailed summary of findings is presented in each chapter. In addition to the analysis of the service delivery and outcome 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 progress on selected outcomes, relative to targets, for each initiative.

Exhibit A.1 Goals, Initiatives and Impact

First 5 Strategic Goal Area	Initiative/ Program	Clients Served
ALL	All Initiatives	61,407 Children 21,819 Parents/Caregivers 3,710 Providers 86,936 Total
HEALTH	Healthy Development Services (HDS)	24,061 Children 12,324 Parents 1,576 Providers
	Oral Health Initiative (OHI)	26,440 Children 4,383 Pregnant Women 1,755 Providers
	Healthcare Access (HCA)	14,296 Children 3,913 Pregnant Women
	KidSTART	381 Children
LEARNING	Preschool for All (PFA)	6,942 Children 1,088 Parents 41 Providers
	School Readiness (SR)	4,567 Children 1,049 Parents
FAMILY	Child Welfare Services (CWS)	1,059 Children 745 Families
COMMUNITY	Text4 Baby	1,739 Pregnant Women
	211 San Diego	39,742 Families

Note: Data on children and parents served are unduplicated service counts based on client-level data in CMEDS; the Commission's database. "Parents" includes any type of guardian or caregiver. Data on providers are not client-level and, therefore, may be duplicated counts of providers if multiple trainings were attended by the same provider.

Clients Served

Exhibit A.1 summarizes the total number of clients served by all initiatives and a few key community projects. First 5 initiatives provided critical health, education, developmental, behavioral and parenting services to more than 61,000 children and nearly 22,000 parents and caregivers in FY 2010-11. In addition, more than 3,700 health care, education, dental care and human service providers received professional development support through First 5 funding, for a total of 86,936 individuals served. These data highlight the broad scope and reach of the First 5 programs.

[4] In March of 2011, the Legislature passed AB99, which would allow State government to capture half of the Commission's fund balance as of June 2010. At the time of publication, this legislation had been overturned by the courts, but it remained uncertain whether there would be further litigation.

The following highlights the key results of the First 5 programs in each of the strategic goal areas by initiative in Fiscal Year 2010-11.

Health

First 5 San Diego addresses the health needs of children through four major initiatives: Healthy Development Services (HDS), Oral Health Initiative (OHI), Health Care Access (HCA), and KidSTART.

Healthy Development Services (HDS)

Supporting a child's early development and identifying potential problems early can help parents, early education providers and health professionals minimize long-term effects that may drastically alter the course of that child's life. Early interventions for children identified with developmental delays or social-emotional challenges are optimal for the child, most cost-effective for the health and education systems, and make a lifelong difference for the individual. The cumulative cost of special education services is 30% if intervention begins when a child is young, rather than waiting until he or she is school age to provide services. The First 5 Commission of San Diego launched the Healthy Development Services Initiative (HDS) to promote children's optimal development and learning by improving access to developmental and behavioral services so that problems that impact children's learning are prevented, identified and addressed as early as possible. These are the key accomplishments of HDS in FY 2010-11:

- HDS is the most far-reaching initiative. In FY 2010-11, HDS provided 24,061 children with developmental, behavioral, vision and hearing services, and/or care coordination services. A total of 12,324 parents were provided with parent education, support and empowerment services.
- 5,212 children were screened for developmental concerns and 1,920 received developmental or speech treatment. After treatment, these children made significant gains in key domains: cognitive, receptive and expressive language, gross and fine motor skills, and social-emotional development.
- 5,654 children were screened for behavioral concerns and 1,557 received behavioral treatment, improving their readiness to succeed in school.
- Parents of children receiving HDS services met or made progress on 73.1% of home activity goals, which support the developmental needs of their children. Parental involvement in treatment is essential to helping a child make developmental and behavioral gains.
- Children whose early care education (ECE) providers were receiving HDS behavioral services strengthened their "protective factors" (such as self-control and bonding with their caregiver) and reduced behavioral concerns (such as aggression and lack of focus).
- HDS provided support to early childhood educators who face behavioral challenges in their care centers and classrooms. 883 ECE staff attended classes on social-emotional topics and 638 received consulting services on individual children. In addition, 76 staff members received up to 30 hours of intensive consulting services. These providers significantly improved in three of four key areas focusing on child interaction.
- Children whose families received care coordination services were more likely to initiate the services they were referred to within HDS in a timely manner than all children receiving HDS services.

HDS remains a flagship program of the First 5 Commission, delivering critical developmental services across a network of integrated providers.

Oral Health Initiative (OHI)

Children with untreated dental disease require more extensive and expensive care, where early detection can prevent more costly future treatment and improve a child's oral health and overall quality of life. Dental treatment is also critical for pregnant women, as untreated dental disease increases the risk of preterm deliveries, low birth weight babies, and the transmission of infectious oral bacteria between mother and child.

There is a strong economic case for investing in oral health:

- The Fiscal Impact Project commissioned by First 5 San Diego in 2009 found that the return on investment of OHI was close to five dollars for every dollar of funding spent.[5]
- Children who have their first dental visit by age one average almost 40.0% less in dental costs over five years.[6]
- Prevention interventions (sealants and fluoride) can save $66-$73 per tooth over filling caries.[7]
- Regular screenings and early interventions can save 7.3%.[8]
- Children whose mothers have poor oral health are five times more likely to have oral health problems as well.[9]

The Oral Health Initiative provides needed dental services to qualifying children ages 0 through 5 and pregnant women. Overall, 26,440 children, 4,383 pregnant women and 1,755 providers received OHI services. These are the key accomplishments of OHI in FY 2010-11:

- OHI provided oral health screenings for 26,440 children and 4,383 pregnant women. These numbers reflect an increase in the number of children screened by 37.1% and increase in the percentage of pregnant women screened by 87.0%.
- 12,189 dental exams were provided to children and 3,248 exams to pregnant women – an 85.3% increase in exams to pregnant women.
- Over 9,000 children and 3,600 pregnant women received routine dental treatment. 53 children received treatment requiring oral surgery or anesthesia. OHI also provided treatment funds to 892 children and 1370 pregnant women and new mothers with urgent oral health needs and no other means to pay.
- More than 1,755 providers received trainings on serving young children and pregnant women and technicians were trained in applying sealants.
- 3,619 children and 1,479 pregnant women received care coordination to assure the completion of needed treatment.
- The Centers for Disease Control estimates that every dollar invested in fluoridation saves $38 in dental treatment.[10] To promote oral health, the Commission also invested in expansions in water fluoridation to help prevent dental disease in children and pregnant women. As of February 2011, nearly 107,000 additional children ages 0-5 benefited from the fluoridation of the City of San Diego's water supply.

[5] Van Gilden, Jennifer and Berri, David. "An Economic Analysis of First 5 San Diego" (submitted: December, 2009). Page 39.
[6] Savage, Mather, Lee, Jessica, Ketch, Jonathan and Vann Jr., William. "Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs." Pediatrics 2004; 114 pp. 418-423.
[7] Ramos-Gomez, FJ and Shepard DS. "Cost-effectiveness Model for Prevention of Early Childhood Caries." J Calif Dent Association. 1999 Voll 27, pp. 539-44.
[8] Zavras, Al, Edelstein, BL, Vamvakidis, A. "Health Care Savings from Microbiological Caries Risk Screening of Toddlers: a Cost Estimation Mode." Journal of Public Health Dentistry. Summer 2000. 60(3) pp. 182-8.
[9] Brown, Amy, "Access to Oral Health Care During the Perinatal Period: A Policy Brief" National Maternal and Child Resource Center, p.7.
[10] Centers for Disease Control and Prevention "Natures Way to Prevent Tooth Decay: Water Fluoridation" (2006)

Health Care Access (HCA)

More than 4.0% of children ages birth through five in San Diego County are without health insurance. As a result, these children are less likely to receive their well-child and dental visits, are more likely to have poor health outcomes and are more likely to go to the emergency department for health services. Uninsured pregnant women are less likely to receive proper prenatal care, which increases the risk of poor birth outcomes. The Healthcare Access Initiative performs outreach to locate the uninsured, assists with insurance enrollment and re-enrollment and coaches families on establishing a medical home, the importance of preventative care and appropriate utilization of health services. These are the key achievements of HCA in FY 2010-11:

- More than 40,000 residents were exposed to HCA outreach activities delivered at a wide variety of events, such as school events, farmers markets and health fairs, in all regions of the county.
- Nearly 14,300 children and over 3,900 pregnant women were assisted with health insurance enrollment.
- 10,609 children and 2,512 pregnant women enrolled or re-enrolled in health insurance through HCA – a 13.0% increase over the previous year.

Since the beginning of the HCA program in 2004, more than 72,000 children and 24,700 pregnant women have been enrolled in health insurance through HCA. Access to health insurance promotes prevention and avoids more costly health problems through early access and averted expensive emergency department costs. The Fiscal Impact Study commissioned by First 5 San Diego in 2009 found between $24.90 and $48.61 of benefits for each dollar spent on HCA.[11] Moreover, HCA is an important access point for children and families to other initiatives, such as OHI and HDS.

KidSTART

KidSTART was initiated as a multi-disciplinary and multi-agency program in the fall of 2010 to triage and assess children with complex needs, and provide them with or connect them to a coordinated set of needed services. This project is a partnership with Children's Mental Health and Child Welfare Services. In this first year, KidSTART primarily served children in foster care. KidSTART is a center that provides children with complex and multiple needs screenings, a triage, assessments, and referrals to needed services. Treatment can include physical, occupational, and speech and language therapy, as well as behavior therapy, parent/children therapy, and parent support. The KidSTART Clinic serves children with behavioral challenges, partially funded through a federal match (EPSDT funds). These are the key achievements of KidSTART in FY 2010-11:

- A total of 161 children were assessed at the KidSTART Center and 220 were assessed at the Clinic.
- Treatment plans were developed for 52 children at the Center. Ninety-five children began behavioral therapy at the Clinic in FY 2010-11.
- 90.0% of parents and caregivers were involved in their child's care treatment and planning at the KidSTART Center, thus increasing the chances of child gains and support in the home.

This program works with other developmental services (such as HDS) and also with other projects serving children in the child welfare foster care system. KidSTART is a groundbreaking and innovative model to serve children with complex needs.

[11] Van Gilden, Jennifer and Berri, David. "An Economic Analysis of First 5 San Diego" (submitted: December, 2009) p.39. Note that costs vary due to different factors as geographic location (e.g., rural, urban, size of area) and delivery method (e.g., mobile clinics).

Four additional health projects are funded by First 5 San Diego, which target specific community needs: Black Infant Health, the HDS Alcohol and Drug Services pilot project, "The Incredible Years" trainings for mothers in recovery and the Childhood Obesity Initiative.

Learning

First 5 San Diego invests in early learning primarily through two key projects: the Preschool for All (PFA) and School Readiness (SR) Initiatives.

Preschool for All (PFA)

Research shows that children who participate in high quality pre-kindergarten programs are better prepared to enter kindergarten, are less likely to repeat a grade in the long-term, require fewer special education services, and are more likely to graduate from high school. The First 5 San Diego Preschool for All (PFA) Initiative improves children's access to quality preschool in 11 communities. The core components of PFA are: improving classroom quality, providing developmental screenings to all children, including those children with special needs, engaging parents in their child's education, providing professional development to teachers and administrative staff and promoting the importance of quality preschool in the community. The RAND Corporation found that the return on investment of a half day of quality preschool for four-year-olds in California is $2.62 per dollar invested. The return on investment increases to $6.35 when considering benefits to children with special needs and those in foster care.[12] A meta-analysis of studies reviewed by the American Institute for Research found that "quality preschool programs are estimated to save taxpayers from $4 to $17 for every dollar invested." The savings come from reducing grade retention, special education use, dependence on cash assistance, and involvement in crime.[13]

These are the key achievements of PFA in FY 2010-11:

- More than 6,900 children (a 77.7% increase) and 1,088 parents were served by PFA's 41 different agencies, of which 20 were family child care, 13 were non school-based and 8 were school-based.
- More than 85.0% of children measured improvements in seven developmental domains from fall to spring.
- Over 82.0% of children participating received a developmental screening. Nine percent (9%) of children served by PFA had special needs.
- Nearly all (96.0%) of PFA classrooms increased the quality of the learning environment as a result of PFA support and training.
- 100% of PFA teachers drafted professional development plans, supported by PFA coaching and staff development trainings.
- 98.1% of PFA parents surveyed read to their children in the past week.

[12] Karoly, L.A., & Bigelow, J.H. (2005*). The economics of investing in universal preschool education in California*. Santa Monica, CA: RAND Corporation.
[13] Muenchow, S., & Manship, K. (2011). First 5 Commission of San Diego Quality Preschool Initiative (QPI) Final Report: Findings and Recommendations. (August).

School Readiness (SR)

The School Readiness Initiative (SR) served children in four school districts with low API scores. The project takes a "whole child" approach, focusing on learning, health, parent involvement and support and the school structure to assist children age 0 to 5 to be ready for kindergarten. This was the final year of the School Readiness Initiative. Some components of SR have been integrated into PFA. These are the key achievements of SR in FY 2010-11:

- Provided preschool to 165 children, early childhood education services to 193 children at parent/child activity centers and enhanced services to 2,890 children.
- Provided 4,651 parents with support and education services.
- Nearly 3,000 children received developmental screenings, which help to identify critical developmental and health issues that could delay a child's readiness to learn. Of these children, 2,319 received a health screening, 127 received behavioral screenings and 1,668 received referrals or case management.
- 2,959 preschoolers participated in kindergarten transition activities.

Four additional learning projects were funded by First 5 San Diego, which target specific community needs: the Special Needs Demonstration Project, Mi Escuelita Therapeutic Preschool, Preschool Learning Foundations, and Stage 3 Childcare.

Family

The Strategic Plan goal for Family is primarily addressed by two key Child Welfare Services projects.

Child Welfare Services Projects (CWS)

Young children, when placed in care outside of their 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 the child welfare foster care system exhibit behavioral and social competency problems warranting mental health services.[14] In San Diego County, 40% of the children in the child welfare system are under age six. To address the needs of this vulnerable population, the Commission supports two projects that work together to improve the coordination and flow of services to these children – CWS Early Childhood Services (ECS) and CWS Developmental Screening and Enhancement Program (DSEP) projects. These are some of the accomplishments of the CWS projects in FY 2010-11:

- 1,072 children received screenings for developmental and social-emotional issues.
- 67.1% of children ages birth through 5 in the child welfare system in San Diego County were reunified with their families in FY 10-11. This is an 8 percentage point increase from the previous year – a marked improvement. 81.3% of children had two or fewer placements (a decline of 1.6 percentage points) – though this is consistent with other county trends.
- An Individual Care Plan was developed for 1,059 children, which outlines their health, development and early learning needs. This plan is a roadmap used by foster parents /relative caregivers, social workers, case managers and sometimes dependency court to best coordinate and meet the child's needs.
- 575 children with identified needs and their caregivers were provided support, case management and/or behavioral intervention through the CWS system of care.

[14] 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.

- Polinsky Children's Center staff receiving coaching showed significant improvement in four areas of child interaction and 72% of PCC staff and social workers who received training on promoting early childhood development showed significant knowledge gains.

Three additional family projects are funded by First 5 San Diego, which target specific community needs: the Families Together Program, the Kit for New Parents and the San Diego Adolescent Pregnancy and Parenting Program.

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, information and referral services (211 San Diego) and the capital projects supported by First 5 San Diego.

Information and Referral Services: 2-1-1 San Diego

2-1-1 is the free national dialing code for information about community, health and disaster services. Locally, 2-1-1 San Diego provides live information and referral specialists who offer personalized information to callers seeking services in San Diego County. The 2-1-1 network also includes the First 5 "Warm Line" (1-888-5-FIRST-5) which serves families with a child age 0 through 5 and provides information about First 5 programs and services. These are the key accomplishments for FY 2010-11:

- Handled 39,742 cases related to children 0-5
- Answered 2,681 calls to the Warm Line
- Provided 2,168 referrals to First 5 San Diego programs

Parent and Public Education

The goals of parent and public education efforts are to increase awareness of the importance of children's early development, educate parents on supporting their child's optimal development, and increase awareness of Commission-funded services and programs available to children and families. In FY 2010-11, First 5 launched the third phase of its "Good Start" parent education campaign, with a focus on the importance of oral health for children 0-5 and pregnant women and on OHI services. These are the key accomplishments for FY 2010-11:

- Leveraged $4 dollars for every $1 spent on media outreach by negotiating $1.5 million dollars in bonus media.
- Achieved more than 52 million gross impressions at a cost of ¾ of a cent. (Gross impressions are the number of times elements from the campaign were seen.)
- Referrals[15] to First 5 San Diego programs and services increased 183% from 131 per month to 372 per month.
- First 5 San Diego Warm Line calls (1-888-5 FIRST 5) calls increased 157% from 135 per month to 348 per month.[16]

First 5 San Diego also provided funding for Text4Baby and five separate capital projects in FY 10-11.

[15] Includes referrals from both the Warm Line and the 2-1-1 General Line.
[16] Referral and Warm Line data are the average of 4-months prior to the campaign compared to 4-months during the campaign.

The First 5 Impact

As stated in the Commission's five-year Strategic Plan, a priority of First 5 is to "strengthen essential partnerships" between the providers delivering the critical health, learning, family and community services to children birth to age five. One of the main achievements of First 5 San Diego is building systems in the fields of healthy development, oral health, education, early childhood mental health and child welfare that support the needs of young children and their families. These systems work to integrate services, communicate effectively, refer seamlessly and work in multi-disciplinary teams across agencies to assure that children receive needed services to be healthy and to be ready and able to learn.

In the 11th year of First 5 San Diego, the data demonstrate the benefits of these mature partnerships. Children and their parents/caregivers have greater access to health, early learning and family services.

- Children are receiving high quality, coordinated, multi-disciplinary services that meet mild to moderate, as well as complex needs otherwise not available to them, through the HDS system of care and the newly launched KidSTART program.
- Moreover, the impact of First 5 has been so broad and deep that the impact of five years of oral health prevention is being seen in lower rates of dental disease among new children being screened. The increased knowledge and behaviors of parents as a result of HDS and OHI parent education services will affect subsequent generations of children.
- PFA has helped transform the system of early education – shifting the focus to improving quality, measuring and tracking individual child development, and making early education a critical priority in school districts across the county.

Continued support of these existing networks is serving children now, and strengthening the health and learning systems for future generations of San Diego's children.

Health

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

- Healthy Development Services
- Oral Health Initiative
- Health Care Access
- KidSTART
  - Black Infant Health
  - HDS / Alcohol and Drug Services
  - The Incredible Years
  - Childhood Obesity Initiative

First 5℠ San Diego

CHAPTER 1

Healthy Development Services

2010/2011 Scorecard

Goals	Measures	Target	Actual	Performance
1. Numbers Served	Number of unduplicated children served	N/A	24,061	N/A
	Number of unduplicated parents served	N/A	12,324	
	Number of unduplicated providers served	N/A	1,576	
2. Parent Education, Support and Empowerment Goal: Increase parent knowledge and skills to promote their child's developmental and social-emotional health	Number of parents attending parent education classes	3,790	3,618	95.5%
3. Behavioral Services Goal: Provide early identification and treatment of behavioral concerns	Number of children that received behavioral treatment	1,051	1,557	138.4%
	76.6% of children in behavioral treatment showed a decrease in behavioral concerns.			

90.0% or above target 75.0-89.0% of target <75.0% of target

HDS 2010/2011 Scorecard, continued

Goals	Measures	Target	Actual	Performance
4. Developmental Services **Goal: Provide early identification and treatment of developmental delays**	Number of children that received developmental / speech treatment	1,132	2,434	215.0%
	67.6% of children in developmental treatment demonstrated developmental gains.			
5. Vision and Hearing Services **Goal: Provide early identification for vision and/or hearing needs**	Number of children screened for vision	6,230	9,717	156.0%
	Number of children screened for hearing	6,875	9,422	137.0%
6. Care Coordination **Goal: Assist families in navigating the system of care to connect children to treatment**	Number of children 0-5 who received care coordination services	3,673	5,312	144.6%

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

Introduction

"HDS has created a change in my confidence. I was very impressed with how everything was run… they really do care. HDS boosted my confidence not just as a parent but for my view of these organizations out there who really take the time, and really care for children."

- HDS Parent

Research is clear about the importance of a child's early years to their ability to grow, develop and succeed in school.[1] Knowing how to support a child's early development and identifying potential problems early can help parents, early education providers and health professionals minimize long-term effects that may drastically alter the course of that child's life. While the average age parents report developmental concerns is 17-18 months, nationally, fewer than half the children with developmental delays are identified prior to entering school and many do not receive services until they are struggling in school. Postponing treatment is regrettable for a number of reasons. Intervention during the first 5 years – while critical brain and social emotional development is occurring – is optimal for a child to make more significant gains in a briefer interval. The longer treatment is delayed, the more challenging it can be for a child to "catch up" to peers and the more likely delays and social emotional issues will develop or deepen.[2] Deferring treatment will also lead to increased costs and often shift the burden of identifying and addressing problems to the school system. The cumulative cost of special education services is 30% lower if intervention begins when a child is young (especially in the first 2 years) rather than waiting until school age.[3] The cost in dollars of ignoring these potential opportunities can span from $30,000 to $100,000 per child when less costly resources and tools are available to identify potential problems at a much earlier age.[4]

In January of 2006, the First 5 Commission of San Diego launched the Healthy Development Services (HDS) Initiative to promote children's optimal development and learning by: (1) improving access to developmental and behavioral screenings and treatment, and (2) identifying and addressing problems that can affect children's learning as early as possible. The initiative consists of a contract with the American Academy of Pediatrics, California Chapter 3 (AAP-CA3), to oversee and coordinate the continued successful implementation of HDS countywide and six Regional Service Network (RSN) lead agency contracts. These contracts are held by four organizations: Family Health Centers, Rady Children's Hospital, Palomar Pomerado Hospital and South Bay Community Services.

Initiative Goals

- Decrease the percentage of children entering kindergarten with undetected and/or untreated **developmental, social emotional or behavioral delays or problems**.
- Increase the number of households with children ages 0 to 5 that regularly engage in **age-appropriate parent-child activities** that promote early learning.
- Increase the use of **positive parenting practices** to promote the healthy social emotional development of children ages 0 to 5.
- Increase parents' and caregivers' **access to needed services** for their children.

[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 predictors of placement for young children with autism: A four to six-year follow-up. Journal of Autism and Developmental Disorders, 30, 137–142.

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

[3] Wood, M.E. "Costs of Intervention Programs." In Cl Garland and others, eds., Early Intervention for Children with Special Needs and Their Families: Findings and Recommendations Westar Series Paper No. 11. Seattle, WA: University of Washington, 1981. ED 207-278.

[4] 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.

A new five-year contract cycle began in June of 2010, funded at a total of $65,000,000 ($13,000,000 per year over 5 years). HDS aligns with the County of San Diego's ten-year plan *"Live Well, San Diego!"* in that it provides integrated care and treatment services that address the social-emotional, physical, and behavioral needs of high-risk children with multiple challenges.

Key Elements

HDS is built upon several key features that together create a strong foundation for success and sustainability:

- **System wide screening and assessment tools** that are standardized across the county;
- **High quality treatment services** that measure gains and address the child's and family's need;
- A **comprehensive approach** that encompasses direct services and also provider capacity building, community strengthening and awareness, and systems change;
- **Experienced subcontractors and extensive partnerships** with a variety of key stakeholders that will allow the project to utilize and build upon the existing strengths and resources within the regions and across the county;
- **Integration with other First 5 San Diego services**;
- **Integration with existing health and education systems** to ensure there is a continuum of services so children are optimally ready to succeed in school;
- **Parent education, support and empowerment** woven into all activities and services, providing parents with the tools and knowledge they need to promote and monitor their children's development, access the services they and their children need, navigate service systems and successfully advocate for their children's needs.

Summing It Up

In Fiscal Year 2010-11, new HDS contract with more standardized tools and curriculum were implemented. This year, HDS services were accessed by 24,061 children 0 to 5 years of age and 12,324 parents (unduplicated counts). As shown in Exhibits 1.1 and 1.2, the majority of children served by HDS were Hispanic/Latino, (63.3%) and most were English (61.6%) or Spanish (36.9%) speakers. Similarly, the parents who received HDS services were also mostly Hispanic/Latino, (62.0%) and primarily spoke English (52.7%) or Spanish (44.8%).

Exhibit 1.1 Ethnicity and Language of Children 0-5

Ethnicity	n=24,061	%	Language	n=24,061	%
Hispanic/Latino	15,228	63.3%	English	14,821	61.6%
White (non-Hispanic)	3,838	16.0%	Spanish	8,879	36.9%
Other	2,585	10.7%	Other	251	1.0%
African-American/Black	1,340	5.6%	Don't know/Declined	110	0.5%
Don't know/ Declined	1,070	4.4%			

Exhibit 1.2 Ethnicity and Language of Parents/Caregivers

Ethnicity	n=12,324	%[5]	Language	n=12,324	%
Hispanic/Latino	7,636	62.0%	English	6,494	52.7%
White (non-Hispanic)	2,451	19.9%	Spanish	5,521	44.8%
Other	1,351	11.0%	Other	230	1.9%
Don't know/ Declined	480	3.9%	Don't know/Declined	79	0.6%
African-American/Black	406	3.3%			

HDS Services Help Meet the Health Needs of the Community

HDS offers an array of developmentally focused services designed to help parents learn to encourage and assess their child's development and, if necessary, access treatment. HDS services to families fall into four key categories: care coordination (to help families understand their child's needs and access services), development and speech, behavior, and parent education, support and empowerment. As parents play a critical role in promoting their child's development, most HDS services involve both the parent and child.

As shown in Exhibit 1.3, of the four primary service areas, the majority of HDS clients received care coordination services during FY 2010-11 – more than 10,100 parents and children. Approximately, 8,500 parents and children received development and speech services, and nearly 5,400 parents and children received behavioral services. Nearly 8,000 parents and children were served through the 2,901 parent education, support and empowerment (PESE) sessions offered.

Exhibit 1.3 Number of Children and Parents Served by Service Area in FY 2010-11

Service Area	Unduplicated Number Served*	
	Children	Parents
Care Coordination	5,312	4,836
Development and Speech	4,261	4,311
Behavior	2,702	2,670
Parent Education, Support & Empowerment (PESE)	3,935	3,618

**Client counts are unduplicated within each service area but may be duplicated across service areas.*

[5] Due to rounding the total percentage is equal to 100.1%.

HDS services also include vision, hearing, development/speech and behavioral screens for children 5 years old or younger. If necessary, follow-up treatment services to development, speech or behavior screens are provided. HDS also conducts general and development- or behavior-specific education classes and one-on-one consultation for parents where they are provided with in-home strategies to address their child's delays.

Exhibit 1.4 shows the number of clients served by the different HDS services.

Exhibit 1.4 Number of Clients Served by Service in FY 2010-11

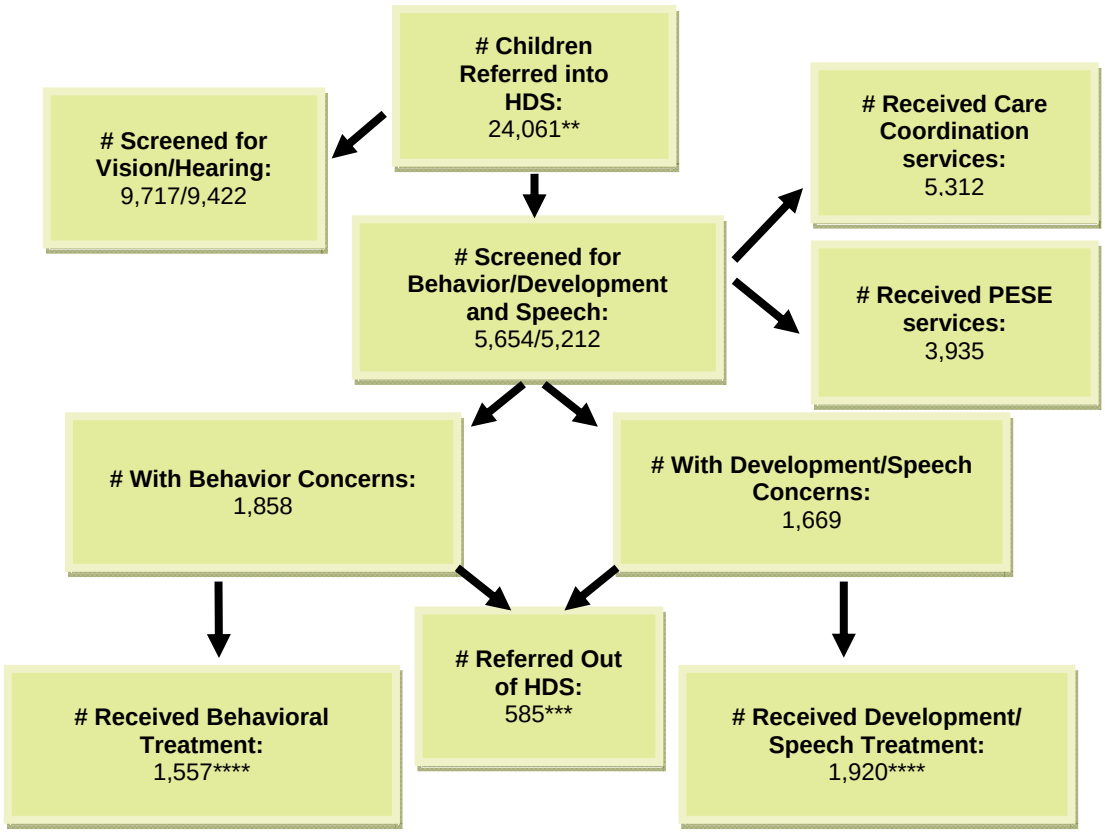
Service		Unduplicated Number Served*	
		Children	Parents or Providers
Development and Speech	Parent Classes	3,838	3,784
	Parent Consultations	1,384	1,420
	Clinical Intervention (parent and child)	1,050	1,043
Behavior	Parent Classes	1,236	1,174
	Parent Consultations	851	973
	ECE Provider Classes	N/A	883
	ECE Provider Consultations	409	638
	ECE Provider Intensive Consultations	N/A	76
	Clinical Intervention (parent and child)	604	583
Care Coordination		5,312	4,836
Parent Education, Support & Empowerment (PESE)		3,935	3,618

**Clients considered unduplicated within each service level.*

- **Development and Speech services** include development and speech screens and assessments, specialized classes and one-on-one consulting services for parents and clinical intervention for children with development or speech concerns. In FY 2010-11, 1,050 children received clinical treatment in development and/or speech.
- **Behavior services** consist of behavior screens and assessments, specialized behavioral classes and one-on-one consultations for parents and clinical intervention for children with behavioral concerns. Over 600 children received clinical treatment for behavioral concerns during FY 2010-11. In addition, HDS provides services to early childhood education (ECE) providers serving children that may have behavioral problems. These include classes, consultations on working with individual children and intensive 30-hour consults provided on-site that address classroom management. Over 800 early childhood education providers attended classes about children's behavior and classroom management, nearly 700 received individual consultations and 76 received on-site intensive services.
- **Care coordination** plays an important role in maximizing clinical service. Care coordinators assist families by addressing barriers that keep them from receiving necessary services, connecting them to outside resources, and supporting them to implement treatment recommendations at home. Close to 5,000 parents and over 5,000 children received care coordination services during FY 2010-11.
- **Parent education, support and empowerment (PESE)** classes are general parenting classes focused on strengthening the relationships that are essential for the healthy development of young children. They are available to all families and are specific to three age groups (i.e., infant, toddler, and preschooler). Any parent or caregiver interested in learning more about their child's development can attend PESE sessions. These classes cover five topics: health, learning, family, community and advocating for your child. Of the parents enrolled in PESE classes, 23.7% of them attended four or more sessions, and 32.3% attended three or more classes. The learning session – which includes behavioral and developmental screenings for children – was the most frequently attended session.

The following flowchart (Exhibit 1.5[6]) displays the number of children served in each step of HDS. Of the 24,061 children who were referred into and served by HDS in FY 2010-11, nearly 40.0% received vision and/or hearing screenings, over 22.1% received care coordination services, 16.4% benefitted from PESE services, and 23.5% and 21.7% were screened for behavior or development/speech concerns, respectively. About one-third (32.9%) of children screened showed behavior concerns and a similar percentage (32.0%) showed development or speech concerns. Those with concerns were either placed in treatment or referred out of HDS.

Exhibit 1.5 HDS Flowchart*



**All numbers in flowchart represent children ages 0-5. Parents and providers served are not included.*
*** Includes children who initiated services after being referred by pediatricians, parents, early care and education, Regional Center/CA Early Start, 211, KidSTART, CWS, or First 5 parent education campaigns*
****Number Referred Out includes children referred to CA Early Start, mental health services and other child development services.*
*****Number received treatment may be higher than the number with concerns as some children were referred straight to treatment after receiving a screening outside of HDS.*

[6] The values in Exhibit 1.5 represent unduplicated counts within a service area but not across service areas, therefore cumulative totals may exceed 100.0%.

Making a Difference

Early identification of developmental delays is critical to ensuring children enter school ready to learn. Yet, while 17.0% of children under 18 years of age have developmental or behavioral disabilities and a greater number have language delays, less than 50.0% of these children are identified prior to entering school and most are not identified until after grade three. By thattime, the delay may become more significant and the optimal time for treatment (the first five years of life) has been missed. HDS promotes children's optimal development and learning by improving access to health, developmental and behavioral services so that problems that can affect children's learning are prevented or identified and addressed as early as possible. The aim of HDS is to provide mild to moderate services for children, families, and providers in order to fill a gap in the contunuum of services while emphasizing early intervention services. HDS is a service continuum composed of: 1) identification of concerns through screenings; 2) development/speech services; 3) behavior services; 4) care coordination services; 5) parent education support and empowerment services.
HDS strives to identify children with developmental or behavioral concerns as early as possible, provide services to meet those needs, or refer the child and family to receive the needed services.

HDS Screenings

HDS offers a comprehensive system of care in which clients may enter and exit at a number of points. HDS provides children with screenings for vision, hearing, behavioral and developmental (including speech) concerns. Screenings may be done in clinics, in community settings or parent education classes. As shown in Exhibit 1.6, HDS providers administered more than 30,000 screenings during FY 2010–11. Almost 5,700 children were screened for behavioral concerns, and close to 5,200 children were screened for developmental concerns.[7] Approximately 9,400 children were screened for hearing deficits, and more than 9,700 received vision screenings.

Exhibit 1.6 Number of Children Screened in FY 2010-11

Screenings	Unduplicated Number of Children Screened
Developmental	5,212
Behavioral	5,654
Vision	9,717
Hearing	9,422

HDS also encourages and provides support for developmental and behavioral screenings to be completed by parents, pediatricians and early education providers. This allows more of HDS's resources to focus on filling the gap in developmental and behavioral treatment services. Children that demonstrate mild to moderate concerns that meet eligibility requirements can receive further assessments and HDS treatment services or be referred to appropriate services based on their identified needs.

Development Services

HDS provides an array of developmental services that include assessments for development and speech delays, specialized developmental classes and one-on one coaching and consultations for parents, as well as intensive clinical intervention for parents and children together. All services and recommendations for future services are based on the child's need. Tools, clinical judgment, and family circumstances inform service recommendations. During FY 2010-11, 32.0% of children screened through HDS showed concern and 36.8% of these were referred to treatment. .

During FY 2010-11, HDS launched a pilot implementation of the Hawaii Early Learning Profile® (HELP) for all children receiving HDS developmental or speech services throughout the county.

[7] Screenings were performed using the Ages and Stages Questionnaire (ASQv3) for development and the Ages and Stages Questionnaire for Social Emotional (ASQ:SE) for behavioral.

The HELP is a family-centered, curriculum-based assessment for professionals working with infants, toddlers, young children, and their families. The HELP is used in HDS to identify needs, track growth and development, and determine target objectives to promote the child's development and positive parent-child interactions.

Developmental Results

The developmental results represent a sample of children who received services in FY 2010-11. The developmental gains of children receiving developmental services during the fourth quarter of FY 2010-11 were assessed with the HELP assessment. The HELP covers 685 skills and behaviors in six domains: cognitive, language (split into receptive and expressive), gross motor, fine motor, social, and self-help. As described in the text box, the majority of children assessed through the pilot (67.6%) showed a gain in at least one of the domains. Children showed the most improvement in the fine motor, cognitive and expressive language domains.

Developmental Gains

67.6% of children showed developmental gains in at least one domain assessed.

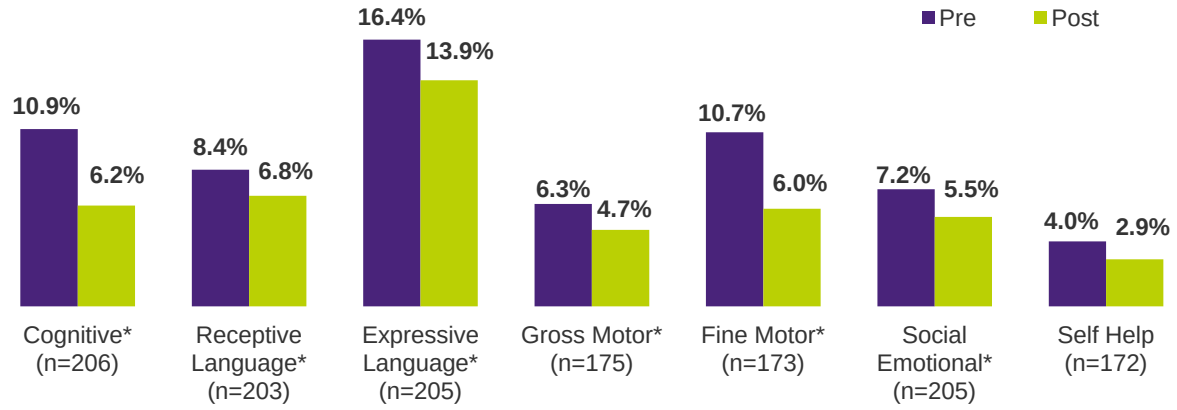
Percentage of children that showed developmental gains by domain:

- 63.1% Cognitive
- 44.3% Receptive Language
- 55.1% Expressive Language
- 37.7% Gross Motor
- 67.6% Fine Motor
- 42.9% Social Emotional
- 33.7% Self Help

Overall, the top three areas that showed a developmental delay were the expressive language, cognitive, and fine motor domains. These were the same domains that had the highest percentage of children who demonstrated gains, showing that the services targeted the areas of most need. There were slight differences in the type of concerns shown in two different age groups. Children under three years of age had more delays in fine motor skills while children 3-5 years of age had more delays in receptive language.

Exhibit 1.7 shows the percent delay at pre and post developmental services for each domain. **A decrease in percent delay implies a positive developmental gain.** Every domain except self-help showed a statistically significant developmental gain after receiving HDS treatment services.

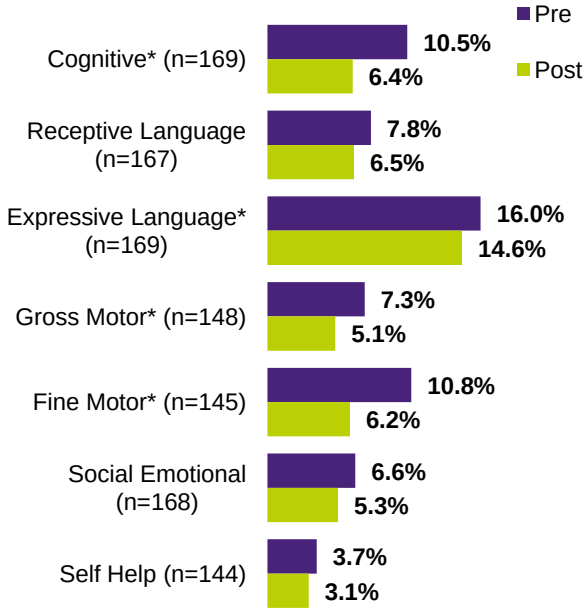
Exhibit 1.7 Average Percent Delay for each Domain for Children at Pre & Post Developmental Services



**Statistically significant at p<0.05*

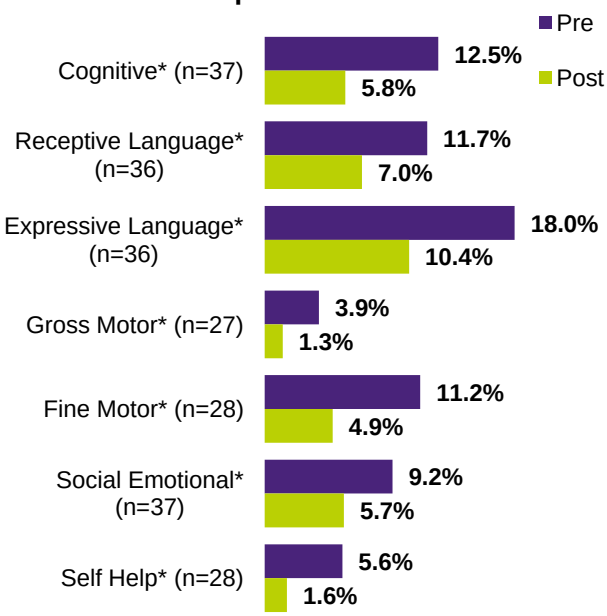
Exhibits 1.8-1.9 show percent delay per domain for each age group (less than 3 years old and 3-5 years old). There were significant developmental gains after receiving developmental services for over half of the domains for children under 3 and children ages 3-5 showed significant developmental gains in all domains. Also important to note is the larger number of 0-3 year old children who were assessed which illustrates that HDS providers are intervening and addressing developmental concerns at an early age; a goal of HDS.

Exhibit 1.8 Average Percent Delay for each Domain for Children Ages 0-<3 years at Pre and Post Developmental Services



**Statistically significant at p<0.05*

Exhibit 1.9 Average Percent Delay for each Domain for Children Ages 3-5 years at Pre and Post Developmental Services



**Statistically significant at p<0.05*

Areas showing significant developmental gains

In FY 2010-11, there were significant developmental gains in the following domains: **cognitive, language (expressive/receptive), gross motor, fine motor, social emotional and self help (3-5 year olds only).**

- The **cognitive domain** focuses on the development of mental processes related to thinking, memory, and reasoning.
- The **language domains** relate to the child's ability to understand and express the meaning of information, ideas, and feelings expressed by other's verbal and nonverbal communication.
- The **gross motor domain** assesses abilities using the large muscle groups, such as the child's endurance, strength, symmetry, and activity level.
- The **fine motor domain** assesses abilities using the small muscle groups, such as hand-eye coordination.
- The **social emotional domain** is divided into five interrelated areas: attachment/separation/ autonomy, development of self, expression of emotions/feelings, learning rules and social expectations, and social interactions and play.
- The **self help domain** assesses the child's ability to do certain activities by themselves, such as dressing, eating and toileting.

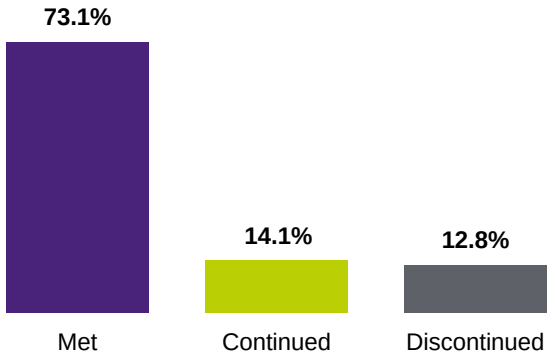
Helping Parents Support their Child's Developmental and Behavioral Needs

Whether a child had developmental, speech or behavioral concerns, the HDS model focuses on early intervention that involves the entire family in their child's treatment. Through this approach, the child progresses more quickly as the parents and caregivers learn the skills necessary to support their child's developmental and social-emotional health in their home environment. As part of both developmental and behavioral services, HDS providers work with parents to create a written Home Activity Plan (HAP) for any specific developmental or behavioral concerns that the child is presenting. The HAP consists of take-home activities that support the achievement of personalized goals for the family based on the child's specific needs. Providers monitor the family's progress towards goals and the frequency in which HAP activities are completed. Examples of HAP goals are presented in the text box below. A total of 3,485 families completed a HAP and created a total of 4,109 goals in both service areas combined. Results show that the majority of families who created a goal (73.1%) met their goal (see Exhibit 1.10).

HAP Goal Examples

- Child will increase speech clarity for 4-5 word phrases to 80.0%
- Child will increase imitation of syllables and parts of words during play
- Child will increase ability to take turns without throwing a fit
- Child will reduce aggression and throwing of toys
- Child will be able to use his words to express when he is upset and/or frustrated

Exhibit 1.10 Percentage of Home Activity Plan Goals Met, Continued, or Discontinued



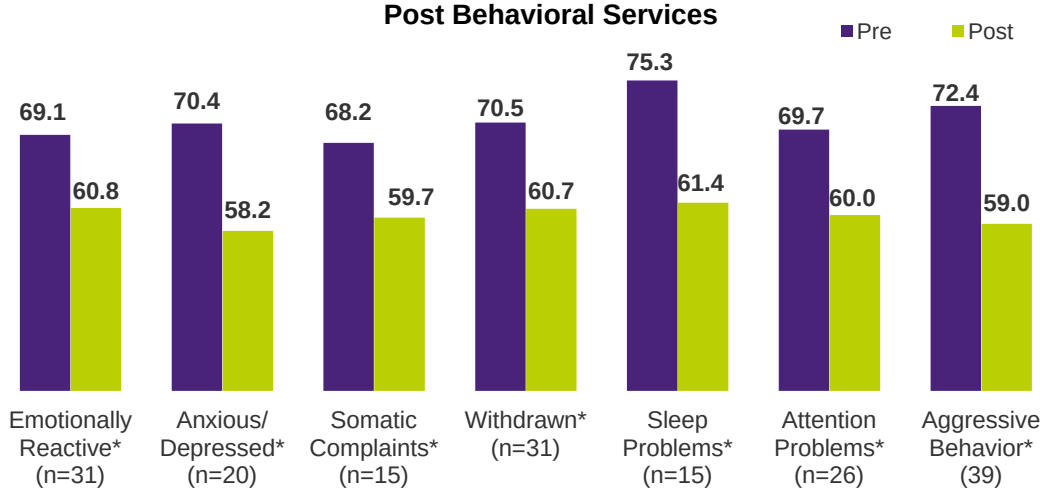
Behavioral Services

HDS offers a variety of behavioral services that are provided based on the child's needs. Behavioral services include: assessments for behavioral concerns, specialized parent classes designed for families with children identified with a similar behavioral concern (e.g., aggressiveness); parent consultation services designed for families with children who have behavioral concerns and would benefit from one-on-one assistance; provider classes and consultations designed for childcare providers and teachers with concerns about children's behavior; intensive provider consultations focused on classroom management training; and clinical treatment for families. Typically, services are for children who have behavioral issues that are manifesting in more than one setting (e.g. in home, at school) or are complicated by child developmental concerns or family/ environmental factors (i.e. family stress, financial stress, parental substance abuse).

Behavioral Results

During FY 2010-11, 32.9% of children screened for behavioral concerns showed concern and were referred to services. The behavioral results represent a sample of children who are receiving services. The behavioral gains of children receiving behavioral services were assessed with the Child Behavior Checklist (CBCL), a standardized instrument for assessing behavioral and emotional problems and competencies. The CBCL assesses internalizing behaviors (e.g., anxious, depressive, and over controlled) and externalizing behaviors (e.g., aggressive, hyperactive, noncompliant, and under controlled). The CBCL was completed by parents at the beginning and end of behavioral services. A decline in the level of behavioral concerns indicates a behavioral gain. Results showed that for each area measured, the average scores of behavioral concerns at the end of treatment were significantly lower than the scores at the start of treament. Exhibit 1.11 shows that all behavioral concerns, as measured by the CBCL, significantly declined for children who showed concern in that domain at the start of behavioral services. Overall, the top areas of concern at entry into HDS were sleep problems and aggressive behavior; both concerns scored in the clinical range of above 70.

Exhibit 1.11 Mean Behavioral Concerns for Children at Pre and Post Behavioral Services

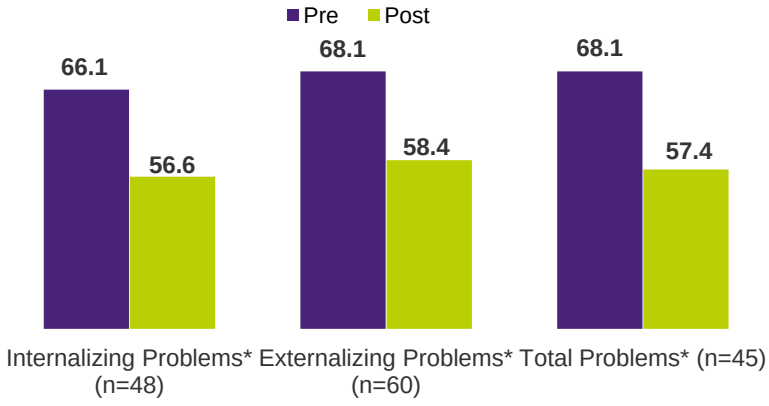


**Statistically significant at p<0.05*

Excessively responding with emotion	Feelings of excessive fearfulness/ sadness	Unexplained stomach aches	Not wanting to play with anyone	Lack of sleeping routine	Lack of attention skills	Explosive behaviors
Examples of each behavioral concern measure						

The CBCL also provides an overall level of behavioral concerns. The overall CBCL results showed that the percentage of behavioral concerns at the end of treatment was significantly lower than the percentage of behavioral concerns at the start of treatment. Exhibit 1.12 shows that the overall behavioral concerns also significantly declined for children who showed concern at the start of behavioral services. All three overall concern scores were above 63 and in the clinical range at pre, but declined to the normal range by post.

Exhibit 1.12 Overall Behavioral Concerns for Children at Pre and Post Behavioral Services



**Statistically significant at p<0.05*

Behavioral Concerns as Reported by Providers

HDS provides consulting services to early care and education professionals who provide services to children with behavioral concerns. To measure the success of these services, the Devereux Early Childhood Assessment Clinical Form (DECA-C) was used to determine the significant improvement of a child's protective factors and whether behavioral concerns are reduced for these children. The DECA-C was administered twice for each child; once at the beginning of services and once at the completion of services. Overall, the DECA-C results show that providers saw the top concerns of the children they were working with as lacking in self control and high in attention problems. Aggression problems were not a top concern among providers, though it was among parents (as measured by the CBCL, see Exhibit 1.11).

The pre and post DECA-C results showed that there was a significant increase for all protective factors measured (initiative, self control and attachment), including the overall total, and a significant decrease in a child's demonstration of attention and aggression problems. There was also a significant decrease in the overall levels of behavioral concerns measured before and after services (see Exhibits 1.13 and 1.14).

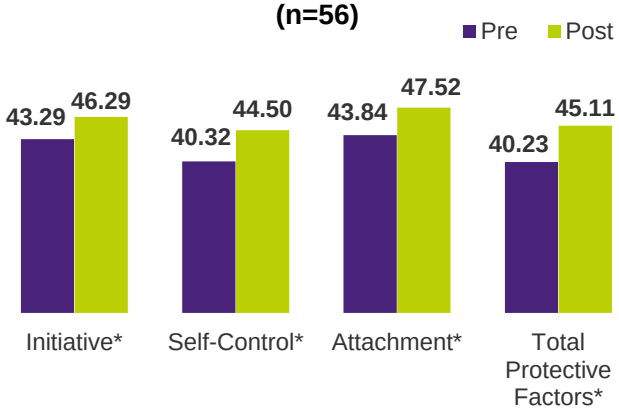
Protective Factors

- ***Initiative*:** the child's ability to use independent thought and action to meet his/her needs.
- ***Self Control:*** the child's ability to experience and express a range of feelings through the use of socially appropriate words and actions.
- ***Attachment:*** a measure of a mutual, strong, and long-lasting relationship between a child and significant adult(s).

Behavioral Concerns

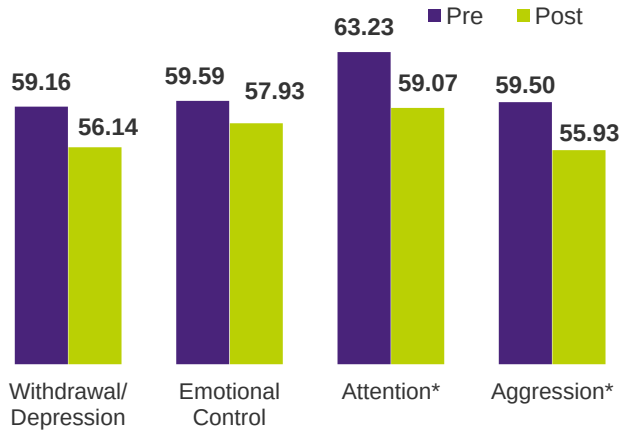
- ***Withdrawal/Depression:*** measures behaviors related to emotional and social withdrawal (e.g., if the child is self-absorbed).
- ***Emotional Control Problems:*** measures the child's exaggeration of negative emotion (e.g., screaming, temper tantrum).
- ***Attention Problems:*** measures the child's inability to focus on a task and ignore competing environmental stimuli.
- ***Aggression:*** measures hostile or destructive acts directed at other persons or things.

Exhibit 1.13 Mean DECA-C Scores for Protective Factors at Pre and Post (n=56)



**Statistically significant at p<0.05*

Exhibit 1.14 Mean DECA-C Scores for Behavioral Concerns at Pre and Post (n=67)

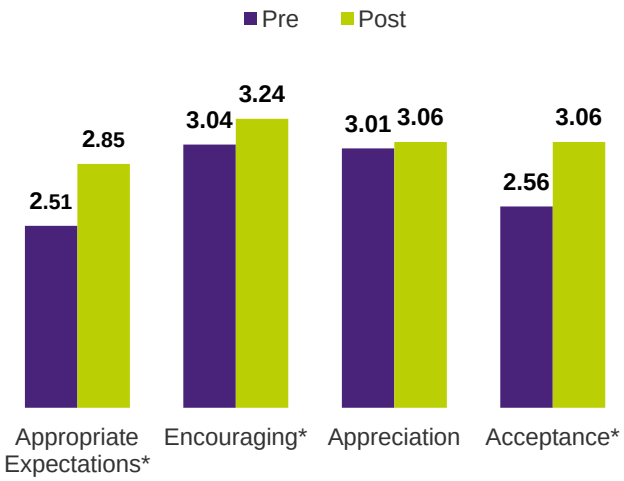


**Statistically significant at p<0.05*

ECE Provider Services

Intensive provider consultation services are designed for childcare providers and teachers with concerns about ongoing behavioral issues in the classroom and interest in intensive classroom management training. Behavioral issues occurring in the classroom may be linked to a specific child but the focus of the service is not directed at a particular child/family. Ideally, the intensive consults are center-based with multiple providers to build capacity within the center. Intensive provider consultation services provided by HDS emphasized a highly sensitive and responsive approach to caregiving. Research demonstrates that children who engage with high quality caregivers who have received specialized training have greater social competency, fewer behavioral problems, higher levels of language development, and higher performance in all school subjects in elementary school than those without this exposure.

Exhibit 1.15 Mean Arnett Scores at Pre and Post (n=51)

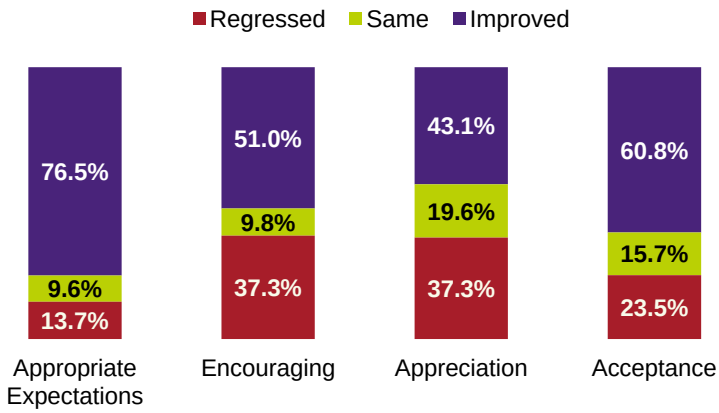


**Statistically significant at p<0.05*

Baseline (pre) and follow-up (post) data were collected on teachers and early education providers receiving intensive consultations through HDS. The Arnett Caregiver Interaction Scale (CIS) was implemented by an external rater who conducted an hour and a half classroom observation for each of the caregivers to assess 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 results presented are only for those caregivers who completed both pre- and post-test data collection (n=51).

The average scores for each scale are shown in Exhibit 1.15. The total score is out of a possible score of 4.00. These results suggest that the program had a positive impact on the quality of caregivers' interactions with young children as shown by the purple sections of bars which indicate those with "improved" practices. Caregivers demonstrated the greatest increases from pre- to post assessment on setting developmentally age-appropriate expectations and showing acceptance for children[8] (Exhibit 1.16).

Exhibit 1.16 Percentage of Providers receiving intensive consultations who showed an improvement, regression or no change (n=51)



[8] Due to rounding the total percentages many not add up to 100.0%.

Provider Classes

In FY 2010-11, 883 early care and education providers attended behavioral classes based on an evidence-based Center on the Social Emotional Foundations for Early Learning (CSEFL) curriculum. The training sessions titled "Positive Behavior Support: Addressing Challenging Behavior" and "Creating Effective Schedules, Routines and Transitions" were most frequently attended. The Provider Education Survey was implemented during the second half of the fiscal year and 71 providers completed the survey. The vast majority of providers agreed or strongly agreed that the training sessions were valuable (97.1%), will help to improve their interactions with children (97.2%), gave them tools to better manage difficult childhood behaviors (97.1%) and would recommend that other teachers and caregivers attend these trainings (97.2%).

Care Coordination Services

Care coordination plays a critical role in the HDS system, especially for families that require services from multiple service areas or agencies. Care coordinators assist families in navigating services, follow-up with them when they miss appointments, link families to community resources and serve as a source of consistency and support in a complex system. The effectiveness of care coordination was measured in two ways: whether families completed their care plan goals for their child and how quickly a child was connected to services. The following results represent the outcomes for families who received care coordination services through HDS.

Families Engaging in the Creation of Care Plans

Care Plans are tools that Care Coordinators use with families receiving more intensive care coordination services that capture families' strengths, needs, goals and progress. Care Coordinators help families create goals and activities for themselves and provide regular follow-up to help the families meet their goals. Over 40.0% of families served by Care Coordination met their care plan goals (Exhibit 1.17). Of those parents surveyed, close to 60.0% reported that they completed all of their care plan goals (Exhibit 1.18). Examples of these goals are included in the text box below.

Exhibit 1.17 Number of Families with Care Plan Goals

# of Care Plan Goals	Frequency	Percentage of families that met goals
One goal	1,094	42.9%
Two goals	131	37.4%
Total	**1,225**	**42.3%**

Care Plan Goal Examples

- To support my child's development
- To support my child's learning and socializing
- To learn how to manage my child's behavior
- To access community resources

Exhibit 1.18 Number and Percentage of Families who report completing Care Plan Goals

# of Care Plan Goals completed	Frequency	Percent
All	122	59.2%
Most	54	26.2%
Some	15	7.3%
None	1	0.5%
Not Sure	14	6.8%
Total	**206**	**100.0%**

Data Source: Transition Survey - Self Report

Timeliness of Services

A key role of care coordination is helping families initiate the services they are referred to, whether they are within or outside the HDS system. As shown in Exhibit 1.19, within HDS, children who were receiving Care Coordination services were more likely to initiate services within six weeks than all children receiving HDS services (81.5-90.6% vs 57.2-75.7%, respectively).

When referred outside of HDS, children 0-<3 years of age receiving Care Coordination services showed no significant differences in timely service initiation; however, children age 3-5 receiving Care Coordination were less likely to initiate services within six weeks for a referral outside of HDS than all children receiving HDS services (52.9-62.9% vs 75.1-79.5%). [9] This is being examined to determine why this is occurring.

Exhibit 1.19 Percentage of Clients who Initiated Services within 4 or 6 weeks after Receiving a Referral within or Outside of HDS

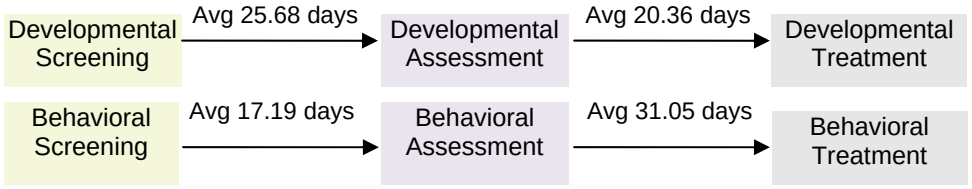
	Referrals Within HDS		Referrals Outside HDS	
Time between HDS Referral and Service for *ALL HDS Clients*	**Children 0-<3 (n=4,377)**	**Children 3-5 (n=2,647)**	**Children 0-<3 (n=658)**	**Children 3-5 (n=1524)**
4 Weeks or less	57.2% (2,505)	58.6% (1,552)	54.9% (361)	75.1% (1,145)
6 Weeks or less*	75.7% (3,314)	75.9% (2,010)	67.2% (442)	79.5% (1,212)
Time between HDS Referral and Service for *CC Clients*	**Children 0-<3 (n=319)**	**Children 3-5 (n=166)**	**Children 0-<3 (n=480)**	**Children 3-5 (n=221)**
4 Weeks or less	81.5% (260)	78.9% (131)	54.6% (262)	52.9% (117)
6 Weeks or less*	90.6% (289)	88.0% (146)	66.3% (318)	62.9% (139)

**Clients who received services in 4 weeks or less are included in the percentage of clients who received services in 6 weeks or less.*

Service Barriers and Wait Times

Focus groups were held with parents whose children were receiving developmental or behavioral services through HDS. Participants noted that waitlists, transportation problems, and a lack of services in remote areas as the main barriers to accessing HDS services. Service wait times between screenings, assessments and treatment were calculated and displayed in Exhibit 1.20. On average, children waited about 26 days between the developmental screening and assessment and about 20 days between developmental assessment and their first developmental treatment session. Wait times between behavioral screening and assessment were shorter (17 days) though there was a longer wait time between behavioral assessment and the first behavioral treatment session (31 days).

Exhibit 1.20 Wait times between screening, assessment and treatment



[9] A goal of the First 5 San Diego Strategic Plan is for children ages 2 and under to initiate services within 4 weeks and children ages 3-5 to initiate services within 6 weeks.

Referrals

Referrals within the HDS Service Network

Many of the clients served by HDS have multiple needs and HDS providers are trained to take a comprehensive look at the family to identify needs and treat the whole child. HDS providers are well connected with each other and often refer clients to other services within the HDS system. Exhibit 1.21 shows the majority of referrals resulted in initiated services, with the most common reasons why referrals were not initiated being because the family declined services (10.4%) or the providers were unable to locate or contact the family (9.5%).

Exhibit 1.21 Referrals Issued within HDS

Referral Destination	Frequency	Percent of total referrals[10]	Percent of referrals that resulted in initiated services
Developmental Services	4,302	38.8%	77.4%
Behavioral Services	2,400	21.6%	52.9%
Parent Education, Support and Empowerment	1,668	15.0%	64.1%
Hearing Screening	881	7.9%	68.5%
Vision Screening	833	7.5%	71.0%
Care Coordination	693	6.2%	79.0%
Other HDS Region	313	2.8%	59.7%
Total	**11,090**	**100.0%**	**68.7%**

Exhibit 1.22 Referrals Issued Outside HDS

Referral Destination	Frequency	Percent
Non-HDS Hearing and Vision Services	2,690	37.5%
Primary Care Physician	1,504	21.0%
School District	707	9.9%
Basic Needs	474	6.6%
California Early Start	355	4.9%
Early Child Education	210	2.9%
Mental Health Services	131	1.8%
Other	1,102	15.4%
Total	**7,173**	**100.0%**

In addition to referrals within HDS, providers also referred clients to other community resources providing highly specialized services not provided by HDS. Exhibit 1.22 displays the top referral destinations outside of HDS. The most common referrals outside HDS are for hearing and vision treatment and to primary care physicians.

Due to economic conditions, State government changed the eligibility requirements to receive services through San Diego Regional Center (SDRC). HDS stepped in to fill the gap and saw 325 children with special needs who previously might have been referred to SDRC

[10] Due to rounding total do not add up to 100.0%

Making the Connection

HDS was first launched in 2006 as a four-and a-half year project. Fiscal year 2010-11 was the first year of a new five-year cycle for HDS which builds upon the lessons learned in the initial years – in particular, the need for more standardized and focused services, curricula, assessments and measurements. Despite expected challenges that accompany the rollout of a new service delivery model, the initiative was successful in service implementation and achievement of positive outcomes. In addition, program implementation was standardized and streamlined, allowing for leveraging of administrative work and more rigorous evaluation of gains. The American Academy of Pediatrics, California Chapter 3 (AAP-CA3) continued to serve as the countywide coordinator of the initiative and focused on collaboration with community partners to better integrate HDS with existing resources for children. Key outcomes from the collaboration include a multi-disciplinary approach to designing treatment plans for a child, improved referral pathways into HDS from other developmental and behavioral services, and more focused training and support for ECE providers. During FY 2010-11, system-wide activities included the following:

+ **Community Multi-disciplinary Team (MDT) Meetings**. Each regional lead convened regular regional MDT meetings to encourage dialogue between their external community providers and to actively link children and their families to additional needed services. A total of 40 MDT meetings were held throughout the county and, based on an online survey implemented during late Spring 2011, 100.0% of MDT members who completed the survey agreed that the MDT meetings are helpful and that HDS provides a needed service in San Diego County that would otherwise not be provided.

> "[HDS is] an amazing network of providers dedicated to enhancing the growth and development of children and families 0-5 years of age."
>
> **– MDT member**

+ **Trainings**. As many of the tools and curricula were new this fiscal year, trainings were provided for HDS service providers, regional leads, care coordinators, public health nurses and San Diego Regional Center providers. Trainings covered new curricula, screening and assessment tools, care coordination and cultural competency.

+ **Physician Outreach and Education.** Customized training services were provided at physician's offices for fourteen physicians and five physician assistants to increase implementation of developmental screenings. HDS is spearheading the effort to make the Ages and Stages Questionnaire (ASQv3) the standard screening tool in San Diego County.

+ **Capacity Building**. AAP-CA3 worked to increase capacity within the developmental and behavioral system of care by expanding knowledge about behavioral and developmental services in the community, training HDS providers to improve their skills, and expanding the workforce that delivers services to young children; specifically advancing the field of early childhood mental health through conferences and scholarships.

> *Would you recommend HDS services to a friend?*
>
> "Yes doesn't even answer it. Yes, yes. I mean, yes definitely. That's why I'm here; because [my child] just got such great services."
>
> **– HDS parent**

+ **Service Area Workgroup Meetings**. Monthly meetings for each service area were held with regional leads and providers to ensure successful implementation and to discuss ways to improve services.

+ **Pilot Projects**. In order to continually improve HDS services and ensure the success and appropriateness of the curricula and instruments, changes in service delivery must be tested. Processes were created this year to pilot new projects and tool administration.

Update on FY 2009-10 Recommendations

.	Update on Recommendation
Utilize standardized tools and curricula across regions and providers	✚ HDS providers began using standardized tools and curricula across all regions which allowed for streamlining administration countywide, creating more in depth evaluation and comparison to normative data. ✚ As many of the tools were new this fiscal year, pilot testing was necessary and some tools were found to be inappropriate for the HDS population. These tools will be replaced in FY 2011-12.
Increase capacity for the provision of behavioral, developmental and speech/language treatment	✚ HDS has fostered the capacity of the San Diego medical community to provide healthy developmental services for young children and their families through provider trainings and provided scholarships to help professionals gain certification in early childhood mental health. ✚ With the initiation of services by level of intensity capacity was improved for behavior, development and speech and language services. ✚ There remains a need for more trained professionals in each service area.
Continue to provide evidence-based interventions resulting in gains	✚ FY 2010-11 saw piloting of a developmental assessment tool and specific methods to identify quantifiable gains. In FY 2011-12 HDS will continue to identify measureable and quantifiable tools that can be used to measure clinical gains.
Empower and educate families through care coordination	✚ Care Coordinators served over 10,000 parents and children during FY 2010-11 and helped teach parents how to support their child's development and access community resources. ✚ Progress in identifying Care Coordination goals was slow in FY 2010-11 and tools were created to assist the families with identifying and prioritizing their needs and achieving specific goals. More work continues to be done with expanding evaluation by care coordinators and connecting families to appropriate HDS services.
Promote the goals of HDS to expand the network of care	✚ Through multi-disciplinary team meetings, members of the broader system of care for early childhood were able to interact with HDS providers and better understand the HDS system. ✚ HDS has helped build awareness about the importance of early and regular developmental screenings through trainings for primary care physicians, public health nurses and other service providers throughout San Diego County.

Recommendations

The following recommendations are based on FY 2010-11 data and evaluation findings.

- **Examine efficiencies to reduce wait times between screening and treatment.** As prompt services are key to early intervention and reducing the number of families that are lost to follow up, HDS should continue to build community capacity and increase the workforce of professionals that provide behavioral and developmental services to young children to serve more families and reduce wait times.

- **Educate physicians and early care and education providers outside of HDS to conduct regular developmental screenings with young children**. By working to make developmental screenings a regular part of well child visits and preschool or daycare curricula, HDS can create a culture of early identification and intervention of developmental concerns amongst all professionals who serve young children and their families throughout San Diego County. This will allow HDS to focus more on providing assessment and treatment to those with concerns and reduce the resources spent on screenings.

- **Coordinate high quality services to identify and improve gains for children and families.** As shown by the HELP and CBCL results, HDS services are helping children make developmental gains and behavior improvements. In the next year, coordination of developmental and/or behavioral treatment with parent education can systematically provide opportunities to increase children's qualitative and quantitative gains.

- **Improve referral outcomes through care coordination.** Care Coordinators should continue their successful work in helping families connect to services within HDS, but also spend more effort linking families to agencies outside of HDS. This will not only help the families in need, but also improve the overall network of services for young children throughout the County.

- **Build more connections between HDS and other community organizations and projects.** HDS seeks to provide services for the children with mild to moderate needs that are not eligible to receive services through other programs. In order to leverage resources and develop a smoother system of care, HDS should continue to connect with other community organizations and projects that serve similar populations. Existing pathways between KidSTART and HDS should also be improved as KidSTART is fully implemented so that families are appropriately served and referred and do not fall through the cracks.

- **Establish a protocol for appropriately identifying providers for intensive behavioral consultations for ECE providers.** Intensive behavioral consultations conducted through HDS are an investment in the ECE providers selected to receive them. The ECE providers should be identified through an eligibility protocol that selects providers whose needs best fit the intensive services offered and who are committed to remaining in the ECE field.

- **Improve data collection to increase the number of matched cases for evaluation analysis.** The standardization of curriculum and tools used throughout the HDS system was an improvement from previous years. However, the data collection during FY 2010-11was a learning process and less valid data were collected than hoped. HDS providers should identify ways to improve data collection and increase the number of clients who have matched pre and post data for analysis.

CHAPTER 2

Oral Health Initiative

2010/2011 Scorecard

Goals	Measures	Target	Actual	Performance
1. Increase oral health screenings coupled with education	Number of children receiving an oral health screening	10,500	26,440	251.8%
	Number of pregnant women receiving an oral health screening	2,100	4,383	208.7%
2. Increase the number of clients receiving dental examinations	Number of children 1-5 receiving dental exams	6,800	12,189	186.7%
	Number of pregnant women receiving dental exams	1,800	3,248	175%
3. Provide care coordination for oral health services to those at risk	Number of children 1-5 receiving care coordination	3,500	3,619	103.4%
	Number of pregnant women receiving care coordination	1,000	1,479	147.9%

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

OHI 2010/2011 Scorecard, continued

Goals	Measures	Target	Actual	Performance
4. Increase the number of parents/ caregivers who are knowledgeable about promoting children's oral health	Number of parents/ caregivers participating in educational outreach	3,000	11,872	395.7% 
	Number of pregnant women participating in educational outreach	800	1,937	242.1% 
5. Increase the number of providers who are knowledgeable about how to promote children's oral health	Number of providers given education/ training	790	1,755	222.2% 

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

Introduction

"Through the OHI program, we are able to make huge differences in our patients who cannot afford the care. It is really nice to see patients be so thankful for the service."

- **OHI Provider**

The importance of dental care for young children is sometimes misunderstood. Misconceptions exist that dental health is not as critical for baby teeth. Yet, untreated oral health disease can affect a child's nutritional status and diet, sleep patterns, appearance, impair psychological status and social interaction, and cause problems with speech and language development. Gum disease that begins in young children can cause life-long dental problems.[1] Over one-third (36.4%) of San Diego County's children ages 1-5 have never visited a dentist.[2] Yet, children who have their first dental visit by age one average almost 40% less in dental costs over five years.[3] Children with untreated dental disease require more extensive and expensive care; early detection can prevent costly future treatment and improve a child's oral health and overall quality of life.[4] Preventative measures such as water fluoridation, regular dental screenings, and dental sealants are important, cost-effective ways of preventing dental disease and can potentially eliminate dental decay in school-age children.[5] Prevention interventions alone; such as sealants and fluoride treatments, can save $66-$73 per tooth compared to filling caries.[6] Dental treatment is also critical for pregnant women, as untreated dental disease increases the risk of preterm deliveries, low birth weight babies, and the transmission of infectious oral bacteria between mother and child.[7,8] Children whose mothers have poor oral health are five times more likely to have oral health problems.[9]

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 $2,600,000, OHI provides screenings, examinations, care coordination, preventive oral health services (such as fluoride varnishes), and comprehensive treatments for young children and pregnant women who would otherwise not receive oral health services. This past year, OHI provided treatment funds for those with no other methods to pay for services: $800,698 in treatment funds for children and pregnant women and $82,169 for specialty treatment for children 0-5 with severe dental conditions that required oral surgery or anesthesia. A fiscal impact study, commissioned by First 5 San Diego in 2009 found that the return on investment of OHI was close to five dollars for every dollar of funding spent.[10]

[1] 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 >
[2] University of California, Los Angeles. California Health Interview Survey. 2007. Accessed October 9, 2009. <www.chis.ucla.edu>.
[3] Savage, Matther,, Lee, Jessica, Kotch, Jonathan and Vann Jr., William. "Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs." Pediatrics 2004; 114 pp. 418-423.
[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] Centers for Disease Control and Prevention. Oral Health: Preventing Cavities, Gum Disease, Tooth Loss, and Oral Cancers At A Glance 2011. Accessed 5 October 2011 <http://www.cdc.gov/chronicdisease/resources/publications/aag/doh.htm>
[6] Ramos-Gomez, FJ and Shepard DS. "Cost-effectiveness Model for Prevention of Early Childhood Caries." J Calif Dent Association. 1999 Voll 27, pp. 539-44.
[7] 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.
[8] Kohler B, Andreén I:Influence of caries-preventive measures in mothers on cariogenic bacteria and caries experience in their children Arch Oral Biol 1994, 39(10):907-911.
[9] Brown, Amy, "Access to Oral Health Care During the Perinatal Period: A Policy Brief" National Maternal and Child Resource Center, p.7.
[10] Van Gilden, Jennifer, Berri, David and Grammy, Abbas. "An Economic Analysis of First 5 San Diego" (submitted: December, 2009) p.39.

Key Elements

As the lead agency, the Community Clinics Health Network (CCHN) 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, early care and education 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 2010-11 marks the sixth year for OHI. This section compares results from FY 2009-10 and FY 2010-11 for the number of children and pregnant women who received screenings, exams, treatments, care coordination, and education.[11] 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. [12] Overall, the data trends reflect a strong and stable initiative that has created an effective system of oral health care delivery for children and pregnant women.

Demographic Data

The demographics of the children and pregnant women served are presented in the tables below. Of the 26,440 children served by OHI in FY 2010-11, the majority were Hispanic (73.1%). Another 13.4% of children served were White. Reflecting the large proportion of Hispanic participants, 50.2% of children were Spanish speakers.

Exhibit 2.1 Ethnicity and Language of Children 0-5

Ethnicity	(n=26,440)	%	Language	(n=26,440)	%
Hispanic/Latino	19,329	73.1%	Spanish	13,286	50.2%
White (non-Hispanic)	3,545	13.4%	English	11,130	42.1%
Other	3,556	13.5%	Other	2,024	7.7%

The demographic profile of the pregnant women served by OHI is presented in Exhibit 2.2 and is similar to the demographic profile of children served. Of the 4,383 pregnant women served, 70.5% were Hispanic and 59.7% spoke Spanish. Another 22.3% were White and 38.0% spoke English. These data show the success of OHI providers in reaching the children and pregnant women from different ethnic backgrounds.

[11] 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.

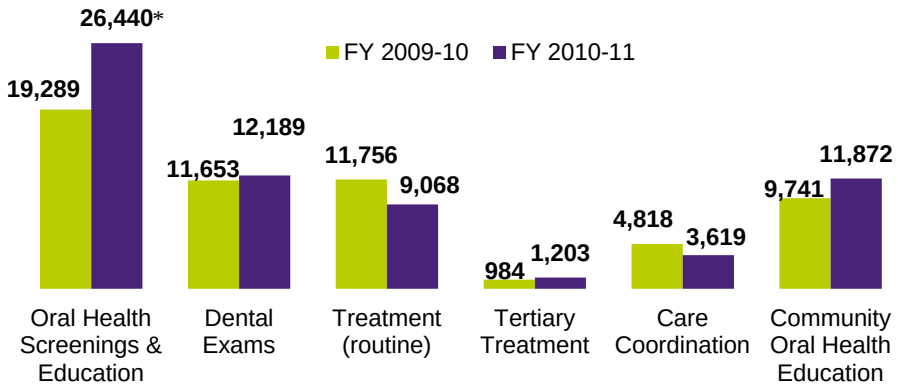
[12] The OHI treatment fund is a payer of last resort for children ages 1 to 5 and pregnant women in need of dental services.

Exhibit 2.2 Ethnicity and Language of Pregnant Women					
Ethnicity	**n=(4,383)**	**%**	**Language**	**n=(4,383)**	**%**
Hispanic/ Latino	3,089	70.5%	Spanish	2,617	59.7%
White (non-Hispanic)	978	22.3%	English	1,665	38.0%
Other	316	7.2%	Other	101	2.3%

Oral Health Services Delivered to Children

Exhibit 2.3 summarizes the type and number of services provided by OHI to children in FY 2009-10 and FY 2010-11. As noted above, OHI providers deliver a full range of oral health services including screenings, parent education, exams, care coordination and treatment. The number of children served in FY 2010-11 increased across all services, with the exception of routine treatment and care coordination. The increases ranged from 4.0% (dental exams) to 37.1% (oral health screenings & education). These significant gains are the result of a number of factors: an increased investment in outreach coordinators who bring screenings and education to community settings, a special screening effort conducted this year by Share the Care, a mobile unit used in one area serving schools and medical clinics, and the First 5 San Diego oral health public education campaign.

Exhibit 2.3 Number of Children Served by OHI FY 2009-10 & FY 2010-11



**10,128 of these screenings took place in a community setting.*

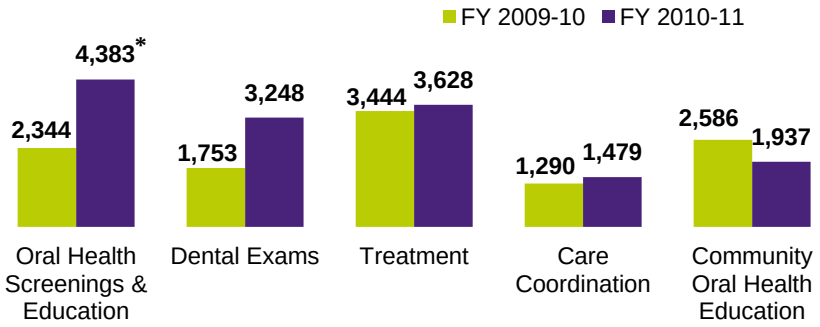
Decreases in routine treatment (22.9%) are attributed to improved preventative practices leading to less need for treatment, and families declining to have needed treatment due to cutbacks in dental coverage from public health insurance, like MediCal. The decrease in the care coordination figures is due to a change in the way care coordination patients are counted; it is now focused on more in depth tracking of high risk patients in order to increase accuracy and reduce the data collection burden.[13] In addition, due to the few number of specialty providers, some clients are wait listed and do not receive care coordination until an appointment can be made for these specialized services. Then clients are re-engaged and care coordination continues until their treatment is complete.

[13] There are three specialty providers in the OHI network who are equipped with diagnostic and treatment facilities not generally available at local clinics. Attempts to recruit additional specialty providers have been unsuccessful due to low MediCal reimbursement rates.

Oral Health Services Delivered to Pregnant Women

As shown in Exhibit 2.4, the number of pregnant women served by OHI increased from FY 2009-10 to FY 2010-11 across all OHI service areas except screenings and oral health education, which decreased by 25.1% due to a change in the way this service was counted. The increase in the number of pregnant women served ranged from 5.3% (treatment) to 87.0% (oral health screenings & education). The significant increase in screenings has been attributed to full-time outreach coordinators hired at seven provider locations, increased participation in community events such as health fairs and school-based events, a First 5 San Diego oral health public awareness campaign and a special expanded community screening project through Share the Care.

Exhibit 2.4 Number of Pregnant Women Served by OHI FY 2009-10 & FY 2010-11



**817 of these screenings took place in a community setting*

Provider Trainings Delivered

A skilled set of providers is needed to meet the oral health needs of children and pregnant women in San Diego; threfore, OHI delivered a broad range of trainings for local providers and their staff. The number of all types of OHI providers receiving training increased markedly between FY 2009-10 and FY 2010-11. The increases ranged from 6.4% (prenatal providers) to 1,053% (primary care providers). Training received by ancillary staff increased 394% and training received by dental providers increased by 149%. These increases are attributed to expansions in training opportunities to more types of providers, including medical residents and ancillary staff in all clinic offices. Training outreach was also enhanced to reach more dental and medical student groups and others through coordinated training, such as those offered at conferences.

Exhibit 2.5 Overview of the Number of OHI Providers Receiving Trainings, Comparing FY 2009-10 to FY 2010-11

Results	FY 2009-10	FY 2010-11	% Change
Dental Providers	155	386	149%
Prenatal Providers	47	50	6.4%
Primary Care Providers	49	565	1,053%
Ancillary Staff	50	247	394%
CBOs	406	507	24.9%

Making a Difference

OHI has been providing screenings, exams, treatments, and services to children ages 1-5 and pregnant women in the community for six years. This was the third year for care coordination services, which focused on high risk clients and those receiving more intensive services. Care coordination services included on-going communications, support and tracking of clients throughout their treatment to ensure follow through on referrals and completion of their treatment plan. The six-year data trends presented below represent all services areas, with the exception of care coordination.[14]

Oral Health Services for Children

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

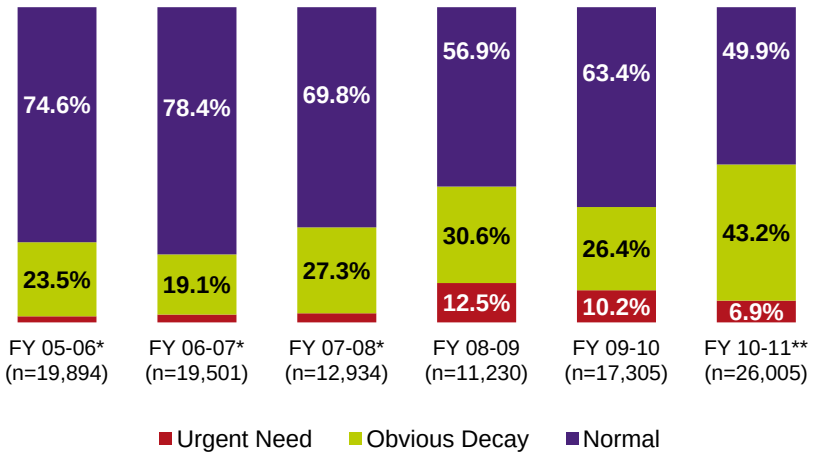
Oral Health Screenings

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

Oral Health Screenings for Children age 1-5

In FY 2010-11, there was a 13.5% decrease in the number of children who had normal screenings (i.e., no decay; Exhibit 2.6), and a 17.3% increase in obvious decay. The percentage of children identified with urgent oral health needs decreased from 10.2% to 6.9% between FY 2009-10 and FY 2010-11. Patients with warning signs of decay are referred to a full examination.

Exhibit 2.6 Results of Oral Health Screenings for Children FY 2005-11



**Urgent Need in FY 2005-06, FY 2006-07, and FY 2007-08 total less than 4%.*

*** Children whose results were unknown are not included in this figure.*

It is challenging to identify a trend in dental disease from screening data as some key factors have changed. In FY 2010-11, screenings increased because an OHI contractor, Share the Care, had a special project to expand screening efforts and more OHI outreach coordinators were added to OHI. As a result, more than 8,000 additional children were screened this year, reaching children with limited access to care in community screening events. This higher need population is likely to have more dental decay. Overall, the six-year trend for screening results shows an increase in the percentage of patients with urgent dental needs and with obvious decay.

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

Some of the increase is also attributed to improvements in equipment, which allow providers to see more potential decay during these visual screens.

Preventative Treatments Delivered in Community Settings

OHI screenings provided in community settings include the application of fluoride varnishes and sealants. These cost-effective, preventative treatments are known to reduce the risks of cavities (caries) and other dental problems, especially for young children.

During FY 2010-11, there was a significant increase in the number of fluoride varnishes provided and a small increase in the number of sealants provided to children ages 1 to 5 (Exhibit 2.7). There are two key reasons for these increases: OHI clinics increased their efforts to provide screenings and prevention services at schools and health fairs, and changes in regulations that allowed ancillary providers to apply sealants and varnishes.

Exhibit 2.7 Fluoride Varnishes & Sealants in Community Screenings for Children 1-5

Fluoride Varnishes	
FY 2009-10	6,221
FY 2010-11	7,023
Sealants	
FY 2009-10	121
FY 2010-11	130

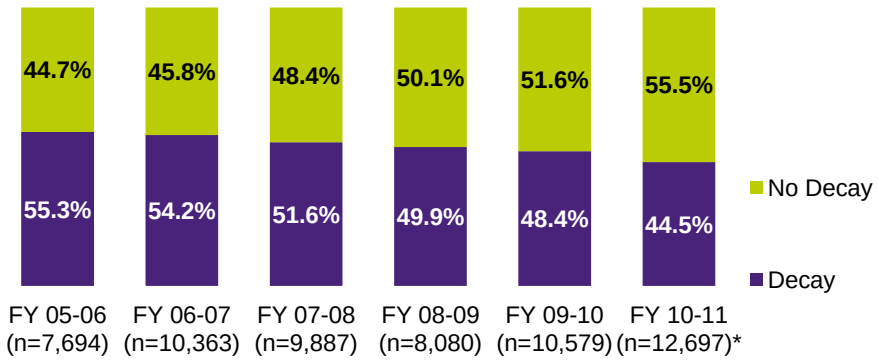
Results of Oral Health Exams

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 in OHI from FY 2005-11.

Results of Dental Exams

Dental exam results provide an indication of the status of oral health care among children seen in clinics. Fiscal Year 2010-11 shows an improvement in the percentage of children identified with no decay, as compared to FY 2009-10 results (Exhibit 2.8).

Exhibit 2.8 Results of Dental Exams for Children FY 2005-11



**Note: FY 10-11 includes exams both in clinics and tertiary care.*

Over the past six years, exam results have continuously improved, with just over half (55.5%) of children in FY 2010-11 who received an exam identified without decay at the time of the examination. These results have improved over 10.0% since the inception of OHI and are believed to be the result of OHI preventative and treatment services reaching the target population.

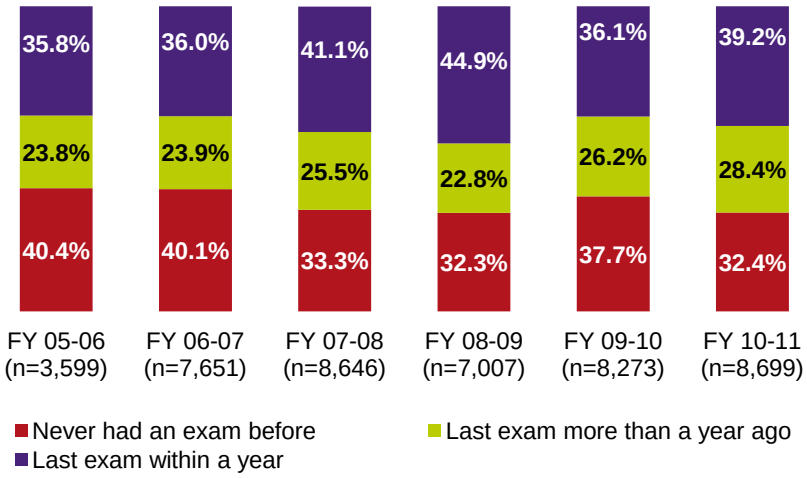
Timely Access to Dental Exams

Frequency of Dental Exams

An annual dental exam is an important preventative practice for young children. The data in Exhibit 2.9 show the trend in the frequency of dental exams. The percentage of children aged 2-5 years old who had a dental exam within the past year increased slightly from FY 2009-10 to FY 2010-11 and the percentage of children who had never had an exam before (32.4%) decreased by 5.3% from the previous year.

The overall trends in these data since the beginnning of OHI are positive, yet improvements are needed to increase the rate of children receiving timely dental exams.

Exhibit 2.9 Time Since Last Dental Exam for Children FY 2005-11



Care Coordination

Clients who are high risk for dental disease and other oral health problems receive additional treatment, follow up, and a variety of care coordination services to promote the completion of all needed services and oral health education. In FY 2010-11, 3,619 children were identified through the Carie Risk Assessment process to be at high risk for dental disease, and received care coordination services to assist them in receiving needed treatment.[15] This represents a 25.4% decrease over FY 2009-10. The reduction in the number of children identified as high risk is believed to be a reflection of the preventative education and early care that children are receiving through OHI. Additionally, as discussed in Exhibit 2.3, the methodology was changed from FY 2009-10, to track solely high-risk children, which reduced the reporting of the overall number of children served. Access to education and routine care reduces children's risks for dental disease. These clients are supported through the services, treatment, and education they receive as part of the care coordination process.

[15] Any family needing support to connect their child to treatment can receive care coordination services, but data are collected, analyzed and reported only for high risk clients to reduce the data burden.

Care Coordination Services Delivered

Exhibit 2.10 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. In addition, care coordinators provide other services including: reminder cards, specialy referrals and calls to remind clients to return for needed services. All of these efforts are targeted to increase patient participation and assure that children receive needed dental care.

Exhibit 2.10 Care Coordination Services Provided to Children 0-5 (n=5,285)*

Appointment Reminder Call	2,856
Follow-Up Call (with patient)	1,434
Insurance Referral	108

**Other Care Coordination Services include post card or letter, insurance referral, specialty treatment pool referral, no-show call, and follow up call (with provider)*

Caries Risk Assessment

The Caries Risk Assessment (CRA)[16] 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 for oral health issues. During the patient interview, a dental professional asks questions to identify any oral health protective factors or risk indicators. Protective factors for children include: mother/caregiver/sibling had no decay for past three years; regularity of dental care; having water fluoridation; having fluoride varnishes; and the mother/caregiver's use of xylitol gum.[17] The CRA involves assessing protective and risk behaviors with a clinical examination These protective behaviors are discussed with parents and additional education is provided to parents to encourage implementation of these protective practices. 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 to determine any decay, plaque, past dental procedures,[18] orthodontics,[19] or dry mouth. Based on the interview and the exam, the provider determines the caries risk level of the child as low, moderate, or high.

> "The CRA provides a good framework for patient education."
>
> **– F5 OHI Provider**

[16] Caries is the medical term for cavities
[17] 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.
[18] Dental procedures include fillings, crowns, and implants.
[19] These include braces and other devices used to adjust teeth.

Common Risk Indicators and Protective Factors

Exhibit 2.11 provides the most commonly identifed protective factors and risk indicators based on the CRA. Caregivers reported the use of fluoride toothpaste (76.3%) as the most common protective measure taken to prevent dental disease, followed by regular dental care (32.0%) and drinking flouridated water or taking flouride supplements (28.5%).

Exhibit 2.11 Most Common Caries Risk Assessment Protective Factors and Risk Indicators of Children FY 2010-11

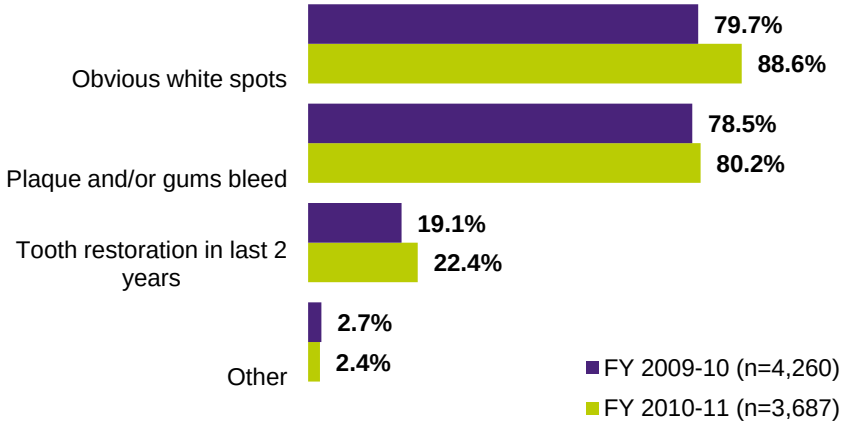
Indicator/Factor	Children (n =3,687)	
	Issue	%
Protective Factor	Uses fluoride toothpaste	76.3%
	Child has regular dental care	32.0%
	Child drinks fluoridated water or takes fluoride supplements	28.5%
Risk Indicator	Mother, caregiver, sibling(s) with decay in past 12 months	57.3%
	Frequently drinks sweetened beverages or snacks (more than 3 times/day)	54.4%
	Child has sporadic dental care	35.9%

Turning to risk indicators, 57.3% of high risk children had a household member with recent dental decay. This increases the risk of transmitting dental disease to children and is indicative of inadequate preventative dental care in the family. Other common risk factors among children were the frequent consumption of sweetened beverages or snacks and sporatic dental care.

Exam Results

Clinic exams provide an in-depth assessment of risks and needs. Exhbit 2.12 shows the outcomes of OHI provided clinical exams for high risk children for FY 2009-10 and FY 2010-11. This figure shows that the most common risk factors are: obvious white spots (88.6%), followed by plaque and/or bleeding gums (80.2%), and tooth restoration in the past two years (22.4%).

Exhibit 2.12 CRA Clinical Exam Results of High-Risk Children FY 2009-10 & FY 2010-11



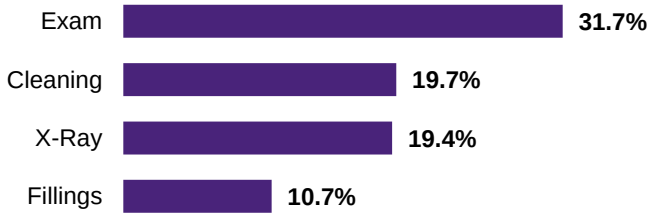
Prevention and Treatment Services Provided to High-Risk Children 1-5

Once children are assessed by the CRA, a plan of prevention and treatment services is developed. The following data summarize the prevention and treatment services that were provided to children who were deemed high risk by the CRA.

Prevention/Treatment Services

The most common prevention and treatment services provided to high risk children are presented in Exhibit 2.13. In FY 2010-11, the most common services delivered to high risk children were exams (31.7%), cleanings (19.7%), x-rays (19.4%) and fillings (10.7%).

Exhibit 2.13 Prevention/Treatment Services Provided to High Risk Children*



**The percentages do not add to 100% because infrequently reported categories are not included.*

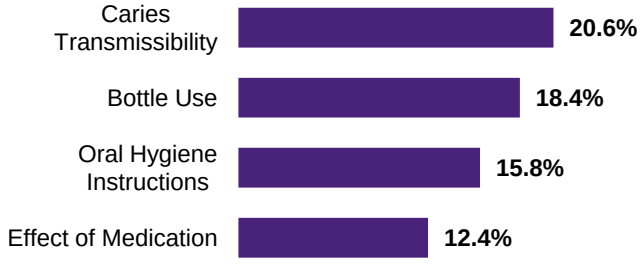
Education and Assistance Topics Provided to High-Risk Children 1-5

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

Education/Assistance Services

In FY 2010-11, among all education/ assistance services provided to high risk children and their caregivers, the two most common education topics covered of all those discussed were: caries transmissibility (20.6%) and proper bottle use (18.4%). These topics were discussed with the parents and child, emphasizing the importance of preventing caries. Other topics included proper oral hygiene instructions (15.8%), such as how to brush and floss, and the impact of certain medications on saliva flow and dental disease (12.4%).

Exhibit 2.14 Education/Assistance Service Topics Provided to High Risk Children*



** The percentages do not add to 100% because infrequently reported categories are not included.*

Oral Health Services for Pregnant Women

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

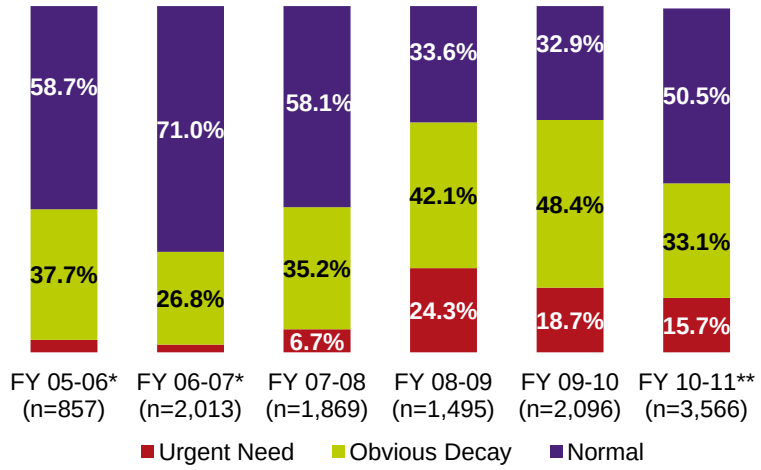
Oral Health Screenings

The data below summarize the results of the OHI oral health screenings in both the clinic and community settings for pregnant women.

Results of Oral Health Screenings

Exhibit 2.15 displays the six-year trend in oral health screening results for pregnant women. The proportion of pregnant women screened who had obvious decay decreased by 15.3% to 33.1% in FY 2010-11. Pregnant women with urgent needs increased slightly in FY 2010-11, though the number of pregnant women being screened nearly doubled. The dramatic increase in the number of women who received oral health screenings is a direct result of concentrated efforts by oral health outreach coordinators and the special screening project performed by Share the Care.

Exhibit 2.15 Results of Oral Health Screenings in a Clinic Setting for Pregnant Women FY 2005-11



**Urgent Need in FY 05-06 and FY 06-07 total less than 4%*
***Note: The FY 10-11 n differs from the scorecard n as this figure includes only clinic-based screenings to be consistent with the previous year's measurement.*

Preventative Treatment Delivered in Community Settings

The application of fluoride varnishes is an important preventative practice for pregnant women as well as children. During FY 2010-11, the number of fluoride varnishes provided to pregnant women (Exhibit 2.16) increased by 241.7% 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, as well as an increase in participation in community health fairs. In addition, there were legislative changes that allowed additional levels of staff to apply varnishes, increasing the number of fluoride services delivered to pregnant women.

Exhibit 2.16 Fluoride Varnishes in Community Screenings for Pregnant Women

FY 2009-10	175
FY 2010-11	423

Results of Oral Health Exams

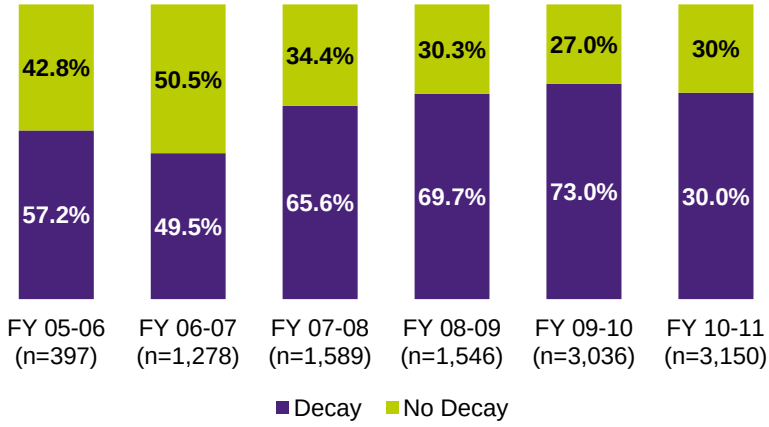
The results of OHI oral health exams show the percentage of pregnant women who had dental decay (Exhibit 2.17) as well as the time lapse since their last dental exam (Exhibit 2.18). These results provide a picture of the oral health of pregnant women upon examination.

Exam Results

Since FY 2005-06, there has been a steady increase in the percentage of pregnant women who had examinations showing the presence of dental decay, with a slight 3.0% decrease in FY 2010-11 (Exhibit 2.17).

As a result of efforts by primary care and OB/GYN physicians and oral health outreach coordinators to refer pregnant women to dental clinics, OHI saw an increased number of pregnant women in FY 2010-11; many of these patients were from the high risk population. This, combined with services that are provided through the treatment fund is believed to explain the increase in patients with greater dental decay.

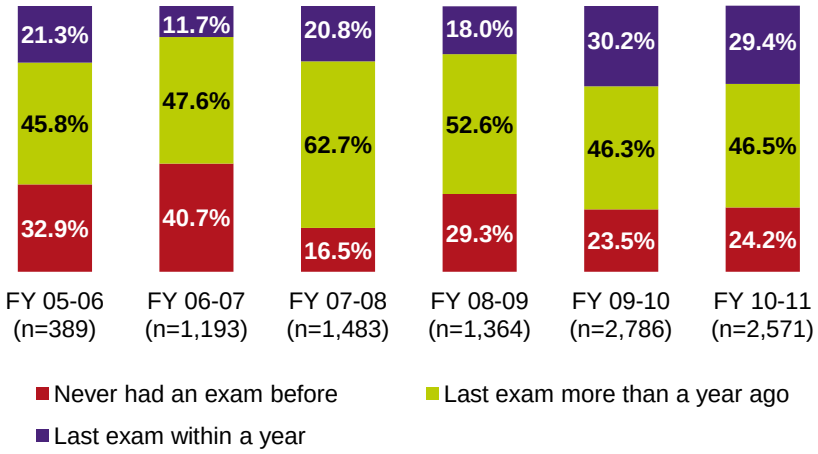
Exhibit 2.17 Results of Dental Exams among Pregnant Women FY 2005-11



Frequency of Dental Exams

In FY 2010-11, 29.4% of pregnant women seen had an exam within the previous year – only a slight decrease since the previous year, which saw the greatest percentage increase in OHI's history (Exhibit 2.18). Additionally, there was only a slight increase in the percentage of pregnant women reporting never having an exam compared to the previous fiscal year. Efforts by OHI providers continue to increase the percentage of pregnant women who receive dental exams in order to reduce dental disease.

Exhibit 2.18 Last Dental Exam for Pregnant Women FY 2005-11



Care Coordination

The Caries Risk Assessment is also administered to pregnant women during oral health screenings or exams to assess their risk for dental disease and other oral health problems. In FY 2010-11 1,479 pregnant women rated as high risk for dental disease after completing the CRA received care coordination services to assist them in receiving needed treatment.[20] This was a 14.7% increase over FY 2009-10. The services, treatment, and education received by pregnant women as part of the care coordination process are carefully tracked and reported below.

Care Coordination Services

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. Other coordination services include mail reminders, calls to other providers, insurance referrals and connecting clients to the specialty treatment pool. These services frequencies are similar to those in care coordination services for children.

Exhibit 2.19 Care Coordination Services Provided to Pregnant Women (n=2,920)*

Appointment Reminder Call	1,716
Follow-Up Call (with patient)	269
No-Show Call	43

**Other Care Coordination Services include post card or letter, insurance referral, specialty treatment pool referral, no-show call, and follow up call (with provider)*

Caries Risk Assessment (CRA)

During the patient interview, the CRA assesses protective factors and risk indicators to determine a patient's risk of having cavities (i.e., caries). 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.[21] 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. Based on an assessment of all these factors, the provider determines the caries risk level of the pregnant woman as low, moderate, or high.

Exhibit 2.20 represents 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.

[20] Any family needing support to connect their child to treatment can receive care coordination services, but data are collected, analyzed and reported only for high risk clients to reduce the data burden.
[21] Chlorhexidine rinse is as an active ingredient in mouthwash to reduce dental plaque and oral bacteria.

Common Risk Indicators and Protective Factors

Patient interviews using the CRA with pregnant women revealed the most common risk indicators and protective factors. The most frequent protective and risk factors are reported in Exhibit 2.20. High risk pregnant women reported the use of fluoride toothpaste (87.3%), as the most common protective measure taken to prevent dental disease, followed by the use of fluoride mouth rinse (29.5%) and the drinking of fluoridated water (25.3%).

Exhibit 2.20 Most Common CRA Protective Factors and Risk Indicators for Pregnant Women FY 2010-11

Pregnant Women (n =1,442)		
Indicator/Factor	**Issue**	**%**
Protective Factor	Uses fluoride toothpaste	87.3%
	Used fluoride mouth rinse	29.5%
	Drinks fluoridated water	25.3%
Risk Indicator	Caries in the last 3 years	76.3%
	Frequently drinks sweetened beverages	54.3%
	Frequent snacks of sweet/starches (more than 3 times/day)	51.3%

The most frequent risk factor among high risk pregnant women was the presence of caries in the last 3 years (76.3%), the frequent consumption of sweetened drinks (54.3%) and sweet or starchy snacks (51.3%). These findings are consistent with those reported by pregnant women who were given the CRA in FY 2009-10.

OHI Treatment Funds

Specialty Treatment Fund

Since it was established in 2006, the OHI Specialty Treatment Fund has served children whose dental needs are so severe, they require oral surgery or their treatment requires anesthesia. In FY 2010-11, the specialty treatment fund:

- Provided $81,060 in specialty treatment services and
- Treated 53 children.

There were four providers who administered treatment for children through this fund.

Since its inception in 2006, the specialty treatment fund has provided 269 children (unduplicated) with specialty treatment services totaling $605,140.

Treatment Fund

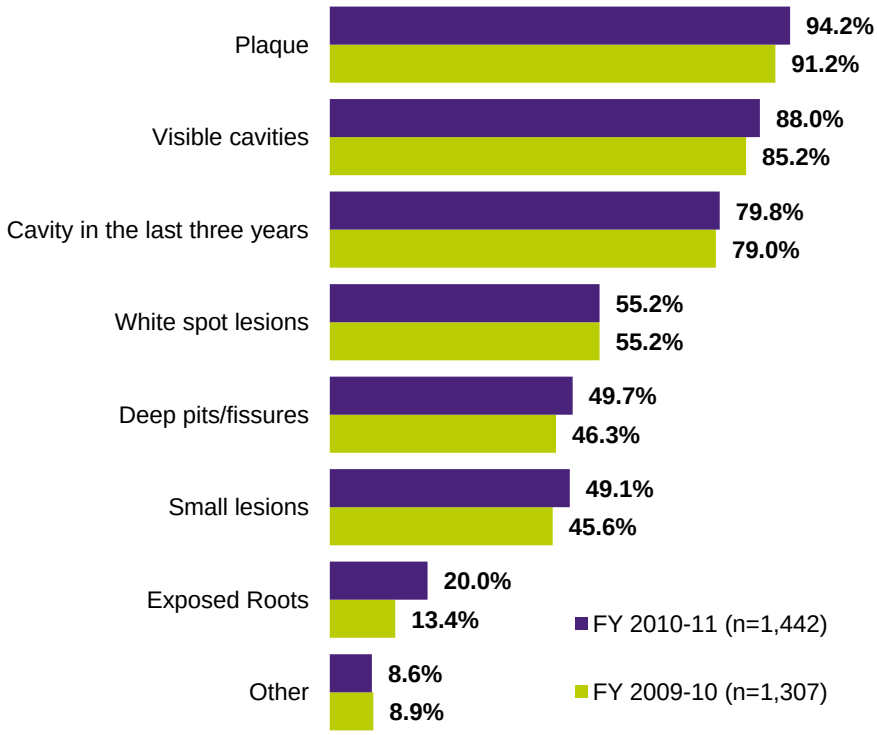
The OHI Treatment Fund is the payor of last resort for uninsured or underinsured children ages 1-5 and women who are pregnant or up to 90 days postpartum who are in need of dental services. Patients may be seen at any dental provider at a participating OHI dental clinic. In FY 2010-11, the treatment fund:

- Provided $800,698 in treatment services; and
- Treated 892 children, 1,009 pregnant women, and 361 postpartum women (unduplicated).

Exam Results

Exhibit 2.21 provides CRA results for pregnant women. Clinical exam results for high risk pregnant women revealed plaque (94.2%), visible cavities (88.0%), a cavity in the last three years (79.8%), white spot lesions (55.2%), deep pits/fissure (49.7%), and small lesions (49.1%) as the most common exam results contributing to a high risk categorization.

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



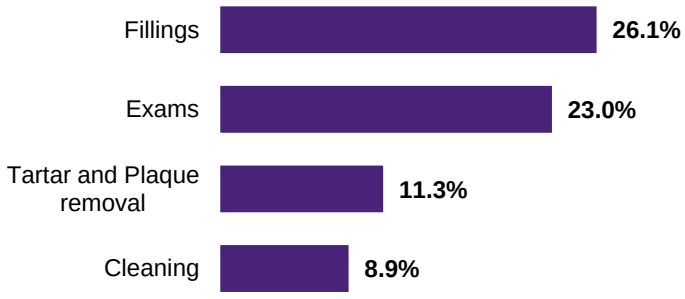
Prevention and Treatment Services Provided to High-Risk Pregnant Women

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.

Prevention and Treatment Services

As seen in Exhibit 2.22, the most common prevention/treatment services provided to high risk pregnant women in FY 2010-11 were fillings (26.1%) and exams (23.0%). Other services include tartar and plaque removal (11.3%) and cleanings (8.9%). These results were similar to FY 2009-10.

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



** The percentages do not add to 100% because infrequently reported categories are not included.*

Education and Assistance Topics Provided to High-Risk Pregnant Women

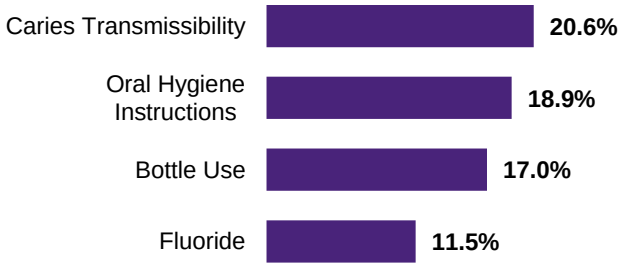
The following outcomes represent the education and assistance services provided to pregnant women who were deemed high risk from the CRA.

Education and Assistance Services

Of the education/assistance services provided to high risk pregnant women in FY 2010-11, the most common education services provided were caries transmissibility (20.4%) and oral hygiene instructions (18.9%). Other topics covered included the proper use of bottles with babies (17.0%) and the importance of fluoride (11.5%).

These results were slightly different than in FY 2009-10 where oral hygiene instructions, nutrition counseling, and fluoride education were the most common topics presented to pregnant women.

Exhibit 2.23 Education/Assistance Service Topics Provided to High Risk Pregnant Women*



** The percentages do not add to 100% because infrequently reported categories are not included.*

Making the Connection

OHI's six service areas incorporate a comprehensive approach to promoting and actively ensuring positive oral health habits and practices among children 1-5 and pregnant women. The Community Clinics Health Network, 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. Throughout its history, OHI has played a leadership role in building awareness of the importance of oral health in early childhood and in promoting the importance and safety of providing dental services to pregnant women. In this area, OHI has built partnerships with pediatricians and OB/GYNs who now refer patients with visible problems to the dentist. In addition, many health providers now include the importance and safety of seeing the dentist in their prenatal orientations.

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, targeted trainings were provided to private dental practitioners on specific oral health topics in an effort to improve OHI services and visibility on a systems level. Specifically, this year OHI providers were able to secure additional resources to provide training to a larger number of providers than was possible in previous years (see Exhibit 2.5). 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.

Supporting First 5 Cross-Initiative Collaborations

OHI contractors coordinated with other First 5 initiatives by cross-referring clients with Healthy Development Services (HDS) and Healthcare Access (HCA) and collaborating with these health providers at community events throughout the county. For example, OHI providers delivered screenings on-site at many Preschool for All (PFA) and School Readiness sites, and more than 1,380 children were referred from PFA schools to OHI providers for oral health care. The coordination among these agencies and across the initiatives is believed to have improved enrollment into needed dental services through referrals from other providers, as well as improved overall health care management of children 0-5.

OHI worked with the Commission's communications contractor, MJE Marketing Services, Inc., on a very successful oral health public awareness campaign. The campaign included television and radio spots, billboards and displays in local shopping malls. The campaign focused on the importance of oral hygiene and regular visits to the dentist for young children and pregnant women.

Promoting Best Practices for OHI Providers

In January 2010, AB 667 was passed in California allowing any provider, trained in the technique, to apply fluoride varnishes and topical fluoride treatments in public health settings. In response to this, the CCHN arranged trainings for OHI providers and their staff in the application of varnishes and sealants. As seen in Exhibit 2.16, this training expanded a best practice and increased the number of fluoride varnishes to pregnant women from 175 in FY 2009-10 to 423 in FY 2010-11.

In addition to this training, OHI providers were offered a broad range of trainings in a variety of settings. OHI providers reported these trainings have had an impact on their skills and capacity. Not only are more providers trained to apply sealants and varnishes, but more providers understand and can teach the value of preventative practices for infant oral health to new mothers and can meet the needs of the target population.

Community Water Fluoridation

By the time California children enter kindergarten, more than half have already experienced dental decay, 28.0% have untreated decay and 19.0% have rampant decay.[22] The U.S. Surgeon General reports that community water fluoridation is the most cost-effective dental disease prevention program available, especially for large, multiethnic populations with disparities in health conditions. Additionally, the Centers for Disease Control (CDC) estimates that every dollar invested in fluoridation saves $38 in dental treatment.[23] Decades of studies demonstrate that water fluoridated at the optimum level is safe and effective in reducing cavities, especially among children.

In November 2007, the Commission allocated $5.6 million to support community water fluoridation in areas of the county without optimal levels of fluoridation. In March 2008, The California Endowment awarded the Commission a grant of $1 million to support this effort. This partnership contributed $3.9 million to optimally fluoridate the City of San Diego's water supply beginning in February of 2011, benefitting the oral health of nearly 107,000 children ages 0 through 5 and pregnant women. The Commission has allocated additional funds to provide fluoridation in two additional water districts.

[22] Dental Health Foundation (February 2006). "Mommy, It Hurts to Chew" The California Smile Survey: An Oral Health Assessment of California's Kindergarten and 3rd Grade Children.
[23] Centers for Disease Control and Prevention "Natures Way to Prevent Tooth Decay: Water Fluoridation" (2006)

Update on FY 2009-10 Recommendations

Last year's Recommendation	Update on Recommendation
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, helped identify and assist high need patients to receive needed treatment and improved patient care. These practices should be promoted for all OHI providers.	+ Referrals between OB/GYN and OHI providers has become a standard practice among clinic providers. Outreach coordinators frequently provide educational activities at prenatal care clinics and events for new mothers, focusing on oral health preventative practices for pregnant women and their children.
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. Promoting all available health insurance program options to pregnant women can help to increase enrollment and alleviate barriers to dental care.	+ Despite reductions in healthcare coverage, providers continue to work to connect children and pregnant women to dental health insurance and the OHI treatment funds. Providers report encouraging their pregnant patients to get all of the necessary dental care while they are pregnant and covered by Medi-Cal.
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. Providers agreed that a more standardized 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.	+ Despite differences in the way some services are provided (i.e., in health clinics vs. oral health clinics), OHI providers standardized tracking methods which has made reporting and analysis more clear and consistent.

Recommendations

The following recommendation is based on data from the FY 2010-11 as reported in this chapter.

- **Focus oral health education efforts on the topics identified by the Caries Risk Assessment.** The Caries Risk Assessment identifies how frequently high risk families engage in behaviors that either promote oral health or increase the risk of dental disease (Exhibits 2.11 and 2.20). These CRA results identify key areas of focus for oral health education: daily brushing and flossing, drinking fluoridated water or using fluoride supplements and toothpaste, avoiding transmitting dental disease among family members, reducing intake of sweetened beverages and snacks and regular dental care. Focusing education efforts on these areas offers the best opportunity to reduce dental disease among high risk children and their famies.

CHAPTER 3

Health Care Access

2010/2011 Scorecard

Goals	Measures	Target	Actual	Performance
1. Increase and sustain enrollment of eligible children from birth through age 5 and pregnant women in health insurance	Number of children assisted with health insurance	9,870	14,296	144.8%
	Number of pregnant women assisted with health insurance	4,010	3,913	97.6%
	Number of children enrolled into health insurance	7,280	10,609	145.7%
	Number of pregnant women enrolled into health insurance	3,095	2,512	81.2%

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

Introduction

"[HCA provides assistance to obtain/enroll] health insurance for children who wouldn't otherwise have access."

- 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 are uninsured children.[1,2,3] In addition, the uninsured are five times more likely to use the emergency room for primary care[4] and emergency room costs are triple those of an outpatient visit.[5]

As of 2009, 3.4% of San Diego County's children ages birth through 5 remain uninsured.[6] To improve health coverage among children, the First 5 Commission of San Diego implemented Health Care Access Initiative (HCA) to provide health insurance application assistance and ongoing support and education on the importance of maintaining insurance coverage for children birth through age 5 and pregnant women. HCA staff assists families in enrolling their young children in Medi-Cal and Healthy Families. They also work to identify and assist pregnant women who may be eligible to enroll in state and federal programs such as Medi-Cal, Healthy Families, or Access for Infants and Mothers (AIM). Since its inception in February 2004, First 5 San Diego has invested a total of $14,319,104 in HCA ($3,069,504 in FY 2010-11). A fiscal impact study, commissioned by First 5 San Diego in 2009 found that the return on investment of HCA was between $24.90 and $48.61 for every dollar of funding spent.[7]

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 through age 5 and pregnant women by: 1) identifying and reaching out to uninsured families; 2) assisting families in completing enrollment applications; 3) providing ongoing support to families to ensure they retain health insurance; and 4) educating families on the importance of establishing and maintaining a medical home and appropriately utilizing healthcare services. HCA's Certified Application Assistants (CAAs) coach families in attending regular well child and dental check-ups, using preventative medical care and avoiding the use of the emergency room for primary care issues.

[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] "The Uninsured: A Primer. Key Facts about Americans without Health Insurance." The Henry J. Kaiser Family Foundation. October, 2006.
[5] "Marginal Costs of Emergency Department Outpatient Visits: An update using California data," USC Center for Health Financing, Policy, and Management, November 2005.
[6] California Health Interview Survey, 2009. Accessed 11/23/11.
[7] Van Gilden, Jennifer, Berri, David and Grammy, Abbas. "An Economic Analysis of First 5 San Diego" (submitted: December, 2009) p.39.

Five organizations serve as lead agencies providing HCA services in six San Diego regions: Social Advocates for Youth (SAY) San Diego (two regions), Home Start, Inc., North County Health Services, Neighborhood Healthcare, and Vista Community Clinic. These providers collaborate to develop new and creative approaches to identifying and serving the ever-changing uninsured population.

Summing it Up

A total of 18,904 children and 4,311 pregnant women were served by HCA in FY 2010-11. Exhibit 3.1 shows the vast majority of children served by HCA were Hispanic/Latino (89.5%), more than three quarters spoke Spanish (77.2%) and 22.4% of children were English speakers.

Exhibit 3.1 Ethnicity and Language of Children 0-5

Ethnicity	(n=18,904)	%	Language	(n=18,904)	%
Hispanic/Latino	16,914	89.5%	Spanish	14,586	77.2%
Other	1,156	6.1%	English	4,241	22.4%
White (non-Hispanic)	834	4.4%	Other	77	0.4%

The demographic profile of the pregnant women served by HCA (Exhibit 3.2) shows similar trends. Of the 4,311 pregnant women served, 76.1% were Hispanic/Latino, over half (57.5%) spoke Spanish, and 32.1% were English speakers.

Exhibit 3.2 Ethnicity and Language of Pregnant Women

Ethnicity	(n=4,311)	%	Language	(n=4,311)	%
Hispanic/ Latino	3,280	76.1%	Spanish	2,488	57.7%
Don't know/ Declined	484	11.2%	English	1,385	32.1%
White (non-Hispanic)	354	8.2%	Don't know/ Declined	421	9.8%
Other	193	4.5%	Other	17	0.4%

Making a Difference

"The biggest benefit is knowing that [my] children are healthy and are getting their physicals, their immunizations, or if they're sick and they need treatment … that they're able to get it [because they now have health] insurance."

- HCA Provider

HCA has been serving the community for seven years. Since its inception in February 2004, HCA has provided extensive health care access services to reduce the number of uninsured.

Since February 2004:

- **100,880 children ages birth through 5** have been assisted with enrolling or re-enrolling into a health insurance program
- **72,143 children ages birth through 5** were enrolled or re-enrolled into a health insurance program
- **24,709 pregnant women** were enrolled into health insurance

Children Served

Exhibit 3.3 presents data on children from birth through age 5 served by HCA in FY 2010-11 and FY 2009-10. There was a 5.0% increase in the number of children receiving application assistance and 15.0% increase in the number of children enrolled in insurance in FY 2010-11. Exhibit 3.4 presents the number of services delivered by HCA contractors to children from birth through age 5. The total number of services was greater than the number of children served primarily because some clients may apply for insurance more than once in the fiscal year. (This may be due to delays with the enrollment process, a missed renewal, or changing insurance coverage (e.g., Healthy Families to Medi-Cal).

Exhibit 3.3 Number Children 0-5 Served

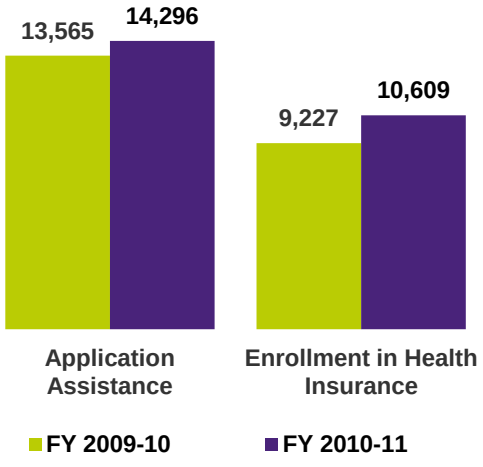
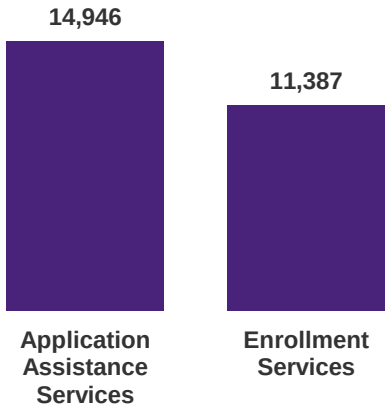


Exhibit 3.4 FY 2010-11 Number HCA Services Provided to Children 0-5



Pregnant Women Served

Exhibit 3.5 presents data on pregnant women served by HCA in FY 2010-11 and FY 2009-10. There was a 9.0% increase in the number of pregnant women receiving application assistance and 5.0% increase in the number of pregnant women enrolled in insurance from FY 2010-11 to FY 2009-10. Exhibit 3.6 presents the number of HCA services delivered by HCA contractors to pregnant women. Similarly to what was reported for children in Exhibit 3.4, the total number of services was greater than the number of pregnant women severed primarily because some clients may apply for insurance more than once in the fiscal year.

Exhibit 3.5 Number Pregnant Women Served

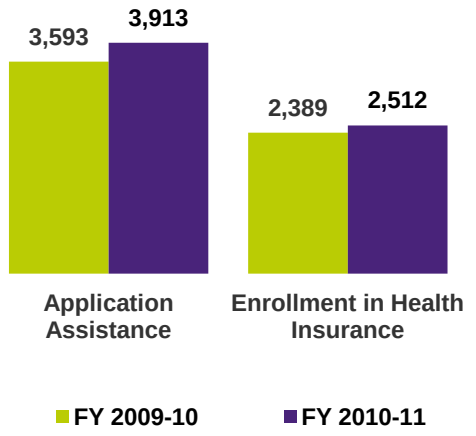
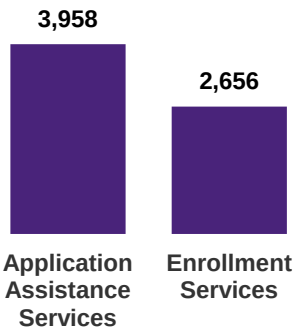


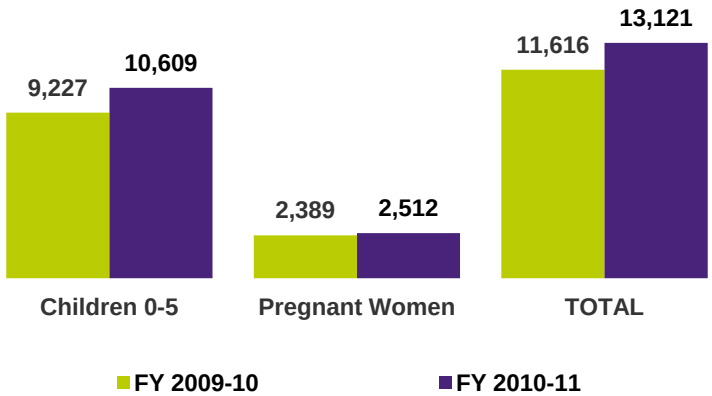
Exhibit 3.6 FY 2010-11 Number of HCA Services Provided to Pregnant Women



Clients Enrolled

Exhibit 3.7 shows the number of children from birth through age 5, pregnant women, and total enrollment in health insurance in FY 2010-11 and FY 2009-10. For children, this number represents both new and renewal enrollments while for pregnant women it represents new enrollments only. Although there was an increase in enrollment across both fiscal years, the percentage was greater for children. 1,505 more clients were enrollment in FY 2010-11, representing an overall 13.0% increase in enrollment.

Exhibit 3.7 Number of HCA Clients Enrolled in Health Insurance FY 2009-11



Renewals and Enrollments

Exhibit 3.8 presents the number of confirmed health insurance re-enrollments and new enrollments for FY 2009-10 and FY 2010-11. Overall, there was an increase in total enrollment activities in FY 2010-11 as compared to FY 2009-10. There was a slight increase in the number of children assisted across both fiscal years. There were an additional 1,382 children were newly enrolled or who retained their health insurance – a 13.0% increase over the previous year. The largest increases were in renewals, illustrating the importance of how CAA's build relationships and maintain contact with families to ensure they maintain health insurance. Due to the continued economic downturn, more families have lost their employer-sponsored health insurance due to layoffs or a reduction of their job benefits. These families are new to the requirements and processes of public health insurance and benefit from the assistance provided by the CAA's.

Exhibit 3.8 Number of People Reached by HCA in FY 2009-10 & FY 2010-11

Enrollment Activity	New Enrollment		Renewal		Total New and Renewal	
	FY2009-10	FY2010-11	FY2009-10	FY2010-11	FY2009-10	FY2010-11
Children ages 0-5 assisted	8,496	8,715	5,069	5,581	**13,565**	**14,296**
Children ages 0-5 confirmed enrolled*	6,301**	6,835	2,926**	3,774	**9,227**	**10,609**
Pregnant women enrolled	2,389	2,512	N/A	N/A	**2,389**	**2,512**

**Includes children enrolled into Medi-Cal, Healthy Families, and other types of health insurance.*
*** Number was corrected from FY 2009-10 Annual Report.*

Locating and Assisting the Uninsured

HCA contractors conduct ongoing outreach activities to identify uninsured families who may be eligible but are not enrolled in state and federal health insurance plans, as well as assist families to retain their insurance coverage. In FY 2010-11, 40,976 families with children birth through age 5 received outreach services via face-to-face contact. Contractors have continued to expand their reach into target communities by utilizing subcontractors with a deep knowledge of targeting First 5 populations. Outreach activities included attending community events (e.g., farmer's markets, WIC Centers, shopping centers, etc.) where information related to HCA services was provided. In FY 2010-11, HCA staff attended a total of 1,509 outreach events.

Current Factors Affecting Health Insurance Enrollment

HCA has been operating in a climate of considerable change which makes it difficult to to track and anticipate enrollment trends. A review of existing data found the following contributing factors.

Declining Economic Conditions

- The faltering economy is coinciding with a decline in the birth rate as parents struggle to provide for their current household. This is evidenced by an 11.0% decrease in birth rates in California and 5.4% in San Diego County the last four years (2007-2010).[8] This trend is greater for families in poverty. The birth rate for women in poverty decreased by 15.0% in San Diego County from 2007 to 2010.[9] As a result, the number of pregnant women enrolling in health insurance is only slightly increasing.
- Increased costs for public healthcare are also believed to be impacting insurance enrollment. For Healthy Families, premiums increased by 3.0% in November 2009 and the fee for doctor visits doubled. In AIM, the cost for pregnant women to enroll is a one-time, up-front fee of 1.5% of the family's adjusted annual household income.

In this climate, the CAA's play an important role in educating families on the importance of retaining insurance during challenging economic times.

[8] Source DHCS Reports Link: http://www.dhcs.ca.gov/pages/sitemap.aspx
[9] US Census Bureau and SANDAG, accessed 9-12-11

Changes in the Processes for Obtaining Public Health Insurance

- There have been major changes in the process for enrolling and retaining insurance. The volatility of State funding has affected health insurance. In 2006, the Outreach, Enrollment, Retention and Utilization (OERU) Program – which meshed well with HCA – was funded and defunded in the same year, causing an initial upsurge in enrollments and then disruption in services.
- Recent changes in the enrollment process have made it more difficult for HCA application assistants to verify enrollment status of clients and has added time to the process for HCA providers. First 5 staff has worked with County staff and HCA contractors to identify ways to reduce these delays.
- Since November of 2010, the public can now apply for health insurance online with Health E-App (HEA). It was projected that many of the newly unemployed would choose this option to apply for insurance. In FY 2010-11- with only a partial year of operations - 31.5% of Healthy Families applications were Health E-Apps. CAA's assist clients with Health E-Apps and in checking the status of their applications.

These factors require HCA contractors to monitor the changing landscape of health insurance and adjust their approach to identifying and serving the uninsured. The collaboration of HCA contractors has helped this project continue to maintain strong results despite these changes.

CHAPTER 4

KidSTART

2010/2011 Scorecard

Goals	Measures	Target	Actual	Performance
1. Children are Assessed, Enrolled and Treated at the KidSTART Center	Number of children assessed	150	161	107.3%
	Number of children enrolled	N/A	86	N/A
	Number of children who received treatment	N/A	52	N/A
2. Children are Assessed, Enrolled and Treated at the KidSTART Clinic	Number of children assessed	200	220	110.0%
	Number of children enrolled	N/A	95	N/A
	Number of children who received treatment	N/A	95	N/A
3. Children will have a Home-Based Assessment	Percentage of Center children who received a home-based assessment	80.0%	84.9%	106.1%
4. Parents/Caregivers will be involved in treatment planning meetings	Percentage of Center treatment team meetings that included participation by a caregiver	90.0%	90.0%	100.0%

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

Introduction

Developmental delays affect approximately 13.0% of two-year-old children nationwide[1]. Over the past few years, First 5 Healthy Development Services (HDS), and other organizations have identified an unmet need for intensive developmental or mental health treatment for children 0-5 years old, especially those within the foster care system. Recognizing that delaying treatment leads to more severe and possibly complex issues for the child and increased health-related costs, which typically are incurred by the County, the First 5 San Diego Commission demonstrated their commitment to children with the most complex developmental needs by approving on September 11, 2009, five years of funding (totaling $4.5 million) for the implementation of an integrated and comprehensive system known as KidSTART. The goal of KidSTART is to provide infants, toddlers and preschoolers experiencing atypical development and behavior, along with their families and caregivers, ready access to treatment at the appropriate level of intensity. KidSTART is focused on providing timely intervention when treatment can be most efficient and cost-effective, resulting in a reduction in long term dependency on public resources. In addition, it also carries forward the vision of the County's ten-year plan, *Live Well, San Diego!* to create a culturally-competent, seamless, model of care system that will channel services into a pathway that will provide children and families in the target population with accessible, coordinated, and monitored services while utilizing already existing community resources.

Initiative Goal

- To provide comprehensive triage, assessments, referral, and treatment for children ages birth through five (0-5) with complex developmental problems in order to:
- Improve developmental and emotional outcomes;
- Reduce long-term dependency on public resources; and
- Improve overall health and well-being.

KidSTART is separated into two inter-connected programs: KidSTART Center (Center) and KidSTART Early and Periodic Screening, Diagnosis, and Treatment Clinic (Clinic). County Child Welfare Services (CWS) is the overseeing agency for KidSTART, working closely with Children's Mental Health Services (CMHS), First 5 San Diego and other community partners to assure the seamless and integrated delivery of services to this vulnerable population. Fiscal Year (FY) 2010-11 was the first year of KidSTART services. As a new program, staffing and operations development consumed the first three months of the fiscal year, with client services beginning in October, 2011. Despite a partial year of services, the KidSTART Clinic leveraged nearly $194,000 was leveraged in EPSDT funds. As a result, this summary of the KidSTART program will focus on program development and the early stages of child services, including screening, triage and assessment. Year 2 of the program will allow for a fuller analysis of child treatment and outcome data.

KidSTART Center

Located in Kearny Mesa, the KidSTART Center provides early identification and treatment of developmental delays and social emotional issues using an integrated system of screening, triage, assessment, referral and treatment of children ages 0-5. The KidSTART Center has a family-centered approach utilizing a care coordinator who is assigned to guide the child's treatment plan. Rady Children's Hospital (Rady's) is the lead agency in charge of providing Center services and assembling and coordinating the integrated clinical team, that is in charge of creating the trans-disciplinary treatment plans for each child. In addition, the KidSTART Center collaborates with existing public and community based providers to coordinate screening and referrals for children with complex developmental needs.

[1]Robinson CC, et al. Prevalence of Developmental Delays and Participation in Early Intervention Services for Young Children. *Pediatrics* 2008;121;e1503; originally published online May 26, 2008.

KidSTART Clinic

The KidSTART Clinic specifically aims to provide mental health treatment services for Center participants, and children in the community with complex mental health needs. The KidSTART Clinic, which is overseen by CMHS, is a Medi-Cal certified outpatient mental health program which provides a full range of diagnostic and treatment services for children. The Chadwick Center is the lead agency in charge of providing clinical services for KidSTART. Clinic children are assessed and if appropriate, are assigned to an evidence based practice which will best meet their individual needs. In order to provide the most effective treatment, the Clinic has three locations within the county: Central San Diego, North Coastal and South Bay. Though the initial client pathway was for Center children to be referred to the Clinic, children who are directly referred to the Clinic may also be referred to the Center to ensure that all needs are being addressed. The Clinic also accepts direct referrals from other programs.

Key Elements

KidSTART provides a centralized program where young children with the most serious and complicated developmental problems can receive the timely intervention, treatment, and support they need to reach their highest potential, live safely, and access support services. The KidSTART acronym summarizes the process:

S = Screening

- Screening typically occurs outside of KidSTART at local community partners. The primary location for FY 2010-11 was Developmental Screening and Enhancement Program (DSEP) at Rady's - San Diego. DSEP, which is funded by First 5 San Diego as part of the Healthy Development Services Initiative, provides systematic developmental screening for children ages 0-5, who are entering the child welfare system. Children identified by the screening that they may benefit from KidSTART are referred to either the Center or the Clinic.

T = Triage

- Eligibility is determined during Triage. During this phase, a comprehensive eligibility evaluation is conducted and reviewed by co-clinical directors. Eligibility is calculated using an algorithm created by Rady's based on the level of concern (mild, moderate, severe or confusing/uncertain) in the following areas:
  - Developmental
  - Mental health
  - Medical
  - Family
- If a child is determined to be not eligible for KidSTART services, a referral out to another program in the county can occur.

A = Assessment

- If a child is eligible to participate in KidSTART, they are assigned a care coordinator and receive a home visit followed by an integrated clinical team (ICT) assessment. The ICT is a uniquely comprehensive clinical team including a: care coordinator, developmental behavioral pediatrician, clinical psychologist, speech-language pathologist, occupational therapist, physical therapist, mental health therapist, behavioral therapist, and psychiatrist. The result of the assessment is the creation of a trans-disciplinary treatment plan, which leads into the next two sections.

R = Referral

- Collaboration with already existing systems such as, school-based services and California Early Start, is a fundamental value of KidSTART. Therefore, some children may receive treatment services within KidSTART and be simultaneously referred out to receive some of their treatment elsewhere; however, they remain under the supervision of the care coordinator.

T = Treatment

- The Center and Clinic both provide a myriad of treatment modalities from occupational therapy to Child Parent Psychotherapy. Treatment varies depending on the severity and complexity of the child's need, and the child's overall progress is monitored by the care coordinator. One of the more unique features of the program is that KidSTART engages both the foster parents and the biological parents (whenever possible) in supporting the child's treatment plan.

Demographic Data

The demographics of the children served by the Center and Clinic in FY 2010-11 can be seen in these following tables, Exhibits 4.1 and 4.2. As highlighted in the bolded text, a majority of children served by the Center were Hispanic/Latino (57.1%) and spoke English (70.2%). Nearly one-quarter of children were White (23.6%), followed by 11.2% African-American/Black. At the Clinic, the largest proportion of children served, but not the majority, were also Hispanic (39.5%), and a large proportion were of an unknown or unreported ethnicity (32.7%), followed by 12.3% White and 6.4% African-American/Black. English was the spoken language of 82.7% of children at the Clinic.

Exhibit 4.1 Ethnicity and Language of Center Children 0-5

Ethnicity	(n=161)	%	Language	(n=161)	%
Hispanic/Latino	92	57.1%	English	113	70.2%
White (non-Hispanic)	38	23.6%	Spanish	44	27.3%
African-American/Black	18	11.2%	Other	4	2.5%
Asian	10	6.2%			
Other	3	1.9%			

Exhibit 4.2 Ethnicity and Language of Clinic Children 0-5

Ethnicity	(n=220)	%	Language	(n=220)	%
Hispanic/Latino	87	39.5%	English	182	82.7%
Don't know/ Declined	72	32.7%	Spanish	36	16.4%
White (non-Hispanic)	27	12.3%	Other	2	0.9%
African-American/Black	14	6.4%			
Multiracial	13	5.9%			
Other	7	3.2%			

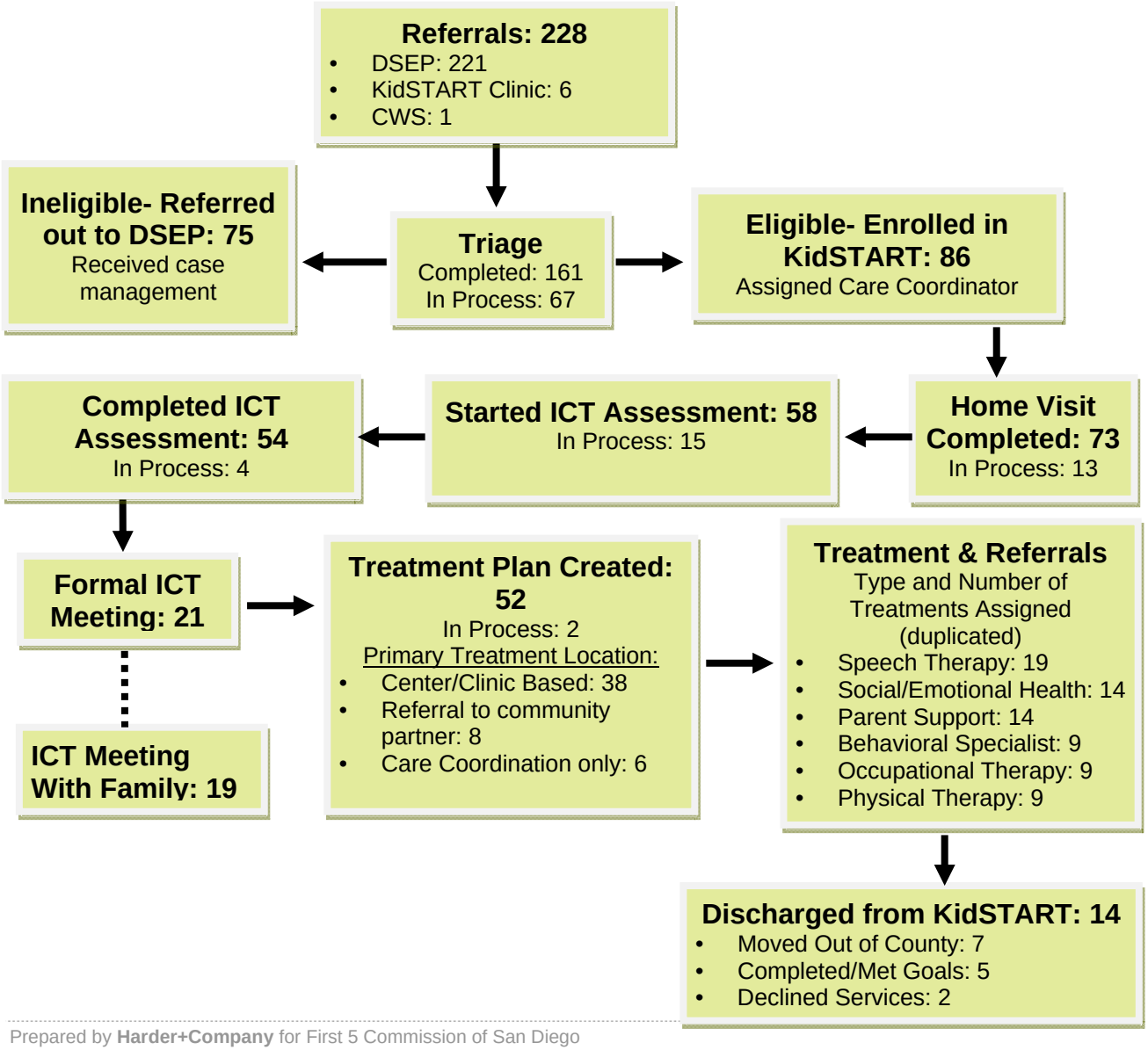
Summing It Up

This section demonstrates the flow of children through services within each program and the corresponding Year 1 process numbers.

KidSTART Center Client Flowchart

The Center had 228 referrals in Year 1 and completed 161 triage evaluations. Of the 161 children who received a triage evaluation, 86 were enrolled into the Center and assigned a care coordinator. Of the 54 children who received a complete ICT Assessment, 52 also received a treatment plan. Due to the complex needs of these children, a treatment plan could recommend that a child be referred out to a community partner for treatment services, be treated at the KidSTART Center and/or Clinic, or both. In FY 2010-11, 38 children began treatment at the Center. Overall, 14 children were discharged from the Center, of which 5 completed their treatment plan or met their treatment goals.

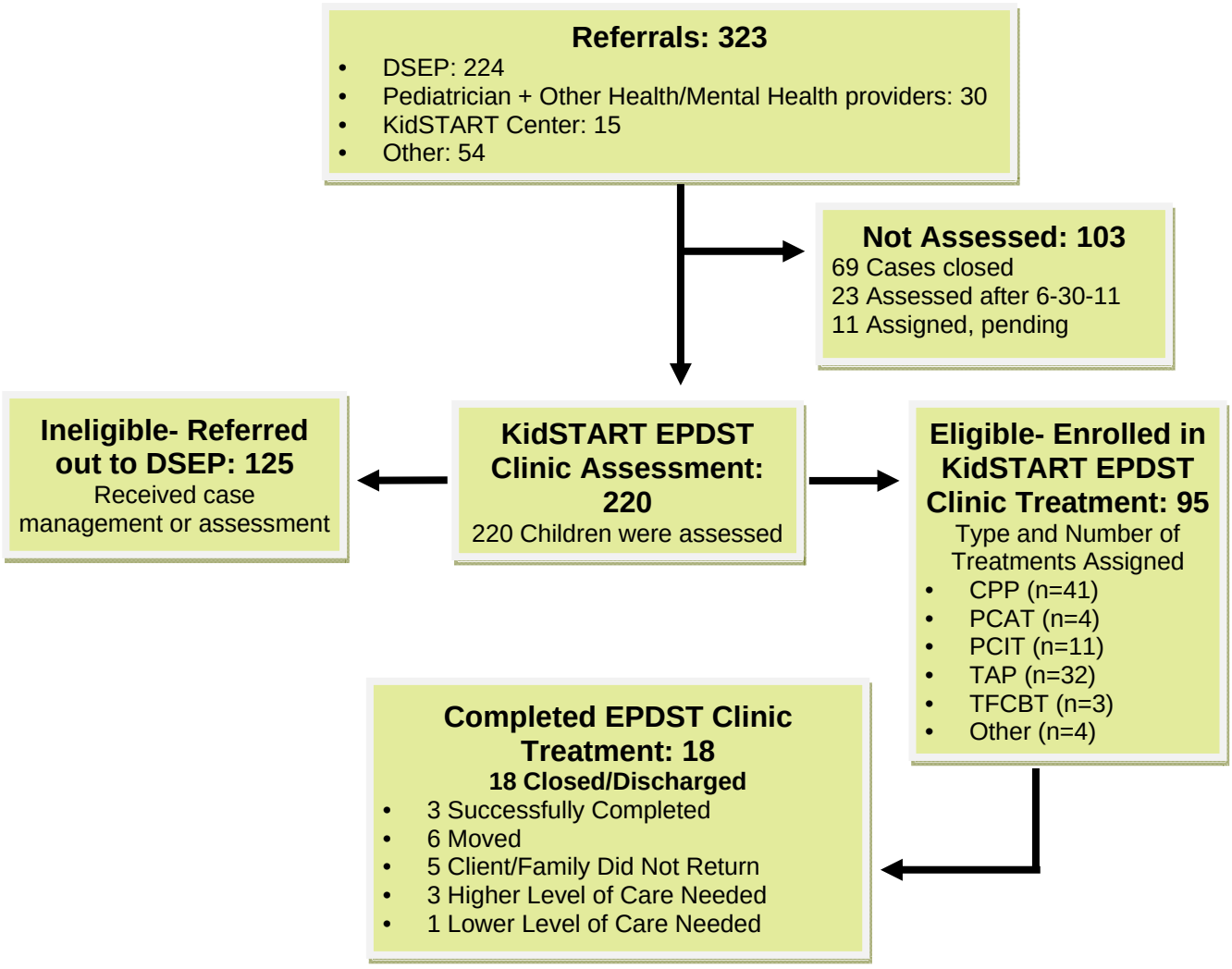
Exhibit 4.3 Center Client Flowchart



KidSTART Clinic Client Flowchart

There were 323 children referred to the Clinic and 220 received an assessment during FY 2010-11. All children referred to the Clinic were not assessed for a variety of reasons; such as, case closed after repeated attempts to make contact with caregivers, or the screening revealed the child did not meet KidSTART eligibility criteria. Twenty-three children were assessed after the end of the fiscal year and will be counted in Year 2 data. Of the 220 children, 95 of them were enrolled into the Clinic and started their mental health treatment; one of a variety of evidence based practices.[2] Three children successfully completed their treatment or met their treatment goals and exited the Clinic, while the rest exited the program for other reasons.

Exhibit 4.4 Clinic Client Flowchart



[2] See Exhibit 4.4 for a full explanation of Clinic treatments

Making a Difference

KidSTART Center and Clinic provide a myriad of treatments all coordinated by either a Center or Clinic care coordinator. This section provides a summary of these treatments.

Center Treatment

The Center had a goal of triaging 150 children and exceeded this goal by serving 161 children. A total of 52 treatment plans were created and 38 children received direct treatment from the Center. A child is provided with the combination of treatments needed; including any or all of the treatments presented in Exhibit 4.5. In addition to the treatments provided directly by the Center, eight (8) children were referred to treatment from the following community partner services:

- KidSTART Clinic
- School-Based Services
- Head START
- California Early Start
- Pediatricians
- Other developmental services

Exhibit 4.5 Center Provided Treatment

Treatment	Participants	Class
Physical Therapy	Caregiver and Infant	Baby Bonding Through Infant Massage
Occupational Therapy	Caregiver and Child	ALERT
Speech and Language Therapy	Caregiver and Child	Hanen: It Takes Two to Talk
Behavior Therapy	Caregiver and Child	Positive Behavior Support
Parent Support	Caregivers	

Clinic Treatment

The Clinic goal of providing 200 children with an assessment was also exceeded: a total of 220 children were assessed by the Clinic in FY 2010-11. Of those 220, 95 children were eligible to receive the evidence based practices administered by the Clinic. As seen in Exhibit 4.6, 91 of the children received an appropriate mental health treatment modality provided by the Clinic as of the end of the Fiscal Year [note: The other four children are expected to enter treatment during FY 2011-12].

Exhibit 4.6 Clinic Provided Treatment

Evidence Based Practice	Participant Type	Number of Participants (n=91)	Summary
Child Parent Psychotherapy (CPP)	Caregiver and Child	41	CPP is a treatment for trauma-exposed children aged 0-5.
Parent Child Interactional Therapy (PCIT)	Caregiver and Child	11	PCIT was developed for families with young children ages 3-6 experiencing behavioral and emotional problems.
Parent Child Attunement Therapy (PCAT)	Caregiver and Child	4	PCAT is a modification of PCIT for children ages 12 months to 36 months.
Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)	Caregiver and Child	3	TF-CBT is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events.
Trauma Assessment Pathway (TAP)	Child	32	TAP is a treatment model that incorporates assessment, triage, and essential components of trauma treatment into clinical pathways.

Making the Connection

KidSTART Center and Clinic were created to meet unmet needs in San Diego County: providing an integrated system of healthcare and support for children and their families with complex, severe developmental delays. KidSTART has been successful in meeting those needs and working in tandem with HDS and other community partners to provide the services needed to improve the lives of many children in San Diego County.

Center Successes

The Center was successful in achieving a number of key program development goals in Year 1, including hiring and training Center staff and creating the trans-disciplinary team. As this was the first year of KidSTART, the Center prioritized identifying and training the proper individuals to staff the Center and to be part of the ICT. Though the Center was successful, these tasks did take more time than anticipated. The establishment of a coordinated process of care delivery included the necessary development of a common language and processes for information sharing across the expertise of diverse care providers, from social workers and physicians to psychologists. This trans-disciplinary model of care is unique and effective, though challenging to establish. In addition, the Center also created and refined the eligibility criteria process and corresponding criteria matrix with an algorithm to determine whether a child was a "good" fit for enrollment into the Center. This matrix was an important achievement as the speed and accuracy of identifying children who are appropriate for KidSTART was improved. As a new project, the Center had to be integrated into the already established system at Rady Children's. This required the creation of new electronic medical records (EMRs) and the development of a database and tracking system to ensure seamless integration and follow-up for participating children. The Center was able to establish referral processes and refined them over Year 1, in combination with developing and implementing an outreach strategy to involve more children in the county. The Center conducted five community outreach trainings to increase awareness of KidSTART.

Center Challenges

The Center also faced some start-up challenges, as most new programs do. Implementing the infrastructure needed took longer than anticipated and led to a delay in receiving referrals. The startup was complex and developing screening criteria as well as assessment and treatment pathways required a plethora of meetings, both internal and external. In addition, many meetings and revisions were needed to ensure that all measures and diagnostic tools were effective and culturally appropriate. As with many complex programs, some facets required more time than initially thought, though the Center is now poised to triage, assess and treat many more children in Year 2.

Clinic Successes

The Clinic also achieved a number of key programmatic goals in Year 1. Similar to the Center, the Clinic successfully hired and trained their staff. They were also successful in obtaining Medi-Cal certification, which is necessary to be designated as an EPSDT Clinic. This certificate is required by federal law and regulations. The Clinic established referral processes and created their own database and tracking system independent of the Center. The Clinic also developed outreach strategies and conducted presentations/ trainings to community partners to increase the awareness of Clinic activities, mental health issues of children 0-5, and to highlight eligibility requirements.

Clinic Challenges

The Clinic faced challenges similar to the Center; however, the following were unique challenges to the Clinic: identifying referral sources and implementing the first EPSDT program for the Chadwick Center. Initially, all Clinic referrals were supposed to originate from the Center or CWS; however, due to the slower than anticipated start-up, there were not enough referrals to ensure that the Clinic would meet their target. The Clinic expanded their referral sources beyond the Center and CWS and was able to meet their targets. As the KidSTART Clinic is the first EPSDT center for Chadwick, the Clinic had to work diligently to complete all necessary federal requirements for EPSDT centers.

Recommendations

The following recommendations are based on FY 2010-11 data and evaluation findings.

- **Continue to refine the service delivery model to assure timely services and referrals, including referrals between the Clinic and Center.** The coordination of a complex set of services like KidSTART requires on-going monitoring and improvements to assure that children and families receive services in an efficient manner. Frequent communications between all partners, including First 5 staff, will help to assure that services are integrated across First 5 initiatives and that appropriate monitoring and evaluation data are being collected.

- **Expand the population served beyond foster children.** Both the Center and Clinic had to expand their referral sources in order to ensure that they met their targets relating to serving the minimum number of children. Expanding beyond the foster care system, as is planned for FY 2011-12, will allow for more children to receive the critical services provided by KidSTART.

- **Continue to standardize data collection and use CMEDS for program improvement.** By strengthening client tracking, gaps in service provision can be better identified and addressed.

Other Health Projects

In addition to its broad-reaching initiatives, First 5 San Diego funds single projects that target particular needs in the community. These projects are funded through the Commission's *Responsive Funds* or its *Emerging Critical Needs Fund*. These are the key projects in the health area.

Exhibit 4.7 Other Health Projects

Program/ Contractor	Children Served	Adults/ Families Served	Description of Project/Services
Black Infant Health / Health and Human Services Agency - Public Health Services	84	153	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 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. In FY 2010-11: + 100.0% of pregnant women were in prenatal care within 30 days + 93.0% of infants were born with normal birth weight + 92.0% of pregnant women who smoked quit or reduced their level of smoking while pregnant
Healthy Developmental Services, ADS Pilot / Health and Human Services Agency – Alcohol and Drug Services	26	N/A	Children of substance abusing parents are among the highest risk population of children for developmental delays as a result of direct exposure to substance abuse related family stress, trauma and domestic violence, and are more likely to develop drug and alcohol dependency in later life. Providing for their children's developmental needs while in treatment is often out of reach for parents enrolled in substance abuse treatment programs. Children are often in childcare on site while their mothers attend treatment services. The First 5 Commission approved a 2-year pilot program that began in February 2011 providing Healthy Development Services (HDS) to children at treatment program sites.

(*continue*) Program/ Contractor	Children Served	Adults/ Families Served	Description of Project/Services
Incredible Years Curriculum and Training / Health and Human Services Agency – Alcohol and Drug Services	102	122	The County ADS women's programs require all pregnant and parenting clients attend parenting classes. *The Incredible Years* is an evidence based parenting curriculum that targets the type of issues faced by young children that have lived with substance abuse including attachment disorders, emotional dysregulation, and impulse control. *The Incredible Years* parenting training was being provided at six of the ten County substance abuse treatment programs for women with children. The Commission provided $56,000 to bring *The Incredible Years* curriculum to the remaining four women's treatment programs. System-wide implementation of *The Incredible Years* promotes evidence-based parenting skills and healthy development for all children of women in treatment into the organizational culture of all women's treatment programs in the county.
Childhood Obesity Initiative / Health and Human Services Agency – Public Health Services	N/A	N/A	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 their families through advocacy, education, policy development and environmental change. First 5 participated in the inception and launching of the Childhood Obesity Action Plan and holds a seat on the Initiative Leadership Council. In FY 2010-11, First 5 invested $130,000 in staffing and program support to the San Diego County Childhood Obesity Initiative. This project supports the goals of *Live Well, San Diego!*

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
- Special Needs Demonstration Project
- Mi Escuelita
- Preschool Learning Foundations
- Stage 3 Childcare

First 5℠ San Diego

CHAPTER 5

Preschool for All

2010/2011 Scorecard

Goals	Measures	Target	Actual	Performance
1. Ensure quality preschool programs are provided in 11 communities	Number of children enrolled / Total number of funded slots	5,000 / 5,000	6,942 / 6,133	138.8% / 122.7%
2. Improve parent engagement	Percentage of caregivers who tell stories or read to their child in the past week	75.0%	98.1%	130.8%
3. Promote parent education	Number of parents who attended at least one parent education class	1,000	1,088	108.8%
4. Increase preschool quality	Percentage of PFA sessions that retained or improved in quality since joining PFA	N/A	96.0%	N/A
5. Impact the growth and development of children	Percentage of children in each domain that increased their score by at least one point from fall to spring	N/A	Between 85.2% and 95.7%*	N/A

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

PFA 2010/2011 Scorecard, continued

Goals	Measures	Target	Actual	Performance
6. Increase developmental screenings and special need identification	Percentage of PFA children who undergo the developmental screening process	80.0%	82.5%	103.1% 
	Percentage of children enrolled in PFA who are identified with special needs	10.0%	9.0%	90.0% 
7. Enhance professional development	Percentage of teachers who completed their professional development plan	N/A	84.8%	N/A

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

* Children showed significant improvement in all seven domains (p<.001).

Introduction

"…Overall, it [PFA] has been an extremely positive thing for our community; it has been positive for our children and families. I think it has improved the quality across the county."

- Community Stakeholder

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] There have been numerous studies showing the benefit of quality preschool, including cost/benefit analyses – the results vary according to the components and the duration of the program. The RAND Corporation found that the return on investment of a half day of quality preschool for four-year-olds in California is $2.62 per dollar invested. The return on investment increases to $6.35 when considering benefits to children with special needs and those in foster care.[2] A meta-analysis of studies reviewed by the American Institute for Research found that "quality preschool programs are estimated to save taxpayers from $4 to $17 for every dollar invested."[3] The savings come from reducing grade retention, special education use, dependence on cash assistance, and involvement in crime.

Initiative Goals

- **Developmental progress** of children participating in PFA 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 PFA staff

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 First 5 San Diego County Preschool for All (PFA) Demonstration Project in 2005. The Commission dedicated $30,000,000 to fund a five-year PFA Demonstration Project, including $12,132,533 in FY 2010-11, the fifth year of the project. The Demonstration Project will continue into a sixth year in FY 2011-12, when a new Quality Preschool Initiative is competitively bid. In FY 2010-11, PFA funded 41 agencies with preschool sites in 11 priority communities throughout San Diego County: Borrego Springs, Chula Vista, El Cajon, Escondido, Valley Center/Pauma, Vista, Lemon Grove, Mountain Empire, San Ysidro, South Bay, and National City.

Key Elements

The overarching goal of PFA is to successfully enroll and serve 70.0% 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:

[1] Lynch, R. Enriching Children, Enriching the Nation: Public Investment in High-Quality Prekindergarten. Economic Policy Institute, 2007. Accessed August 2007. Available at: http://www.epi.org/content.cfm/book_enriching.
[2] Karoly, L.A., & Bigelow, J.H. *The economics of investing in universal preschool education in California*. Santa Monica, CA: RAND. 2005. Corporation
[3] Muenchow, S., & Manship, K. First 5 Commission of San Diego Quality Preschool Initiative (QPI) Final Report: Findings and Recommendations. August, 2011.

- **Classroom Quality:** Each session (or classroom) is assigned a tier level based on its external review scores and teacher education level.
- **Screening and Inclusion:** Providers offer universal developmental screenings and identification of developmental delays, as well as ensure that children with special needs have the opportunity to participate in PFA and are referred to needed services to promote their development.
- **Parent Engagement:** Providers offer opportunities and support for families to be involved in their children's education to maximize each child's development and learning experiences.
- **Professional Development**: Education and trainings are offered to teachers and administrators to develop a qualified workforce to meet the needs of their students.
- **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.

Demographic Data

The demographics of the children who attended PFA can be seen in Exhibit 5.1.

Exhibit 5.1 Ethnicity and Language of Children 0-5

Ethnicity	(n=6,942)	%	Language	(n=6,942)	%
Hispanic/Latino	5,693	82.0%	Spanish	3,749	54.0%
Other	707	10.2%	English	3,096	44.6%
White (non-Hispanic)	542	7.8%	Other	97	1.4%

Summing It Up

Fiscal year 2010-11 marks the fifth year of the PFA Demonstration Project. 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.)

Exhibit 5.2 Number of Agencies by Site Type by Year

Site Type	06-07	07-08	08-09	09-10	10-11
School-Based	5	5	7	7	8
Non School-Based	6	9	13	13	13
Family Child Care	5	6	6	8	20
Total	**16**	**20**	**26**	**28**	**41**

- **Agencies and sessions:** As shown in Exhibit 5.2, the total number of agencies participating in PFA increased to 41 in FY 2010-11, bringing the total number of sessions, or classrooms, to 333 (Not shown).

- **Children:** Exhibit 5.3 shows that the number of children enrolled in PFA increased by 77.7% from last fiscal year. Enrollment in Year 5 was 1.4 times higher than the target enrollment of 5,000 children.

Exhibit 5.3 Number of Children Served by Site Type by Year

Site Type	08-09	09-10	10-11
School-Based	1,879	2,012	3,206
Non School-Based	1,469	1,795	3,519
Family Child Care	65	99	217
Total	**3,413**	**3,906**	**6,942**

- **Slots**: There were 6,133 slots in FY 2010-11; this was an increase of 170.0% from the last fiscal year (not shown). As seen in Exhibit 5.4, the number of fully funded slots has increased every year.

- **Attendance:** Over three-quarters (77.1%) of children attended at least 91 days of preschool (Exhibit 5.5). The average number of days attended was 124.

Exhibit 5.4 Number of Fully Funded Slots

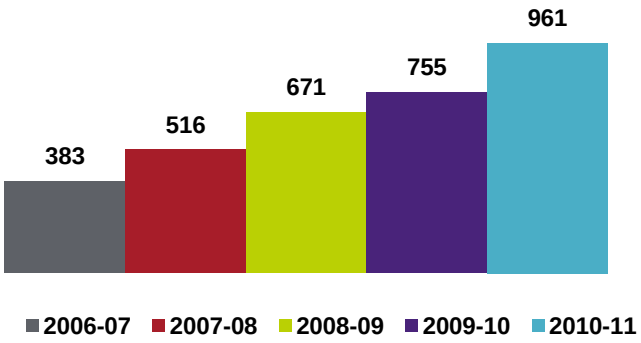
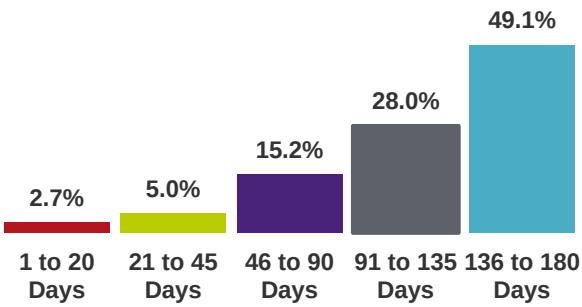


Exhibit 5.5 Percentage of Children Attending PFA by Range of Days (n=6,942)



Making a Difference

PFA outcomes were measured for classrooms, 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

PFA 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)[4] 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).

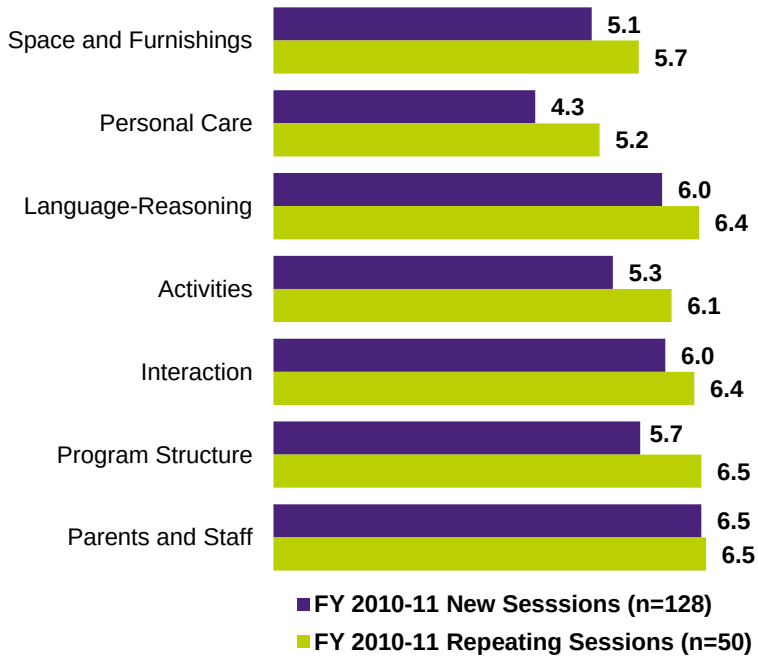
Quality of PFA Funded Classroom-Based Sites

Overall, ECERS-R scores for PFA sites were very high (see Exhibit 5.6), which is a positive result that may be related to the funding structure which provides incentives for improving classroom quality.

In FY 2010-11, ECERS-R scores for repeating sessions (sessions that have participated in PFA for more than one year) were significantly higher than the scores for new sessions in every category except *Parents and Staff*.[5] This reflects PFA's focus on classroom quality improvement. Sites that participate in PFA 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 although repeating sessions are improving their scores, this area continues to be a challenging area for all PFA sessions.

Exhibit 5.6 ECERS-R Mean Scores for Year 5*



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

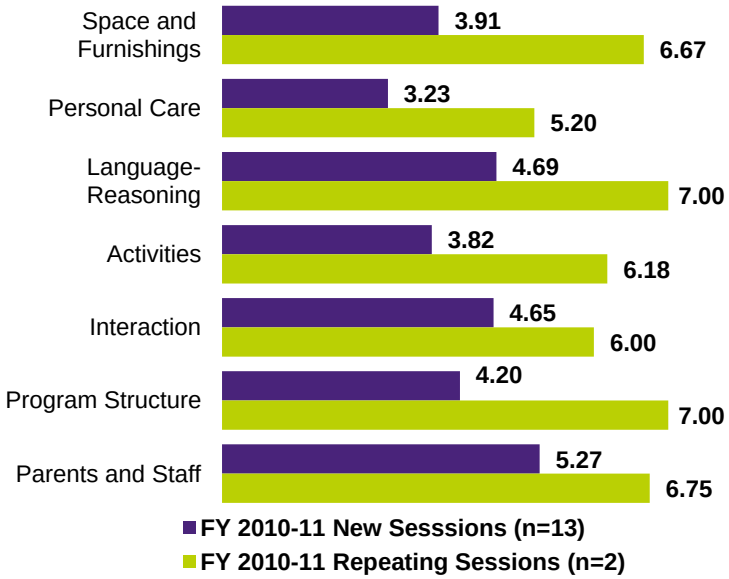
[4] Pianta, R. C., La Paro, K. M., & Hamre, B. K. (2008). *Classroom Assessment Scoring System (CLASS) Manual, Pre-K*. Baltimore, MD: Paul H. Brookes Pub. Co.

[5] Significant difference; p-value equal or less than .05

Quality of PFA-Funded Family Child Care Sites

Family Child Care (FCC) scores for repeating sessions (sessions that have participated in PFA for more than one year) were higher in every category compared to new sessions, as displayed in Exhibit 5.7.[6] Overall, scores were very high for repeating sessions, but low for new sessions, which is to be expected. The lowest scores for both new and repeating sessions in FY 2010-11 were in *Personal Care*.

Exhibit 5.7 FCCERS-R Mean Scores for Year 5*



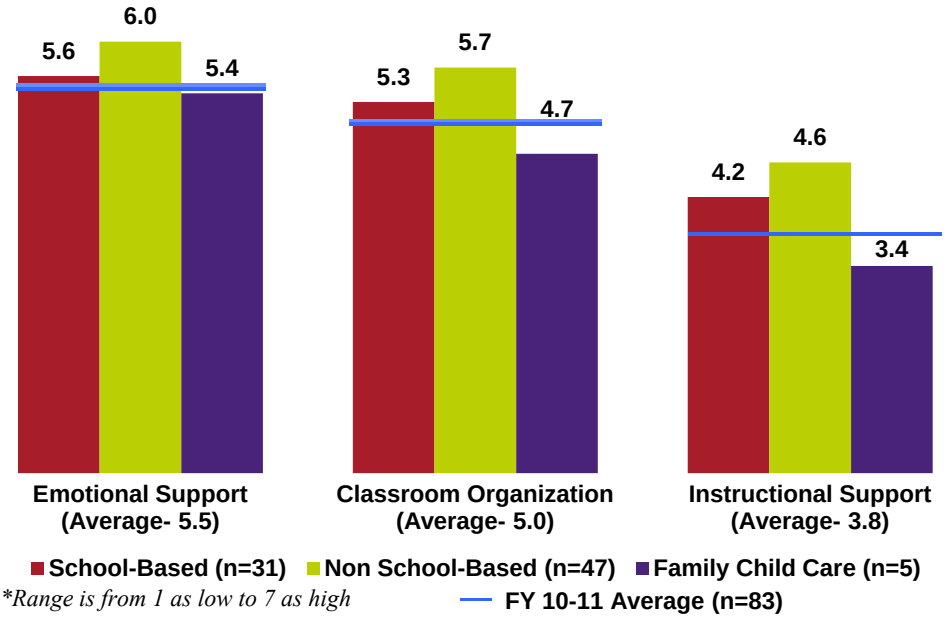
**Range is from 1 as low to 7 as high.*

Review of Highest Quality Classrooms

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 or FCCERS-R. Exhibit 5.8 shows all sessions reviewed in FY 2010-11.

Emotional Support, which measures a teacher's ability to support children's social and emotional functioning, was the highest average scoring area. *Instructional Support* continued to be the lowest scoring area, especially in FCCs. Except for the FCC's, CLASS scores from FY 2010-11 are higher than the national average.

Exhibit 5.8 Mean Scores for Sessions Receiving CLASS by Provider Type in FY 2010-11 (n=83)*



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

The CLASS was administered in FY 2008-09 by an in-person reviewer. This year, each session had the choice between an in-person reviewer or a video recording. Thus, comparing scores between years is not appropriate. CLASS administration is becoming more standardized, and in future years, year-to-year comparisons will be possible.

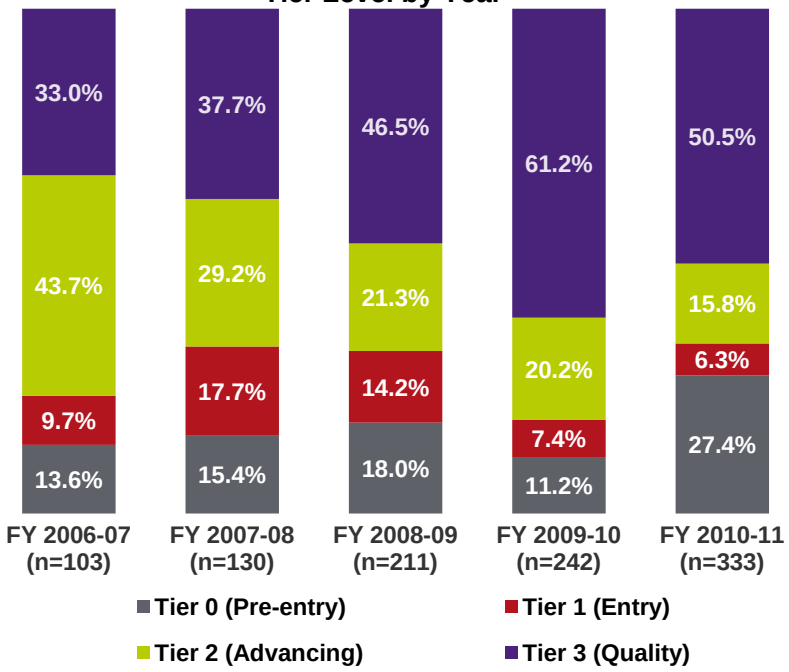
[6] Due to the small sample size, no statistical analyses were performed.

Overall Quality Improvements

Overall Quality of PFA Sessions

In FY 2010-11, there was an overall increase in the number of sessions (see Exhibit 5.9). In all five 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 until this year. This is due to the large number of new agencies joining PFA. It is important to emphasize that the number of Tier 3 sessions did increase from 148 in Year 4 to 169 in Year 5, exemplifying PFA's commitment towards improving classroom quality.

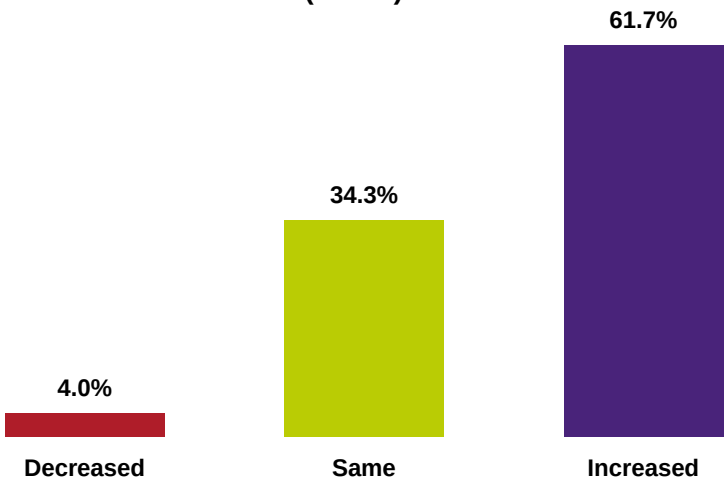
Exhibit 5.9 Percentage of Sessions at Each Review Tier Level by Year



Impact of PFA Participation on Session Quality

Exhibit 5.10 shows that almost two-thirds of sessions (61.7%) increased in tier level since their first year of participation in PFA. In addition, 84.8% of the sessions that remained at the "same" tier level were already at the highest tier level and could not improve; a categorization of "same" is not necessarily a negative finding.

Exhibit 5.10 Review Tier Growth from Baseline (first year of participation) to Year 5 (2010-11) (n=175)



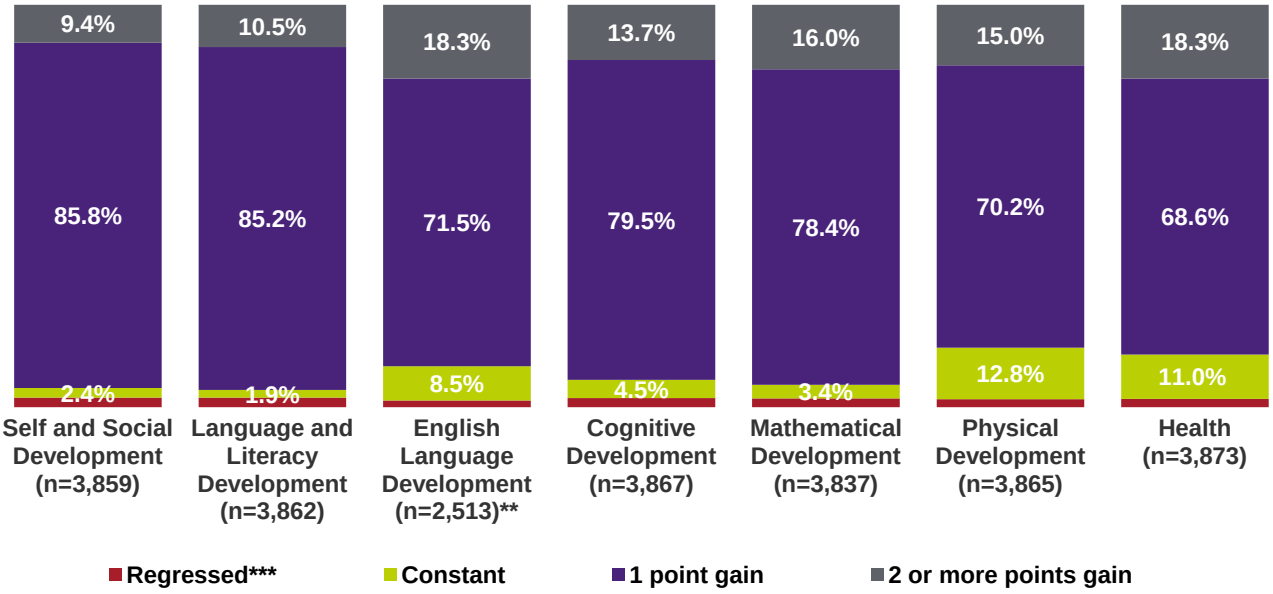
Developmental Gains for Children

Classroom-based child outcomes are measured through the Desired Results Developmental Profile-Preschool (DRDP-PS).[7] Teachers assess children's competencies in seven domains and all data and findings are for children with both fall (pre) and spring (post) matched cases who attended two-thirds of their allotted PFA days.

Developmental Progress Results

Exhibit 5.11 displays the extent of developmental progress of children from fall to spring, while the corresponding box below provides more detail on how the data are presented. Overall, more than 85.0% of children improved their scores from fall to spring in each of the seven DRDP-PS domains. The greatest improvement in Year 5 was within the *Self and Social Development* domain in which 85.8% of children gained at least one point, followed by the *Language and Literacy Development* domain. The *Physical Development* domain had the highest percentage of children who regressed or remained constant. The changes in all domains from fall to spring were statistically significant.[8] In Years 1-4, a different version of the DRDP-PS was used, but a similar trend of significant developmental gains was exhibited every year.

Exhibit 5.11 DRDP-PS Assessment: Children's Developmental Progress from Fall to Spring for FY 2010-11 (n=3,877)*



**Only children who attended 2/3 of their allotted PFA days were included.*
*** English Language Learners were removed from the analysis.*
**** All Regressed percentages are below 2.5%.*

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

[7] The DRDP is a new instrument used by State Preschool throughout California. The instrument is still under development and is not yet normalized and validated.
[8] Significant difference; p-value less than .001 for all seven domains.

Screenings and Special Needs

Universal Screenings Results

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.[9]

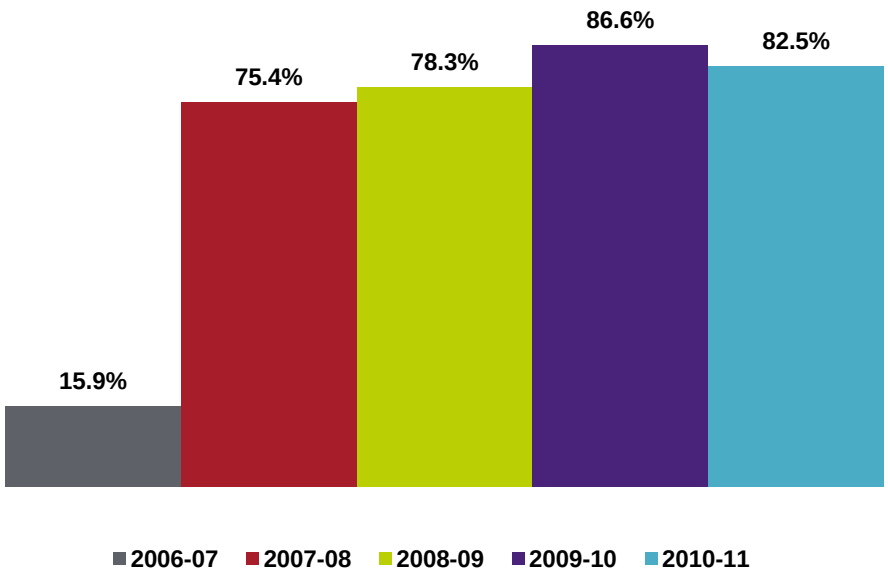
Over 8 out of 10 children (82.5%) received a completed screening in FY 2010-11, as shown in Exhibit 5.12. Non school-based sites appear to have the highest percentages of children with screenings returned and scored compared to children at school-based or family child care sites.

Exhibit 5.12 Percentage of Children who Completed Screenings in FY 2010-11

	Children Served	Screenings Distributed	Screenings Returned and Scored
School-Based	3,206	94.1%	79.1%
Non School-Based	3,519	94.9%	86.0%
Family Child Care	217	86.6%	74.7%
Total	**6,942**	**94.3%**	**82.5%**

As shown in Exhibit 5.13, the percentage of children receiving developmental screenings has ranged from 78% to 87% since Year 3, and declined slightly last year.

Exhibit 5.13 Percentage of Children Receiving Scored Screenings



[9] 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.

Identification of Children with Special Needs and Requiring Individualized Education Plans (IEPs)

The percentage of PFA children identified with special needs in FY 2010-11 was 9.0% (Exhibit 5.14). 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 2010-11, 5.5% of PFA children had an IEP.

Exhibit 5.14 Children with Special Needs and IEPs by Agency Type at Enrollment and at the End of FY 2010-11

	Children Served	IEPs		Special Needs	
		Upon Enrollment	At End of Year	Upon Enrollment	At End of Year
School-Based	3,206	4.0%	6.4%	4.0%	10.7%
Non School-Based	3,519	3.7%	4.8%	5.0%	7.8%
Family Child Care	217	1.8%	2.8%	2.3%	4.1%
Total	**6,942**	**3.7%**	**5.5%**	**4.4%**	**9.0%**

Trends in the percentage of children with special needs and IEPs over time are shown below (Exhibit 5.15 & 5.16).The percentage of children with special needs has been decreasing since FY 2008-09. This may be because many new providers have joined PFA in this period and the PFA's special needs support resources have remained constant and may not be keeping up with the project's expansion.

Exhibit 5.15 Percentage of Children With Special Needs Upon Enrollment and End of Year

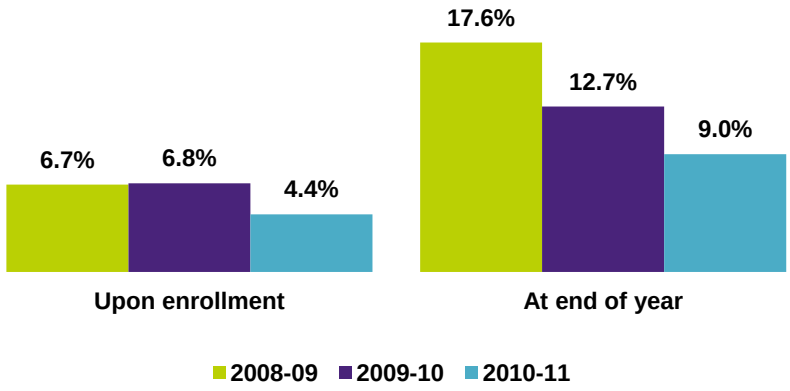
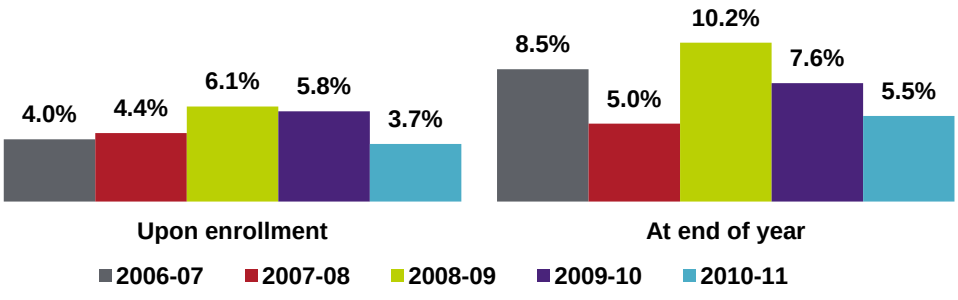


Exhibit 5.16 Percentage of Children With IEPs Upon Enrollment and End of Year



Referrals for Children with Health or Special Needs

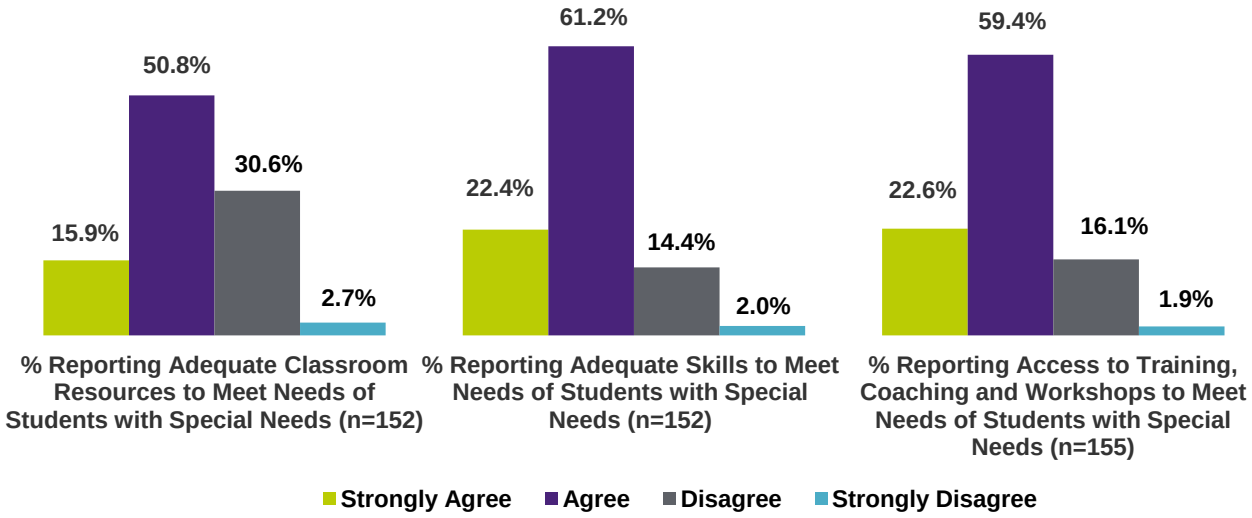
Over 1,200 children were referred out to receive services based on their health needs. PFA works in tandem with other First 5 initiatives by referring their children to Oral Health Initiative, Healthcare Access Initiative, and Healthy Development Services Initiative. In For FY 2011-12, SDCOE will be improving their data collection procedures for referral types to allow for a more complete picture of the impact of PFA on children's health.

PFA Teachers Self-Reported Capacity to Address the Needs of Students with Special Needs

As shown in Exhibit 5.17, more than three-quarters (83.6%) of teachers surveyed agreed or strongly agreed that they have the skills to meet the needs of students with special needs. Over three-quarters (82.0%) of teachers agreed or strongly agreed that they have access to training, coaching and workshops. However, one-third (33.3%) disagreed or strongly disagreed that they have adequate classroom resources to meet the needs of students with special needs. These findings indicate that most PFA teachers are fairly confident in their ability to meet the needs of children with special needs but are lacking in classroom resources and 18.0% 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 that require extra attention from teachers. Directors see this as an area where teachers could benefit from more assistance and training.

Exhibit 5.17 Percentage of Teachers Reporting the Ability and Support Required to Meet the Needs of Students with Special Needs



Kindergarten Transition

Agency Participation in Kindergarten Transition

Exhibit 5.18 summarizes the percentage of families (by agency type) who participated in various forms of kindergarten transition services. All agencies participated in some form of kindergarten transition activity in FY 2010-11. The most common activity for parents to participate in was receiving information about their child's developmental progress from the DRDP-PS. However, fewer non school-based and family child care parents participated in some activities compared to school-based agencies.

Exhibit 5.18 Percentage of Families Participating in Kindergarten Transition Services Activities by Agency Type

Transition Activity	School-Based (n=3,206)	Non School-Based (n=3,519)	Family Child Care (n=217)	Total Percentage
Families provided with information about their child's developmental progress	92.0%	65.6%	54.8%	**77.5%**
Families provided with information about local kindergarten programs and registration information	83.2%	58.8%	53.9%	**69.9%**
Number of children who had a real or virtual visit to a kindergarten classroom	83.9%	56.6%	50.7%	**69.0%**

A Note about the Analysis

The data presented in the following sections are drawn from the results of two surveys conducted near the end of FY 2010-11. The surveys were distributed to parents and teachers of all PFA agencies that participated during the entire fiscal year. A total of 4,397 parent surveys and 162 teacher surveys were completed and returned.

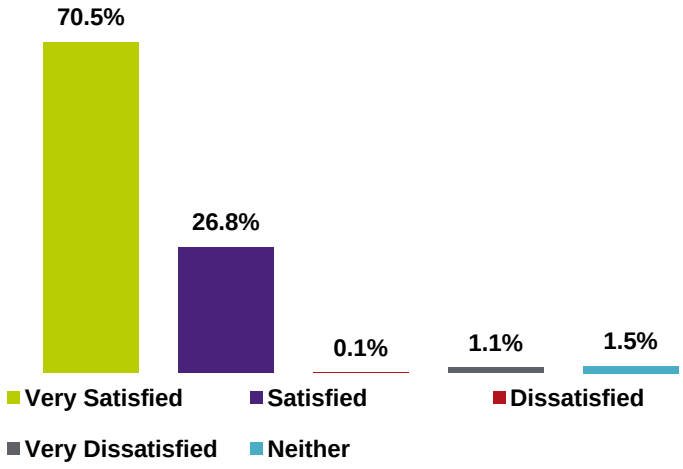
Parent Satisfaction, Involvement/Engagement and Education

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.

Parental Satisfied with the Quality of PFA Programs

Exhibit 5.19 shows that the majority of parents (70.5%) were very satisfied with the overall quality of the program; in addition, 97.3% were either satisfied or very satisfied. Parents appeared to view PFA as a high quality program.

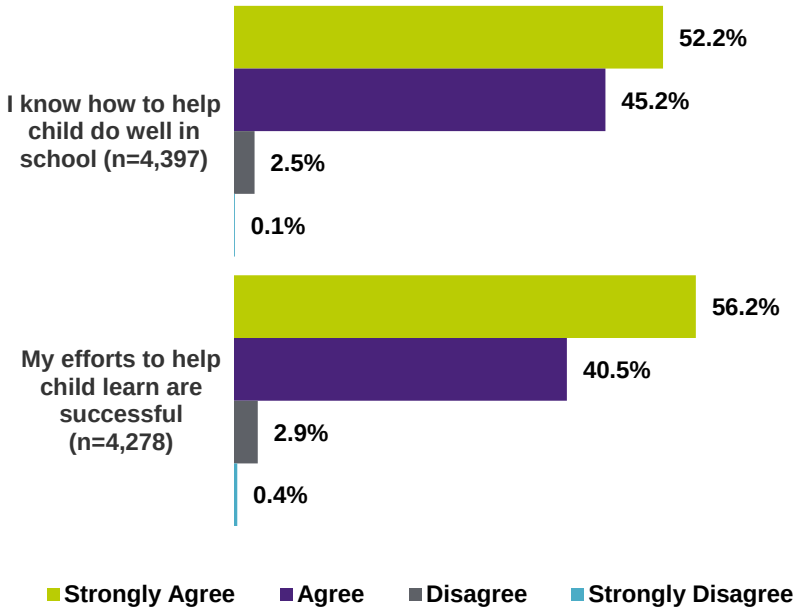
Exhibit 5.19 Parent Satisfaction with Overall Quality of PFA Programs (n=4,235)



Parental Confidence in Helping their Children Learn

Almost all parents (97.4%) agreed or strongly agreed that they knew how to help their child do well in school, and that their efforts to help their child learn were successful (96.7%), as displayed in Exhibit 5.20.

Exhibit 5.20 Parent Knowledge and Confidence



Parental Involvement in PFA Agencies

Parent involvement is a critical part of a child's early learning and development.[10] Both parents and teachers reported that parent/teacher conferences and special events or classroom volunteering were the most common involvement activities (Exhibit 5.21 and 5.22).

The goal for most agencies is to make participation easy for parents. Agencies provided a variety of ways for parents to volunteer or participate in activities. However, 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 and strive to improve parent engagement.

Exhibit 5.23 displays parent's participation in engagement activities at home with their children. These data show that almost all parents (97.0%) participated in helping their child learn letters, words and numbers. Engagement with children appeared high with over 80.0% of parents engaging in each activity. This is an important aspect of PFA as it shows that the home environment and school environment are working together to improve outcomes for children.

Exhibit 5.21 Percentage of Parents Participating in Parent Involvement Activities in FY 10-11

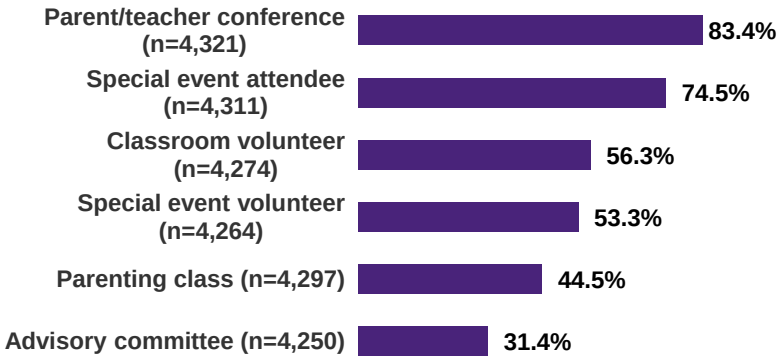


Exhibit 5.22 Percentage of Teachers Participating in Parent Involvement Activities in FY 10-11 (n=162)

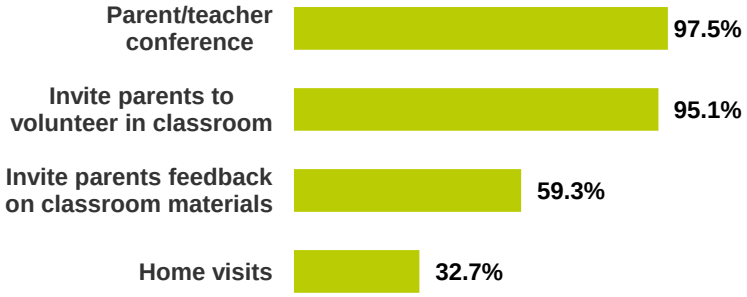
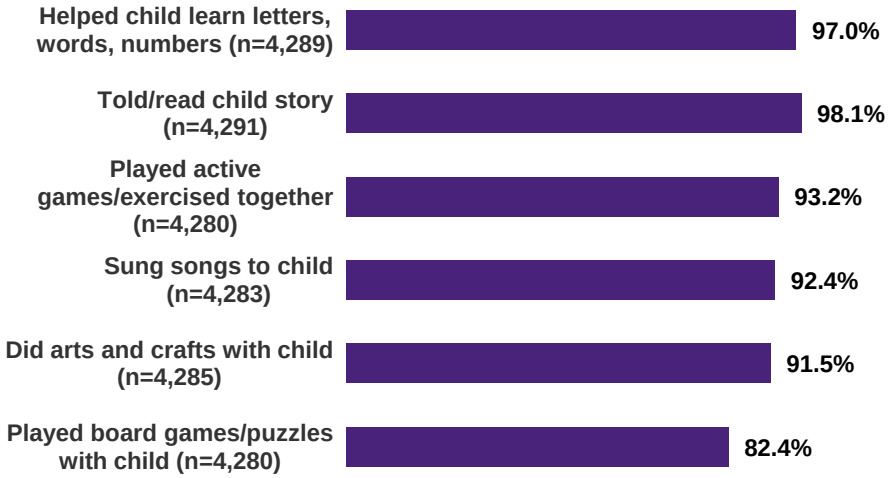


Exhibit 5.23 Percentage of Parents Participating in Parent/Child Engagement Activities in FY 10-11



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

Parent Reported Communication between Parents and Agencies

Communication between schools and parents is an essential part of school readiness services for young children. Overall, parents surveyed reported high levels of communication between their families and their child's school. At least 90.0% 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. 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 (Not shown).

Exhibit 5.24 shows the type of information parents received, and the greatest percentage of parents reported receiving information on how to help their child learn (94.3%) and how to get involved with the program (93.7%). The areas where the fewest parents reported receiving information were related to parenting skills, (85.2%) the preschool staff's training and experience, (85.2%) and where to report health and safety concerns (85.3%). Overall, PFA sessions appear to have strong communication and relationships with their students' families.

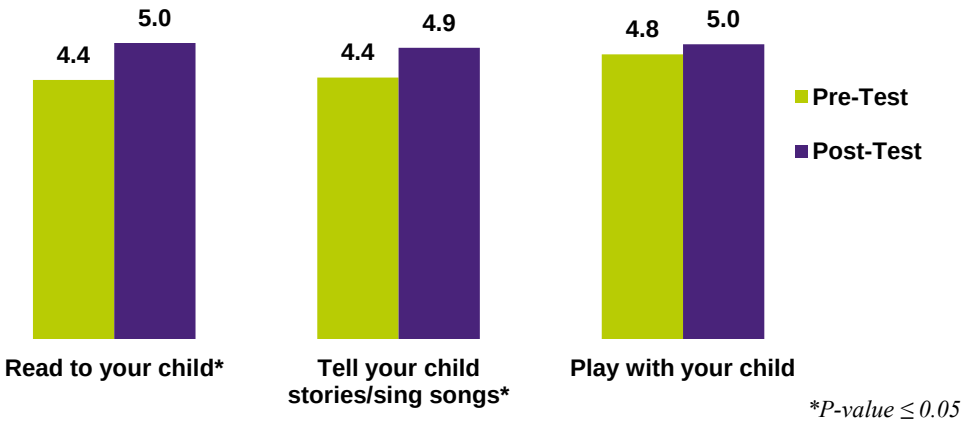
Exhibit 5.24 Percentage of Parents Reporting that Program Provided Information on the following in FY 10-11

What you can do to help your child learn and develop (n=4,263)	94.3%
How you can get involved with your child's program (n=4,249)	93.7%
How your child is growing and developing (n=4,267)	90.8%
How to find services in the community (n=4,266)	87.6%
How children develop at different ages (n=4,264)	87.5%
Where to report health or safety concerns and complaints (n=4,247)	85.3%
Experience and training of preschool staff (n=4,257)	85.2%
Parenting Skills (n=4,397)	85.2%

Results of Parent Education Classes

Over 1,000 parents (1,088) participated in parent education classes provided by the UC Davis Cooperative Extension. These classes focused on improving parent knowledge, attitudes and behaviors. Parents were invited to attend multiple sessions, and 247 parents attended three or more sessions. As seen in Exhibit 5.25, significant changes in parent behavior occurred -- parents increased the number of days a week they read and told stories/sung songs to their child. In addition, after participating in the classes, more parents strongly agreed with the statement, "I know that I am my child's first and most important teacher" (Not shown).[11]

Exhibit 5.25 Average Number of Days Per Week Performing Activities



P-value ≤ 0.05

[11] Significant difference; p-value equal or less than .05.

Teaching Experience, Retention and Professional Development[12]

Experience and Work History of PFA Teachers

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 5.26, 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 50.0%, as seen in Exhibit 5.27. In Year 5, the percentage decreased slightly, but the number of teachers increased due to the number of new agencies that joined.

Exhibit 5.26 Percentage of Teachers Who Have Taught Preschool for More Than Five Years

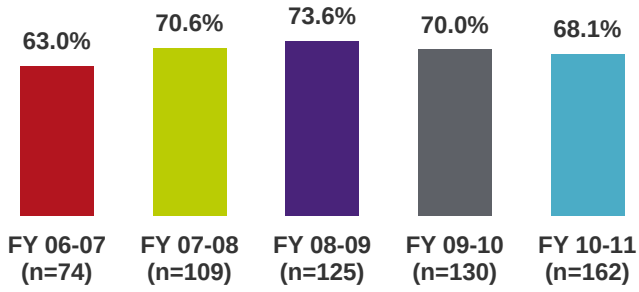
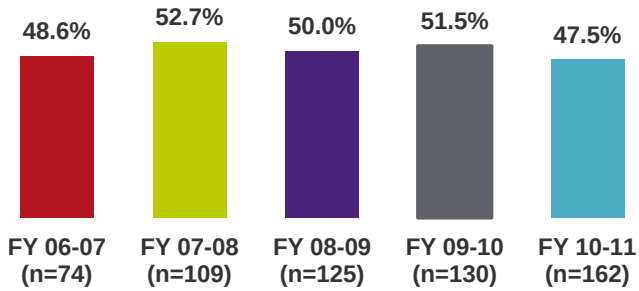


Exhibit 5.27 Percentage of Teachers Who Have Taught at the Same Preschool for More Than Five Years

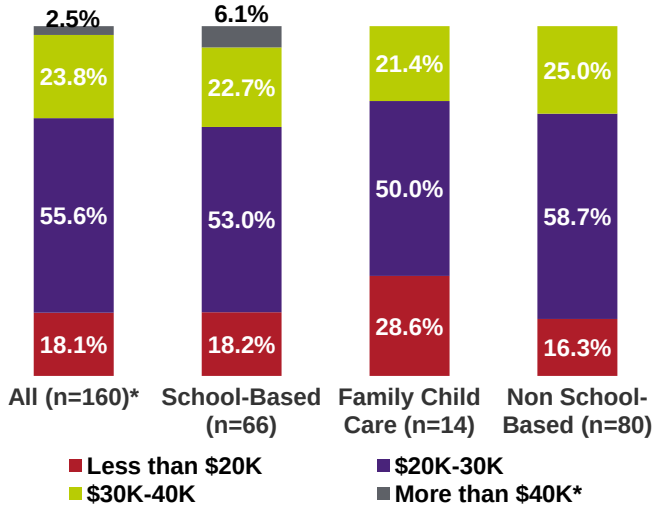


Income of PFA Teachers

PFA 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 20.0% earn less than $20K (see Exhibit 5.28).

Salary and work setting play a role in teacher retention. Teachers working in family care settings received lower salaries. Teachers with more experience were more likely to earn higher salaries.

Exhibit 5.28 First 5 San Diego PFA Teacher Salaries (Excluding Stipend)



** 2.5% of teachers made $40k*

[12] Data provided by the San Diego County Office of Education.

Education Level of the PFA Workforce

Workforce education level is a core component of PFA quality. As seen in Exhibit 5.29, since FY 2006-07, 518 degrees have been earned by site supervisors/directors, lead teachers and instructional assistants. The stipend program encourages staff to advance their education and permit level, further enhancing their knowledge and ability to educate young children.

Exhibit 5.29 Number of Degrees earned by Administrators and Teachers participating in PFA since 2006 (n=908)

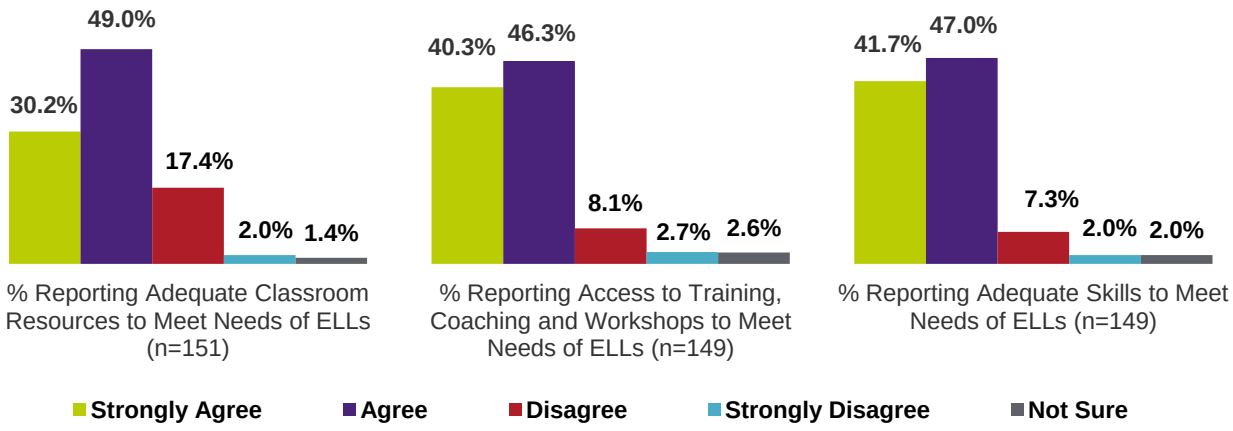
Degree Type	Site Supervisors/ Directors	Lead Teachers	Instructional Assistants	Total
AA/AS	21	134	93	248
BA/BS	49	147	33	229
MA/MS	18	17	3	38
PhD/EdD	2	0	1	3
Total	**90**	**298**	**130**	**518**

PFA Teachers Self-Reported Capacity to Address the Needs of English Language Learners

Almost all teachers (94.9%) reported having English Language Learners (ELLs) in their classrooms. Exhibit 5.30 below shows the percentage of teachers agreeing or disagreeing that they have adequate ability, access to training, and resources to meet the needs of ELLs.

Almost 9 out of 10 teachers (88.7%) strongly agreed or agreed to having adequate skills to meet the needs of ELLs in their classrooms; 86.6% strongly agreed or agreed to having access to the training, coaching and workshops they needed; while 79.2% strongly agreed or agreed that they had adequate classroom resources to help ELLs.

Exhibit 5.30 Percentage of Teachers Reporting Ability and Access to Training and Resources to Meet Needs of English Learners



Teachers' Perceptions and Ratings of Their Professional Development

All lead teachers create an individual professional development plan which they must complete in order to receive their PFA stipend. In addition, they are offered a multitude of professional development opportunities. Teachers were asked to rate aspects of their professional development. Almost all teachers (92.3%) strongly agreed or agreed that their external assessment (ECERS/FCCERS/CLASS) was valuable in helping them improve (Exhibit 5.31). As seen in Exhibit 5.32, Lead Teachers rated one-to-one coaching as the most useful, followed by workshops and then small group coaching.

Exhibit 5.31 Percentage of Teachers Agreeing their External Assessment (ECERS/FCCERS/CLASS) is a Valuable Tool in helping them Improve their Teaching Practices and Preschool Environment (n=155)

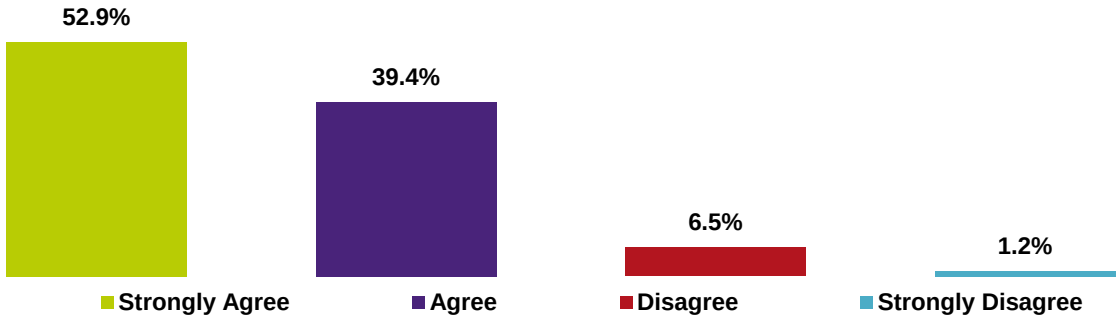
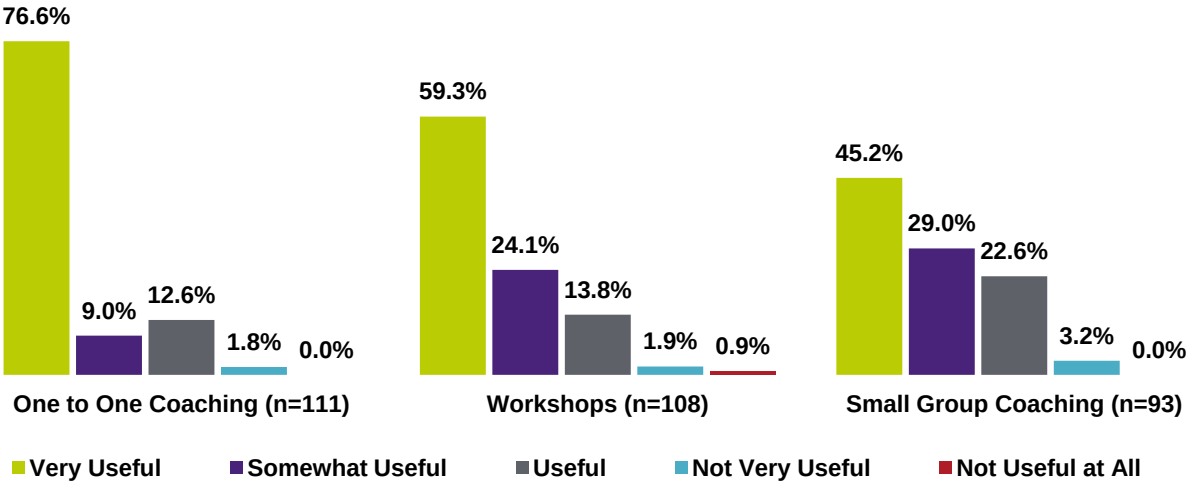


Exhibit 5.32 How do PFA teachers perceive professional development activities?



Making the Connection

"If you go into a PFA classroom you can tell the difference between PFA and non-PFA classrooms. It's a higher quality: the way the class runs, the children are engaged- it's all better."

-PFA 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. The purpose of this section is to document the continuing and new successes and challenges of the project.

Successes

The fifth year of the PFA Demonstration Project saw the addition of thirteen new agencies for a total of 41 agencies in the eleven designated areas of San Diego County. Agency directors and SDCOE staff provided insight in what occurred in FY 2010-11. Overall, they identified successes that are continuing achievements of PFA, including: 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 PFA's ability to provide quality preschool to a broad cross-section of children. Agencies utilized their PFA funding in a variety of ways including improving their classroom quality environment (e.g., purchasing classroom materials) while others used it for professional development to enhance staff qualifications.
- **Professional coaching services and trainings.** PFA teachers were offered professional coaching services that focused on a variety of topics including improving the classroom environment, behavioral and special needs issues, and language and writing.
- **Encouraging educational advancement for teachers.** PFA's structure and model encourages preschool teachers to further their education and advance in their careers. Even as new teachers join PFA, the percentage of teachers with a bachelor's degree has continued to increase. Lead teachers, Instructional Assistants and Administrators have earned 518 degrees.
- **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. Directors most commonly reported using SDCOE support for staff training and development, professional development coaching, assistance with developmental screenings though the inclusion specialist and budget support.
- **Collaboration with other First 5 initiatives.** PFA agencies aimed to and were successful at referring their children identified with a health or developmental need to other First 5 initiatives, such as; Oral Health Initiative, Healthcare Access Initiative and Healthy Development Services.

Challenges

In the fifth year of the demonstration project, many of the initial challenges identified in previous fiscal years have been overcome. However, there are a few elements that were not as successfully addressed.

- **Sustainability.** Program providers and teachers reported wanting to learn about other funding streams and reported not having an adequate sustainability plan. At this time, neither providers nor parents provide any matching funding. Thus, alternative sustainability plans need to be created because there are currently no other additional public funding sources for PFA.
- **Universal Screenings and Referrals.** Overall, screening rates improved substantially from Year 1, and an appropriate tool was implemented in Year 5. However, the initial goal of screening 100.0% of children served has not yet been met.
- **Kindergarten Transition.** PFA has had some success in improving kindergarten transition, but many more improvements are needed to fully prepare families for Kindergarten. For example, communication between First 5 San Diego PFA programs and the K-12 system could be improved.

- **Parent Education.** There was a slow start to integrating parent involvement, education and empowerment into PFA. The Epstein model of parent engagement has now been implemented by most providers, though there are varied levels of understanding the model. In FY 2010-11, a standardized parent education program was introduced.

Update on FY 2009-10 Recommendations

Last Year's Recommendation		Update on Recommendation
Explore strategies to improve *Personal Care* scores for the ECERS-R and FCCERS-R.	→	+ Personal Care scores are improving for repeating sessions; however, the scores are still lower that the other domains.
Improved identification and inclusion of children with special needs.	→	+ The identification of children with special needs has continued to decrease from last year and it continues to be an area of improvement for the project.
Address the decrease in completed secondary (ASQ) screenings.	→	+ The ASQ was used by all PFA providers as the primary screening tool in FY 2010-11. Completing timely screenings and referrals was complicated by a lack of special needs resources, use of a variety of implementation procedures, and coordination issues. This area continues to be a focus for improvement.
Create a culture that supports and encourages professional development.	→	+ More professional development opportunities were provided to all staff in Year 5, and overall, staff members were very satisfied with the professional development opportunities.

Recommendations

The following recommendations are based on recommendations from FY 2009-10, the data in this report, previous interviews conducted with providers, and the First 5 San Diego Preschool for All Demonstration Project: Five-Year Summative Report. Some of these recommendations may be included in the design of the FY 2011-12 RFP for the new Quality Preschool Initiative.

- **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 PFA sessions. However, *Personal Care*, which assesses greeting, eating, napping, toileting, and health and safety, continues to be the lowest area, particularly for center-based and family child care sites. (See Exhibit 5.6 and 5.7).

- **Implement a standardized PFA process for identifying and including children with special needs.** There were fewer children with special needs or IEPs identified in FY 2010-11 than in previous years (see Exhibit 5.15). It is recommended that the First 5 definition of special needs be broadly disseminated to providers and PFA teachers. Fully implementing universal developmental screenings plus providing additional training and resources for teachers are also recommended to help identify students with special needs and meet their needs in the classroom (see Exhibit 5.17). Inform providers about the expectations and protocols around identifying, tracking and including children with special needs. In addition, provide more support services to parents of children with special needs.

- **Employ Technology to Deliver Professional Development.** Many 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. Provide more opportunities (as requested by teachers) for more technologically advanced professional development opportunities (e.g. online webinars, video chatting, discussion boards, etc.) to improve flexibility in utilization and to keep the cost of participation low (i.e. gas and time).

- **Standardize and Strengthen the Kindergarten Transition Practices.** Ensure that kindergarten teachers are provided with as much information about the incoming child as possible by creating a standardized process (including obtaining parent signature for release of information) with sample forms and adequate training. There were no kindergarten transition criteria until 2009 and privacy policies are still a barrier to providing detailed information to Kindergarten teachers.

CHAPTER 6

School Readiness

2010/2011 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 preschool early childhood education services	164	165	100.6%
	Number of children receiving intensive education services at parent and child centers	175	193	110.3%
	Number of children receiving enhanced School Readiness services	2,738	2,890	101.0%
2. Children are in home environments supportive of optimal cognitive development	Number of parents and caregivers participating in parenting and family support services	3,434	4,651	135.4%
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	3,133	2,988	95.4%
	Number of children screened as part of the Special Needs Project	500	541	108.2%
4. Schools and school systems are ready for children	Number of children participating in kindergarten transition activities	2,859	2,959	103.5%

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

Introduction

"The program has been nothing but great to our family."

– 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 a child's 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.

The SR programs are based on the National Education Goals Panel's " 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). Four local school districts received $4.02 million in total in FY 2010-11 for this project. SR has been funded at a total of $44.64 million since its inception.

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

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 engagement, education, and support services. Finally, SR programs 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 Special Needs 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.

FY 2010-11 was the final year of both the School Readiness Initiative and the Special Needs Demonstration Project as neither project was continued by First 5 California or First 5 San Diego. Initially, there were eight School Readiness school districts. This chapter includes the final four districts with active contracts: Escondido Union Elementary, Oceanside Unified, San Diego Unified and Vista Unified School Districts.[3]

[1] California Department of Education, *California Public Schools - County Report*. Accessed 31 July 2011. http://dq.cde.ca.gov/dataquest/Enrollment/GradeEnr.aspx?cYear=2010.
[2] Child Trends Data Bank. Child Trends. 2003. Accessed 8 August 2008. <http://www.childtrendsdatabank.org/indicators/7EarlySchoolReadiness.cfm>
[3] The contracts for Chula Vista Elementary, National Elementary, Cajon Valley Union and San Ysidro Elementary School Districts concluded in previous years.

Key Elements

School Readiness (SR) is the longest running Commission initiative. During its nine 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).[4, 5, 6]
- **Variation in design:** Two districts are classroom-based programs and are located on elementary school sites, and two are parent-child activity center programs located in neighborhoods.
- **Multi-level:** SR programs focus on three target groups: children, families and schools.

Demographic Data

The demographics of the children and parents served are presented in Exhibits 6.1 and 6.2 below. Of the 4,567 children served by SR in FY 20120-11, the majority were Hispanic/Latino and Spanish speaking.

Exhibit 6.1 Ethnicity and Language of Children 0-5

Ethnicity	(n=4,567)	%	Language	(n=4,567)	%[7]
Hispanic/Latino	3246	71.1%	Spanish	1957	42.9%
White (non-Hispanic)	549	12.0%	English	1307	28.6%
African-American/Black	351	7.7%	Don't know/ Declined	1140	25.0%
Other	229	5.0%	Other	163	3.6%
Asian	192	4.2%			

The demographic profile of the parents/caregivers served by SR are presented in Exhibit 6.2 and differed from the demographic profile of children served. Of the 1,049 parents/caregivers served, more caregivers were Hispanic/Latino and English speaking.

Exhibit 6.2 Ethnicity and Language of Parents/Caregivers

Ethnicity	n=(1,049)	%	Language	n=(1,049)	%
Hispanic/ Latino	547	52.1%	English	605	57.7%
White (non-Hispanic)	396	37.8%	Spanish	422	40.2%
Other	106	10.1%	Other	22	2.1%

[4] Early Connections: Technology in Early Child Development. Five Areas of Child Development. 2005. Accessed 17 August 2006. <http://www.netc.org./earlyconnections/index1.html>
[5] National Education Goals Panel (1997), "Getting a Good Start in School," Washington, D.C. : National Education Goals Panel.
[6] 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.
[7] Due to rounding the total percentage is equal to 100.1%.

Summing It Up

"[This program] is a tremendous help in guiding and helping my son's development."
– F5 SR Parent

Pre-kindergarten programs play a vital role in a child's social, emotional, and cognitive development.[8] 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 numbers of children and parents served and in the number of services provided is because there are fewer participating school districts as compared to previous years.

School Readiness Early Childhood Education (ECE)

Early Care and Education Services

Exhibit 6.3 shows the number of children in full-time (59) and part-time preschool (106). Another 193 children were served through parent and child activities. In addition, 2,890 service enhancements were provided to children enrolled in preschool including health and social services, and 1635 (duplicated count) were provided "light touch" services.

Exhibit 6.3 Children Served through Early Childhood Education

Services	FY 2010-11
Full-time Preschool	59
Part-time Preschool	106
Parent & Child Activities	193
Service Enhancements *	2,890
Additional Services	
"Light Touch" Services **	1,635

** Includes service enhancements such as curriculum and access to health, behavioral and social services.*
*** Includes children who drop-in for services and those who do not consistently attend.*

[8] 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>

Improved Family Functioning

Parent and Family Support Services

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.[9] School Readiness programs offered a variety of services to parents and caregivers, as seen in Exhibit 6.4. The majority of parents participated in sequential parent classes (n=3,167), such as the parent literacy classes offered by San Diego Unified School District and Oceanside School District. The decline in services is due to fewer districts participating in the SR Initiative.

Exhibit 6.4 Parent and Family Support Services

Services*	FY 2008-09	FY 2009-10	FY 2010-11
Sequential Parent Classes	1,891	2,981	3,167
Single Session Parent Classes	4,436**	3,930 ***	1,235****
Single Session Parent & Child Together (PACT)	108	123	111
Home Programs	356	284	138

* *May include duplicate counts within and between services.*
** *These parents and caregivers participated in approximately 452 classes.*
*** *These parents and caregivers participated in approximately 500 classes.*
**** *These parents and caregivers participated in approximately 214 classes.*

Improved Child Health

Screenings and Interventions for Special Needs

The School Readiness Initiative either directly or in partnership with community partners, provided a variety of health and social services to participating children and families. Health services included 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 special needs. All children intensively served through SR programs are required to have a developmental screening.

Exhibit 6.5 Children Served through Health and Social Services

Services *	FY 2008-09	FY 2009-10	FY 2010-11
Developmental Screenings	1,450 **	3,879	2,988
Health Screenings ***	4,010	4,249	2,319
Behavioral Services	169	106	127
Referrals/ Case Management ****	1,345	1,655	1,668
Total	**6,974**	**9,889**	**7,102**

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

As shown in Exhibit 6.5, a total of 7,102 health and social services were provided to children in FY 2010-11. The drop in services from last fiscal year is primarily due to the fact that four school districts no longer participate in the SR initiative. Yet, the relatively high number of services rendered was maintained because the largest district, San Diego Unified, remained.

[9] 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>

A total of 2,988 children who were provided SR services received a developmental screening. Those with identified needs were given referrals for further assessments and/or services.

Improved Systems of Care

Supporting Transitions 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 2010-11, 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, 2,959 children participated in kindergarten transition activities, such as Kinder Camp, kindergarten visitation, and kinder-readiness assessments. A total of 75 preschool parents participated in school-based activities and 68 SR staff participated in kindergarten articulation meetings with elementary staff (the total number of parents who could have attended is not known, so a percentage cannot be calculated).

Exhibit 6.6 Number of Children, Parents and Staff Participating in Kindergarten Transition Activities

Participants	Number Served
Children	2,959
Parents	75
Staff	68

The School Readiness Initiative concluded at the end of FY 2010-11. Many of the SR school districts are now participating in the First 5 San Diego Preschool for All Initiative and continue to provide high quality early education to children in need. Through the legacy of SR and continuation of Preschool For All the following changes initiated by SR will continue beyond FY 2010-11:

- Incorporating professional–level staff (including speech and language therapists, behavioral specialists, mental health specialists, and others) to screen, assess and provide needed services to children with special needs.
- Curricula and instructional materials purchased for parent education and preschool.
- Professional development that enhanced the knowledge and skills of teachers and other instructional staff.
- A focus on intentional instruction, differentiated to meet specific, individual child needs.
- Establishment of kindergarten transition activities.
- Enhanced community outreach and engagement to help link families to needed services.
- Inclusion of preschool staff in district-wide leadership meetings and decision-making.

Special Needs Demonstration Project

In 2005, the Chula Vista Elementary School District (CVESD) was one of ten sites across the state selected to participate in the First 5 Special Needs Demonstration Project (SNP). The local project, named Kids on TRACK, has three components: screening and assessment, access to services, and community participation and inclusion.

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

- 541 children screened received a health survey, completed by a parent or guardian.[10]
- 594 children received a social emotional screening and 634 children received a developmental screening, completed by trained Kids on TRACK staff and parents/caregivers together.
- The majority of parents and caregivers of these children completed a parent stress assessment (90.2%).

Screening and Assessment

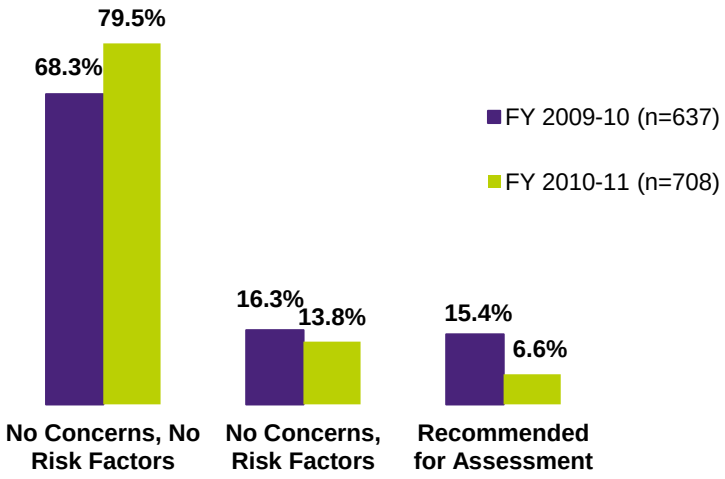
The Kids on TRACK program promotes early childhood development and school readiness through proactively identifying children with special needs or who are at risk of developmental delays. The program provides services to these children identified with mild to moderate developmental delays or special needs, or who evidence risk factors based on screening outcomes. Approximately 10.0% more children received screenings in this fiscal year compared to last (708 vs. 637). Of those screened, just 6.6% were recommended for assessment; a drop of nearly 9.0% compared to last fiscal year.

Screenings for Physical and Developmental Issues

Exhibit 6.7 displays the results of the screenings for 708 screenings in FY 10-11 as compared to FY 09-10. The majority of children screened had no concerns, no risk factors (79.5%).

SNP also provided 134 children with follow-up screenings. The majority of children rescreened had no concerns, no risk factors (76.8%), no concerns, risk factors (16.4%), and 6.6% of children rescreened were recommended for assessment (not shown).

Exhibit 6.7 First-Time Screening Results



[10] 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.

Other Learning Projects

In addition to its broad-reaching initiatives, First 5 San Diego funds single projects that target particular needs in the community. These projects are funded through the Commission's Responsive Funds or its Emerging Critical Needs Fund. These are the key projects in the area of early learning:

Exhibit 6.8 Other Learning Projects

Program / Contractor	Children Served	Adults/ Families Served	Description of Project/Services
Mi Escuelita Therapeutic Preschool / South Bay Community Services	73	105	Mi Escuelita is a therapeutic preschool program for children ages 3 through 5 who have been exposed to domestic violence, abuse, and/or homelessness. 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. During this year, all of the children enrolled received group and/or individual counseling services. A number of the children were also referred for speech services (15), developmental services (35), behavioral services (20) and occupational therapy services (3).
Preschool Learning Foundations / San Diego County Office of Education	N/A	67	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. Some teachers also receive 15 hours of coaching services.
Stage 3 Childcare / Child Development Associates and YMCA Childcare Resource Services	711	N/A	First 5 San Diego stepped in during the state budget crisis to provide $391,000 in bridge funding to fill the gap and provide childcare to families transitioning off welfare and into the workforce.

Family

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

Child Welfare Services
Families Together
Kit for New Parents
SANDAAP

First 5 San Diego

CHAPTER 7

Child Welfare Services

2010/2011 Scorecard

Goals	Measures	Target	Actual	Performance
1. Ensure the implementation of the Individual Care Plan (ICP)	Percent of children 0-5 in the child welfare foster care system screened who received an Individual Care Plan (ICP)	90.0%	1,059/ 1,072	99.0%
2. Promote socio-emotional development of children 0-5 in foster care	Number of children 0-5 in the child welfare foster care system identified with needs that received case management	581	575	99.0%
3. 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	59.0%	67.1[1]%	113.0%
	Percent of children 0-5 years in the child welfare foster care system for less than 12 months who had two or fewer placements	84.0%	81.3[1]%	96.0%

[1] Data Source: CWS Data and Quality Assurance Unit

CWS 2010/2011 Scorecard, continued

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

Goals	Measures	Target	Actual	Performance
3. (Cont.)	Provide 12 hours of specialized training focusing on the developmental needs of foster children ages birth through 5 to 25 staff from the Polinsky Center	12	56	467.0% 

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

Introduction

"The responsiveness of DSEP staff attending client meetings has been such a great benefit to children involved in our dependency system. DSEP staff always comes prepared and knowledgeable about the child's developmental needs."

– Social Worker

Maltreatment and child neglect adversely affect a child's physical and social-emotional development, particularly in the early years of life. Young children who are placed in care outside of their 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.[2] These concerns are intensified when children experience multiple placements. To address these concerns, in FY 2010-11, the First 5 Commission of San Diego County invested more than $6.1 million in early intervention programs to support young children in foster care or placed into relative care:

Initiative Goals

- Increase the continuity of care for children in the foster care system
- Minimize 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 young 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 the provision of specialized training and coaching to 25 PCC staff, who provide direct care to children age birth to five, focused on supporting the developmental challenges of young children in foster care.

+ **Child Welfare Services Early Childhood Services Project (CWS-ECS):** This program supports social worker staff and supervisors (i.e., 39 full-time equivalent Early Childhood Specialist social workers and five 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:** This project was funded for three years, sunsetting in January of 2011. It offered support and stress reduction for foster parents and kinship caregivers of children ages birth to five by providing respite care. Through this program, caregivers attended trainings, appointments, and other personal obligations while the children receive professional care.

Due to the interconnectivity of the elements of these projects, they are evaluated as an integrated set of services and reported together. Both CWS-DSEP and CWS-ECS Programs are led by Child Welfare Services via a subcontract with Developmental Screening and Enhancement Project (DSEP). DSEP is housed in Rady 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 staff at the Polinsky Children's Center to assess the children enter PCC as well as coach and support the staff.

[2] 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.

There is also a team of developmental specialists that visit the homes of 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.

Demographics of Children Served

The CWS projects serve young children who are active in the Child Welfare System. These include children placed with foster families and those placed with relatives. In FY 2010-11, the CWS-DSEP project served 1,059 children. Almost half of them (42.7%) were Hispanic/Latino, and just over a third (32.1%) were White/ non-Hispanic, and 19% African American as shown in Exhibit 7.1. Despite the large number of children who are identified as Hispanic/Latino, nearly all of them (85.0%) speak English as their primary language, shown in Exhibit 7.2.

Exhibit 7.1 Ethnicity of CWS-DSEP Clients

Ethnicity	(n=1,059)	%
Hispanic/Latino	452	42.7%
White (non-Hispanic)	340	32.1%
African American/Black	201	19.0%
Other	66	6.2%

Exhibit 7.2 Primary Language of CWS-DSEP Clients

Language	(n=1,059)	%
English	900	85.0%
Spanish	155	14.6%
Other	4	0.4%

Summing It Up

Fiscal Year 2010-11 marks the second full year of implementation for these CWS projects. This section includes an overall picture of the "System of Care" that was built for the children and families served by CWS. 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 placed in out of home care. A number of components work together to create a system of care for these children. These elements are described below.

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 that screens children birth to three months).

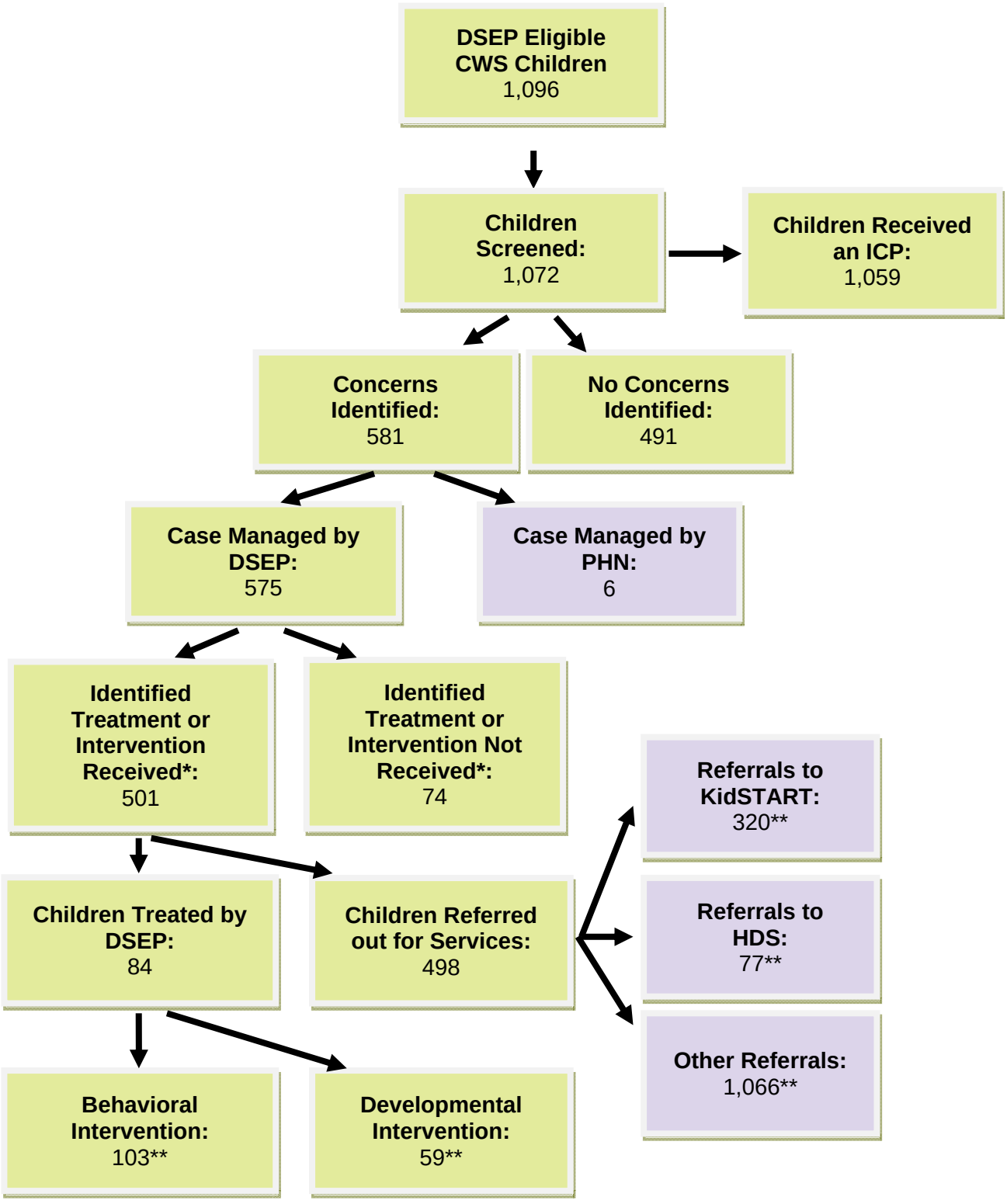
- **Improved Family Functioning- Caregiver Support Services:** Improve the ability of foster parents, kinship caregivers and parents (including teen parents in residence at PCC) to support the developmental needs of young children through the delivery of coaching and case management.

- **Placement and Reunification Support Services:** Support for 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.

The diagram in Exhibit 7.3 (next page) is a general overview of how a child progresses through the system of care, from a child's entrance into the Child Welfare Services system to the interventions that they and their caregivers receive. The diagram also includes the number of children served at each programmatic step during FY 2010-11. The steps included in the diagram are discussed in more detail in the Improved Child Development section of this chapter. 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, and placement transition support for caregivers to support continuity of care when children 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. HHSA social workers receive training in early childhood development and how to interface with existing systems and access community resources. These workers also support the implementation of the ICP recommendations by informing the Court of developmental needs and by working with caregivers to implement activities at home that will further each child's healthy development.

Exhibit 7.3 CWS-ECS and CWS-DSEP "System of Care" in FY 2010-11



**Note: In the chart above, a child is counted as having received an identified treatment or intervention when they receive at least one of services recommended on their ICP.*
*** Children may receive more than one intervention or referral.*

Making a Difference

"Thank you! I will be able to apply this knowledge to my job."

-Social Worker's evaluation of training

The overarching goal of the CWS projects 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. The system has been designed to create and maintain a nurturing environment that will enable and encourage each child's readiness to enter school ready to succeed. This section presents the process and outcome data associated with three key elements: systems change, child development, and family functioning.

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 five; 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.

Professional development for social workers

First 5 San Diego provides funding for the equivalent of 39 full-time 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 age birth to five placed in out-of-home care.

DSEP provided twelve training sessions on early childhood topics to CWS social workers and supervisors. In FY 2010-11 DSEP trained a total of 391 social workers: 211 attended an introduction to the project with instruction on early/intermediate child development stages and recognizing possible developmental delays; and 224 social workers and supervisors completed training on how to access available community resources that are critical for addressing developmental and behavioral needs. The trainings provided social workers with a solid foundation for understanding the results of developmental screenings and evaluations, and will help them to reinforce the critical importance of follow-up when making intervention and treatment recommendations to caregivers.

Professional development for Polinsky Center cottage staff

DSEP staff also provided training, modeling, and coaching to PCC Residential Care Workers. Twenty-two (22) DSEP trainings, totaling 56 hours of instruction, were provided to PCC cottage staff in FY 2010-11. A total of 47 PCC staff attended at least one of these trainings. The training subject matter focused on early child development concepts including: behavioral and social-emotional needs, transitioning children into and out of the Polinsky Center, how to care for drug exposed infants and toddlers, stimulating infant development, and the importance of sibling relationships, etc. to enhance staff expertise in identifying and meeting the specific needs of children in their care.

At the beginning of each training, the instructor administered a pre-test to gauge participants' knowledge on the subject matter and repeated the same test again at the end of the training (post-test). Nearly three-quarters of all training attendees (72.1%) demonstrated knowledge gains; meaning there was an increase in their scores from pre to post tests at each of the trainings offered. In addition, 84 PCC staff received follow-up coaching while working in the PCC infant and toddler cottages.

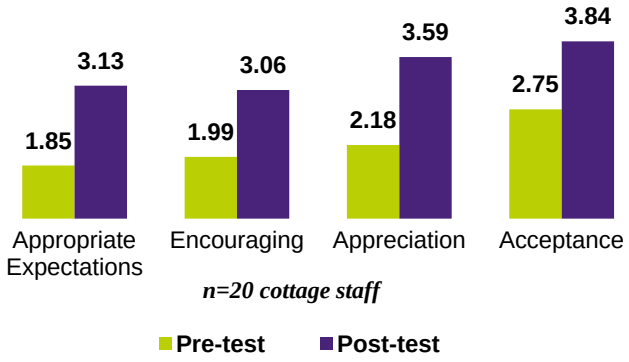
Knowledge gains

DSEP trainings emphasized a highly sensitive and responsive approach to care giving for young children. 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.[3]

Baseline (pre-test) and follow-up (post-test) data were collected on 24 "core" PCC cottage staff from the two early childhood cottage classrooms (e.g., Infant/Toddler and Preschool). The Arnett Caregiver Interaction Scale (CIS)[4] was implemented by an external rater, who conducted an hour and a half classroom observation for each of the PCC cottage caregivers, to measure caregiver-child interaction. The Arnett CIS consists of 26 items that measure four critical dimensions of interaction, which have been renamed here to more easily explain the four dimensions of interaction. The data presented are only for those caregivers who were present for both pre- and post-test data collection (n=20).

The average score for all 20 caregivers at pre-test was a 2.27 out of a possible score of 4.00. The average score at post-test was 3.46, a statistically significant, average increase of 1.20 for the whole group of 20 caregivers. The results suggest that the DSEP intervention program has had a positive impact on the quality of caregivers' interactions with young children. As shown in Exhibit 7.4, caregivers demonstrated the greatest increases from pre- to post-scores on showing expressions of enjoyment and appreciation for children, and providing the children with developmentally age-appropriate expectations for behavior.

Exhibit 7.4 Average Scores for Four Indicators of the Arnett CIS*



**Results are based on the assessments performed by an external rater.*

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

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

Individual Care Plans (ICP) for Children

To assure the rapid triage of children into appropriate care, DSEP's protocol is to develop an ICP within 48 hours of the initial screening for all children residing at PCC, and within one week of their initial screening for children who bypass PCC due to a rapid placement with a relative or foster caregiver. The ICP document contains results from the initial screening data, areas of possible concern, and provides information on recommended activities and needed intervention/treatment services. The ICP informs both the primary caregiver and/or social worker about each child's progress and tracks the follow-up required to help each child reach their critical developmental milestones.

In FY 2010-11, 99.0% of children who showed concerns in their initial screening received an ICP. The difference between the number screened and the number of ICPs developed (n=13) can be explained in three different ways. First, those children screened during the last week of June would not have an ICP counted in the current FY data because it takes up to a week to fully complete an ICP. Second, children may enter PCC and receive a screening but be discharged (within two business days) before an ICP has been completed. Third, some children may have their cases managed by Public Health Nurses (PHNs), and the PHNs do not create ICPs.

The ICP is a living document that is updated throughout a child's enrollment in the CWS-DSEP Project. Social workers use the ICP to help overcome potential barriers to service access such as: the foster parent or caregiver declines to cooperate with recommended services, consent and confidentiality issues, reporting to the court, and efforts made to reach the biological parents as needed. In addition, social workers are able to use the ICP document to update each child's developmental information in their reports to the Court. Finally, Foster Care Public Health Nurses enter relevant information contained in the ICP into each child's Health and Education Passport.

Improved Child Development

Developmental Services

In FY 2010-11, a total of 1,072 children 0-5 years were screened (111 were age birth-3 months), as shown in Exhibit 7.5. Of the children screened, 581 (54.2%) showed concerns. 575 of these children received case management through DSEP, and the remaining 6 children were case managed by a Public Health Nurse (PHN). Of the children receiving case management, 87.7% (504 of 575) received at least one intervention recommended in the ICP. This is a very high rate for children in foster care. A clinician may recommend that several services do not occur simultaneously, depending on many factors, including: the child's developmental stage, their placement stability, or the intensity of the recommended service.

Exhibit 7.5 Children 0-5 years Receiving Screening, Intervention or Coaching

Service	
Screenings Conducted	1,072
Of Children Screened, number identified with Concerns	581
Early Identification/Case Management received	575
Behavioral Intervention	103
Developmental Enrichment Intervention	59

In addition to case management, 103 children also received a behavioral intervention. These are the children who were identified with more severe social/emotional and/or behavioral concerns. The behavioral intervention services are very narrowly focused and include: techniques to enhance secure attachment, self-regulation, and caregiver attunement and nurturing. In addition to the behavioral services provided at PCC, DSEP's child specialists provided in-home interventions to families of children whose screening results indicated a developmental concern. DSEP works with each caregiver to create a Home Activity Plan (HAP), which guides the intervention and enrichment activities that target the domains of concern for their child.

DSEP has placed emphasis on the use of a new clinical assessment protocol for infants ages birth to three months. Prior to First 5 funding for this project, assessments were only provided to children ages three months or older. Young infants are difficult to assess because they have a more limited capacity to respond, and the instruments previously available lacked specific cut-points. However, early identification can make a critical difference to these young children. In FY 2010-11, 47 children under three months of age (42.3%) were identified as needing further evaluation and possible intervention/treatment. Without the funding to provide screening for infants, the needs of these children may not have been identified until a later age.

DSEP also refers children out to receive necessary intervention services, and in FY 2010-11, DSEP made 1,795 referrals. Children may be referred to other First 5 services (Healthy Development Services or KidSTART, for example) or to other state or county services. Some of these other service providers include California Early Start, San Diego County Mental Health Services, the Developmental Evaluation Clinic, and others.

A final component of the DSEP project provides follow-up screenings to young children active in CWS. If a child does not show concern on an initial screening, they are eligible for another screening six months later. In FY 2010-11, 174 children received a six month follow-up screening, and of those children, 56 of them showed concern on their follow-up screening. Because of these services, these children with developmental or behavioral needs were identified and treated in a timely manner.

Developmental progress

A core component of the CWS projects is that children in foster care shall demonstrate increased progress in social-emotional competence areas. Three assessment tools are being utilized to measure child gains, depending on the age of the child, and FY 2010-11 marks the first year that children were consistently assessed with these tools.

The Infant/Toddler Symptom Checklist (ITSC), a parent report checklist, identifies infants and toddlers, from 7 to 12 months of age, who are at risk for sensory-integrative disorders, attention deficits and emotional or behavioral problems. Infants with difficulties in any of these domains are at high risk for later perceptual, language, sensory-integrative, and emotional-behavioral difficulties in the preschool years.

The Infant/Toddler Social and Emotional Assessment (ITSEA) is designed to detect social-emotional and behavior problems and delays in children age 12 to 35 months. The ITSEA relies on parents and child care providers' observations of the child in natural environments. The ITSEA is unique in that it focuses on competencies, as well as deficits, and relies on input from the parent and child care provider. The ITSEA Domains and Subscales include: Externalizing (e.g., Activity/Impulsivity, Aggression/Defiance, Peer Aggression); Internalizing (e.g., Depression/Withdrawal, General Anxiety, Separation Distress (Inhibition to Novelty); Dysregulation (e.g., Sleep, Negative Emotionality, Eating, Sensory Sensitivity); and Competence (e.g., Compliance, Attention, Imitation/Play, Mastery Motivation, Empathy, Pro-social Peer Relations).

The Teacher Child Report (TCR) assesses the social and learning behavior of preschool age children (36 to 60 months). A teacher observes the behavior of a child in the cottage preschool classroom and scores 29 statements on a three point Likert scale (not very true, somewhat true, and very true).

Overall, children in all three age groups have demonstrated a decrease in social-emotional or behavior concerns. However, due to a low number of matched pre and post assessments, there is not yet sufficient data to report on this year. Some challenges that the DSEP provider has identified when completing post-tests on these children include: (1) caregiver non-compliance (refusal) in following up on intervention recommendations and (2) the difficulty of continuing follow up with caregivers at the appropriate time intervals.

When intervention/treatment providers are unable to follow up with caregivers, it is categorized as the caregiver either actively or passively refusing services. “Actively refusing” service occurs when the caregiver directly states to DSEP that they refuse the service. The most commonly cited reasons for actively refusing services are scheduling conflicts or time constraints (often due to having multiple appointments for multiple children in their care) and transportation challenges. “Passively refusing” service occurs when a caregiver accepts an intervention/treatment recommendation but subsequently fails to follow through. Caregivers who “passively refuse” do not respond to DSEP’s repeated attempts to contact them.

To mitigate the issue regarding caregiver refusal, DSEP has attempted to follow-up with caregivers more frequently; however, administering the post assessments sooner than the recommended timeline may ultimately compromise the results of the assessments. Discussions continue among partners, and there will be further adjustments made to the process, the tools, or both in FY 2011-12.

Exhibit 7.6: Summary of Children Receiving Behavioral Intervention

	ITSC	ITSEA	TCR	Total
Number of children who received a behavioral intervention	N/A	N/A	N/A	103
Number of pre tests completed	3	32	41	76
Number of matched pre/post tests completed	3	9	12	24
Mean change (of the matched tests)	N/A	N/A	N/A	N/A

Early Childhood Education Services

Research shows that a quality early childhood education experience can improve a child’s chances of entering school ready to succeed. Through this project, all children screened are assessed for referrals to specific early childhood education services. Of the 136 children identified as having a need for a referral, 25.7% were actively enrolled in early childhood education services, as shown in Exhibit 7.7. The remaining 29.4% of children were referred out and were awaiting enrollment due to the following reasons: caregiver refusal, child was ineligible, a similar service was already being utilized, or the child was already in the process of enrollment.

Exhibit 7.7 Children (0-5 years) Receiving Early Childhood Education (ECE) Services

Service	
Children Case Managed	575
Children Identified as having a need for a referral to ECE	136
Children Referred to and Awaiting Enrollment into ECE Services	40
Children Enrolled in ECE Services	35

One outcome of this project is the identification of an ongoing need to link children to appropriate ECE services. A goal of FY 2011-12 is to strengthen the cross-systems relationships, as well as the collaboration among First 5 programs, that will result in a more expedient ECE enrollment for foster care children.

Improved Family Functioning

Support Services for Caregivers and Teen Parents

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 2010-11, 45 caregivers and biological parents received coaching regarding how to most effectively implement the ICP recommendations and any behavioral interventions needed, as shown in Exhibit 7.8. DSEP case managers indicated that some caregivers offered the following reasons for not accepting coaching services: 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 7.8 Caregivers Receiving DSEP Intervention or Coaching

Service	
Number of Families Served by DSEP	745
Number of Caregivers and Biological Parents eligible to Receive Coaching	127
Number of Caregivers and Biological Parents who Received Coaching	45
Number of Teen Moms in Residence at PCC.	6
Number of Teen Moms who Received Coaching	6

DSEP Developmental Specialists also provided parent education services to teen moms at PCC and other placement settings. In FY 2010-11, six teen moms received expanded support services while in residence at PCC such as child development education and modeling of developmental play activities. Arrangements were made for the teen moms to receive an education credit for these coaching sessions so they could participate during school hours.

Foster Care Respite

The Foster Care Respite program offered support to reduce stress for foster parents and kinship caregivers by providing them with respite care. Through this program, caregivers of foster children attended trainings, appointments, and other personal obligations while their children received professional care. In FY 2010-11, 379 foster children age birth-5 years and 166 parents caring for these children were served by CWS Respite. First 5 funding for the Respite program was concluded on January 31, 2011. Services provided by this program have been sustained by CWS.

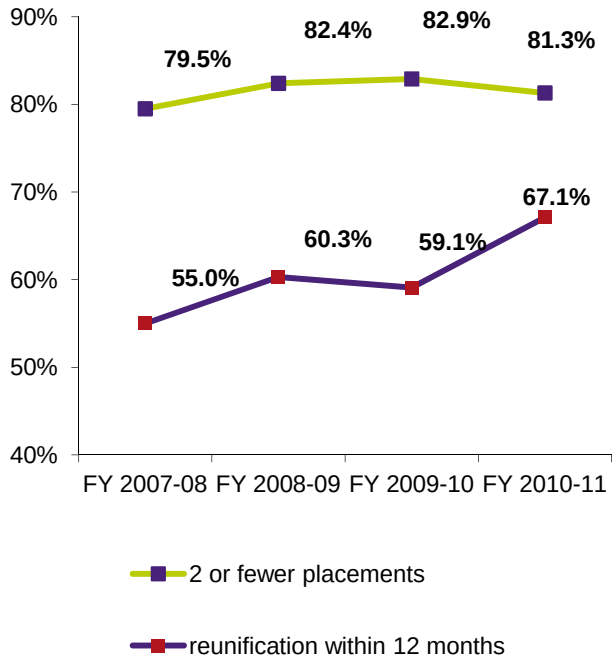
Making the Connection

The three CWS projects represent a 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 has made significant cuts to the Child Welfare budget statewide. In FY 2010-11 the funding from First 5 San Diego enabled the County to leverage an estimated $1,966,632 in federal funds (a 32.0% match from Title IV-E) to serve the youngest in the child welfare system.

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, identified 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 HHSA 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, the CWS foster care projects are intended to impact the placement stability rates for San Diego's young children who are in out-of-home placements. 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 the support to maintain child placements and the assistance needed to follow-up on developmental recommendations noted in each child's ICP. In FY 2010-11, 81.3% of children ages 0-5 in care for less than 12 months had two or fewer out-of-home placements. This is a slight decrease from previous years; however, it is consistent with county trends. The County is faced with several challenges in improving this measure including: regulations limiting the amount of time children can reside at Polinsky Children's Center; the amount of time required to obtain background clearances on potential relative caregivers; and the fact that any temporary placement lasting longer than 23 hours is counted as an additional placement. Despite these challenges, placement stability continues to be an area of focus for San Diego County.

Exhibit 7.9 Placement Stability Trends



Notably, 67.1% of children ages birth to 5 that were reunified did so within 12 months of removal. This is a marked increase from previous years and a trend that CWS hopes to continue.[5]

[5] Data for Exhibit 7.9 is taken from the CWS database.

Recommendations

The following recommendations were developed based on FY 2010-11 data and evaluation findings.

- **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 2011-12, DSEP and CWS will evaluate more effective strategies to encourage caregivers to participate in follow-up appointments.
- **Increase the number of children who get linked to Early Childhood Education Services.** Once partners became aware that the children who are identified for ECE Services are sometimes waitlisted, all partners agreed that collaboration between First 5 programs and across broader county systems can be strengthened. A goal of FY 2011-12 is to establish relationships that will result in a more expedient enrollment for those children who are identified for ECE needs.
- **Review assessment tools.** CWS-DSEP and First 5 will conduct a review of the screening and assessment tools currently being used for young children to determine which are most appropriate and effective. The goal will be to review the data gathered to date and determine if the tools selected are most appropriate for the foster care population (including infants) and work within the competing demands on foster parents.

Sara's Story*

Sara, an 18 month-old girl, was admitted to PCC due to physical abuse. DSEP's Developmental Specialist worked with Sara in her cottage every weekday for the two weeks she was there. In addition to developmental concerns in several areas, there were serious concerns about Sara's social-emotional well-being. She was not able to regulate her emotions, was difficult to console, and when upset or anxious, scratched her own face to the point of drawing blood. The cottage staff was attempting to use positive and negative reinforcement to handle this behavior, with no success.

The Developmental Specialist focused on precursors and on giving Sara new techniques for self-soothing. She taught cottage staff to pay close attention to when Sara seemed to be about to scratch herself. When they saw this, they were taught to gently take Sara's hands, kiss each palm and say, "Hands are not for hurting." After a week of the Developmental Specialist and cottage staff consistently using this technique, when Sara began to feel anxious rather than scratching her face, she would seek out someone to give her "hand kisses" instead.

Two weeks after Sara moved to a foster home, the DSEP Developmental Specialist did a home visit to make sure the transition was going well. When the Specialist entered the front door, Sara ran to her with her hands out, palms up. The Developmental Specialist said, "Hand Kisses!" and kissed each palm. The foster mom saw this and said, "Oh, is THAT why she does that?" Sara had been seeking the calming techniques from her new foster mother, but the caregiver didn't know what Sara was looking for. DSEP taught her this very simple technique to help Sara regulate her emotions and stop scratching her own face.

Joshua's Story*

Joshua is a 2 year old boy who had been placed in foster care due to neglect and domestic violence. Joshua received a developmental screening by a DSEP Assessment Specialist, Kathy. It turned out that Joshua had some gross/fine motor and language concerns and he would need a comprehensive developmental evaluation for. Kathy offered Joshua's foster mom some additional visits so they could work together to enhance Joshua's development. The foster mom explained that Joshua would be starting a 60-day trial with his mother and father and suggested that the Kathy do the sessions with them instead. Kathy discussed this with Joshua's social worker, who agreed and helped her get in touch with the parents.

Kathy met with Joshua's parents and gave them some ideas on gross and fine motor and language activities to help his development. During the second visit with the family, Joshua passed some milestones for the first time. Kathy and the parents were doing an activity with Joshua and clapped for him in encouragement. When he saw his parents clapping for him, he began clapping too, which was the first time he ever clapped. While Joshua was handing blocks to Kathy, she repeatedly told Joshua, "thank you."After a few times, Joshua then repeated the words "thank you." His parents were surprised and thrilled because these were the first words they had ever heard him say. Joshua's parents were extremely encouraged by his progress and were determined to continue the activities throughout the week. Seeing the parents' enthusiasm, Kathy asked Joshua's parents to think of more activities that they could do with Joshua.

Kathy continued to visit the family once a week for the next three weeks while the parents worked with Joshua throughout the week. By the fifth visit Joshua was able to stand and walk by pushing a toy, his fine motor had improved, and he had 2-3 new words. Joshua would still need more intensive services, but the major progress he had made in a short time revealed the parents' commitment to spending quality time with Joshua practicing in order to improve his development.

* All names have been changed in these stories.

Other Family Projects

In addition to its broad-reaching initiatives, First 5 San Diego funds single projects that target particular needs in the community. These projects are funded through the Commission's Responsive Funds or its Emerging Critical Needs Fund. These are the key projects in the area of family.

Table 7.10 Other Family Projects

Program / Contractor	Children Served	Adults/ Families Served	Description of Project/Services
Families Together Program / Horn of Africa	350	149	Horn of Africa focuses primarily on East African refugee families with children ages 0-5. Staff works with pregnant women and their families to ensure that their infants and children have appropriate healthcare, education, and advocates that support them. Key achievements in this year include: • 100.0% of infants were linked to a medical home within 30 days and 100.0% of caregivers within three months • 100.0% of children received a developmental screening • 99.0% of families did not have a CPS referral
Kit for New Parents / UCSD Regional Perinatal Systems	NA	27,708	The Kit for New Parents (Kit) has been an integral part of First 5 California and County Commissions since its inception in 2001. It is distributed locally by UCSD Regional Perinatal Systems through 600 community partners. The Kit, which is offered to parents at no cost in six languages, contains books, DVDs, and other resources that provide information on parenting and children's development. Nearly 28,000 Kits were distributed to parents and caregivers last year.
San Diego Adolescent Pregnancy and Parenting Program (SANDAPP) / San Diego Unified School District	362	525	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 health, educational potential, and healthy relationships of pregnant and parenting adolescents, their children, siblings, and parents by promoting a collaborative, integrated support system." Key achievements include: • 100.0% of clients developed an active pregnancy prevention plan • Only 3.0% of clients had a repeat pregnancy • 100.0% of clients attended parenting skills education • 128 families received behavioral therapy

Community

Goal: Build each community's capacity to sustain healthy social relationships and support families and children.

Community and Capital Projects
- 2-1-1 San Diego
- Parent and Public Education
- Text4Baby
- Capital and Equipment Projects

First 5 San Diego

CHAPTER 8

Community and Capital Projects

In addition to its broad-reaching initiatives, First 5 San Diego funds single projects that target particular needs in the community. These projects are funded through the Commission's Responsive Funds, its Emerging Critical Needs Funds, or its Capital Projects Initiative. These are the key projects that served the community.

Exhibit 8.1 Community Projects

Program / Contractor	Description of Project/Services
Information and Referral Services / 2-1-1 San Diego	2-1-1 is the free national dialing code for information about community, health and disaster services. Locally, 2-1-1 San Diego provides live information and referral specialists who offer personalized information to callers seeking services in San Diego County. The 2-1-1 network also includes the First 5 "Warm Line" (1-888-5-FIRST-5). The Warm Line is promoted through various media and outreach activities as the number to call for information about and referral to First 5 programs and services. These are key accomplishments of 2-1-1 San Diego: + Handled 39,742 cases related to children 0-5 + Answered 2,681 calls to the Warm Line + Provided 2,168 referrals to First 5 San Diego programs
Parent and Public Education / MJE Marketing Services	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 is 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. In FY 2010-11, Phase 3 of the "Good Start" campaign was conducted from February 2011 to June 2011, with a focus on the importance of oral health for children 0-5 and pregnant women and the Commission's Oral Health Initiative (OHI). These are the key accomplishments for Phase 3 of the Good Start campaign: + Leveraged $4 dollars for every $1 spent on media outreach by negotiating $1.5 million dollars in bonus media. + Achieved more than 52 million gross impressions at a cost of ¾ of a cent. (Gross impressions are the number of times elements from the campaign were seen.) + Referrals[1] to First 5 San Diego programs and services increased 183% from 131 per month to 372 per month. + First 5 San Diego Warm Line calls (1-888-5 FIRST 5) calls

[1] Includes referrals from both the Warm Line and the 2-1-1 General Line.

(Continued)	increased 157% from 135 per month to 348 per month.[2]
Text4Baby / San Diego County Medical Society Foundation	Text4Baby is a free national mobile information service that provides health information to mothers from the beginning of their pregnancy through their baby's first year. First 5 San Diego is providing $82,500 for the development and management of an integrated media/marketing campaign for Text4Baby in San Diego County from July 1, 2010 through December 31, 2011. In FY 2010-11, Text4Baby enrolled 1,739 pregnant women and new parents – 96.6% of its adjusted 18-month goal.

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 48 projects were funded as a result of these funds. Listed are the projects that were completed in FY 2010-11 or are still underway.

Exhibit 8.2 Capital Project and Equipment Projects – Completed in FY 10-11

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. Total Investment: $50,000.
Rady Children's Hospital	Improve the playground at the Oceanside Developmental Services Center and the Children's Toddler School. Equipment for the behavioral treatment/observation rooms of the new Autism Discovery Institute. Project period: 4/1/08-.11/30/10. Total Investment: $47,168.
San Diego Unified School District	Restructure, renovate, replace and enhance the facility at Rowan Children's Center. Project period: 9/10/08-10/31/10. Total Investment: $660,478.

Table 8.3 Capital Project and Equipment Projects – Still Underway

Capital Improvements	Use of Funds
St. Vincent de Paul / Father Joe's Villages	Construct a new facility to house St. Vincent de Paul Village's therapeutic child development services. Project period: 5/20/05 - 12/19/12. Total Investment: $6,968,025.
U.S. Department of the Navy, Navy Region Southwest	Construct two new Child Development Centers at the Coronado Naval Air Station (completed) and at the Murphy Canyon community. Project period: 3/31/06 - 3/30/13. Total Investment: $10,803,043. Murphy Canyon project: $6,269,995

[2] Referral and Warm Line data are the average of 4-months prior to the campaign compared to 4-months during the campaign.