Health Matters:
The Role of Health and the Health Sector in Place-Based Initiatives for Young Children

November 2008

Prepared for
The W.K. Kellogg Foundation
by
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ACKNOWLEDGMENTS

The authors wish to thank Al Yee, Program Director at the W.K. Kellogg Foundation, whose vision, support, and guidance made this study possible. We are also indebted to the key informants, as well as the program innovators from our eight study initiatives, whose insights and experiences form the basis of this monograph.

EXECUTIVE SUMMARY

Study Goals

This study provides an initial scan of the role of health and the health sector within broader place-based initiatives for young children. The long-term goal of the study is to better link children and families to the full array of services and supports needed to promote healthy growth and development. The more immediate goal is to assist program planners and implementers, policy makers, funders and other key stakeholders in identifying, understanding and promoting the role of health and the health sector within innovative, multi-sector, place-based initiatives that serve children and their families.

Landscape for Early Childhood Initiatives

Two pulls — new knowledge and increased challenges — have created for many a new sense of urgency and action around early childhood. In part, this reflects recent scientific findings about brain development and developmental trajectories, both of which provide new insights into the interplay between genes and environment and the importance and life-long impact of healthy development in the early years. At the same time, today's young children and their families — as well as those who provide services and supports to children and families — are facing new and increasing challenges, as evidenced in several spheres, including education, health, and family functioning/family support.

The emerging focus on early childhood is evident in programs and projects across the country, and across multiple sectors. However, all too often, the pieces don't fit together: in many instances the various sectors seem to be engaged in the "parallel play" stage of development; that is, working side-by-side but with little or no interaction. In other cases, where early childhood efforts do cut across sectors, it appears that the health sector is either not actively engaged, or simply missing-in-action. Thus, an initiative might work to ensure children get health coverage, but there is not necessarily any interplay between health care providers and others working to improve developmental trajectories for children. Likewise, while federal and state systems change initiatives are increasingly common, these initiatives are not always embraced or owned at the local level. Nevertheless, there are positive developments. Heightened activity for early childhood is a promising starting point. Moreover, there *are* existing multi-sector, place-based initiatives, which are, in fact, putting the pieces together in support of young children and their families.

Study Initiatives

This study identifies and describes eight exemplary, early childhood initiatives, all of which include a strong and active health component, and have successfully integrated efforts across multiple service sectors and settings. The study initiatives include: Children and Families Commission of Orange County (CA), Children's Board of Hillsborough County (FL), Children's Futures (Trenton, NJ), First 5 Ventura County (CA), Help Me Grow (CT), Opportunity Knocks (Middletown, CT), Region A Partnership for Children (Western NC), and Westside Infant-Family Network (Los Angeles, CA). In addition to providing an in-depth profile for each of the eight initiatives, the study report also describes common cross-initiative themes, strategies, and program elements.

Cross-Initiative Program Framework

In order to better understand and describe how multi-sector, place-based initiatives for children are organized, the study sought to identify the basic program framework for each initiative, along with key

program elements. While there is a great deal of variation in specific program implementation, with individual services and approaches tailored to meet local circumstances, there is also remarkable consistency in the overall program framework across the initiatives, including three core service sectors, four key audiences, and three primary program strategies. Each of these basic program building blocks is described in further detail in the report.

Health Matters: Cross-Initiative Program Framework		
Core Sectors	**Key Audiences**	**Primary Program Strategies**
▪ Health ▪ Education ▪ Family Support	▪ Children ▪ Parents/Family ▪ Providers ▪ Community/Community Systems	▪ Enhanced Services ▪ Capacity Building ▪ Systems Change and Integration

Health Sector Engagement in Systems Change and Integration

Systems change and integration play a special role in the exemplary multi-sector, place-based initiatives highlighted in this study. This primary program strategy helps the study initiatives move from a collection of individual service and capacity-building projects to an integrated set of programs that work at a community-wide level. In keeping with its focus on the health sector, the study further examines the role of the health sector in systems change and integration. This includes health sector engagement at three levels:

1. ***Systems Change/Integration within the Health Sector***. Within the health sector, services are strengthened, expanded and vertically integrated.

2. ***Changes in the Interface between Health and Other Sectors***. Across sectors, health services are better linked and horizontally integrated with other existing services.

3. ***Health Sector Engagement in Community-Wide, Cross-System Change/Integration***. At the community systems level, the health sector is engaged in community-wide/cross-systems planning, service development, and policy change.

Summary Findings

Key study findings include the following:

- ***Innovative, multi-sector initiatives for young children that include an active role for the health sector do exist, and they are making a difference***. While health sector engagement in broader place-based initiatives is not yet the norm, this review points to the important roles these initiatives and their health components can play in improving the lives and life trajectories of young children and their families. These initiatives serve as platforms for engaging families, service providers and communities in promoting healthy development; improving services and service delivery within individual sectors; organizing and delivering integrated services across sectors; and working toward broader policy and systems change to better meet the needs of children and families.

- ***Several common building blocks lay the foundations for multi-sector collaboration, coordination and integration within place-based initiatives for young children.*** These include a

whole child/whole family focus; funder-driven collaboration; the initiatives' role as a neutral convener/facilitator; multi-sector community-based planning and engagement; and an underlying service philosophy that focuses on "going where the children are."

- ***While there is a great deal of variation in specific program implementation, with individual services and approaches tailored to meet local circumstances, there is also remarkable consistency in the overall program framework and key program elements across the initiatives.*** This includes consistency in core service sectors (health, education, and family support); key audiences (children, parents/family, providers, community/community systems), and primary program strategies (enhanced services, capacity building, and systems change/integration).

- ***Although the study initiatives have different "frames", all work toward improving health and healthy development, as broadly defined.*** Specifically, the initiatives fit well with the broad definition of health proposed in the National Academy of Sciences report, *Children's Health, the Nation's Wealth.* Applying this definition helps to clarify the ways in which these and other broad, place-based initiatives for young children intersect with health, and may make it easier to engage the health sector.

- ***The health sector plays an important role in the study initiatives, helping children realize their full developmental potential: physically, emotionally, socially and cognitively.*** As part of place-based early childhood initiatives, health professionals promote healthy development using the same key strategies, focused on the same audiences as the other sectors. In addition to providing direct services through traditional clinical settings, health sector players also provide clinical services in non-traditional settings; offer parent education classes; promote early literacy; link children and families to additional services and supports in their communities; provide home visiting consultation and therapeutic intervention; provide consultation to service providers from other sectors; collect and analyze data on service needs and gaps; and work to develop new or enhanced services that address the health and developmental needs of children in the communities they serve.

- ***Participation in broad, place-based initiatives plays an equally important role in strengthening and transforming the health sector.*** As part of broader place-based initiatives for young children, health professionals and other key players are engaged in systems change at three levels: within the health sector; between health and other sectors; and at the community-wide/cross-systems level. Health sector systems change at these three levels has strengthened and transformed health sector roles, services, capacities and impact within communities.

- ***The success of these initiatives does not rest on a single sector, audience, or strategy. Rather, it is the initiatives' ability to integrate their broad program strategies across multiple sectors and audiences that sets them apart.*** The concept of an integrated strategic framework is central to this study and report. What the initiatives share in common is the kind of funding, framing, and political will needed to implement integrated program strategies across multiple services and sectors. This means that initiative leaders (i.e., lead staff, advisory boards, and funders) plan for their initiatives in ways that link and reinforce program approaches and relationships across sectors. Examples include: using the same key messages across sectors and audiences; developing cross-sector referral-linkage and data systems; and using cross-sector training to improve basic service capacities and to enhance relationships across sectors. The level at which individual service providers are engaged in working directly with other sectors varies by initiative, by program, and by provider. Some providers have literally moved into new service settings (e.g., moving clinical care or consultation to an early childhood center or school); or are now part of a broader early childhood provider team in a community setting; or are part of a

cross-discipline team that is drafting a consistent set of messages for young children and their families community-wide. In other instances, individual providers may continue to work in their specialized settings, but receive direct assistance from other service providers; or providers may have access to online data from partner agencies serving the same clients; or they may be on the receiving end of new referral/linkage pathways. The point is that by developing strategically integrated program frameworks, these initiatives are putting the pieces together for children, families and service providers; and they are effectively using their resources to achieve outcomes that cannot be achieved one sector at a time.

- ***The cross-initiative program framework, key program elements, and basic building blocks for multi-sector collaboration, coordination and integration identified in this report have been successfully used across the initiatives, and therefore it is likely that they can be applied successfully elsewhere, as well, particularly when coupled with the kind of flexible implementation that has allowed the study initiatives to adapt and tailor their work to the specific circumstances of the communities they serve.***

- ***Financing has played a key role in shaping the study initiatives.*** In most cases, the study initiatives have benefitted from a significant source of start-up funding that not only allowed, but actually promoted collaboration, coordination and integration of services, as well as program strategies, for the benefit of young children. For many of the initiatives, financing has covered far more than the usual grant period of one to three years; extending to ten years or more. Also of note, funding for the study initiatives has not been tied to a single, pre-existing agency or sector. Instead, for most of the initiatives, funds were awarded to a new entity, which has allowed that entity to serve as a neutral convener and facilitator across agencies and sectors.

- ***Sustainability remains an ongoing issue even for the effective and successful initiatives in the study.*** All of the initiatives that were studied face serious questions about their long-term sustainability. Several are dependent on time-limited private grants, and even for those that have obtained public financing, revenue sources are far from secure. The consensus among study initiatives and national experts participating in the *Health Matters* meeting in April 2008 is that, ultimately, macro-level systems and policy changes will be needed to sustain these and similar initiatives in the long run.

Conclusions

This review leads to four overarching conclusions:

- ***The study initiatives and others like them provide effective platforms for improving the lives of young children and their families, promoting healthy development, and transforming child health and other service systems in the communities where they have been implemented. As such, they can serve as models for transforming child and family services, supports, programs and policies nationwide.***

- ***With adequate support and resources, place-based initiatives such as those profiled in this study can also serve as "innovation incubators," testing new ideas, establishing new approaches within and across service sectors, and finding new ways to build capacity within families, service sectors, and communities.*** In this way, the place-based, multi-sector initiatives can make important changes within their own geographic boundaries, *and* build an evidence base that can help guide other communities, program planners and implementers, funders, and policy makers nationwide.

- ***Health sector participation in multi-sector place-based initiatives for young children should be promoted and further developed, both as a means of strengthening multi-sector initiatives and their impact on children, and as a means of improving the health system.***

- ***Long-term issues around financing and sustainability suggest that broad policy and macro-level systems changes (at the local, state and national levels) will be needed to sustain these and similar initiatives in the long run (including sector-specific changes currently supported by the initiatives).*** Therefore, there is a need to identify current and potential policy options for long-term sustainability, build an evidence-base around these options, and build political will to support needed policy and systems changes.

Recommendations

The report includes four major recommendations organized around the study's four key conclusions. Potential starting points are also offered for each of the following recommendations:

1. ***Further explore and disseminate information on the eight exemplary initiatives highlighted in this report, and others like them, as models for transforming child and family services, supports, programs and policies nationwide.*** This study serves as an introduction to multi-sector, place-based initiatives for young children, with a particular focus on the role of health and the health sector within the initiatives. As such, it is a first step. Many additional aspects of these and similar initiatives can and should be further explored and described so that others can build on their work.

2. ***Develop and provide the support and resources needed to help these and similar initiatives become "innovation incubators," testing new ideas, establishing new approaches within and across service sectors, and finding new ways to build capacity within families, service sectors and communities.*** Beyond capturing and disseminating what has already been done, there is a great opportunity to work collaboratively with existing initiatives in order to jointly problem solve, test new ideas, and build an evidence base for successful interventions.

3. ***Promote and enhance health sector participation in multi-sector, place-based initiatives for young children, both as a way to strengthen the initiatives and their impact on young children, and as a means of improving the health system.*** Multi-sector, place-based initiatives for young children provide an extraordinary opportunity for health professionals, health care services, and public health programs to: (1) expand and strengthen healthcare services; (2) build capacity; and (3) change and integrate systems of care (within the health sector and between health and other sectors). In addition, the study initiatives, and others like them, can provide the resources and opportunities needed to rethink and realign healthcare content, organization, and delivery (including delivery sites).

4. ***Identify, develop and promote policy and systems changes for long-term sustainability.*** Ultimately, broad policy and systems changes will be needed to sustain most of the study initiatives, and others like them, so that multi-sector, collaborative, place-based and community-owned efforts can become the norm.

HEALTH MATTERS:
THE ROLE OF HEALTH AND THE HEALTH SECTOR IN PLACE-BASED INITIATIVES FOR YOUNG CHILDREN

INTRODUCTION

Study Purpose

This study, *Health Matters: The Role of Health and the Health Sector in Place-Based Initiatives for Young Children*, was commissioned by the W.K. Kellogg Foundation to provide an initial scan of promising place-based initiatives that address the developmental needs of young children, with a particular focus on the role of health and the health sector in these efforts**.** More specifically, *Health Matters* was undertaken to help program planners and implementers, policy makers and funders identify and understand a set of innovative and successful multi-sector, place-based initiatives that focus on young children, include a health component, and feature two-way linkages into and out of the health sector. The initiatives reviewed in the study have the potential to serve as models for future work, and as a source of lessons learned and recommendations for those who seek to improve the lives and life course of our nation's youngest children.

Health Matters builds on a recent study, *Beyond Referral: Pediatric Care Linkages to Improve Developmental Health*[1], which was conducted by Amy Fine and Rochelle Mayer and funded by the Commonwealth Fund. *Beyond Referral* focused on how pediatric primary care practices link children to needed developmental services and supports in their communities, starting from a "pediacentric" focus. *Health Matters* focuses first on successful place-based initiatives serving young children, and then looks more closely at how these initiatives intersect with health and the health sector.

Organization of the Report

In addition to this introduction, the report is organized around five sections:

- ***Study Context and Overview.*** This section of the report provides information on the context, methodology and conceptual underpinnings for the study. Specific sub-sections include: Landscape for Early Childhood, Landscape for Early Childhood Initiatives, Study Goals, Study Questions, Methodology, and Selection Criteria and Rationale.

- ***Introduction to the Initiatives.*** Brief introductory paragraphs describe each of the eight study initiatives, highlighting key features of each initiative, with a particular emphasis on approaches to coordination, collaboration and integration.

- ***Cross-Initiative Findings and Assessment.*** This section focuses on five sets of themes and findings: (1) Foundations for Multi-Sector Collaboration, Coordination and Integration; (2) Cross-Initiative Program Framework; (3) The Role of Health and the Health Sector within the

[1] A. Fine and R. Mayer, *Beyond Referral: Pediatric Care Linkages to Improve Developmental Health* (New York: The Commonwealth Fund, December 2006).

Program Framework; (4) An Integrated Strategic Framework for Success; and (5) Financing and Sustainability.

- ***Summary Findings, Conclusions and Recommendations.*** This section provides summary study findings, with four key conclusions and related recommendations, each followed by potential starting points.

- ***Appendices***

  - *Appendix A: Initiative Profiles.* The eight study initiatives are described in greater detail in individual profiles that provide information on initiative: origins; development; strategic plan and planning; target population; implementation platforms; program overview; anchor programming; staffing, administration, and governance; financing and allocation of funds; data, evaluation and accountability; and sustainability. Contact information is also provided, for those who seek additional information.

  - *Appendix B: Key Informants List*

  - *Appendix C: Initiative Interviewee List*

  - *Appendix D: Meeting Participant List*

STUDY CONTEXT AND OVERVIEW

Landscape for Early Childhood

This study has been undertaken at a time when there is new and growing interest in early childhood in the United States and abroad. In part, this interest reflects recent scientific findings about brain development and developmental trajectories, which provide new insights into the interplay between genes and environment and the importance and life-long impact of healthy development in the early years. Landmark reports such as the Institute of Medicine's *Neurons to Neighborhoods*[2] and *Children's Health, the Nation's Wealth*[3] provide ample evidence of why early childhood is so important and why there should be renewed attention focused on helping young children achieve their full developmental potential.

At the same time that this explosion in knowledge has occurred, today's young children and their families — as well as those who provide services and supports to children and families — are facing new and increasing challenges, as evidenced in several spheres.

- ***Education.*** Within educational settings — childcare, pre-school and schools — educators are seeing more children with behavioral problems, and at earlier ages. Children are being suspended or expelled from childcare and preschool settings because of disruptive behavior. And, as children get older, increasing numbers are failing to achieve basic competencies in reading, math, and other subjects. Thus, we see a new emphasis on school readiness and on school success, especially in the early years. At the same time, the quality of childcare and early childhood education varies tremendously, with the field hampered by low wages and the lack of formal training for many providers. Quality is an issue for schools as well, nationwide.

- ***Health.*** Health care providers are seeing a rise in chronic conditions for the population as a whole, and these conditions are starting at younger ages and with greater severity. Conditions such as asthma, diabetes, obesity, dental caries and behavioral/developmental issues occur at alarming rates among even our youngest children and have a profound effect on both current and future functioning. In addition, pediatricians and other primary care physicians are being asked to do more with less time and less money; and even if these constraints were not in play, our health care system is not currently geared to effectively address the morbidity of the late 20th and early 21st centuries — chronic, non-infectious diseases and conditions. Nor is it positioned to effectively incorporate strategies that promote optimal health and development, whether in the office setting or through linkages with other services and sectors within communities. This, despite the fact that parents want to learn more about how to optimize the development of their children and that they expect their pediatricians to help them identify and address developmental issues.[4]

- ***Family Support.*** Similarly, those working in family support services report increased stress on parents and families, especially those living in or near poverty, including: food insecurity; lack of health coverage; inadequate housing; community violence; job loss; or the need to work multiple jobs, none of which pay a living wage. And, even for those who are lucky enough to make it to a

[2] J.P. Shonkoff and D.A. Phillips, eds., *From Neurons to Neighborhoods: The Science of Early Childhood Development* (Washington, D.C.: National Academy Press, 2000).
[3] Committee on Evaluation of Children's Health, The National Research Council, *Children's Health, the Nation's Wealth: Assessing and Improving Child Health* (Washington, DC: National Academy Press, 2004).
[4] E.L. Schor, "Rethinking Well-Child Care," *Pediatrics,* 2004 114:210-216.

relatively secure middle or upper-middle class life, U.S. lifestyles are becoming increasingly more fragmented, overscheduled, sleep-deprived, and just plain stressed.

Thus, two pulls — new knowledge and increased challenges — have moved many to a new sense of urgency and action around early childhood. Beyond the "usual suspects" such as educators, pediatricians, and family service workers, we now see new voices coming to the forefront: economists making the case for early childhood investments, policymakers establishing special tax funds for early childhood and school readiness, and mayors and governors appointing special commissions and blue ribbon panels focused on early childhood. Despite the challenges, then, a new window of opportunity exists for those concerned with the health and development of our nation's children.

Landscape for Early Childhood Initiatives

This emerging focus on early childhood is evident in programs and projects across the country, and across multiple sectors. For example, many states and counties have developed "school readiness" and "school success" initiatives, seeking to improve the quality of early childhood education settings, provide pre-school for all, enhance reading and math scores among school children, and address bullying and other behavioral issues from the earliest ages on up. Communities and states are investing in one-stop Family Resource Centers to provide multiple services and supports that families need. Within the health sector, national and state systems reform efforts are working with pediatric primary care practices to improve developmental care. Quality improvement efforts help pediatric practices systematically address chronic conditions such as obesity, asthma, and behavioral health issues. At the federal and state levels, public health programs are working to better integrate early childhood systems of care, and to improve the range and focus of available health services, particularly for low-income children.

However, all too often, the pieces don't fit together: in many instances the various sectors seem to be engaged in the "parallel play" stage of development; that is, working side-by-side but with little or no interaction. In other cases, where early childhood efforts do cut across sectors, it appears that the health sector is either not actively engaged, or simply missing-in-action. Thus, an initiative might work to ensure children get health coverage, but there is not necessarily any interplay between health care providers and others working to improve developmental trajectories for children. Likewise, while federal and state systems change initiatives are increasingly common, these initiatives are not always embraced or owned at the local level.

Nevertheless, there are promising developments. Heightened activity for early childhood is a promising sign, even if all the pieces don't yet fit together. Moreover, there *are* existing multi-sector, place-based initiatives, which are, in fact, putting the pieces together in support of young children and their families.

Study Goals

The long-term goal of *Health Matters* is to better link children and families to the full array of services and supports needed to promote healthy growth and development. The more immediate goal is to assist program planners and implementers, policy makers, funders and other key stakeholders in identifying, understanding and promoting the role of health and the health sector within innovative, multi-sector, place-based initiatives that serve children and their families.

Study Questions

The overarching study question and related sub-questions are as follows:

- What is the role of health and the health sector in multi-sector, place-based initiatives for young children 0-8 years old?
  - What are the promising and innovative models/initiatives?
  - What are the key program strategies and organizational components (for the general program and for the health sector in particular)?
  - What are the lessons learned and recommendations based on a review of these initiatives?

Methodology

This study involved a three-part methodology:

- ***Key informant interviews, plus selected Website and literature reviews***. Key informant interviews were conducted with 35 national, state and local experts in child health and early childhood to identify potential initiatives nationwide. Several national organizations — e.g., American Academy of Pediatrics (AAP), CityMatCH, and the National Association of City and County Health Officials — sent queries to key members or leadership requesting suggestions for initiatives to include in the study. In addition, extensive Website and literature reviews were conducted to identify and review eligible initiatives.

- ***Selection of exemplary initiatives followed by interviews and review of supplementary materials.*** In-depth interviews were conducted with multiple representatives from each initiative selected for study, including key staff or other principals. In addition, each initiative was sent a brief written protocol to complete prior to the interviews. Supplementary written materials were obtained for all initiatives including documents such as: strategic plans, evaluation results, program descriptions, meeting minutes, media coverage, annual reports, and reports to foundations.

- ***Meeting of the initiatives and national experts.*** In April 2008, a meeting was held in Washington, DC, bringing together key staff and principals from each initiative, national experts in maternal and child health and early childhood, and foundation representatives to discuss preliminary findings and to further discuss promising strategies and components, as well as actions and activities that might further enhance these kinds of innovative initiatives.

Selection Criteria and Rationale

Primary Selection Criteria

In order to be included in the study, initiatives needed to fit all of the following characteristics:

- Focused on young children aged 0-8years (or some segment of this age range);
- Place-based (neighborhood, community, city, county, or region of a state);
- Three or more sectors involved, one of which is health;
- Broader than one specific health condition; and
- Two-way linkage into and out of the health sector (i.e., there are established, reciprocal referrals and interactions between health and other sectors; and the health sector is actively engaged with other sectors in working to improve the lives of young children in the community).

Secondary Selection Criteria[5]

Once an initiative made the initial "cut," the search was further refined to assure that each initiative in the study was innovative in its approach, going beyond "business as usual" either for individual sectors or across sectors. More specifically, initiatives were screened to see if they included a focus on one or more of the following:

- Vertical integration within sectors.
- Horizontal integration across sectors.
- Developmental trajectories.
- Social-economic and environmental determinants.
- Transformative strategies.
- Universal and targeted strategies.

Rationale for Selection Criteria

The study focuses on young children birth through eight years old because these are formative years, a period in which dramatic learning and growth occurs and in which the foundations for life-long capacities and skills are established and/or strongly influenced.

The study focuses on local initiatives because children live their lives on a very local level, with family, neighborhood, community services and environments shaping their development. National and state initiatives were not excluded from the study altogether, but they needed to include a strong, locally run and "owned" component that could be the subject of in-depth review.

The criterion that initiatives include three or more sectors was included in order to identify initiatives that were more likely to be broad-based, community-wide, and to engage multiple actors and sectors. The study sought initiatives in which multiple resources are marshaled on behalf of *all* the children living in a particular local geographic setting: a neighborhood, city, county, or even several counties. In short, the study sought initiatives that functioned as "children's zones" or as the proverbial "village" that it takes to raise a child.

The focus on initiatives that engage more than one health condition was included in order to identify initiatives that are working to improve the health and development of the whole child; that is, initiatives that are child-driven, not condition-driven.

The criterion on two-way linkages into and out of the health sector was added to identify initiatives in which the health sector is actively engaged and is more than a passive beneficiary of increased referrals or increased coverage for children. At a minimum, the study sought to identify initiatives in which the health sector better connects children to additional services and supports within the community, and vice versa. In addition, the study sought to identify models in which health services have been improved or enhanced as a result of being part of the initiative, and in which the health sector has contributed to broader planning and development of services for children. *This criterion is based on the belief that increasing the number of children receiving traditional health services is not enough: the health sector must also change to better promote healthy growth and development, to better link children to additional services and supports, and to help change the conditions in a community so that children can thrive.*

[5] These criteria were informed in part by discussions at "Transforming Early Childhood Systems of Care: Critical Elements and Policy Levers for System Reform," a meeting organized by the Blue Sky Initiative to Transform the US Health System and the Children and Families Commission of Orange County, held October 3-5, 2007 in Los Angeles, California. See the UCLA Center for Healthier Children, Families and Communities Website for more information on the Blue Sky Initiative: http://www.healthychild.ucla.edu/BlueSky.asp

With regard to the secondary selection criteria, vertical integration (i.e., integration within sectors) was included for two reasons: First, to identify initiatives that make it easier for children and families to navigate through systems of care; and second, because initiatives focusing on vertical integration may be more likely to incorporate a full spectrum of services and supports for children and families, including promotion and prevention efforts focused on helping children reach their developmental potential.

Horizontal integration (i.e., integration across services and sectors) was of interest because it signals collaborative efforts on behalf of children and families, rather than a series of unconnected services that families have to integrate. Like vertical integration, horizontal integration makes it easier for families to navigate care — in this case, across service sectors. It also makes it easier for service providers to connect with each other, on behalf of the children they are serving. Perhaps most important, horizontal integration has the potential to make services and supports more effective and more efficient, with children, families and providers all benefitting. Horizontal integration was of particular interest in this study because it reflects an effort to go beyond the "parallel play" stage so often seen among early childhood services and supports.

The study looked for initiatives that recognize and incorporate two concepts — developmental trajectories and social-economic and-environmental determinants of health and development — based on the belief that these factors need to be incorporated into the delivery of healthcare and other services, in order to adequately address many of today's most pressing health and developmental problems among children. The concept of developmental trajectories takes into account a child's projected development over time. For health and other services this means addressing health and developmental issues not as independent problems or episodes, but rather with an eye toward future development. Services that take developmental trajectories into account are more likely to focus on prevention and early intervention. The concept of social-economic and environmental determinants recognizes that a child's health and development are shaped by broad societal factors in addition to specific services, such as healthcare or education. So, for example, family economic status, housing, food security, neighborhood environment, and community services all have a role in determining outcomes for children.

"Transformative" strategies were included in the selection criteria because they signal innovative initiatives and because current service systems need to change dramatically if they are to meet the needs of children and their families. Transformative approaches are defined as fundamental changes in the way things are done, reflecting an underlying shift in both philosophy and practice. Examples of transformative strategies in the health arena include: parents as partners, medical home, quality improvement approaches to practice level systems change, well child care focused on developmental stages rather than on the immunization schedule, and a focus on developmental trajectories.

Finally, the selection criteria include a focus on initiatives that combine both universal and targeted strategies (i.e., strategies directed to all children in the community as well as strategies directed to vulnerable children, who are "at-risk" of or have a diagnosed problem). This criterion is based on several assumptions: (1) It is crucial to address the needs of vulnerable children and families, and services and supports should be targeted to those needs. (2) At the same time, one of the best ways of assuring equity across populations is to assure that all children get "the basics," a set of services and supports needed for healthy development (including systems designed to assure that basic material, social and emotional needs are met; as well as universal screening, early identification of problems and timely intervention). (3) By shifting a portion of community resources and systems to focus on "front-end" universal promotion and prevention, communities can reduce the number of children who become vulnerable in the first place.

Roads Not Taken

There are many outstanding projects and initiatives that address health or developmental needs of children, but do not fully fit the study criteria. Some examples include: The *Medical Legal Partnership for Children*[6] (a clinically-based, nationally replicated strategy that links medical and legal expertise to help families address social determinants of health); *Family Place Libraries*[7] (a national network of community libraries that have redesigned their services to support families in promoting early childhood development — literacy and beyond); *Community Schools*[8] (a national network of schools that serve as a hub for family and community resources), and *The Children's Health Fund*[9] (a national network of programs focused on providing comprehensive health care to the nation's most medically underserved children). These and many other outstanding efforts deserve further exploration by those who are interested in developing or enhancing place-based initiatives for young children.

One question explored early on was whether an individual family resource center (FRC), or similar "hub" with co-located and integrated services, qualifies as an initiative. After considerable discussion, it was determined that FRCs and other "hubs" by themselves do not constitute the level of initiative to be highlighted in the study. While these are important platforms for delivering services to children and families, especially in resource-poor communities, for purposes of this study an initiative is defined as more comprehensive: including multiple platforms for service delivery (e.g., local hospitals, primary care practices, early childhood education centers, schools, *and* FRCs); and directly changing the organization and delivery of service in multiple sites across the community. The decision was made easier as it became clear that in a number of local communities or counties, FRCs were part of broader initiatives, not stand-alone. Many of the initiatives selected for the study provide good examples of how FRCs and other hubs are incorporated into broader initiatives.

Similarly, there are a number of important strategies that focus on a particular health issue (e.g., coverage) or health condition (e.g., obesity), or that engage just two sectors (e.g., health in schools), which are not included in this study. Instead the study focuses on initiatives that are both more comprehensive and more broadly integrated, and therefore have a greater capacity to address the whole child in a range of service settings and across a broad spectrum of needs.

The study does not include initiatives that do not specifically focus on young children. Again, there are some outstanding initiatives across the county that are working to ameliorate the impact of poverty, lift families out of poverty, or transform whole communities. There are important initiatives, too, that focus specifically on achieving racial equity, in health, as well as in other areas. These initiatives were not included because their broad scope made it difficult to tease out their relationship to early childhood, and in some instances, to health and the health sector. Nevertheless, these initiatives can contribute a great deal to the overall health and development of young children: as the work on early childhood initiatives develops it is important to explore current and potential interfaces between early childhood, place-based initiatives and other, more broadly defined place-based initiatives. Similarly, it would be useful to more thoroughly examine the interface between, local, state and federal systems change initiatives and local, child-centered initiatives focused on healthy development.

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[6] *See* Medical Legal Partnership for Children Website for more information, including the Partnership's 72 sites in the U.S. and Canada: http://www.mlpforchildren.org/

[7] *See* the Family Place Libraries Website for more information: http://www.familyplacelibraries.org/whatMakes.html

[8] *See* the Coalition for Community Schools Website for more information: www.communityschools.org/

[9] *See* the Children's Health Fund Website for further information: http://www.childrenshealthfund.org/index.php

Finally, as noted above, since the study defines "place-based" as local, it does not include national- or state- led initiatives that do not have a clear, locally-embraced and locally-owned component. However, it would be useful to more thoroughly examine the interface between state or national initiatives and local, place-based early childhood initiatives. As a first-step in that direction, the Kellogg Foundation has funded the National Academy of State Health Policy to conduct a concurrent "sister study" that examines the role of state health policy in multi-sector service linkages for young children.

INTRODUCTION TO THE INITIATIVES

Overview

Based on the study goals and selection criteria, eight exemplary initiatives were selected for in-depth review. These initiatives represent a diverse range of origins, budgets, target areas/size and even target populations, all within the parameters of the selection criteria. For example, half of the study initiatives are public-sector initiatives, started either as state initiatives or through state policy, and half received their initial funding through private sector foundations. The annual budgets of the initiatives vary dramatically, ranging from $125,000 to $42 million per year. And, the geographic focus of the initiatives ranges from city centers, to suburban or midsized communities, to a multi-county region that includes an Indian reservation.

The descriptions below provide only a brief introduction to the initiatives, with a particular emphasis on examples of cross-sector collaboration, coordination and integration. Each initiative is described in greater detail under "Appendix A: Initiative Profiles," which includes case studies that address: origin; early development; current strategic plan; platforms for implementation; target population; anchor programming; staffing and administration; financing and allocation of funds; data, evaluation and accountability; sustainability; and selected health and developmental outcomes.

The Initiatives

Children and Families Commission of Orange County (CA)
The Children and Families Commission of Orange County (CFCOC) is part of First 5 California, a statewide school readiness initiative for children from the prenatal period through age 5. Both the State and County Commissions were established in 1998 and funded through a statewide surtax on tobacco products. In keeping with the First 5 framework, CFCOC program areas include: Early Care and Education, Health, Family Supports, and Community Capacity Building. The initiative uses three main platforms for service delivery: hospitals, schools, and family resource centers. CFCOC has developed a well-integrated system of care that combines broad community education with both universal and targeted services for young children and their families. A partnership among the county's major birthing hospitals, eight neighborhood-based family resource centers and a variety of community agencies reaches virtually all of the county's newborns and their families, providing basic information about healthy development (through a parent education kit distributed by birthing hospitals); linkage to a medical home; screening for health and other risk factors; and linkage to follow-up care, as needed. Similarly, *School Readiness Nurses* in each elementary school district in the county provide developmental screening and assessment, preventive care, and linkage to treatment services for children age five and younger. A new program, *Help Me Grow-OC,* uses a 211 call-in line to help families and service providers link children to needed services, and offers networking opportunities for community service providers. Finally, CFCOC supports new and enhanced neurodevelopmental and other pediatric health services, early literacy programs, and homelessness prevention services for children and families in need. With an annual budget of $42 million, CFCOC operates as an independent entity established by the Orange County Board of Supervisors. It employs 19 staff, some of whom are part-time, and approximately 40 outside consultants.

Children's Board of Hillsborough County (FL)
Established by voter referendum in 1988 under a state statute that allows counties to create special taxing districts, The Children's Board of Hillsborough County (CBHC) funds over 150 local agencies, organizations, and collaboratives (known as partners) that provide support and services to pregnant women and young children and their families through a variety of delivery platforms. CBHC-supported

activities cover five main programs areas: Healthy Births, School Readiness, Early School Success, Improving Delivery Systems, and Building and Maintaining Infrastructure. Using a two-tiered approach, CBHC and its partners provide, coordinate and improve access to direct services, while also working to improve family and community capacity. CBHC's strategy for Healthy Births involves 15 partner agencies and organizations providing direct services and supports for pregnant and post-partum women and their infants. An emphasis is placed on providing "warm hand-offs" for families moving from one set of maternal and child health services to another. Such collaboration also allows for children and families identified as having complex or intense needs to be easily and seamlessly referred to other services in the county. The School Readiness and Early School Success strategy includes multi-disciplinary planning and service delivery teams. Programs under this strategy area link families to multiple services and supports while also working to improve systems of care. On the capacity-building side, the Administrative Services Organization works directly with families to help them develop goal-setting, planning and budgeting skills; and the Investment Initiative uses co-funding and matching agreements to bring additional income into the county. CBHC's annual budget is $34.7 million; it currently employs 56 full-time staff and 27 staff on a reduced-hour, limited duration or part-time basis.

Children's Futures (Trenton, NJ)

Established in 2001 with major support from the Robert J. Wood Foundation (RWJF), Children's Futures (CF) is a non-profit organization that brings public and private agencies together to improve child health and development outcomes in Trenton, NJ. CF focuses on four broad program objectives: Strategic Parenting, Primary Care Systems Improvement, Child Care Systems Improvement, and Integrating Community Support. CF's primary platforms for implementation are its Centers for Children and Families, located in each of the city's four wards. The Centers serve as central hubs for CF services and activities, as well as linkage and care coordination sites connecting children and parents to a wide variety of community-based health and social services. Each Center is led by an established organization known to the particular community it serves; and each of these lead agencies enters into an agreement with CF (to provide services to children and families) and with other community agencies and organizations (to augment Center-based services and supports). Through this hub-and-spoke system, CF helps partner agencies provide direct services to more than 4,000 children and families each year; while it also promotes interagency collaboration and coordination. In addition to its Centers, CF relies on a number of partners for program implementation, including early education and child care facilities, schools and community colleges, pediatric primary care offices, behavioral health organizations, and local health centers and hospitals, among others. In 2007, CF began implementing a shared data system to link its partners to the central office, as well as to each other. The system allows partner agencies to enter and access data (on a limited basis) on children and families who seek CF services and supports. CF is primarily funded through a five-year (2007-2011), $14.5 million RWJF grant. It employs 9.5 staff in a central office, with another 41 staff supported by CF funds at the various partner agencies.

First 5 Ventura County (CA)

First 5 Ventura County (F5VC) was established in 1998 as part of First 5 California, and is funded through a state surtax on tobacco products. As such, it is focused primarily on school readiness for children birth through age five, but defines that broadly to include: Early Learning, Family Strengthening, and Health. In addition, F5VC incorporates an overarching focus on Community Capacity Building. F5VC's primary platforms for implementation are 11 geographically-defined, local collaboratives called Neighborhoods for Learning (NfLs), each of which incorporates local decision-making, community engagement, and parent/family empowerment. Each NfL serves as an umbrella for three core components: Early Education Enhancements (designed to increase the proportion of young children participating in quality pre-school environments); Family Resource Centers (service hubs for children and families); and Multi-disciplinary Health Teams (deployed to the NfLs by the Ventura County Health Care Agency). Under the leadership of the NfLs, these core components form an integrated set of local services. In addition, F5VC also funds county-wide or regional strategies that support systems integration,

gap filling, capacity-building, and linkage to existing services. In general, these efforts supplement, support and link to local services: For example, F5VC partners with United Way to support the county's 211 information and referral line, which provides referrals to health and human services, including referrals to the NfLs. At the same time, the 211 line has become an important referral/linkage resource used by the local Family Resource Centers. Similarly, F5VC funds the Health Outreach Program (HOPE), which provides Certified Application Assistant training, technical assistance, and direct services to help eligible county residents obtain, use and retain health coverage. In addition to supporting core staff at the HOPE home office, F5VC funding is used to train local NfL staff, and to place HOPE application assistants onsite in the NfLs. In this way F5VC fills county-wide service gaps and integrates new services into existing community resources. F5VC operates as an independent entity established by the Ventura County Board of Supervisors. It employs 13 core staff with an annual budget of $10 million.

Help Me Grow (CT)

HMG began as an innovative community-based program in Hartford known as ChildServ. Launched in 1988 with support from the Hartford Foundation for Public Giving, ChildServ was developed in response to concerns among local health organizations, child health providers, advocacy organizations and parents that Hartford's children were too often entering school without the necessary emotional, behavioral or developmental skills for school success. In 2002, after four years of effectively serving the Hartford community, ChildServ's creators were successful in securing funds from the state legislature to expand the program statewide. The new effort, renamed Help Me Grow (HMG), was placed under the authority of the Children's Trust Fund, an independent state agency. Today, HMG is an integrated, cross-sector system that promotes and coordinates developmental care throughout the state of Connecticut. Key program elements include: promotion of universal surveillance and early identification; a centralized resource for referral/linkage and care coordination; and training and support for providers and parents. These elements are combined to form an integrated system of developmental care: Parents, pediatricians, childcare providers, teachers, and other community service providers are given information and training on healthy development, how to recognize the early signs of developmental problems, and how to contact HMG for assistance. Children who are facing difficulties are then connected to community resources and local programs. A toll-free telephone number serves as a statewide single entry point for HMG services and supports. Callers are screened by professionally trained Care Coordinators who triage, refer and provide care management for children and their families, using an up-to-date electronic resource inventory of community-based child development and family support programs. At the same time, the program's Primary Prevention Services Coordinators cultivate relationships with community providers and agencies, and promote cross-agency networking, information-sharing, and joint problem solving through regional breakfasts for child-serving organizations. With an annual budget of $580,000, HMG currently employs five staff and retains a contract for telephone triage with the United Way of Connecticut.

Opportunity Knocks (Middletown, CT)

Opportunity Knocks (OK) was established in 2003 in response to a request-for-proposals from the Funder's Collaborative, a group of four Connecticut foundations seeking to integrate health into early care and education programming. Focusing on Middletown children birth through five years old, Opportunity Knocks has developed a well-coordinated set of programs and strategies to address three aspects of early childhood health and development: (1) nutrition and physical activity; (2) oral health; and (3) social-emotional-behavioral health. OK uses three primary platforms for implementation: health care practices; early care and education (ECE) settings; and other community service providers. A planning collaborative — including representatives from the local hospital, the School Readiness program, mental health, the United Way, and parents, among others — has developed an integrated set of interventions built on the following "basic tenets": intervention in early life periods; development of a multidisciplinary model of consultation and education to help service providers modify their behavior in the arenas of screening, teaching and early intervention; and systems change. Programming for social-emotional health,

for example, includes: a social-emotional health curriculum for ECE centers; training for pediatricians to promote the routine use of developmental screening tools; monthly rounds and center-, classroom- and child-specific consultation for ECE providers; and home-based education and support for parents of children with behavioral difficulties, to complement and reinforce interventions used in the ECE settings. Programming for nutrition/physical activity and for oral health includes a similar set of complementary interventions. OK employs one half-time program planner and has an annual budget of $125,000 ($100,000 from the Funders Collaborative, plus $25,000 in matching funds from local community partners).

Region A Partnership for Children (Western NC)

The Region A Partnership for Children is part of North Carolina's Smart Start initiative, a state-funded program designed to ensure that every child begins school healthy and prepared to succeed. Launched in1993 under the leadership of then-Governor Jim Hunt, the Smart Start initiative is administered at the local level by non-profit organizations called "Local Partnerships." The Region A Partnership for Children (the Partnership), representing seven counties and an Indian reservation in the Western part of the state, was among the first recipients of Smart Start funding. Consistent with the funding allocations and service guidelines produced at the state level, the Partnership offers programming in three areas: Early Care and Education, Family Support, and Health. The Partnership offers coordinated, comprehensive services and supports for children and families through a range of delivery platforms; Family Resource Centers offer a centralized location for screenings, referrals and services. Other service settings include child care and family day care settings, primary care practices, libraries and mobile units. The Partnership's work across its three focus areas is integrated at the staff and initiative levels. Programs include efforts to fill service gaps; improve service quality; increase the use of validated screening and assessment tools; establish service referral networks; and coordinate care for children with identified needs. These priorities are achieved through funding for direct services and service linkage (e.g., community learning groups for children not in childcare; evaluation, treatment and respite care services for special needs children; referral/linkage to needed health and family support services; etc.), as well as for training, education and quality improvement programs for providers. The Partnership currently employs 12 staff and has an annual budget of $6.2 million, which includes funding from other state programs as well as private funding.

Westside Infant Family Network (Los Angeles, CA)

The Westside Infant-Family Network (WIN), an early childhood mental health initiative, was collaboratively developed by six well-established agencies in West Los Angeles County. WIN's original funder, The Atlas Family Foundation, has played a key role in funding each of the individual agencies and in launching and facilitating the development of WIN as a cross-agency initiative. As such, WIN addresses the mental health needs of young children (birth to three years) and their families who are served by one or more of the participating agencies. WIN programming combines three key components: (1) case management and direct services for children and families at risk of mental health issues; (2) capacity building, training and support for partner agencies; and (3) community service system linkage, integration, and capacity building. While WIN specifically focuses on mental health issues, its scope is much broader than traditional mental health diagnosis and treatment: From the clients' perspective, the initiative provides a nested set of services designed to address current and potential family mental health issues and to promote healthy child development. The initiative takes a "family systems" approach to strengthen family stability, which includes working to meet the families' material needs (food, shelter, healthcare, etc.), as well as providing case management and direct therapeutic care (including in-home parent-child therapy, and medication and psychiatric care, if needed). For the partner agencies, WIN's case management, training and support services expand capacity to identify and address mental health and developmental needs in-house, to link children and families to additional appropriate clinical and other services, and to collaboratively identify and address community-wide needs. From the community service system perspective, WIN provides a means of networking across service providers to improve care for

children and families, and it offers new gap-filling services. Of particular note is WIN's online, shared client data system for agencies participating in the case management program component. Currently funded by multiple foundations and private donors, WIN employs eight staff with an annual budget of approximately $888,000.

CROSS-INITIATIVE FINDINGS AND ASSESSMENT

This section focuses on five sets of findings: (1) Foundations for Multi-Sector Collaboration, Coordination and Integration; (2) Cross-Initiative Program Framework; (3) The Role of Health and the Health Sector within the Program Framework; (4) An Integrated Strategic Framework for Success; and (5) Financing and Sustainability.

Foundations for Multi-Sector Collaboration, Coordination and Integration

While the study initiatives vary in scope and specific programming, all have successfully incorporated multi-sector collaboration, coordination, and integration to address the needs of young children. For purposes of this report, collaboration, coordination and integration are seen as a continuum, with collaboration defined as working together in some fashion, coordination defined as bringing together some key program components, and integration defined as joint planning and implementation around shared goals. Across the initiatives, several common building blocks lay the foundations for enhanced multi-sector collaboration, coordination and integration. These include:

- ***A Whole Child/Whole Family Focus.*** Each of these initiatives starts with a focus on improving the lives of the children living in a geographically defined population or community. Keeping children front and center, the initiatives then work to improve multiple services, supports, and other factors affecting how children in the community fare. The initiatives recognize that multiple factors shape a child's growth and development; and they recognize that physical, emotional, social and cognitive development are inter-related. Based on this understanding, they use a whole child/whole family philosophy to develop services and supports that "connect the dots" for children and families, across service sectors and disciplines.

- ***Funder-Driven Collaboration.*** Many of the multi-sector partnerships that characterize the study initiatives were initially formed in response to external funding opportunities or requirements. For some, the sectors came together in response to a specific request for proposals requiring a multi-sector approach. For others, such participation was the outgrowth of a specific funding opportunity that sought to address early childhood health and development at a community-wide level.

- ***The Initiative as a Neutral Convener and Facilitator.*** While the study initiatives work closely with established organizations and agencies, each initiative is also an independent entity. This allows the initiatives to serve as neutral conveners and facilitators, brokering collaboration across service providers and systems of care. In addition, the initiatives with substantial funding act as funders themselves, creating innovative and integrated programming that allows existing agencies and organizations to engage in the kind of cross-sector work that would not otherwise be possible under the usual constraints of categorical funding. In all of the initiatives, initiative staff function as the "glue" that helps link efforts across sectors and services.

- ***Multi-Sector, Community-Based Planning and Engagement.*** For a number of initiatives, the multi-sector work began with a collaborative, community-based planning process that brought together players across sectors to collectively identify local needs and resources, establish shared goals and objectives, and jointly determine what would constitute initiative success. This planning helped both to lay the agenda for the initiative itself and to formalize early on the partnerships and collaborations needed to sustain work across sectors. In addition, on an ongoing

basis, each of the study initiatives engages community "members," including individuals, organizations, and agencies, among others. Building on existing community strengths and resources to inspire and implement change, the initiatives work to develop a shared sense of "community ownership," where families and others in the community are engaged in and committed to the initiative at all stages — from planning to program activities to evaluation.

- ***Going Where the Children Are.*** While all of the study initiatives are local in orientation, application of this underlying philosophy goes much deeper than just serving a particular geographic area: it also affects how and where services are delivered. Rather than waiting for children and families to seek out needed services and supports in the usual settings, the study initiatives tend to bring services to children and families in their own settings and neighborhoods, to places where they spend a good portion of their time; for example, in childcare or early education settings, at home, in local schools, or in neighborhood-based centers. Thus, a child might get a dental exam in a childcare setting, or early literacy promotion at a pediatric clinic. This willingness to go beyond conventional service settings helps to integrate efforts across sectors.

Cross-Initiative Program Framework

In order to better understand and describe how multi-sector, place-based initiatives for children are organized, the study sought to identify the basic program framework for each initiative, along with key program elements. While there is a great deal of variation in specific program implementation, with individual services and approaches tailored to meet local circumstances, there is also remarkable consistency in the overall program framework across the initiatives, including three core service sectors, four key audiences, and three primary program strategies. These basic program building blocks are outlined and further described below.

Health Matters: Cross-Initiative Program Framework		
Core Sectors	**Key Audiences**	**Primary Program Strategies**
▪ Health ▪ Education ▪ Family Support	▪ Children ▪ Parents/Family ▪ Providers ▪ Community/Community Systems	▪ Enhanced Services ▪ Capacity Building ▪ Systems Change and Integration

Core Sectors

Program activities are primarily undertaken by three core service sectors:

- ***Health.*** This includes engagement of and by hospitals, primary care providers, sub-specialty providers, public health, mental and dental health providers, federal and state health programs (e.g., Healthy Start), and professional associations (e.g., local AAP chapters or local dental societies).

- ***Education.*** Engagement includes early care and education (ECE) providers and centers (including Early Head Start and Head Start Programs), as well as schools and school districts.

- ***Family Support.*** Family Resource Centers (FRCs), family advocacy programs, social service programs and community organizations all fall under this category.

Key Audiences

Initiative programming is directed to four key audiences:

- ***Children.*** Based on the study criteria, this includes children through age eight, or some subset of this group. Almost all of the initiatives also include some component providing prenatal care for pregnant women.

- ***Parents/Families.*** All of the initiatives provide services and supports to parents, families and other primary caregivers. This includes services that help parents improve their own life circumstances and skills, as well as services and supports that help them in their role as parents.

- ***Providers.*** This includes both public and private sector providers in the three main sectors: *health (*physicians and other pediatric care providers; mental/behavioral and oral health care providers); *early care and education* (early childhood educators; teachers); and *family support* (e.g., social workers, case managers, parent educators, other family resource center staff).

- ***Community/Community Systems.*** Each of the initiatives also goes beyond individual providers to target community-wide "systems of care" (e.g., all pediatric primary care providers in a community or all early childhood education centers in a county). In addition, the initiatives address issues for the "community as a whole" such as community-wide gaps in services or basic infrastructure (e.g., the lack of developmental services in the community for children with mild to moderate delays; the need for better referral/linkage across services and providers; or the lack of affordable housing for low-income families).

Primary Program Strategies

Across the initiatives, three broad program strategies are employed:

- ***Enhanced Services.*** Each of the initiatives has enhanced direct services to children and families through a combination of service strategies that range from promotion of healthy development, to prevention and early identification of problems, to treatment for identified needs and referral to additional resources. These service strategies include:[10]

    - *Uniform and universal messaging,* to foster healthy growth and development (physical, social, emotional and cognitive). Messages can be verbal, written, by video, or experiential. Both within and across initiatives, a variety of topics are covered (e.g., healthy eating, oral health promotion, early literacy/reading to young children, and the importance of early childhood development).

    - *Universal screening and assessment*, focusing on early identification of problems or issues (physical, social, emotional, cognitive, economic, environmental, etc.). Screening opportunities are provided in multiple settings (e.g., pediatric primary care practices, early care and education centers, schools, and family resource centers), and focus on a range of issues (e.g., developmental delays, oral health, mental health).

[10] These service categories are consistent with the developmental services framework described in Fine and Mayer's *Beyond Referral,* which was adapted from the framework in M. Regalado and N. Halfon, "Primary Care Services Promoting Optimal Child Development from Birth to Age 3 Years: A Review of the Literature," *Archives of Pediatrics and Adolescent Medicine,* Dec. 2001 155(12):1311-22.

- *Treatment and intervention,* to address identified needs. Treatment and intervention can range from treatment for physical, mental or behavioral health issues, to meeting material needs of families (e.g., food, shelter, transportation), to literacy training for parents.

- *Referral and linkage,* to connect children and families to additional services and supports in the community, as needed. Referral/linkage is enhanced through centralized, community-wide resources, improved cross-agency agreements, improved in-house processes within provider settings, and networking and relationship-building activities across agencies.

- *Ongoing, supportive relationships,* provided through routine, ongoing care and, if needed, through special support via case management, parent support groups, etc. The initiatives encourage organizations and agencies to continue to work with children and families in-house, even as they are referred for additional care. When referrals are needed, the initiatives also foster "warm-hand-offs" between agencies and organizations.

The same service strategies are used across service sectors (i.e., health, education, family support), tailored to focus on each initiative's specific goals. The initiatives typically incorporate all five of the enhanced services strategies within each sector, using either similar or complementary program activities across the sectors. In this way, the initiatives enhance their impact for children and families community-wide.

- ***Capacity Building.*** Capacity building aims to strengthen underlying skills and resources of parents, service providers, and community/community systems in order to effect long-term change.

  - *For parents/families.* This includes helping parents improve basic capacities to meet the immediate material needs of their children (e.g., food, housing, healthcare); helping parents develop new skills to help children with specific conditions (e.g., behavior modification techniques for children with difficult behaviors); and helping parents with their own life skills and life trajectories (e.g., literacy, job training, financial management).

  - *For service providers.* This includes training and tools for providers so they can improve or expand the care they give directly (e.g., training in classroom behavioral management techniques for early childhood educators); consultation for providers to help them problem solve on difficult cases (e.g., mental health case management services available to family support service staff); adding new services and service providers to a practice setting (e.g. incorporating oral healthcare providers into a primary care clinic, or offering preventive dentistry services at early childhood centers); and providing information and resources that make it easier for providers to link children and families to other services in the community (e.g., providing lunchtime informational sessions to introduce primary care practitioners to community referral systems.). Provider capacity building is often accomplished through quality improvement and collaborative learning approaches.

  - *For communities/community systems.* Capacity building at this level includes expanding existing services (e.g., number of service providers, sites, hours); strengthening or enhancing services offered throughout a service sector (e.g., sector-wide quality improvement to assure certain services are routinely offered by all providers/educators/caregivers in the system); and developing new services to fill gaps in community systems of care.

- ***Systems Change and Integration.*** Systems level change and integration includes new ways of organizing services within sectors, between sectors, and community-wide, with the goal of better

linkage and integration across the three primary service sectors for all four key audiences. Five approaches to this change and integration include:

- "*Rethinking" and realigning how or where care is given.* This approach reshapes care by going beyond traditional delivery systems; for example: providing "treatment without diagnosis" (that is, providing classes for parents of children with difficult behaviors without requiring a formal diagnosis; thus, reducing stigma and increasing parent willingness to participate); sending mental health professionals into classrooms to help early childhood educators manage specific children with behavioral problems; incorporating oral health exams and prevention into routine pediatric well-child care; and developing a case management system that is designed to empower families and connect them to resources, services and supports not otherwise available through other systems of care.

- *Service and system integration through shared data.* Data collection and analysis are integral to all of the study initiatives, and are used for a variety of purposes, including program planning and development; service delivery; quality assurance; implementation monitoring; and evaluation and accountability. Many of the initiatives have secure, online data systems that support coordinated client intake and tracking, program implementation, service delivery, outcome measurement, and program evaluation. These same systems can assess resources and needs across providers and service systems, as well as for the community as a whole.

- *Tiered services and clear pathways for referral and linkage to increasingly complex care, as needed.* This approach involves providing all children with a basic set of services, screening to identify children with additional needs, providing initial care via the primary service provider, connecting the primary provider with back-up consultation and support, and having clear avenues for referral to additional off-site services for children and families needing more complex care. This kind of approach helps children and families access the right level of care for their particular needs. It also provides a seamless transition to and from diverse services, and keeps the connection between the child/family and the primary service site. In addition, it helps service providers get back-up support and assistance in assessing and addressing the needs of children/families they serve.

- *Centralized call-in centers for consultation, referral, and linkage across services and service systems.* This approach involves a community-wide resource with up-to-date information on a wide range of services that children might need to support healthy development. Having a single, more comprehensive source of referral information, along with professional triaging of complex cases, makes it easier for providers to connect children and families to services within the community; and it also provides a direct route for families to identify and link to services on their own. In addition, data systems incorporated into the call-in centers can provide timely information on changing needs of children and families, as well as information on the fit between community services and community needs.

- *Service "hubs, such as family resource centers, that co-locate services, allowing families to access multiple services from one site.*

- *Shared messaging and multi-sector layering of services.* This includes: repetition of simple, shared messages across service sectors to promote healthy development; using multiple service systems and sites to identify children "at-risk" or with additional needs; and providing multiple options for accessing services to address needs.

The Role of Health and the Health Sector within the Program Framework

At its core, this study is about the role of health and the health sector within broader place-based initiatives for young children. This interface is a two-way street: the participation of the health sector and health professionals in place-based initiatives contributes to the shape and breadth of the initiatives and impacts outcomes for children served. At the same time, the initiatives provide opportunities to expand, strengthen and redefine the scope and delivery of health services and systems at the local level.

Definitions

This study uses the broad definition of children's health proposed in the National Academy of Sciences report, *Children's Health, the Nation's Wealth*:

> …the extent to which individual children or groups of children are able or enabled to (a) develop and realize their potential, (b) satisfy their needs, and (c) develop the capacities that allow them to interact successfully within their biological, physical and social environments.[11]

Similarly, the study uses a broad definition of the health sector to include both private sector and public sector personal health services, population-based health services, and other public health functions, such as data and reporting. Mental and dental health care are also included, even though these often function as separate health systems.

Health and Healthy Development as a Unifying Theme

While the overarching framing of the study initiatives varies — including school readiness, healthy development, and mental health frames — in its broadest sense, promoting health and healthy development is the unifying theme across the initiatives, all of which work toward helping children realize their potential, satisfy needs, and successfully interact with their environments.

The study initiatives "get" and act on the social determinants of health and well-being, working across sectors to make sure that young children and their families are able to meet their most basic needs (e.g., food, housing, health care). They understand and address the impact of biological, physical and social environments in which children grow up, working to make those environments safe and supportive for children and families, while at the same time helping children address particular biological, physical and social challenges. All of the initiatives invest in building the capacity of families, service providers, and communities as a whole, so that these in turn can help children build skills, gain competencies, and develop behavioral patterns that will allow them to develop their full potential. And all pay special attention to vulnerable children, those who are most at risk of failing to meet their full potential for a healthy, successful life.

This is not a job that any single sector can tackle alone, and the beauty of these initiatives is that they have figured out how to work across disciplines and sectors to focus on improving the lives of young children in their communities.

Health Sector Engagement

The study reviewed four aspects of health sector engagement across the initiatives:

- ***Key Health Sector Players.*** At the organizational or agency level, the most prominent health sector players across the initiatives are: hospitals, public health departments, and Healthy Start

[11] Committee on Evaluation of Children's Health, The National Research Council, *Children's Health, the Nation's Wealth: Assessing and Improving Child Health* (Washington, DC: National Academy Press, 2004).

Programs. In addition, local chapters of the AAP and local Dental Societies both actively participate in some of the initiatives.

At the provider level, the specific health disciplines most frequently engaged in the initiatives include pediatricians and other primary care providers; developmental pediatricians and other sub-specialty providers; clinical social workers, psychologists, psychiatrists and other behavioral health specialists; public health nurses; dentists and oral hygienists; and nutritionists.

- ***Health Topic Areas.*** Health topic areas most frequently addressed by the initiatives include behavioral-mental health (for parents as well as children); other developmental health conditions; oral health, and healthy births. Immunizations, nutrition/fitness, asthma and other chronic lung problems, metabolic disorders, and safety issues are also areas of focus for some of the initiatives.

- ***Health Sector Program Framework.*** As with the other sectors and the initiatives as a whole, key health sector program strategies include enhanced service delivery, capacity building, and systems change and integration. In addition, health sector strategies are directed to the same four audiences as for the initiatives as a whole: children, parents/families, providers, and community/community systems. Thus, a framework on health sector strategies and strategy levels is a pared down version of the multi-sector framework, as follows:

Health Matters: Health Sector Program Framework		
Core Sector	**Key Audiences**	**Primary Program Strategies**
Health	Children Parents/Family Providers Community/Community Systems	Enhanced Services Capacity Building Systems Change &Integration

- ***Health Sector Engagement in Systems Change and Integration.*** Systems change and integration play a special role in the exemplary multi-sector, place-based initiatives highlighted in this study. This primary program strategy helps the study initiatives move from a collection of individual service and capacity-building projects to an integrated set of programs that work at a community-wide level. In keeping with the study interest in the role of the health sector, it is instructive to further examine the role of the health sector in systems change and integration. This includes health sector engagement at three levels: (1) systems changes within the health sector; (2) changes in the interface between health and other sectors; and (3) health sector engagement in community-wide/cross-system change.[12] Key systems changes for each level are highlighted in the framework below:

[12] These categories are consistent with findings in *Beyond Referral*, which focused on the role of pediatric primary care in connecting young children to developmental services. *See* A. Fine and R. Mayer, *Beyond Referral: Pediatric Care Linkages to Improve Developmental Health* (New York: The Commonwealth Fund, December 2006).

Health Matters: Health Sector Systems Change and Integration Framework	
Systems Change Levels	**Key Systems Changes**
Level 1: *Systems Changes/Integration within the Health Sector*	▪ Within the health sector, services are strengthened, expanded and vertically integrated.
Level 2: *Changes in the Interface between Health and Other Sectors*	▪ Across sectors, health services are better linked and horizontally integrated with other existing services.
Level 3: *Health Sector Engagement in Community-wide/Cross-System Change/Integration*	▪ At the community systems level, the health sector is engaged in community-wide/cross-systems planning, service development, and policy change.

Within each systems change level, similar activities, approaches and tools are being used across many of the initiatives, as described below:

- *Systems Changes within the Health Sector.* These include expanding and enhancing services; developing new, gap-filling services; better linking pregnant women, children and parents to needed health services; and better integrating services within the health sector. Typical examples include: integrating oral, mental/behavioral, and developmental health into pediatric primary care; connecting pregnant women to both basic and high-risk prenatal care; developing new, mid-level developmental health services (i.e., services for suspected or identified mild to moderate delays); and developing a nested set of services going from promotion/prevention through complex subspecialty care. Within primary care settings, the study initiatives frequently use quality improvement approaches to effect change, including the use of "learning collaborative"-type quality improvement approaches championed by the Institute for Healthcare Improvement, the National Initiative for Children's Healthcare Quality, and the U.S. Department of Health and Human Services, Health Resources and Services Administration, among others.

- *Changes in the Interface between Health and Other Sectors.* These include activities focused on better linking and integrating health services with other services (or service settings) for young children. In some cases, this involves moving health sector services beyond traditional clinical settings (e.g., providing health screening at child care facilities or community locations). In other cases, the linkage involves developing a cross-sector, tiered service system, in which other sectors may take the lead in working with children with either less complex or non-medical needs, while still having the assurance that access to back-up or "bump-up" services is available through the health sector (e.g., training child care workers to identify and resolve common behavioral issues, with the option of additional services as needed). And finally, the initiatives develop or enhance referral and linkage resources, making it easier for health service providers to link children and families to services and supports beyond healthcare, and vice versa (e.g., centralized call-in centers offering referral, linkage and case management services).

- *Health Sector Engagement in Community-Wide/Cross-System Change.* Beyond service delivery, health professionals play an important role as part of cross-sector teams focused on community-wide/cross-systems change. Each of the initiatives has engaged health sector players at this broader level. Typical examples include: involving health players in the initial planning, ongoing development, governance, and evaluation of the place-based initiative as a whole; appointing health professionals to community or state commissions on early

childhood and related topics; and capitalizing on the status of health professionals by engaging them in direct policy/legislative advocacy.

An Integrated Strategic Framework for Success

While each core sector is essential to the work of the study initiatives, it is important to note that the success of these initiatives does not rest on a single sector, audience, or strategy. Rather, it is the initiatives' ability to integrate their broad program strategies across multiple sectors and audiences that sets them apart. Similarly, the initiatives do not rely on the use of one specific, unique program or approach. In fact, all of the initiatives have primarily borrowed and adapted programs and approaches from others. In short, there is no single element or "magic bullet" that can be applied across all communities or all initiatives to achieve success. However, the broad program framework, key program elements, and basic building blocks for multi-sector collaboration identified in this report have been successfully used across the initiatives, and therefore it is likely that they can be applied successfully elsewhere as well, particularly when coupled with the kind of flexible implementation that has allowed the study initiatives to adapt and tailor their work to the specific circumstances of the communities they serve.

The concept of an integrated strategic framework is central to this study and report, and deserves further elaboration. What the initiatives share in common is the kind of funding, framing, and political will needed to implement integrated program strategies across multiple services and sectors. This means that initiative leaders (i.e., lead staff, advisory boards, and funders) are planning in a way that links and reinforces program approaches, and relationships, across sectors. Examples include: using the same key messages across sectors and audiences; developing cross-sector referral-linkage and data systems; and using cross-sector training to improve basic service capacities and to enhance relationships across sectors. The level at which individual service providers are engaged in working directly with other sectors varies by initiative, by program, and by provider. Some providers have literally moved into new service settings (e.g., moving clinical care or consultation to an early childhood center or school); or they are now part of a broader early childhood provider team in a community setting; or they are part of a cross-discipline team that is drafting a consistent set of messages for young children and their families community-wide. In other instances, individual providers may continue to work in their own settings, but receive direct consultation from specialists to help them work with specific children and families; or providers may have access to online data from partner agencies serving the same clients; or they may be on the receiving end of new referral/linkage pathways. The point is that by developing strategically integrated program frameworks, these initiatives are putting the pieces together for children, families and service providers; and they are effectively using their resources to achieve outcomes that cannot be achieved one sector at a time.

Financing and Sustainability

These findings would not be complete without mention of financing and sustainability. Financing has played an essential role in shaping the study initiatives, from critical start-up funding to ongoing support and sustainability.

In several ways, the initiatives have benefited from unusual financing:

- In most cases, the study initiatives have benefitted from a significant source of start-up funding that not only allowed, but actually promoted collaboration, coordination and integration of

services, as well as program strategies, for the benefit of young children. The significance of this kind of funding focus cannot be overstated.

- For many of the initiatives, financing has covered far more than the usual grant period of one to three years. Public sector initiatives such as First 5 in California and the Children's Board of Hillsborough County are funded through new, dedicated taxes that provide ongoing funding for a decade or more. Even among initiatives funded through the private sector, funding cycles have gone well beyond the norm: for example, the Robert Wood Johnson has provided 10 years of funding for Children's Futures in Trenton, New Jersey.

- Also of note, funding for the study initiatives has not been tied to a single, pre-existing agency or sector. Instead, for most of the initiatives, funds were awarded to a new entity, which has allowed that entity to serve as a neutral convener and facilitator across agencies and sectors.

Nevertheless, all of the study initiatives face issues around long-term sustainability. Those that rely primarily on private funding are required to reapply for continuation funds or to submit new proposals for expanded or enhanced activities. While initiatives supported through a dedicated tax base or whose funding has been incorporated into state budgets are generally more secure than those that have been privately funded, even these initiatives are subject to pressures from a weak economy, or in some instances a shift in elected officials. The consensus among study initiatives and national experts attending in the *Health Matters* meeting in April 2008 is that ultimately, macro-level systems and policy changes will be needed to sustain these and similar initiatives in the long run.

SUMMARY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

Summary Findings

Key study findings include the following:

- ***Innovative, multi-sector initiatives for young children that include an active role for the health sector do exist, and they are making a difference***. While health sector engagement in broader place-based initiatives is not yet the norm, this review points to the important roles these initiatives and their health components can play in improving the lives and life trajectories of young children and their families. These initiatives serve as platforms for engaging families, service providers and communities in promoting healthy development; improving services and service delivery within individual sectors; organizing and delivering integrated services across sectors; and working toward broader policy and systems change to better meet the needs of children and families.

- ***Several common building blocks lay the foundations for multi-sector collaboration, coordination and integration within place-based initiatives for young children.*** These include a whole child/whole family focus; funder-driven collaboration; the initiatives' role as a neutral convener/facilitator; multi-sector community-based planning and engagement; and an underlying service philosophy that focuses on "going where the children are."

- ***While there is a great deal of variation in specific program implementation, with individual services and approaches tailored to meet local circumstances, there is also remarkable consistency in the overall program framework and key program elements across the initiatives.*** This includes consistency in core service sectors (health, education, and family support); key audiences (children, parents/family, providers, community/community systems), and primary program strategies (enhanced services, capacity building, and systems change/integration).

- ***Although the study initiatives have different "frames", all work toward improving health and healthy development, as broadly defined.*** Specifically, the initiatives fit well with the broad definition of health proposed in the National Academy of Sciences report, *Children's Health, the Nation's Wealth.* Applying this definition helps to clarify the ways in which these and other broad, place-based initiatives for young children intersect with health, and may make it easier to engage the health sector.

- ***The health sector plays an important role in the study initiatives, helping children realize their full developmental potential: physically, emotionally, socially and cognitively.*** As part of place-based early childhood initiatives, health professionals promote healthy development using the same key strategies, focused on the same audiences as the other sectors. In addition to providing direct services through traditional clinical settings, health sector players also provide clinical services in non-traditional settings; offer parent education classes; promote early literacy; link children and families to additional services and supports in their communities; provide home visiting consultation and therapeutic intervention; provide consultation to service providers from other sectors; collect and analyze data on service needs and gaps; and work to develop new or enhanced services that address the health and developmental needs of children in the communities they serve.

- ***Participation in broad, place-based initiatives plays an equally important role in strengthening and transforming the health sector.*** As part of broader place-based initiatives for young children,

health professionals and other key players are engaged in systems change at three levels: within the health sector; between health and other sectors; and at the community-wide/cross-systems level. Health sector systems change at these three levels has strengthened and transformed health sector roles, services, capacities and impact within communities.

- ***The success of these initiatives does not rest on a single sector, audience, or strategy. Rather, it is the initiatives' ability to integrate their broad program strategies across multiple sectors and audiences that sets them apart.*** The concept of an integrated strategic framework is central to this study and report. What the initiatives share in common is the kind of funding, framing, and political will needed to implement integrated program strategies across multiple services and sectors. This means that initiative leaders (i.e., lead staff, advisory boards, and funders) plan for their initiatives in ways that link and reinforce program approaches and relationships across sectors. Examples include: using the same key messages across sectors and audiences; developing cross-sector referral-linkage and data systems; and using cross-sector training to improve basic service capacities and to enhance relationships across sectors. The level at which individual service providers are engaged in working directly with other sectors varies by initiative, by program, and by provider. Some providers have literally moved into new service settings (e.g., moving clinical care or consultation to an early childhood center or school); or are now part of a broader early childhood provider team in a community setting; or are part of a cross-discipline team that is drafting a consistent set of messages for young children and their families community-wide. In other instances, individual providers may continue to work in their specialized settings, but receive direct assistance from other service providers; or providers may have access to online data from partner agencies serving the same clients; or they may be on the receiving end of new referral/linkage pathways. The point is that by developing strategically integrated program frameworks, these initiatives are putting the pieces together for children, families and service providers; and they are effectively using their resources to achieve outcomes that cannot be achieved one sector at a time.

- ***The cross-initiative program framework, key program elements, and basic building blocks for multi-sector collaboration, coordination and integration identified in this report have been successfully used across the initiatives, and therefore it is likely that they can be applied successfully elsewhere, as well, particularly when coupled with the kind of flexible implementation that has allowed the study initiatives to adapt and tailor their work to the specific circumstances of the communities they serve.***

- ***Financing has played a key role in shaping the study initiatives.*** In most cases, the study initiatives have benefitted from a significant source of start-up funding that not only allowed, but actually promoted collaboration, coordination and integration of services, as well as program strategies, for the benefit of young children. For many of the initiatives, financing has covered far more than the usual grant period of one to three years; extending to ten years or more. Also of note, funding for the study initiatives has not been tied to a single, pre-existing agency or sector. Instead, for most of the initiatives, funds were awarded to a new entity, which has allowed that entity to serve as a neutral convener and facilitator across agencies and sectors.

- ***Sustainability remains an ongoing issue even for the effective and successful initiatives in the study.*** All of the initiatives that were studied face serious questions about their long-term sustainability. Several are dependent on time-limited private grants, and even for those that have obtained public financing, revenue sources are far from secure. The consensus among study initiatives and national experts participating in the *Health Matters* meeting in April 2008 is that, ultimately, macro-level systems and policy changes will be needed to sustain these and similar initiatives in the long run.

Conclusions

This review leads to four overarching conclusions:

- ***The study initiatives and others like them provide effective platforms for improving the lives of young children and their families, promoting healthy development, and transforming child health and other service systems in the communities where they have been implemented. As such, they can serve as models for transforming child and family services, supports, programs and policies nationwide.***

- ***With adequate support and resources, place-based initiatives such as those profiled in this study can also serve as "innovation incubators," testing new ideas, establishing new approaches within and across service sectors, and finding new ways to build capacity within families, service sectors, and communities.*** In this way, the place-based, multi-sector initiatives can make important changes within their own geographic boundaries, *and* build an evidence base that can help guide other communities, program planners and implementers, funders, and policy makers nationwide.

- ***Health sector participation in multi-sector place-based initiatives for young children should be promoted and further developed, both as a means of strengthening multi-sector initiatives and their impact on children, and as a means of improving the health system.***

- ***Long-term issues around financing and sustainability suggest that broad policy and macro-level systems changes (at the local, state and national levels) will be needed to sustain these and similar initiatives in the long run (including sector-specific changes currently supported by the initiatives).*** Therefore, there is a need to identify current and potential policy options for long-term sustainability, build an evidence-base around these options, and build political will to support needed policy and systems changes.

Recommendations

The recommendations below — and related starting points — are organized around the study's four key conclusions.

1. ***Further explore and disseminate information on the eight exemplary initiatives highlighted in this report, and others like them, as models for transforming child and family services, supports, programs and policies nationwide.*** This study serves as an introduction to multi-sector, place-based initiatives for young children, with a particular focus on the role of health and the health sector within the initiatives. As such, it is a first step. Many additional aspects of these and similar initiatives can and should be further explored and described so that others can build on their work. Three potential starting points for follow-up or companion studies are as follows:

   Starting points

   - Building on the findings in this study, a companion study could be undertaken that looks more closely at the role of other core sectors — specifically education and family support — to better understand their roles in relation to the initiatives as a whole and to health.

   - In addition, a follow-up study could explore and describe in greater depth, one or more of the primary program strategies — enhanced services, capacity building, and systems change and

integration — across these and similar initiatives. Within each of the strategies there are multiple layers and components, many of which deserve additional attention. To name just a few examples, it would be useful to: (1) identify a set of model "messages" used across sectors and across initiatives; (2) identify and describe common screening tools used within and across sectors; and (3) explore in greater depth various models for tiered services and related referral and linkage strategies, including the potential role information technology can play.

- Finally, it would be useful to focus on one or more of the "foundations for multi-sector collaboration" described in the report. Of particular interest are: (1) the role of funders in promoting collaboration; (2) the role of neutral convener and facilitator; and (3) the implications of "going where the children are" for how and where services are delivered.

2. ***Develop and provide the support and resources needed to help these and similar initiatives become "innovation incubators," testing new ideas, establishing new approaches within and across service sectors, and finding new ways to build capacity within families, service sectors and communities.*** Beyond capturing and disseminating what has already been done, there is a great opportunity to work collaboratively with existing initiatives in order to jointly problem solve, test new ideas, and build an evidence base for successful interventions.

   Starting points

   - Provide resources and facilitation for the development of "learning collaboratives" comprised of successful place-based initiatives for young children. The focus of these collaboratives would be on joint problem-solving around a common set of concerns. Initial issues of interest might include: the design of evaluation frameworks; selection of outcomes and related indicators; and development of shared client data systems and related capacity-building for individuals and agencies using the systems.

   - Provide resources and support for the development of ongoing, staffed information systems that can receive, catalogue and retrieve information on promising practices, and strategies that might inform and be informed by the development of multi-sector, place based initiatives for young children. These systems should be designed for easy use by initiatives like those in this study. They could incorporate and build on information generated by learning collaboratives.

   - Provide resources and support for "adaptation collaboratives"; that is, collaboratives designed to facilitate the spread of successful programs and strategies to multiple initiatives in sites nationwide. These collaboratives could help distill key elements of successful programs and strategies, while also providing a laboratory for local adaptation. In part, these collaboratives could help test and clarify issues related to fidelity and replication of successful programs.

3. ***Promote and enhance health sector participation in multi-sector, place-based initiatives for young children, both as a way to strengthen the initiatives and their impact on young children, and as a means of improving the health system.*** Multi-sector, place-based initiatives for young children provide an extraordinary opportunity for health professionals, health care services, and public health programs to: (1) expand and strengthen healthcare services; (2) build capacity; and (3) change and integrate systems of care (within the health sector and between health and other sectors). In addition, the study initiatives, and others like them, can provide the resources and opportunities needed to rethink and realign healthcare content, organization, and delivery (including delivery sites).

Starting points

- Ensure that initiative framing and funding both require and support active engagement of the health sector from the planning stages forward. Adding a requirement or an RFP for programming that focuses on the coordination between health and other sectors (e.g., early childhood education, family support), can provide the kind of broad strategic frame that is needed to launch more systemic joint planning and service integration across sectors.

- At the local level, individual health professionals, health delivery services, public health programs, and professional associations can and should take the lead in reaching out to develop formal or informal working relationships with broader place-based initiatives. For example, health sector players could join forces with a local, place-based initiative to: (1) develop a quality improvement initiative that simultaneously trains pediatric primary care providers and early childhood educators to incorporate routine developmental surveillance or screening into practice settings, and develops a cross-sector protocol for follow-up care; or (2) develop similar quality improvement initiatives around obesity and/or oral health.

- Currently, within the health sector there are a number of highly effective strategies and programs for young children that are not yet — or not consistently — linked to broader place-based initiatives. Examples include the Medical-Legal Partnership for Children; health equity initiatives; health impact assessments; projects focused on the built environment; efforts to improve local availability of fresh fruits and vegetables; and "maternal life-course" and preconceptional health programs. As a starting point, health sector players involved in these and other innovative approaches should reach out to place-based initiatives for young children, and vice versa.

- At the state and national levels, professional associations (e.g., American Academy of Pediatrics, Association of Maternal and Child Health Programs, American Public Health Association, CityMatCH) should educate themselves regarding multi-sector, place-based initiatives for young children and should begin to explore and promote both the current and potential interface between their constituents and these initiatives.

4. ***Identify, develop and promote policy and systems changes for long-term sustainability.*** Ultimately, broad policy and systems changes will be needed to sustain most of the study initiatives, and others like them, so that multi-sector, collaborative, place-based and community-owned efforts can become the norm.

Starting points

- Identify, describe and disseminate information on sustainable, *dedicated* funding streams that have been used to finance multi-sector place-based initiatives for young children, or other similar initiatives focused on a different target population (e.g., the elderly). Examples include use of a tobacco surtax and use of a millage tax on property. It would be particularly useful to understand the circumstances that gave rise to dedicated funding, the specifics of how the funds are raised and administered, pros and cons of separate funding that goes beyond established agencies or service sectors; and value-added of this kind of financing. This kind of information could be gathered as a follow-up study and/or it could be gathered through convening initiatives that have benefited from this kind of funding.

- Further explore models for blended and/or braided funding streams, master contracts and other efforts that combine existing categorical funding to support and sustain multi-sector initiatives.

As with dedicated funding streams, information could be gathered in follow-up study or through convening multi-sector initiatives that have used these strategies. Again, examples from initiatives serving other target populations (such as the elderly) could be instructive.

- Begin to build, gather and disseminate information on financing and policy changes that could sustain sector-specific program innovations within broader, place-based initiatives. Examples include: Medicaid or SCHIP financing that covers in-home, parent-child therapy sessions; adequate payment for referral/linkage and case management services; and payments to developmental pediatricians who make "house calls" to early childhood education centers in order to work directly with children and their childcare providers.

- As these long term financing approaches are being explored, funders can also assist these and similar initiatives by funding in ways that promote collaboration and integration; by extending the grant period for start-up and continuation funds; and by serving as advocates, helping to broker additional funds for place-based, multi-sector, early childhood initiatives.

APPENDICES

Appendix A: Initiative Profiles

Appendix B: Key Informants

Appendix C: Initiative Interviewees

Appendix D: Meeting Participants

APPENDIX A

INITIATIVE PROFILES

The preceding sections of the report provide an overview of cross-initiative themes, findings and recommendations. These were drawn from multiple interviews focusing on each initiative's unique combination of priorities, approaches and components. The profiles that follow complement and provide specific examples of the themes identified in earlier sections of the report and provide a more detailed introduction to each of the study initiatives. The profiles include information on the initiative: origins; development; strategic plan and planning; target population; implementation platforms; program overview; anchor programming; staffing, administration, and governance; financing and allocation of funds; data, evaluation and accountability; and sustainability. Contact information is also provided for each initiative.

CHILDREN AND FAMILIES COMMISSION OF ORANGE COUNTY (CALIFORNIA)

ORIGIN OF THE INITIATIVE

First 5 California

The Children and Families Commission of Orange County (CFCOC) is part of a statewide early childhood/school readiness initiative — First 5 California — established under the California Children and Families Act of 1998 (Proposition 10) and funded through an increased tax on cigarettes and tobacco products. The intent of the Act is to facilitate the development of a comprehensive, integrated system of services and information focused on children from the prenatal period through age five, with a dual purpose of enhancing optimal early childhood development and ensuring that children are ready for school.

The Act established the California Children and Families Trust Fund as a repository in the state treasury for funds collected under the new tobacco surtaxes. Eighty percent of the funds are available for local Commissions based on each county's proportion of statewide births. Twenty percent of the revenues are allocated to the State Commission for statewide expenditures. Programs authorized by the Act are administered by the California Children and Families Commission and by the autonomous county commissions. At the local level, all California counties are eligible to receive First 5 funds, providing that the County Board of Supervisors establishes a local First 5 Commission and that other administrative and implementation requirements are met. Each county then allocates its funds based on its locally developed strategic plan and program priorities. Currently, all 58 California counties have established a First 5 Commission.

As stipulated in Proposition 10 legislation, the State Commission is charged with: (1) providing for statewide dissemination of public information and educational materials; (2) developing and adopting statewide guidelines for a comprehensive, integrated early childhood development system; (3) defining and measuring progress toward results to be achieved by the initiative; (4) identifying standards and best practices for optimal child development; (5) providing technical assistance to the counties in developing their individual strategic plans; and (6) making recommendations to the governor and legislature for changes in state laws, regulations and services to better support early childhood development.

Under the evaluation framework established by the First 5 California Commission in conjunction with local Commissions and the First 5 Association of California, counties report services funded in four "results areas": (1) improved child development, (2) improved child health, (3) improved family functioning, and (4) improved systems of care.

State Strategic Plan

In September 2007, the State Commission adopted a new strategic plan for 2008-2012, updating its vision, mission and goals, as follows:

- ***Vision.*** All children in California enter school ready to achieve their greatest potential.
- ***Mission.*** By 2012, be recognized as California's unequivocal voice for children 0-5 to ensure greater equity in their readiness for school.
- ***Strategic Goal Areas.*** (1) Focus on policy development. (2) Invest in program development. (3) Broaden public awareness. (4) Enhance research and evaluation. (5) Strengthen organizational operations and systems.

State Financing and Allocation of Funds
First 5 California is funded through a surtax levied on distribution of cigarettes and other tobacco products in California. The surtax on cigarettes is $0.50/pack, with an equivalent rate determined annually for other tobacco products.

As stipulated under the Act, funds collected under the new surtax are allocated as follows: 20% to the California First 5 Commission and 80% to be distributed among the County First 5 Commissions, based on each county's portion of the total births in the state (using data from the most recent reporting period).

INITIATIVE OVERVIEW

Early Development
The Orange County Board of Supervisors established the Children and Families Commission of Orange County (CFCOC) and related Trust Fund in December, 1998. In 1999, nine Commissioners were appointed, representing public and private sector leaders in pediatric healthcare and education. The first Executive Director also came on board in 1999, and continues to serve in the position today.

The Commission approved a strategic planning process and its first budget in November 1999, and adopted its first strategic plan in February 2000, consistent with the intent and requirements of the California Children and Families Act of 1998. The plan has been reviewed and re-approved annually since that date.

Current Strategic Plan
Because of the size and scope of CFCOC activities, the Commission uses a nested strategic planning structure, with one umbrella Strategic Plan providing the framework for the Commission's activities as a whole, and a series of related plans focusing on key aspects of CFCOC operations. These plans, which support implementation of the umbrella Strategic Plan, include:

1. *Community Engagement Plan,* focused on engaging the community in the Commission's planning.
2. *Program Plans,* focused on implementation, outcomes and indicators of success for the Commission's major initiatives.
3. *Ten Year Financial Plan,* long-term planning with an annual update.
4. *Annual Budget and Business Plan,* allocating resources to specific programs and projects.
5. *Annual Performance Outcome Measurement System (POMS) Work Plan,* focused on measuring the results of Commission-funded programs and the overall impact of the initiative on Orange County children and families.

The current, overarching Strategic Plan for CFCOC, as updated in March 2006, includes the following key elements:

- ***Vision.*** All children are healthy and ready to learn.

- ***Mission.*** Provide leadership, funding and support for programs that achieve the vision that all children are healthy and ready to succeed when they enter school.

- ***Goals.***

- *Healthy Children.* Ensure the overall physical, social, emotional and intellectual health of children during the prenatal period through age five.

- *Strong Families.* Support and strengthen families in ways that promote good parenting for the optimal development of young children.

- *Ready to Learn.* Provide early care and education opportunities for young children to maximize their potential to succeed in school.

- *Capacity Building*. Promote an effective delivery system for child and family services.

- ***Outcomes.*** These are provided for each goal area as follows:

Goal Area	Outcomes
Healthy Children	▪ Increased % of children born healthy ▪ Increased access to early screening and assessments for developmental, behavioral, emotional, social, and other risk conditions so chronic conditions are identified, assessed, and managed ▪ Increased % of children who have and use a health home for comprehensive health services, to include physical, dental and/or mental health services. ▪ Reduced number of child deaths and disabilities due to preventable causes. ▪ Increased % of children growing up in healthy and safe environments.
Strong Families	▪ Increased family self-sufficiency. ▪ Increased parenting knowledge and skills to support effective child rearing and healthy choices. ▪ Increased access to and availability of family support services/resources.
Ready to Learn	▪ Increased availability/ access to quality early care and coordination. ▪ Increased school readiness of children with special needs. ▪ Increased caregiver knowledge and skills to promote children's readiness for school. ▪ Improved transitions of children from preschool to kindergarten.
Capacity Building	▪ A consumer-oriented, easily accessible system of services that is responsive to local needs and achieves results. ▪ Commission-funded projects are still in existence after five years. ▪ Commission data supports decision making and program improvement.

The Strategic Plan also includes specific indicators, objectives and three types of strategies — policy strategies, program strategies, and, when applicable, research strategies — for each of the goal area outcomes. Examples of these strategies include: reducing the percentage of infants born low birth weight and very low birth weight (i.e., increased percentage of children born healthy); increasing socioeconomic status indicators as gauged by homelessness, hunger, poverty, environmental safety, formal education of parents, employment and social capital/support (increased family self-sufficiency); and developing business plans, business practices and/or grant applications to sustain programs (Commission-funded projects are still in existence after five years).

Platforms for Implementation
The CFCOC logic model, *Pathways to School Readiness,* outlines three primary platforms for service delivery: hospitals, family resource centers, and schools.

Target Population
The target population is young children from the prenatal period through age five years, slightly over 262,000 children. The Commission strives to achieve both universal community engagement on early childhood issues, and universal screening and follow-up services within the target age group. At the same time, CFCOC also directs services to vulnerable populations such as children living in low-income households, homeless children and their families, children in the foster care system, and teen parents and their young children.

Program Overview
CFCOC has developed a well-integrated system of care that balances broad community education about the importance of early childhood, with both universal and targeted services to promote healthy growth and development, early learning, and literacy among young children county-wide. Of particular note is the extent to which health and early learning are *integrated* within CFCOC anchor initiatives: regardless of the service setting (e.g., health, early childhood education, schools, family resource centers), providers seek to identify and address both health and early learning needs. The overall approach includes:

- Raising awareness about the importance of early childhood health, development, early learning and literacy — among the general population, parents, caregivers, early childhood educators and health professionals.

- Providing information, education and tools to help promote and optimize healthy development and early learning in young children — for parents, caregivers, early childhood educators and health professionals.

- Promoting screening and early identification of health and developmental issues in young children and their families.

- Developing and strengthening intervention and treatment services for children and families who have or are at-risk of health, developmental and/or early learning issues. This includes gap-filling services.

- Strengthening systems of care for children and families by promoting operational quality and efficiency, developing data and using measurement systems to improve performance and outcomes, and helping grantees leverage funds and build sustainability.

Anchor Programming
Over nearly a decade, the Children and Families Commission of Orange County has evolved an inter-related set of "anchor" programs and initiatives focused on improving systems of care county-wide. These are generally grouped by the four goal areas, as follows:

- ***Healthy Children.*** Of the 58 First 5 Commissions in California, CFCOC devotes the greatest percent of its budget to health (55-65% in any given year). This strategic decision was grounded in the evidence base around early childhood development and early intervention, along with initial and ongoing Orange County needs/assets assessments. The Commission broadly defines health and its antecedents, and incorporates a full spectrum of health-related services, with a particular emphasis on addressing conditions likely to affect future learning. Among the health issues targeted by the Commission are: behavioral and neurodevelopmental issues such as autism

and ADHD; asthma and other chronic lung problems; delays in speech, language and early literacy; oral health; fitness and nutrition; injuries; immunization; and metabolic disorders. CFCOC incorporates strong relationships with both public and private sector providers of care, including health sector "heavy hitters" such as the county's two children's hospitals; major county birthing hospitals; the local AAP chapter, and its network of primary care providers; elementary school districts and their school nurses; and the County dental association. Key *Healthy Children* programs include:

- *Bridges for Newborns.* This county-wide, universal program is a partnership among the county's major birthing hospitals, family resource centers and community agencies aimed at assuring that all newborns and their families have basic information about healthy development (via a *Kit for New Parents*); are linked to a medical home for preventive services; are screened for health and other risk factors; and receive case management, home visiting and family resource center services, as needed.

- *Project Connections: Family Resource Centers.* Eight neighborhood-based Family Resource Centers throughout the county provide a seamless link in services and supports for pregnant women, young children and their families. FRCs link families to and from prenatal care, birthing hospitals, health education and in-home support services, and medical homes for primary care services.

- *School Readiness Nurses.* Nurses placed in each elementary school district in the county provide an opportunity for children age five and younger to receive health and developmental screening, assessment, preventive and other care, and linkage to additional intervention and treatment services, as needed. This system-wide effort provides another universal access point for screening and services while also firmly establishing the link between health and early education/literacy.

- *The Dental Health Initiative.* The oral health initiative is spearheaded by *Healthy Smiles for Kids of Orange County*, a non-profit established by the Commission. This initiative recasts oral health as a critical health building block, important for early speech and language development. The initiative moves back the clock on oral health, helping parents, pediatricians and others recognize the importance of "baby teeth" and of developing good oral hygiene early in life. More specifically, the initiative improves oral health among Orange County children through prevention education; early identification of caries; nutritional guidance; education of health care providers (with the goal of integrating oral health into primary care pediatrics); facilitating safety net and community providers to increase their capacity to serve children; filling gaps in available treatment services; and advocating for increased access to treatment services for all children.

- *Pediatric Health Services.* This initiative brings together the county's two children's hospitals — Children's Hospital of Orange County (CHOC) and University of California Irvine (UCI) — in a collaborative effort to expand pediatric subspecialty care for Orange County's youngest residents. Among the services expanded under this initiative are neurodevelopmental care, asthma/chronic lung disease, and metabolic disorders. In addition to providing medical care, these services both provide and are linked to community screening, assessment and family support services. Among the specific programs under *Pediatric Health Services* are the following neurodevelopmental programs:

    - *Help Me Grow OC.* This is an Orange County version of Connecticut's successful developmental screening and referral/linkage initiative. The program addresses "front

end" systems barriers by promoting developmental screening, with referral and linkage to needed services. In addition to healthcare and other service providers, the program can and will send screening tools directly to families. Key program components include: developing a data base of developmental services, identification of gaps and barriers in the developmental care service system, developing a referral/linkage call-in line in partnership with 2-1-1 to help connect children and families to services, provider training, and promotion of developmental screening within primary care and other service settings. Community liaisons participate in a variety of outreach and education activities. They have just begun breakfast events called "Connection Cafés," which will provide networking opportunities for community service providers.

- *For OC Kids Neurodevelopmental Center.* The Center provides an inter-disciplinary evaluation and treatment program for autism, ADHD and other developmental, behavioral and learning problems in children birth through five years old. While the program itself is not entirely new, several aspects are: (1) The program is part of the broader OC system of Commission-funded programs, receiving referrals directly from a variety of community partners. (2) Services are available to all OC families in need, not just those with extensive health coverage or the ability to pay out of pocket. (3) The Center spends about twice the usual amount of time with families for an initial neurological or developmental-pediatric consultation (about 90 minutes on average), allowing families to "tell their stories," an important part of coping. (4) Social work and family support, education, and advocacy services are a key part of the intervention. (5) Staff provide extensive outreach and education opportunities in developmental disorders, for all community sectors. This program addresses "back-end" system gaps: providing further assessment and treatment services for children who screen positive for developmental issues.

- *CUIDAR.* An education and training program for parents of children with disruptive behavior, *CUIDAR* (which means "to take care of" in Spanish) provides a 10-week series of parenting sessions based on the *COPE (Community Parent Education)* model. The program operates under the premise that disruptive children will do better if there is a change in the environment in which they grow up, including improved parenting and care-giving skills related to difficult behavior. *CUIDAR* provides "intervention without diagnosis," de-stigmatizing the program for parents who might be concerned about diagnostic labeling. Currently, the program is offered to parents of three to five year olds, with additional outreach and training for teachers. A similar program for the parents of one to three year olds is being piloted together with EDAC (see below).

- *Early Developmental Assessment Center (EDAC).* In addition to serving the usual functions of a multi-disciplinary NICU/high-risk infant follow-up service, EDAC has enhanced its own work and taken on a leadership role county-wide. Among its accomplishments: (1) EDAC has improved tracking and follow-up, to dramatically increase receipt of care among infants referred to the clinic (for one birthing hospital the percent of infants receiving follow-up care increased from 30% to approximately 70%). (2) EDAC has begun to identify and fill service gaps to improve the current OC system of developmental care. For example, in response to a need for behavioral programs for younger children, it developed the Coping with Toddler Behavior Group (COPE for one to three year olds). (3) Finally, based on its own experiences in working with a range of Commission-funded programs, EDAC has been a role model and cheerleader for other clinics to work outside their traditional clinical boundaries to better address the developmental needs of OC's young children and their families.

- ***Strong Families.*** Programs in this goal area are directed toward community partnerships, community outreach and education, and homeless prevention. Anchor programming includes:

  - *Homelessness Prevention.* A partnership with HomeAid Orange County, this initiative develops transitional and emergency shelter facilities for homeless children and their families. Additional programs funded by the Commission help address health and developmental needs of homeless children and their families by linking them with transitional housing, early literacy, health and other support programs.

  - *211- Call-in Line.* The Commission — in partnership with the County of Orange and OC United Way — was instrumental in creating Orange County's 211 phone call-in center, which connects county residents to a wide range of community services and supports (e.g., food, housing, healthcare, family resource centers, etc.). Most recently, *Help Me Grow-OC* has been added to the functions of the 211 call-in line.

- ***Ready to Learn.*** The focus of this goal area is on early literacy and language development, and school readiness. As with other components of CFCOC, the *Ready to Learn* initiative integrates healthcare, in-home, family resource center, early care and education and school programming to support young children and their families. Key initiatives include:

  - *Early Literacy Network.* Recognizing that early literacy is a crucial component of school readiness, the Commission established the *Early Literacy Network* to: (1) support professional development related to early learning; (2) provide resources on early literacy best practices and programs; and (3) promote the expansion of successful literacy program models, including *Home-based Activities Building Language Acquisition (HABLA), Family Literacy Programs,* and *Reach Out and Read (ROR),* which uses pediatric well child visits to "prescribe" and distribute books to young children. CFCOC has enhanced *ROR* activities through the use of Americorps volunteers.

  - *Local School Readiness Program.* This initiative funds School Readiness Coordinators (SRCs) in each of the county's 25 school districts with elementary schools, to assist in getting schools ready for children. Program goals are: (1) to improve the school readiness among young children; (2) to facilitate preschoolers' transition to kindergarten; and (3) to better schools for incoming kindergarteners. The SRCs do not work directly with children; instead, they educate families and childcare providers on how to help children become ready for school, and they advocate with school districts and the early care and education community for aligned curriculum and enhanced preschool and kindergarten transition services.

  - *First 5 California School Readiness Program.* This statewide initiative provides matching funds to local First 5 Commissions to improve school readiness, using a framework that includes early care and education services, parenting and family support services, health and social services. CFCOC is currently in the second round of funding under this initiative, having successfully used initial funding to focus School Readiness Coordinators and local community partners on improving school readiness for children transitioning to 44 low-performing elementary schools in 13 school districts. Partners include: the local AAP chapter, the county's two children's hospitals, the Family Support Network, Healthy Smiles for Kids of Orange County and YMCA Child Health Consultants.

- ***Capacity Building.*** Programming in this goal area focuses on: leveraging strategies; commission operations/infrastructure; technical assistance; capacity building grants; the Commission's data collection and performance measurement systems; and grants to a wide range of programs in the

county. Anchor program initiatives within this goal area include the *Capacity Building Grants Program* (see below) and the *Performance Outcomes Measurement System* (see section on *Data, Evaluation and Accountability*).

- *Capacity Building Grants Program.* The Commission provides capacity building grants to agencies, organizations or collaboratives building new or improved services for children 0-5 in the County. These tend to be one-time start-up grants providing funds and technical assistance for planning and development. To promote sustainable programming, the Commission requires start-up grant recipients to develop a well-thought-through service or business plan, and provides technical assistance, as needed.

Staffing and Administration

The Commission was established by the Orange County Board of Supervisors as an independent entity. It is not part of the county government. Staffing is lean, with a total of about 19 staff members, some of whom are part time. To accomplish its work, the Commission relies on a relatively large group of consultants (approximately 40). This approach allows the organization to be nimble and responsive to community needs.

Financing and Allocation of Funds

Financing. The primary source of funds for the Commission is the state surtax on tobacco products. Orange County's current share of these funds is nearly $36 million per year. The Commission also works with grantees to leverage additional funds for programs and services. This includes assisting grantees with drawing down federal and state matching funds, working collaboratively with other granting agencies and organizations to jointly fund programs and services, and providing technical assistance to grantees in applying for funds from other sources.

Allocation of Funds. Of the program funds expended by CFCOC, by far the greatest share — approximately 55-65% in any given year — is dedicated to the health-related component, *Healthy Children.* In FY 2006-07, program expenditures were allocated as follows:

First 5 OC Program Expenditures by Goal Area, FY 2006-2007		
Program Area	**Percent of Program Funding**	**Expenditures (in Millions)**
Healthy Children	56%	$25.4
Ready to Learn	29%	$13.0
Capacity Building	10%	$4.4
Strong Families	5%	$2.5
Totals	**100%**	**$45.3**

Data, Evaluation and Accountability

CFCOC has developed an extensive data collection, analysis and reporting system to assess progress in implementing programs and initiatives, and meeting performance goals and objectives. Both process and outcome data are incorporated. Data/evaluation activities fall into three broad categories: (1) Commission-wide evaluation and monitoring, aimed at providing an overall picture of the Commission's impact in meeting its targeted goals and objectives; (2) initiative-specific evaluations aimed at assessing the impact of individual Commission-funded programs/initiatives; and (3) participation in the development of community, regional and/or state evaluation efforts, including the development of community-wide indicator data. Early on, the Commission made the decision to provide computers to all grantees, an approach that enhances collection, reporting and use of data to improve services. Evaluation

results are posted on the Commission's Website. Two key elements in CFCOC data and evaluation efforts are as follows:

- ***The Outcomes Collection, Evaluation, and Reporting Service (OCERS)*** collects client and program data via an internet-based data system. This system includes two modules for monitoring and tracking data: one used by all grantees to track and report progress achieving project milestones; and one that is a confidential client-tracking system, which is used only by grantees providing direct client services. Implementation of this module includes the capacity to generate unduplicated client counts. The OCERS system is used both by the Commission and by grantees to monitor and manage grants.

- **The *Performance Outcomes Measurement System (POMS)*** includes an evaluation framework with identified outcomes, indicators, and objectives for each of the Commission's four goal areas (See matrix under *Current Strategic Plan* above.) Each year, the *POMS* Team produces an Annual Report, which includes: (1) grantee-specific implementation milestones; (2) aggregate process data on Commission funded services; (3) reporting on core outcome data related to the Strategic Plan objectives and indicators for children and families; and (4) an assessment of the impact of services on children and families (i.e., an assessment of whether conditions changed as a result of Commission-funded activities.)

Sustainability

CFCOC takes a multi-pronged approach to sustainability. Capacity building grants are used to build a strong foundation for start-up projects. The Commission provides technical assistance to these projects in areas such as business and service planning and financial accountability. In addition, the Commission provides assistance in leveraging funds for grantee services (including help with reporting requirements), and it partners with other foundations to enhance funding for early childhood. Recognizing that First 5 tobacco tax revenues are declining over time, the Commission commits funds to initiatives through a 10-year financial plan to assure longer-term sustainability of its anchor initiatives.

Selected Health and Developmental Outcomes

Key CFCOC outcomes (as reported by Rose, et al; and Golan, et al.) include the following:

- After participating in Commission-funded programs, more children had: a regular medical home (79% to 99%), health insurance (86% to 97%), and appropriate immunizations for their age (81% to 91%).
- More children were rated in excellent health (8% to 24%) after receiving well-child care.
- Fewer children were rated as being at risk of obesity (37% to 35%) after participation in nutrition and fitness services.
- Fewer children had one or more dental caries (67% to 24%) after receiving oral health treatment.
- More children performed at or above age-appropriate levels (52% to 87%) after participation in early care and education services.
- Among 761 children screened for developmental milestones through the Family Support Network/LEAPS program, 519 (68%) were identified with special needs or required specialized services and were referred to specialized speech and language, medical, mental, dental, and other services.
- Among high-risk families in the Bridges for Newborns program, overall psychosocial risk as measured by the Bridges Screening Tool fell by 10 points on average, a decline of approximately 20%.
- After participation in the parenting classes, the percentage of parents rated as having satisfactory or excellent parenting skills more than doubled, from 25% at program entry to 67% at program completion.

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THE CHILDREN'S BOARD OF HILLSBOROUGH COUNTY (TAMPA, FL)

ORIGIN OF THE INITIATIVE

The Children's Board of Hillsborough County (CBHC) is an independent taxing authority established under a Florida law which allows voters to authorize, through public referendum, the formation of special taxing districts. Known as Children's Services Councils (CSCs), these districts serve as county-level strategic grantmakers to promote the healthy development of children. The law permits counties to establish two types of special districts: "dependent" special districts, which are authorized to seek grants and accept donations for the purpose of providing preventive, developmental, treatment and rehabilitative services for children; or "independent" special districts which, with additional voter approval, may annually levy *ad valorem* taxes up to $0.50 per $1,000 of taxable property value to fund children's services. Once such a tax is approved by the electorate, the CSCs need only go back to the voters to raise the millage rate above $0.50; they are not required to seek approval to the levy the tax in future years.

The history of Florida's CSCs began in 1945 in Pinellas County. At that time, the county delegation won approval from the state legislature for a measure permitting the county, with local voter approval, to establish a "juvenile welfare board" and levy an *ad valorem* tax for children's services. Forty year later, voters in Palm Beach County sought a similar provision in that community. In response, local legislators advanced a piece of state legislation known as the Juvenile Welfare Services Act. Passed in 1986, this Act provided that any county in Florida, whose voters agree through referendum, can create a special district for children's services with a governing board and the authority to levy taxes.

The Act endowed these districts with a number of specific powers and functions, including the following:

1. To provide and maintain in the county such preventive, developmental, treatment and rehabilitative services for children as the council determines are needed for the general welfare of the county
2. To provide such other services for all children as the council determines are needed for the general welfare of the county
3. To collect and provide funds for other agencies in the county which are operated for the benefit of children, provided they are not under the exclusive jurisdiction of the public school system
4. To collect information and statistical data and to conduct research, which will be helpful to the council and the county in determining the needs of the children in the county
5. To consult and coordinate with other agencies dedicated to the welfare of children to strengthen the impact and limit the overlap of available services.

It also outlined two alternatives for CSC governance: a 10-member or 33-member governing board, each to include a number of identified stakeholders. The Act did not mandate a particular structure based on a special district's "independent" or "dependent" status, or any other criteria.

Although the state law includes a number of reporting requirements for the CSCs, it provides that these reports be submitted to the county governing body, not the state. For example, immediately following its formation, a CSC is required to provide a written report that assesses county needs; describes the activities, services and opportunities that will be provided to the children; outlines the anticipated schedule for providing services and supports; and documents the types of arrangement and agreements that will be made by the CSC with local partners. This report also must describe the special outreach efforts that will be undertaken to provide services to at-risk, abused or neglected children. It also must address how the CSC will seek and provide funding for any unmet needs. In each subsequent year of operation, CSCs are required to file annual written reports and annual budget statements.

Beyond these requirements, the state law is silent on the particulars of CSC operations. As a result, it is the individual CSCs' responsibility to establish county-specific missions, goals, objectives and activities.

INITIATIVE OVERVIEW

Early Development

The Children's Board of Hillsborough County (CBHC) was established in 1988 with the mission of "improving the lives of children and families in Hillsborough County." CBHC is an independent special district, supported by a voter-approved annual levy of *ad valorem* taxes up to 0.5 mills ($0.50 per $1,000 of assessed property value). It funds "children's services aimed at prevention and early intervention."

CBHC engaged in extensive strategic planning during 2001 through 2002, relying heavily on material produced by the Pathways Mapping Initiative (Pathways). Supported by the Annie E. Casey Foundation and Harvard University, the Pathways philosophy holds that communities are best able to affect positive change when they combine local expertise with "actionable intelligence," defined as the accumulated knowledge about what has worked elsewhere, what is working now, and what appears promising. Pathways is focused on helping inform communities about how best to improve outcomes for school readiness and family economic success. This includes providing guidance to communities on setting and measuring key indicators of progress.

Building on the Pathways model, CBHC issued its strategic plan, "The 2012 Plan: A plan to significantly improve the lives of children in Hillsborough County by 2012," in July 2002. In 2007, CHBC issued a "2012 Strategic Plan Update" to further clarify its vision, mission and organizational values. The Plan Update also sought to provide additional direction for CBHC as it moved from supporting direct services to cultivating family and community capacity in ways that could support self-sufficiency on a long-term basis.

Current Strategic Plan

The 2012 Strategic Plan Update details the following for CBHC:

- ***Vision.*** Hillsborough County will be recognized as one of the top five places to raise children in the nation.

- ***Mission.*** We are committed to building the necessary conditions to value and support the well-being and inherent dignity of children and their families through our leadership and citizen engagement.

- ***Organizational Value.*** We will foster an environment that promotes health and wellness, that is family friendly, customer driven, and demonstrates quality and accountability in everything we do.

- ***Strategic Goal.*** To promote and document changes and conditions in the community that improve the lives of children.

The 2012 Plan Update links CBHC's mission to a number a specific goals and outcomes, including:

- Promoting and documenting changes and conditions in the community so that Hillsborough County can be recognized as one of the top five places to raise children in the nation.

- Fostering an environment that promotes health and wellness, that is family friendly, customer driven, and demonstrates quality and accountability so that CBHC's values infuse internal and external systems of care.

- Measuring and maximizing impact in order to promote long range impact, improve leadership and organizational performance, and improve measures of progress and return on investment.

- Providing citizens with the voice, visibility and opportunities for engagement necessary to enhance community leadership, communications and partnerships.

It also identifies seven benchmarks of achievement, including catalyzing community commitment; improving the capacity of existing providers; advocating for policy and funding; targeting strategic focus; selecting the best practice and best providers; promoting practice and systems improvements; and improving outcomes for young children.

Priority Program Areas

In operationalizing its strategic plan, CBHC identified five priority program areas — Strategic Focus, Resource Enhancement and Management, Learning and Growth, Leadership, and Community Engagement and Partnership — each of which is linked to specific strategies and outcomes. The first of these areas, Strategic Focus, dominates CBHC's funding and is where most of CBHC-supported direct services originate. This area includes the following strategies and priority outcomes which are realized in funded partner contracts:

Strategic Focus Program Area	
Strategies	**Priority Outcomes**
Healthy Births	▪ Women preparing to have children are optimally healthy. ▪ New mothers have healthy, weight appropriate newborns. ▪ New mothers/caregivers have the safety, stability and support they need within their family and community. ▪ Newborns and infants are optimally healthy and developmentally age appropriate.
School Readiness	▪ Child has strong bonds with primary caregiver. ▪ Child's physical, social, emotional and cogitative development is on track.
Early School Success	▪ Child meets academic benchmarks. ▪ Child is emotionally and behaviorally well adjusted.
Improving Delivery Systems	▪ Children are safe in their families. ▪ Children are safe in their community. ▪ Neighborhood residents have open access to information and a wider range of services to meet their needs. ▪ Neighborhood residents live in safe, healthy and supportive environments. ▪ Residents obtain education, training and employment that leads to self sufficiency. ▪ Families with children have safe, affordable housing. ▪ Constructing the social foundation for healthy communities.
Building and Maintaining Infrastructure	▪ Service quality is improved through training and quality improvement activities. ▪ System capacity is increased through leveraged maximized funds. ▪ System decisions are informed by integrated data systems. ▪ Community awareness is raised through marketing and communication. ▪ System is governed and planned through structures that include appropriate participants.

Strategies associated with the other four other program areas include: integrated data systems and policy development (Resource Enhancement and Management); training and quality improvement (Learning and

Growth); governance, planning and systems development (Leadership); and social marketing, communication and citizen participation in decision-making (Community Engagement and Partnership).

Platforms for Implementation
CBHC funds over 150 local agencies, organizations, and collaboratives — known as partners — which provide support and services to pregnant women and young children and their families through a variety of platforms. These include: child care and early education centers, hospitals, partner offices, and community centers and events, among others.

Target Population
The target population for CBHC is all pregnant women and young children aged birth through eight years and their families. Within this general population, select services and supports target young children at risk for persistent behavioral and social/emotional challenges. CBHC also helps support local efforts targeting children, including those over 8 years of age, through short term technical assistance/capacity building grants, co-funding and fund-matching arrangements.

Program Overview
In close collaboration with community stakeholders, including program partners, community organizations, and community citizens, CBHC seeks to:

- Identify barriers to health and wellness for pregnant women, young children and their families.
- Encourage, establish and sustain functional linkages between and among stakeholders in order to mitigate those barriers.
- Increase the community's capacity to effectively identify, respond to and reduce future barriers.

CBHC's role as a funder and community planning partner has helped the community to develop a network of coordinated, comprehensive and well-linked services and supports for pregnant women and young children and their families. With nearly a decade of work under its belt, CBHC is now turning renewed energies to ensuring the long-term sustainability of this network as an integral part of community systems and service structures.

Anchor Strategies
CBHC pursues its vision, mission and goal using a two-tier approach. On the one hand, many of CBHC's partners provide direct services to local children and their families. These services fill gaps in the existing service structure, reduce barriers to service access points, and offer care coordination across and between multiple service and support systems. At the same time, a number of CBHC partners are focused on enhancing family and community capacity, sometimes by working with families to secure needed services or supports, and sometimes by working with community leaders to improve local infrastructures, citizen governance and systems of care.

Examples of CBHC direct services strategies include:

- ***Healthy Births.*** This strategy area is comprised of 15 partner agencies and organizations that provide direct services and supports to prenatal and postpartum women and their infants. Some of these services are administered under Healthy Start Coalition of Hillsborough County, Inc., allowing for close collaboration and "warm hand-offs" for families moving from one maternal and child health related services array to another. Such collaboration also allows for children and families identified as having complex or intense needs to be easily and seamlessly referred to a more intensive CBHC funded or non-funded initiative within the county. Efforts are currently

underway to identify maternal and child health colleagues in surrounding counties who can also begin to facilitate these warm hand-offs for families moving between the local counties.

- ***School Readiness and Early School Success.*** This strategy includes six health-related services that work collaboratively to provide services and support to young children and their families:

  - *Community Developmental Screenings Program.* This program provides hearing, motor, cognition, medical, speech/language, vision, sensory, and behavior screening to approximately 65 young children (aged 0-5 years) and their families each month. It is led by a multidisciplinary planning team, which includes representatives from a number of community organizations, as well as local service providers. In addition to providing logistical and staff support for the screening events, this team works closely with CBHC to identify and respond to community-level barriers to care. For example, when several team members reported they were finding children in need of services not being addressed by the Family and School Support Team (FASST), the Early Childhood FASST was established. (See below for additional information on FASST and Early Childhood FASST).

  - *Family and School Support Team (FASST).* This initiative features multidisciplinary teams comprised of school, community and family representatives, which uses strength-based planning to support children aged 5-8 years and their families. (Strength-based planning is a process through which a comprehensive plan to support all family members is developed, implemented, and reviewed. It involves sharing responsibility among the family, support coordinator, school, community service providers and the family's existing support systems. It recognizes, combines, and uses all of these strengths to achieve goals established by the family. It also links these strengths across systems to establish a collective force to reduce or eliminate barriers faced by the child and family.) The FASST team works to enhance protective factors and reduce factors that place children and families at risk at the family and systems levels. At the family level, typical goals include increasing academic achievement, decreasing disruptive behavior, and increasing family involvement in school. At the system level, goals may focus on increasing the system's responsiveness to families, improving access to services, or enhancing system integration.

  - *Early Childhood FASST.* Similar to FASST, but directed at younger children (aged 0-5 years), this initiative seeks to assist children and their caregivers when the children have been identified as having behavior problems and/or developmental delays. Working in the home or the child's day care setting, Early Childhood FASST teams provide community-based services, including service coordination, family support, information and referral, individualized intervention planning, linkages to community resources, consultation to child care centers, mentoring and coaching.

  - *Care Options.* This program provides support for a child's primary out-of-home caregiver through short-term technical support in the child care setting, as well as free on-site training for caregivers and staff. During technical support, Care Options works one-on-one with caregivers to address an individual child's behavior. While this support focuses the individual child's needs, much of information is intended to help address the needs of all children. During on-site training, Care Options provides information on the Program Wide Positive Behavior Support (PWPBS) to all caregivers and staff on a center-by-center basis. (See below for additional information on PWPBS).

  - *Early Childhood Program Wide Positive Behavior Support (PWPBS).* This initiative provides training, technical assistance and coaching at three community-based child care centers that

serve low-income families. It is based on research affirming the use of positive behavior support strategies to meet the needs of young children who have or are at risk for problem behavior. It also includes a significant research component: initiative staff are working with The Center on the Social and Emotional Foundations for Early Learning at the University of South Florida (USF) to develop valid and reliable programmatic measures such at the Teaching Pyramid Observation Tool and Benchmarks of Quality Checklist.

- *Helping Our Toddlers/Developing Our Children (HOT DOCS).* HOT DOCS consists of six two-hour, interactive and hands-on parent education classes taught by staff from the University of South Florida, Department of Pediatrics, Division of Child Development. It adapts PWPBS principles in order to help parents and other caregivers understand what causes behavior problems and how to implement realistic solutions that support a child's growth and development. In addition to leading the six sessions, HOT DOCS coaches work with families to design individualized behavior plans. The free course, and accompanying materials, is available in English and Spanish.

Examples of CBHC family and community capacity building strategies include:

- ***Administrative Services Organization (ASO).*** This initiative is a CBHC-directed financial program that provides families with the funds needed to obtain services and supports not available through existing CHBC partners. Under the ASO, families work with a case manager to identify needs, create a goals list, prioritize that list, and develop a budget detailing how ASO funds will be used to achieve high-priority goals. ASO also links families receiving financial support to other CBHC partners. ASO funds may be used to obtain services and support in areas traditionally seen as health (e.g., mental health and respite care), as well as areas outside the health sector but broadly construed as contributing to health and wellness (e.g., rent, utilities, and tuition).

- ***Investment Initiative.*** This initiative uses co-funding and matching agreements to bring additional income into Hillsborough County. By serving as co-funder or matching source for local entities seeking outside funds, CBHC is able to better leverage its resources for its target populations. It also helps to increase community capacity by supporting non-CBHC initiatives. And, it is able to effectively extend its reach beyond young children by partnering with organizations serving older children and young adults.

Administration and Staffing

CBHC currently employs 60 full-time equivalents, some of whom work directly with funded partners through contract management and/or continuous quality improvement activities within the five key CBHC strategy areas. CBHC utilizes Hillsborough County's Civil Service Application process for the initial hiring for the majority of its workforce.

Financing

As a result of its independent special district status, CBHC receives significant revenue via a 0.5 mils ($0.50 per $1,000 of assessed property value) annual property tax. Combining levy dollars with additional resources, the FY 2008-2009 annual budget for CBHC was $44 million.

Data, Evaluation and Accountability
With more than 150 partners providing services and supports in multiple program areas to several populations, CBHC outcomes mapping historically has been a challenging process. Recognizing the need to better define and document program success, CBHC recently launched a web application, and related web portal, that allow for program outcomes to be entered and evaluated in real-time. Among other features, the web application includes outcome fields that align with the CBHC's strategic plan. It allows data to be accessed on a variety of levels, including by partner source, family service, population characteristics, and geographic community. It also allows for data to be imported into partner contract documents, as well as individual and community level reports.

At the same time, the web portal allows partners to enter data from their office or location. It allows multiple users to be logged-on simultaneously so that several partners can review the same data or document simultaneously. This is helpful for both case management and for program monitoring.

Having developed this innovative tool for data collection and analysis, CBHC is committed to using a results-based accountability system that examines such issues as: how much was done, how well was it done, and how were individuals and systems improved? CBHC is also committed to sharing its data and evaluation tools with other community partners, with the hope that this will contribute to improving broader community capacity for service delivery, tracking and evaluation.

Sustainability
Because the vast majority of CBHC's funding comes from the voter-approved annual levy on assessed property values, the sustainability of the program depends in large part on the economic health of Hillsborough County and the tax policies of the state's executive and legislative branches of government. While the area has enjoyed a housing boom over the last several years, the national mortgage crisis has hit Florida hard, and many state legislators are looking to property tax relief as a possible salve. Together, these factors have served to threaten CBHC's revenue stream, with flat or even reduced budgets expected for the coming years. Facing tough budget decisions and potential cuts, CBHC has employed a more results-focused planning process and stepped-up its matching and co-funding roles. This trend is expected to continue while the funding situation remains less than robust.

Selected Outcomes
Among the outcomes reported by CBHC partners:

- An estimated 7,000 children have been screened through the Community Developmental Screenings Program since 1998.Among children screened in FY 2007, nearly 97% were determined to be "on track" or to have secured needed developmental services.
- Seventy percent of medical providers who received training on the screening, assessment, referral and treatment of women to improve positive birth outcomes reported increased awareness of community resources.
- Forty percent of community members surveyed recognized program materials, images or messages on the effects of substance use on pregnancy.
- More than 700 children and families received funds through the Administrative Services Organization in 2007, securing such services and supports as clinical services, physical goods, housing, tuition, respite care, and transportation, among others.

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CHILDREN'S FUTURES (TRENTON, NJ)

ORIGIN OF THE INITIATIVE

Children's Futures (CF) was established in 2001 following an 11-month community planning process which grew out of a strategic partnership between community leaders in Trenton, New Jersey and the Robert Wood Johnson Foundation (RWJF). For several years prior to 2001, RWJF, at the behest of its Board of Trustees, had been exploring whether it was feasible to work with one city over a long period of time to improve children's health outcomes. At the same time, community leaders in Trenton had been exploring what their community collectively could do to significantly improve the lives of children. Recognizing the opportunity to build on emerging change, RWJF supported a structured planning process, during which time community leaders from multiple service sectors identified specific goals and strategies for improving children's health outcomes in Trenton, with a particular focus on strengthening prevention.

As an initial step, researchers involved with the planning process identified the most pressing threats to the health of Trenton's children. At the same time, researchers developed an inventory of established programs in the city that were effectively combating those threats. CF then approached the identified programs to determine the potential for partnering. Once it was determined that a number of programs were interested in working collaboratively under a single administrative umbrella, CF applied for and received a five-year, $20 million grant from RWJF to implement a new, city-wide initiative to support early childhood health and development. Following the RWJF award, the city of Trenton began directing another $700,000 annually from a federal Health Resources Services Administration Healthy Start Initiative grant to support CF.

Early Development

From the outset, CF sought to establish a dynamic, city-wide partnership comprised of existing community organizations and public agencies that could work collaboratively to improve the lives of Trenton's children. Much of its early work therefore centered around bringing together these organizations and agencies — many of which had little or no previous contact with each other — to develop shared goals, plans of action, and systems for accountability and evaluation. In addition, CF took a number of steps to formalize this newly established partnership, as well as its role as the convener and director of the partnership. For example, although multiple organizations and agencies were active across the city's four wards, CF chose to solicit just one proposal per ward for the establishment and operation of its Centers for Children and Families. In addition, CF identified specific partner agencies for each of its program objectives.

Current Strategic Plan

Children's Futures' current work is directed by a vision and mission statement, as well as a series of program objectives, strategic objectives and measurable outcomes. These include:

- ***Vision***. To ensure every child in Trenton enters pre-school healthy and ready to learn.
- ***Mission***. To improve child health and development outcomes in Trenton from prenatal to age three**.**

- ***Program & Strategic Objectives***

Program Objectives	Strategic Objectives
Strategic Parenting	▪ All pregnant women and new mothers in Trenton will have access to behavioral health services (addressing alcohol, tobacco and drug use (ATOD); depression; and domestic violence (DV)). ▪ Participating mothers/families will show indications of increased parenting skills. ▪ Participating Trenton parents will demonstrate best practices in parenting activities.
Primary Care Systems Improvement	▪ All pregnant women in Trenton will receive early and comprehensive prenatal care. ▪ All eligible participating women/families will be enrolled in health insurance and linked to quality primary care.
Child Care Systems Improvement	▪ Through a centralized training and technical assistance approach, the quality of child care in Trenton will improve significantly.
Integrating Community Support	▪ Children's Futures will mobilize community support and promote the basic and inherent needs of the Trenton community.

Examples of the measurable outcomes associated with these objectives include:

- By December 2008, 80% of pregnant women who screen positive for ATOD, depression or DV will receive prevention education and brief intervention, including treatment referral as necessary (Strengthening Parenting);.
- By June 2008, the quality of pediatric office practice in Trenton will improve by 30% through participation in NJAAP/EPIC training (Primary Care Systems Improvement).
- By March 2008, CF will increase by 50 % Trenton's providers' access to training and education to improve their child care skills (Child Care Systems Improvement).
- By June 2010, CF will provide for a 50% increase in training and technical assistance to community organizations in Trenton to improve skills and achieve CF established outcomes (Integrating Community Support).

Target Population

Children's Futures serves pregnant women and children aged 0-3 years and their families living in Trenton, New Jersey. It provides targeted services to vulnerable children and their families, including fathers. Data indicate that the vulnerable population in Trenton is significant: for example, nearly 20% of Trenton families live below the poverty line, and of the adults living in Trenton, nearly 40% have not graduated from high-school.

Platforms for Implementation

The majority of CF's work is directed through its Centers for Children and Families, which are located throughout the city's four wards and led by an established organization known to the particular community it serves — for example, St. Francis Medical Center (East Ward), Mercer Street Friends (West Ward), Children's Home Society of NJ (North Ward), and Catholic Charities (South Ward). A city-wide center focused on strengthening the involvement of fathers in the lives of their young children is led by the UIH Family Partners. The Center's lead agencies enters into an agreement with CF (to provide services to children and families) and with other community agencies and organizations (to augment

Center-based services and supports). Through this hub-and-spoke system, CF helps partner agencies provide direct services to more than 4,000 children and families each year.

In addition to its Centers, CF relies on a number of partners for program implementation, including early education and child care facilities, schools and community colleges, pediatric primary care offices, behavioral health organizations, and local health centers and hospitals, among others.

Program Overview

A 501(c)(3) organization, Children's Futures is committed to improving health and development outcomes for children and their families by employing a comprehensive set of interventions that build on existing community efforts, strengths and resources. It accomplishes this by engaging community partners to help break down family isolation; building trust between and among residents; forming alliances with health care providers; promoting positive parenting through information, resources and programs; and helping Trenton's most vulnerable citizens secure essential services. Among its key activities, CF works with public and private sector partners to improve access to prenatal care; maternal and child health care; and support activities that improve birth outcomes, childcare, literacy, parenting skills, access to medical care, education and father involvement. CF also provides technical assistance to faith-based organizations and others dedicated to the prosperity and well-being of Trenton's families.

Anchor Programming

The programs that anchor Children's Futures work are aimed at optimizing early childhood health and development through promotion, prevention and early intervention activities. These programs reflect the objectives identified in CF's planning process. Key programs include:

- **Strengthening Parenting**
  - *Health Screening for Pregnant Women.* Under this program, local prenatal clinics provide screening services to pregnant women in order to identify women who may benefit from home visiting, including: teen mothers; first time mothers; women with cultural, language and/or other barriers; women with substance abuse problems; women with depression or mental health disorders; and, those at risk for domestic violence. Follow-up care is provided by CF partners, including the Capital Health System, Henry J. Austin Health Center, and the Robert Wood Johnson University Hospital-Hamilton.
  - *Home Visiting.* Based on results of the prenatal screening program, eligible women are invited by CF partners to participate in one of three home visiting programs — the Nurse Family Partnership, Healthy Families or TANF Initiative for Parents (TIP). In addition, women identified as medically high risk are invited to join a specially-designed public health nurse program.
  - *Behavioral Health Services.* This program provides screening for depression and other mental health issues for expectant and post-partum parents, and includes additional assessments and linkages to treatment as necessary.
- **Improving Primary Care Systems**
  - *High Risk Pregnancy Initiative.* CF partnered with the Center for Health Care Strategies, state officials and five Medicaid managed care health plans to implement a Best Clinical and Administrative Practices (BCAP) model that includes a universal perinatal risk assessment screening tool. Under the BCAP model, women with social risk factors (smoking, domestic

violence, substance abuse mental health) are identified earlier and referred to services for appropriate treatment.

- *Pediatric Primary Care Project* **.** Working with the New Jersey Chapter of the American Academy of Pediatrics and the New Jersey Department of Health and Senior Services, CF has helped 11 primary care practices in Trenton implement and measure office-based improvements. This effort includes the use of Educating Physicians in the Community (EPIC) training modules to address such early childhood prevention topics as immunization, lead poisoning, suspected childhood neglect and delays, postpartum depression and asthma.

- *Reach Out and Read.* CF partners with Camp Fire USA-NJ Council to distribute new books to thousands of the city's youngest children during their well-child visits at participating medical practices. Before distributing the books to families, parents are encouraged to read aloud often to their children. The distribution of new, developmentally appropriate books is augmented by the encouragement of volunteers, recruited and trained by Camp Fire, who read aloud to young children awaiting services in the physicians' offices.

- **Improving Child Care Systems**

  - *Improving Quality in Childcare.* CF has partnered with Child Care Connection, a regional child care resource and referral agency, in an effort to improve the quality of early care and education programs for young children through training, technical assistance and child care resource development. Under this program, child care center directors and staff receive training in program development and center management. Centers also receive small grants for equipment and materials. Early care and education specialists provide bi-weekly site visits which focus on creating safe and healthy child care environments. This includes focusing on a high quality evidence-based curriculum for infants and toddlers, nutrition education, parent involvement and strengthening staff competency.

  - *Home Visiting Training.* CF works with Prevent Child Abuse New Jersey to provide home visiting training using the Healthy Families America (HFA) model. This training prepares home visiting staff to provide information, education and support for pregnant women and new parents.

- **Integrating Community Support**

  - *Technical Assistance to Organizations.* CF actively works to increase the leadership and capacity of Trenton-serving nonprofit organizations through training and technical assistance such issues as financial management, domestic violence prevention, detection and awareness, and home visitation protocols.

  - *Communications.* CF provides communications support for partner agencies in order to improve their community outreach, as well as their overall effectiveness in raising awareness of their programs. Areas of communications assistance to partner agencies has included grant proposal writing, message development, special event planning, implementation and promotion, signage and publication content, press conferences, news advisories and news releases; photography, outreach to families, and focus group planning.

  - *Forums and Workshops.* CF sponsors and supports public forums and workshops throughout the year in order to promote best practices and strategies, and to translate research into practice.

Administration and Staffing
Children's Futures employs 9.5 staff in a central office, with another 41 staff supported by CF funds at the various partner agencies. Central office staff include a President, Vice President, Director of Finance & Operations, Director of Communications, Director of Family Support Interventions, Program Officer for School Related Affairs, Executive & Operations Assistant, Data Management Specialist, Executive Assistant and an half-time Financial Associate. Partner agency staff includes site directors, program supervisors and home visitation specialists. Central office staff meet with Center staff at least monthly. Central office staff also work closely with CF partners through one-on-one meetings, telephone consultations, and program reporting and outcomes tracking efforts.

Financing and Allocation of Funds
Children's Futures is primarily funded through a five-year (2007-2011), $14.5 million grant from the Robert Wood Johnson Foundation (RWJF). This is the second five-year grant awarded to Children's Futures from RWJF. The first, covering 2001-2006, was for $20 million. Additional funds are received from a variety of public and private sources, including the US Department of Health and Human Services-Health Resources and Services Administration, the New Jersey Division of Youth and Family Services, and Reach Out and Read.

Data Management, Evaluation and Accountability
When Children's Futures started, there were already more than a dozen public and private organizations working in Trenton focused on children. While they shared similar traits, they did not share their data. Many were small operations that did not entertain the concept of working across systems. They only met a fraction of the real needs of Trenton's children. And they could not attract resources to the community.

In 2007, CF began implementing a shared data system to link its partners to the Central office, as well as to each other. Using this system, children and families who seek CF services and supports from one partner are entered into a secure, shared database where their information can be accessed, on a limited basis, by all partners. This facilitates care referral and case management, as well as outcomes tracking.

In addition, CF requires that its partners maintain and submit in a timely manner to CF, performance data based on pre-determined outcome measures. This data improves partner accountability; it allows CF and its partners to better demonstrate their worth to the community and potential funders; and it can help to inform and direct public policy concerning children's health and development.

Sustainability
Given that the vast majority of its funding comes from a single RWJF grant, CF is acutely aware of the importance of securing additional support to sustain its work long-term. CF is working to identify and cultivate new revenue streams from both public and private sources. It also is working with its partners to increase their financial capacity by, among other things, providing training and technical assistance on fiscal management and grant seeking.

Selected Outcomes
Among the outcomes reported by CF and its partners:

- CF's Pediatric Primary Care Project has resulted in a 20% increase for immunization rates and a 13% increase in lead screening rates. In addition, the 11 participating practices (which serve more than 90% of Trenton's children) all have access to or now use the NJIIS (NJ Immunization Information System) to record and report child immunization data.

- Of the children served through CF's home visitation program, 100 % have health insurance, 100% have been linked to primary care, and 93% have up-to-date immunizations.

- Graduates from CF's 12-week parenting program consistently report improved communication with their children and better understanding of their impact on children's learning. Over 2,000 residents have attended CF parenting workshops and 400 fathers have enrolled in CF's Fathers' Initiative.

- More than 7,900 new books were distributed to children and families in Trenton primary care practices (serving approximately 90% of Trenton's children) during 2007 through CF's Reach Out and Read (ROR) program. More than 50 volunteers were been recruited and trained in the ROR model to read to children in waiting rooms. And, CF's success in Trenton has been cited by the HealthCare Institute of New Jersey as the impetus for its decision to provide each of the 44 ROR sites in New Jersey with 1,000 new books for distribution to families.

- CF's technical assistance and training for child care facilities has improved the overall quality of five participating child care centers and more than 20 family day care homes in Trenton, as documented by the Harms/Clifford Infant/Toddler Environmental Rating Scale-Revised Edition and the Family Day Care Rating Scale. In 2007 more than 1000 children and 500 families have been served by CF's child care programs.

- As a result of the financial management training, organizational leaders have reported improvements in raising individual skill levels and strengthening their organizations' overall financial management capacities.

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FIRST 5 VENTURA COUNTY (CALIFORNIA)

ORIGIN OF THE INITIATIVE

First 5 California

First 5 Ventura County is part of a statewide early childhood/school readiness initiative — First 5 California — established under the California Children and Families Act of 1998 (Proposition 10) and funded through an increased tax on cigarettes and tobacco products. The intent of the Act is to facilitate the development of a comprehensive, integrated system of services and information focused on children from the prenatal period through age five, with a dual purpose of enhancing optimal early childhood development and ensuring that children are ready for school.

The Act established the California Children and Families Trust Fund as a repository in the state treasury for funds collected under the new tobacco surtaxes. Eighty percent of the funds are available for local Commissions based on each county's proportion of statewide births. Twenty percent of the revenues are allocated to the State Commission for statewide expenditures. Programs authorized by the Act are administered by the California Children and Families Commission and by the autonomous county commissions. At the local level, all California counties are eligible to receive First 5 funds, providing that the County Board of Supervisors establishes a local First 5 Commission and that other administrative and implementation requirements are met. Each county then allocates its funds based on its locally developed strategic plan and program priorities. Currently, all 58 California counties have established a First 5 Commission.

As stipulated in Proposition 10 legislation, the State Commission is charged with: (1) providing for statewide dissemination of public information and educational materials; (2) developing and adopting statewide guidelines for a comprehensive, integrated early childhood development system; (3) defining and measuring progress toward results to be achieved by the initiative; (4) identifying standards and best practices for optimal child development; (5) providing technical assistance to the counties in developing their individual strategic plans; and (6) making recommendations to the Governor and Legislature for changes in state laws, regulations and services to better support early childhood development.

Under the evaluation framework established by the First 5 California Commission in conjunction with local Commissions and the First 5 Association of California, counties report services funded in four "results areas": (1) improved child development, (2) improved child health, (3) improved family functioning, and (4) improved systems of care.

State Strategic Plan

In September 2007, the State Commission adopted a new strategic plan for 2008-2012, updating its vision, mission and goals, as follows:

- ***Vision.*** All children in California enter school ready to achieve their greatest potential.
- ***Mission:*** By 2012, be recognized as California's unequivocal voice for children 0-5 to ensure greater equity in their readiness for school.
- ***Strategic Goal Areas.*** (1) Focus on policy development. (2) Invest in program development. (3) Broaden public awareness. (4) Enhance research and evaluation. (5) Strengthen organizational operations and systems.

State Financing and Allocation of Funds
First 5 California is funded through a surtax levied on distribution of cigarettes and other tobacco products in California. The surtax on cigarettes is $0.50/pack, with an equivalent rate determined annually for other tobacco products.

As stipulated under the Act, funds collected under the new surtax are allocated as follows: 20% to the California First 5 Commission and 80% to be distributed among the County First 5 Commissions, based on each county's portion of the total births in the state (using data from the most recent reporting period).

INITIATIVE OVERVIEW

Early Development
First 5 Ventura County (F5VC) was launched in 1998, when the Board of Supervisors appointed the county's nine-member First 5 Commission. Initial planning was undertaken by a consultant, based on input from multiple sectors in the community. The first strategic plan was adopted in April 2000 and soon after, in July 2000, the Executive Director came on board.

Current Strategic Plan
The current strategic plan, covering FY2005-2010, was adopted by the Commission in October, 2005. It incorporates findings from the Commission's annual evaluation reports, targeted studies from the Commission's Center for Excellence, other lessons learned over the first five years of the initiative, and a review of nationally recognized best practices related to school readiness. (The best practices review was informed by findings from Harvard University's *Pathways Mapping Initiative.*)

Under the current strategic plan, the Commission has (1) re-focused its work to concentrate on programs with the greatest promise of return on investment, and (2) further enhanced capacity at the community level. The new plan also marks a shift in focus from initiatives to goals and outcomes, with specific outcome measures and indicators. Key elements of the plan are as follows:

- ***Goal.*** The overarching goal of First 5 Ventura County is for children to be emotionally, socially and academically ready for school.

- ***Vision.*** First 5 Ventura County envisions a future where all Ventura County children thrive in health supported environments with loving and nurturing caregivers in the home and throughout the community. This future embraces the value of active partnerships between families, service providers, civic leaders, local business and the community at-large, honors and respects the diversity of our community and prioritizes the need to ensure optimal health and development for young children and their families.

- ***Mission.*** The F5VC mission is to promote school readiness, enhance the potential for young children to engage in life-long learning and support the continuous improvement of environments critical to health and well-being of children, from birth to five years of age and their families in Ventura by creating and maintaining a community-wide effort that provides access to comprehensive, culturally competent, integrated and high quality prenatal and early childhood development services.

- ***Strategies, Outcomes, and Indicators.*** Consistent with the State Commission's guidelines and strategic plan, the Ventura County First 5 Commission has identified three broad strategy areas: Early Learning, Family Strengthening, and Health. In addition F5VC has developed a set of

related outcomes and indicators, which are used to track progress and guide funding investments. (See table below.)

Strategy Areas	Outcomes and Indicators
Early Learning	▪ Children are ready for kindergarten. o Number and % of children who have fully mastered the four results areas of the preschool-aged Desired Results Development Profile. o Number and % of families who read or tell stories regularly to their children. o Number and % of ECE providers with a B.A. or higher in child development or early childhood development. ▪ Children have access to early intervention for identified special needs. o Number and % of children entering kindergarten with reduced physical, behavioral or developmental problems.
Family Strengthening	▪ Families are nurturing and supportive of their children. o Number and % of families with improved family functioning.
Health	▪ Children have access to a regular doctor and dentist for preventive care and treatment of chronic medical conditions. o Number and % of children who have a medical & dental home for pediatric healthcare. o Number and % of children that receive dental care at regular intervals. ▪ Children have access to developmental screenings as early as possible. o Number and % of children receiving developmental screening at regular intervals beginning at birth.

- ***Best Investments:*** The FY 2005-2010 strategic plan also identifies "best investments" for achieving desired outcomes in each strategy area. These best investments have been incorporated into a broader set of program priorities for F5VC.

Strategy Areas	Best Investments/ Program Priorities
Early Learning	▪ Creating new preschool spaces including summer intensive pre-K programs. ▪ Quality enhancements to existing preschool spaces, e.g., curriculum and environmental improvements. ▪ Preschool teacher credentialing. ▪ Kindergarten transition practices — formalized communication between preschool and kindergarten teachers, universal assessment tools. ▪ Strengthening parent/caregiver ability to promote pre-academic skills from an early age, e.g. reading to children. ▪ Providing services for parents and children focused on ages 0-3, e.g., early education programs for children and parents together.
Family Strengthening	▪ Linking families to resources that are available to them and case management. ▪ Providing in-home supports for special needs populations. ▪ Mental health counseling. ▪ Parent education and classes (including reaching parents through non-traditional modes, e.g., cable television, radio, web-based programs).
Health	▪ Enrollment, retention and utilization of existing programs for health coverage (Healthy Families, Medi-Cal, Kaiser for Kids). ▪ Access to health care. ▪ Direct treatment for dental services (for children ineligible for insurance programs). ▪ Developmental screenings at regular intervals, beginning at birth.

Platforms for Implementation
The primary implementation platforms used by F5VC are the local community collaboratives known as Neighborhoods for Learning (NfL). These, in turn, deliver services via family resource centers, and health teams provided by the Ventura County Health Care Agency; and through subcontracts with local early childhood education settings, community-based organizations, and school districts. In addition, county-wide or regional services are provided via regional community organizations, county agencies, pediatric and family practice healthcare providers, dental offices and the county 211 line.

Target Population
The target population for First 5 Ventura County is all children under age six residing in the county, an estimated 68,350 children. Within this broader population, a special effort is made to reach children and families who are most at risk. As described in its County Commission Profile, F5VC "…works to ensure that funded programs are known to, relevant to, inclusive of and utilized by children whose circumstances may place them biologically, socially, or environmentally at greater risk in terms of health, development, or readiness for school." In keeping with this, the F5VC Commission has targeted some of its programs to specific high-risk groups, such as: Mixtec families who immigrated from Oaxaca, Mexico; children and families in the foster care system; and children with special needs and their parents.

In addition, within the 0-5 age group, the focus of programming has expanded somewhat over the life of the initiative: Early on, First 5 Ventura County focused on children 3-5, since they were "aging out" and also because the "best practices" for this group were more concrete. Currently, the Commission is starting to focus greater attention on 0-3 year olds and on prenatal care and support.

Program Overview
F5VC programming combines three broad elements:

- An outcome-driven, strategic framework with defined, evidence-based program priorities for the initiative as a whole.

- Within this framework, decentralized local governance, program development, and implementation with strong central office support for local capacity building.

- Additional services, supports, and capacity-building, funded and delivered at the county or regional level. This approach is used when it is deemed to be more effective or cost-effective.

Anchor Programming

- ***Local Programming—Neighborhoods for Learning.*** At the core of F5VC programming is the Commission's strong commitment to local decision-making, community engagement and parent/family empowerment. Starting in 2000, the Commission brought these concepts into play via geographically-defined, community collaboratives called Neighborhoods for Learning (NfLs), a signature component of the initiative.

  Under the Neighborhoods for Learning framework, the Commission allocated funds to local communities, challenged them to develop community collaboratives and their own strategic plans (consistent with the F5VC plan), and provided resources and support for the planning process (including in-person assistance from facilitators, funded through the Packard Foundation, and a written planning guide from UCLA's Center for Healthier Children, Families, and Communities). School superintendents were among the early champions of First 5 at the community level and were active in NfL planning. Today, school districts hold nine of the eleven contracts for NfL

administration. In most cases, the NfL then subcontracts with other community agencies for local services, from preschools to management of the family resource centers.

Currently, each NfL serves as an umbrella for three core program components, which track with F5VC's three strategy areas. While each core component is described separately below, in reality these services and activities overlap to form an integrated set of services and programs for Ventura County children and their families.

- *Early Education Enhancements (Early Learning Services)*: Each NfL has developed community-tailored strategies designed to increase the proportion of young children participating in quality pre-school environments. Among the NfL strategies are: funding for new preschool spaces; provision of tuition scholarships and sliding scale fees to promote access to existing programs; the development of "mobile early learning activities"; intensive pre-K summer programs, family literacy and early education for children 0-3 and their parents; kindergarten transition services both for parents and schools; and early intervention in preschool settings for children with identified social/emotional behavioral issues.

- *Family Resource Centers (Family Strengthening)*: The majority of the NfLs support one or more family resource center (FRC), located on-site or at an NfL satellite. Currently, a total of 18 FRCs serve as one-stop service centers for families seeking parenting information, education, and support; early childhood learning activities; developmental screening; linkage to health and social services; and service coordination.

- *Multi-disciplinary Health Teams (Health):* Multi-disciplinary teams of health professionals are the newest addition to NfL programming. Through strategic partnerships developed and leveraged by F5VC, multi-disciplinary teams of public health nurses (from the County Public Health Department) and mental health professionals and social workers (from the County Department of Behavioral Health and community-based organizations) are assigned to each NfL. Together with the local staff at the NfLs, they work to foster parental resiliency, social connection, knowledge of parenting, and child development. By funding the health teams, F5VC has increased capacity at the 11 NfLs to provide developmental screening and follow-up, case management through home visitation, and mental health services across the county. In addition, oversight of the health teams by the centralized County Health Care Agency provides a means for assuring quality and consistency with professional standards of care.

- ***County-wide and Regional Programming:*** In addition to local programming falling under the NfL umbrella, F5VC also funds county-wide or regional strategies, through targeted contracts. These contracts focus on linkage to existing services, gap-filling services, capacity building for providers, systems integration and systems change. In general, these efforts supplement, enhance, support and link to local services. In addition, the Commission has used its targeted funds to address several key health and developmental conditions: oral health issues; obesity; developmental delays; sensory issues; autism; behavioral and mental health issues; and other special health needs. Examples of county/regional programming include:

  - *County referral line.* The county-wide 211 information and referral line answers requests for health and human services referrals and also provides information on and referrals to local NfLs. F5VC partners with United Way in supporting the 211 line, run by Interface Children Family Services, a countywide social service organization. The 211 line has also become an important resource for staff in the local Family Resource Centers who are assisting families in accessing and coordinating services.

- *Links to health coverage and care.* The Health Outreach Program (HOPE) provides Certified Application Assistant training, technical assistance, and direct services to help county residents obtain, use and retain health coverage for which they are eligible. F5VC funding for HOPE is used to: train local NfL staff, and to place HOPE application assistants onsite in the NfLs. F5VC also funds core staff for the HOPE home office.

- *Special needs capacity building* for *ECE providers.* F5VC has provided support for Easter Seals to develop and implement an in-depth, in-service training and on-site support program aimed at helping ECE providers effectively include special needs children in their classrooms.

- *Developmental care capacity-building for pediatric and family practice healthcare providers.* F5VC is piloting a "breakthrough collaborative" type training for pediatric health care providers aimed at improving developmental surveillance, screening, assessment and referrals.

- *Oral health collaborative.* This program brings oral health outreach, education, prevention and treatment services directly to children in Ventura County communities. In addition, it includes provider education for dentists and physicians, to increase early referrals for oral health care and to enhance the willingness of dentists to provide services for young children. Thus far, the program has trained physicians in the county's five public health department ambulatory care clinics to: routinely check babies' teeth and gums, apply fluoride dental varnish for very young children, and educate parents about oral health during well child visits. It is anticipated that this training will be expanded to pediatric primary care providers in the private sector, as well. In addition, the program offers technical assistance on how to become a provider under Denti-Cal, and under private insurance.

- *Early literacy promotion through pediatric health care providers.* F5VC funds local implementation of the national Reach Out and Read program, which engages pediatric healthcare providers in promoting early literacy. Through the program, pediatricians and family practice physicians prescribe and hand out books at well-child visits. In addition, pediatric care waiting rooms are stocked with early literacy materials. This program helps to integrate health and early literacy within the county.

- *Support services for foster families.* The Commission also provides funds to foster care families for respite care and subsidized childcare. These funds are provided as an incentive for families to become and continue as foster families.

- *Outreach to parents and physicians.* Using the Website and other resource materials from the national Born Leaning Campaign, F5VC reaches out to parents who can't or wouldn't necessarily visit NfL/FRC sites, and enlists physicians and community businesses to help. Many of these parents don't need the intensity of services provided at NfLs but are looking for trusted resources for information. The campaign provides parent-friendly information and resources on how to promote healthy development in early childhood. F5VC partners with the local United Way in this effort, and uses AmeriCorps volunteers to disseminate parent education materials to physician's offices.

- *Enhanced education and training for childcare providers.* F5VC supports quality improvement for early childhood education through CARES, a priority initiative promoted by First 5 California. Under CARES (Comprehensive Approaches for Raising Educational

Standards), early childhood educators are awarded training and education stipends, resulting in an increase in ECE providers with licenses/permits, AA degrees and BA degrees.

- *Universal preschool.* Ventura is one of nine counties in California selected by First 5 California for a five-year, Preschool for All demonstration project. The project is currently focused on one school district in the county.

Staffing and Administration

First 5 Ventura County was established by the Ventura County Board of Supervisors as an independent public entity. Currently the initiative directly employs 12 central office staff.

Financing and Allocation of Funds

Financing. The primary source of funds for First 5 Ventura County is the state surtax on tobacco products. Ventura County's share of these funds is approximately $10 million per year. The initiative also receives additional funding for its work through both public and private sector sources, including grants from the Packard Foundation and federal funds through the ELOA (Early Learning Opportunities Act). In addition, First 5 Ventura County leverages federal dollars from Title V (MCH Block Grant); Title IV-A (foster care funds); and EPSDT/Medicaid (for behavioral health services).[13]

Allocation of Funds. Approximately 60 % of F5VC funds are allocated to NfLs for locally-driven programming; the remaining 40% of funds are used for Commission-driven programming (this includes funds allocated by the Commission to support on-site health professional teams at each NfL).

F5VC uses a formula that balances population and needs-based considerations to award funds to the 11 geographically-based Neighborhoods for Learning. Of the NfL funds, one-third are allocated based on population, one-third on socioeconomic measures (using school lunch eligibility and the percentage of children in poverty as markers) and one-third on school performance (using test scores as a marker).

Across the three strategy areas, the Commission has targeted 53% of available program funds for early learning, and 47% of funds for family strengthening and health combined. The Commission has a targeted cap on administrative expenditures of 5.5% of the total operating budget.

Data, Evaluation and Accountability

In keeping with First 5 California, F5VC has implemented a results-based evaluation system using Grant Evaluation and Management Solution (GEMS) data collection software. The GEMS system includes data on participants, services and outcomes, allowing for program level performance monitoring and evaluation. Using GEMS, funded "partners" can both enter their own program data and track program performance. GEMS collects both individual and group data on: participant socio-demographic characteristics, services, satisfaction, outcomes, and service systems. The data system provides information for process and impact evaluations and allows for analysis of trends over time.

Annual evaluations of F5VC are conducted by an external evaluator. The Commission also periodically conducts special studies to assess the costs and benefits of potential programming and to review best and promising practices. Concurrently, the Commission focuses on continuous quality improvement of programs, provider skills, organizational expertise and workforce capacity.

[13] Title V funds for Public Health Nurses placed in NfLs are leveraged at a rate of $0.50/$1.00 of F5VC funding. EPSDT/Medi-Cal funds are leveraged at a rate of $0.95/$1.00 in F5VC funds. Medi-Cal pays for social worker/mental health consultations to provide assessment and treatment to Medi-Cal eligible children at NfLs, with some of these services occurring in a preschool setting.

Sustainability
F5VC has developed an endowment fund as a means of moving toward long-term program sustainability and financial stability. At the same time, the F5VC Commission continues to use national evidence reviews as well as data from its own initiatives to carefully weigh programming decisions so that it can obtain the best impact and outcomes from its program investments. The Commission has also developed a self-assessment tool to be used by the Commission and its funded partners to develop sustainability plans for specific strategies.

Selected Health and Developmental Outcomes
First 5 Ventura County reports the following health-related outcomes in its *First 5 Ventura Annual Evaluation Report, Fiscal Year 2006-07*: [Slay, et al.]

- Through F5VC-funded programming, a total of 1,384 children received assistance in obtaining health insurance.
- After receiving F5VC-funded services, a significantly greater percentage of NfL members reported that they knew how to provide a healthy and nutritious diet for their young children.
- Over 270 children received oral health services through F5VC program efforts.
- Emotional and behavioral health services supported by F5VC, provided in both home and pre-school environments, helped to support the emotional development of more than 335 children who were identified as having difficulties in early learning environments.
- Evaluation findings suggest that F5VC- funded developmental services provided in pre-school-based settings resulted in improved social skills and decreased problem behaviors for children who received that service.
- The most common early learning services provided to children through F5VC include preschool (n=1,032) and summer intensive preschool (n=793). Pre-/post-service comparisons using the DRDP-R for preschool and Mini-DRDP for summer intensive preschool demonstrated that children improved in all areas of development (as measured by these instruments) after receipt of F5VC services.
- Over 1400 family members participated in F5VC family literacy activities in 2006-07. Based on outcome data, families with lower levels of literacy activities prior to using these services, reported substantial increases in the number of days per week they participate in such activities with their young child.

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HELP ME GROW/CHILDSERV (CONNECTICUT)

ORIGIN OF THE INITIATIVE

Help Me Grow, Connecticut's statewide, coordinated system for early identification and referral of children at risk for developmental or behavioral problems, began as an innovative community-based program in the city of Hartford known as ChildServ.

Launched in 1988 with support from the Hartford Foundation for Public Giving (Hartford Foundation), ChildServ was developed in response to concerns among local health organizations, child health providers, advocacy organizations and parents that despite numerous community resources, Hartford's children were too often entering school without the necessary emotional, behavioral or developmental skills for school success. Moreover, although reports indicated that nearly a quarter of Hartford's kindergarteners had emotional, behavioral or developmental issues, for most, these issues were neither identified nor addressed prior to school entry.

Recognizing the importance of early detection and intervention to a child's healthy growth and development, ChildServ's creators sought to establish an effective system for linking children and families to existing services and supports in the Hartford community. These linkages were intended to help children and families with intensive medical, behavioral or mental health intervention needs, as well as those children and families with less severe needs. It was believed that both groups could benefit from community-based services such as parent support, child care, or home visiting; and for some children and families, these services would be enough to avoid ever needing "high end" care, thereby allowing reallocation of more intensive services to children with the greatest needs.

In addition to establishing new linkages between existing services and supports for young children and their families, another key idea behind ChildServ was helping Hartford's primary care providers change their office practices to routinely screen for developmental and behavioral issues. This focus was based on the understanding that a very high percentage of the youngest children receive well child care from pediatricians, and therefore pediatric primary care provides an opportunity for nearly universal screening and surveillance in early childhood. ChildServ's creators understood that many physicians may be reluctant to screen without a ready resource for follow-up intervention. By combining physician-directed training and education efforts and new, coordinated linkage system, ChildServ was able to overcome much of the resistance that has hampered other referral and linkage efforts.

Under the ChildServ model, providers who had identified an individual child with possible developmental or behavioral delays were encouraged to contact a centralized triage, referral and case management system staffed by trained professionals, or Care Coordinators, and available through a toll-free telephone line. The Care Coordinators would then work with the individual child's family to identify and facilitate appropriate referrals based on identified needs and resources. After an appropriate period of time, the Care Coordinators would contact the family to ensure that needed services were obtained and report back to the referring provider on case outcomes.

In 2002, after four years of effectively serving and advocating for young children and families in the Hartford community, ChildServ's creators were successful in securing funds from the state legislature to expand the program statewide. The new effort, renamed Help Me Grow, was placed under the authority of the Children's Trust Fund, an independent state agency with the dual mission of preventing child abuse and neglect and establishing resources in communities statewide to support and strengthen families and ensure the positive growth and development of children. Today, Help Me Grow is administered by the Trust Fund in collaboration with the United Way of Connecticut/211 Information Line, the Connecticut

Department of Disabilities' Birth to Three System, the State Department of Education's Preschool Special Education Program, and the State Department of Public Health's Children and Youth with special Health Care Needs (CYSHCN) program.

Current Strategic Plan
Help Me Grow's stated purpose is as follows:

- ***Purpose.*** To identify children at risk for developmental or behavioral problems and to connect these children to existing community resources.

As a state-funded initiative, Help Me Grow participates in Connecticut's results-based-accountability (RBA) system, working toward the following result:

- ***Quality of Life Result.*** Young children in the State of Connecticut will be healthy and ready to learn.

Help Me Grow is directed by the following guiding assumptions and goals, consistent with the early principles of ChildServ:

- ***Guiding Assumptions***
  - Children with developmental or behavioral problems may be falling through cracks or eluding early detection.
  - The challenge is forming the connections to programs and services.
  - Children and families benefit from a coordinated, statewide system of early detection and intervention for children at risk.

- ***Goals***
  - To train child health providers, child care providers and parents on effective developmental and behavioral surveillance and monitoring; and
  - To assist families and providers in identifying developmental concerns, finding appropriate resources and helping families connect with programs and services.

Target Population
Although Help Me Grow services are available to children of all ages living in the state, the primary target population for Help Me Grow is Connecticut children aged 0-8 years and their families, with a focus on children for whom there are questions or concerns about their development or behavior. Additional populations served by Help Me Grow include child health, childcare and other service providers who receive training and materials, as well as policymakers and other stakeholders who receive data on the health and development of children in their communities and statewide.

Platforms for Implementation
Help Me Grow uses two main platforms of implementation. For its provider education and training, as well as community education and outreach, Help Me Grow uses regionally-based staff, who travel to provider offices and community events and host networking breakfasts that include community agencies in their respective regions of the state. And, for its telephone triage, referral and case management system, the program contracts with the United Way of Connecticut/211 Infoline for physical space and telephone support which includes telephone care coordination.

Program Overview
Help Me Grow is a comprehensive, cross-sector system for early identification, referral/linkage, case management, training, and support that promotes and coordinates developmental care throughout the state

of Connecticut. Parents, pediatricians, childcare providers, teachers, and other community service providers are given information and training on healthy development, how to recognize the early signs of developmental problems, and how to contact Help Me Grow when they have a concern or need assistance. Children who are facing difficulties are then connected to community resources and local programs.

A toll-free telephone number serves as a statewide single entry point for Help Me Grow services and support. Callers to Help Me Grow are screened by professionally trained Care Coordinators who triage, refer and provide care management for children and their families. Help Me Grow's Primary Prevention Services Coordinators cultivate relationships with community providers and agencies, further enhancing the network of resources available to the children and families Help Me Grow serves.

Key program components include:

- An electronic resource inventory of community-based programs supporting child development and families.
- A coordinated, statewide system of triage, referral and case management that links young children and families to existing services and support.
- Office-based training and tools for child health providers in effective developmental and behavioral surveillance and monitoring.
- Information, tools and support for parents, childcare providers, and others who work with children to help them understand and promote early childhood development and to enlist their assistance in monitoring and identifying children with developmental risks.
- Networking, information, and joint problem solving opportunities for community service organizations working with young children and families.
- The collection and analysis of data concerning children's developmental status and statewide resources.

Anchor Programming

Building on the successful structure of ChildServ, Help Me Grow's anchor programs consist of three, interrelated efforts to improve the early identification and resolution of suspected developmental and behavioral issues in young children. In particular, these efforts include:

- ***Healthcare Provider Education and Training.*** A chief strategy of Help Me Grow is to effectively reach out to community child health providers, offering education, training, and practical tools for conducting developmental surveillance and screening via the Educating Practices in the Community (EPIC) model. The training, coupled with Help Me Grow's centralized referral system, is designed to eliminate frequently cited barriers to developmental surveillance and to change provider practice so that children's developmental needs are met at the earliest possible age. Through follow-up after referrals are made, Help Me Grow ensures that health providers are informed about evaluations and recommended services, a communication that enhances the role of the health care provider.

  Help Me Grow's training and education program highlights the use of the Ages-and-Stages (ASQ) Monitoring System and the Parents' Evaluation of Development Status (PEDS) — a three to five minute validated screening instrument for detecting developmental delay, which is filled out by the parent, often while in the waiting room. Each practice receives a Child Development Tool Kit, including information on the PEDS, brochures on Help Me Grow, and the ASQ. The family can sign up for the ASQ and give consent for the results to be sent to the primary health provider. Help Me Grow also uses a "tool box" that allows practices to store all developmental

surveillance materials in one place in the office, and is easily integrated with other health supervision materials (e.g., immunization consent forms, safety handouts, and growth charts).

Finally, the education and training also includes information and material designed to help encourage parents to use ASQ developmental screening at home. For example, the Help Me Grow program has distributed "Ages & Stages Child Development Kits" to all pediatric practices statewide in an effort to promote universal monitoring of development by parents that begins at the earliest age possible.

- ***United Way 211/Child Development Infoline.*** Help Me Grow's Child Development Infoline (CDI) is a toll-free telephone line that serves as a single point of entry for Help Me Grow services and support statewide. The CDI number is available for parents, health care providers, childcare workers, and social service agencies who are concerned about a child's development or behavior. When providers or families call the CDI they are asked a series of questions that help the Care Coordinator make an appropriate referral. The Care Coordinators use developmental checklists to help determine if it is appropriate to refer the child for a Birth to Three assessment, Help Me Grow, or preschool special needs programs. The Care Coordinators' ongoing training addresses how to interview and build a relationship with callers, ask for appropriate clarification, use active listening skills, educate callers on how the system works, summarize what has happened during the call, and clarify follow-up program and referral needs.

  If, after initial assessment, the child does not meet the criteria for state programs such as Birth to Three, Pre-School Special Education, or Children & Youth with Special Health Care Needs, the family becomes part of the Help Me Grow system. Together with Help Me Grow's Prevention Specialists, the Care Coordinator research existing resources or services for the family and facilitate appropriate referrals.

  Through this process, Help Me Grow is able to connect children to existing resources such as primary and specialty medical care, early childhood education, developmental disability services, mental health services, family and social support, and child advocacy providers. In addition to their triage and referral work, the Care Coordinators contact the family approximately two weeks after the referral is made to see if they were able to access services. With parental permission, the Care Coordinators also send a letter to the child health provider to let them know when a family has been connected with a community-based resource. These letters are designed to be included in the medical record in order to prompt discussion with parents regarding development, concerns, and needed services at their next office visit.

  The CDI is available Monday-Friday from 8am-6pm. Several of the staff are Spanish speaking, and the system can communicate with TTY users.

- ***Community Outreach, Education, Support and Networking.*** For Help Me Grow to be effective, it must have strong connections with the multiple community-based services and supports across the state. As such, it employs three Primary Prevention Services Coordinators to serve as the conduit between CDI and the community. Among the Prevention Specialists' tasks: identify new resources to be added to Help Me Grow's computerized inventory; provide trainings and information on Help Me Grow to a range of programs serving children in the State; and facilitate networking partnerships among community-based providers, services, supports and agencies.

  One of the most innovative ways the Primary Prevention Services Coordinators facilitate these partnerships is through Help Me Grow's regional Networking Breakfasts. Held monthly in each of the three regions, these breakfasts bring together providers and other program partners to:

share information and to develop solutions to challenging cases; widen their connections to a broader group of service providers; and collaborate to better support each other's organizations. In addition, the breakfasts help identify broader service system gaps. Discussion topics, which are generated by networking participants, focus on current issues of concern to families, new or changing community resources, and broader policy issues such as updates on immigration and special education laws. As an example of the popularity of these breakfasts, in the Hartford region alone, over seventy community-based programs and resources have been represented at the breakfasts.

Lastly, the Primary Prevention Services Coordinators conduct formal presentations on such issues as the Help Me Grow system, the ASQ Developmental Monitoring Program, and current health topics for child health care providers, other professionals in child care, domestic violence shelters, homeless shelters and social service agencies.

New Initiatives

In addition to these three core programs, Help Me Grow continues to evolve, expanding its own services, as well as playing a key role in the development of other local, state and national efforts to improve developmental trajectories for young children. Examples include:

- ***Connecting with Hard-to-Reach Families.*** With support from the Kellogg Foundation, Help Me Grow has partnered with the Maternity and Infant Outreach Program (MIOP), a community-based agency located in Hartford, in order to explore ways to more successfully connect with hard-to-reach families (defined as families who do not have telephones, require in-home assessment, or present complex needs). Under this project, participating families will either be referred to Help Me Grow by their pediatrician or other provider or will already be part of the MIOP client population identified via community outreach services. As with other Help Me Grow program components, training for this effort will be provided to pediatric and other providers on developmental monitoring, as well as accessing services through the CDI.

- ***Hartford Blueprint for Young Children.*** In 2004, Hartford Mayor Eddie Perez launched a new initiative to strengthen early childhood policy and services in Hartford. Specifically, he sought to develop a five-year "Blueprint for Young Children" that would unite diverse programs and services in the City of Hartford and meld them into a cohesive coordinated, family-centered system that focuses public policymaking and financial investment to improve the lives of young children (aged birth to eight years). Recommendations identified in the Blueprint included:

  - Articulating six building blocks — (1) Newborn Screening & Home Visiting For Families, (2) Neighborhood-Based Family Supports and Development, (3) Childcare And Early Childhood Education, (4) Transition From Pre-school To Kindergarten, (5) Educational Excellence and School Success In Early Grades, and (6) Universal Access And Use Of Primary Health Care — to form a comprehensive framework to advocate and deliver services to young children and their families;
  - Creating a Mayor's Cabinet and an Office For Young Children;
  - Consolidating a variety of existing city government and school services for young children;
  - Establishing targets for 26 short and long-term strategic actions; and
  - Building and strengthen practices that engage parents, families and other adults.

  Many of those closely involved with the early launch of ChildServ, and the subsequent statewide expansion of the program as Help Me Grow, were involved with the development this Blueprint and continue to participate in the Mayor's Cabinet. Moreover, many of the key concepts

associated with Help Me Grow/ChildServ helped to influence the Blueprint, as well as the on-going efforts in support of the Mayor's goals.

- ***Connecticut System for Young Children's Healthy Development.*** Help Me Grow is a key component of a new statewide system in Connecticut that aims to support young children's healthy development through early care and education, family support, and child health services. The key focus of this new system lies in strengthening care coordination and outreach, an essential element promoted by Help Me Grow. Several of the individuals involved with the development of Childserv and Help Me Grow have been actively involved with the state's efforts.

- ***National Dissemination.*** With support from The Commonwealth Fund, Help Me Grow will be working with five jurisdictions from the around the country to create similar systems of centralized care coordination for child development services. As part of this effort, Help Me Grow will provide hands-on technical assistance to the various sites. Help Me Grow also will create and revise existing program resources for a more national audience.

Administration and Staffing

Help Me Grow is administered by the Children's Trust Fund, an independent agency within the state government of Connecticut. Its core staff includes one program supervisor and three Primary Prevention Services Coordinators. Additionally, the Trust Fund contracts with the United Way of Connecticut/211 Infoline for its CDI services. There are currently six Care Coordinators at the United Way assigned to the CDI unit.

Financing and Allocation of Funds

As ChildServ, the pilot project received an $18,000 planning grant, a three-year project grant of $455,000, and a one-year continuation grant of $50,000 from the Hartford Foundation. In 2002, the project received a two-year $900,000 appropriation from the state government in order to expand statewide. The legislature has continued to provide the bulk of Help Me Grow's funding since its expansion. Help Me Grow's annual budget for 2007 was $580,000, including $537,000 from state sources and $43,000 from federal grants.

Data, Evaluation and Accountability

Help Me Grow has an electronic data collection and reporting system that is part of the CDI triage, referral and linkage system. In addition to keeping track of individual children and their families, this system provides aggregate data on the number of calls received, reason for the calls, referrals made, number of calls made to assure linkage, and more.

In addition, over the years various ChildServ/Help Me Grow evaluations have been conducted with funding and assistance from private foundations such as the Hartford Foundation and the Commonwealth Fund. One such study involved working with participating primary care practices to conduct 1,000 chart reviews, looking for changes in developmental surveillance practices. Results have been published in several program reports and journal articles.

Finally, as a state-funded initiative, Help Me Grow reports to the state legislature using a Results Based Accountability (RBA) approach. Individualized performance measures for Help Me Grow include: "How much did Help Me Grow do?" (i.e., program utilization and related data); "How well is Help Me Grow doing?" (i.e., family referrals for services and community outreach efforts); and "Is anyone better off as a result of utilizing Help Me Grow?" (i.e., outcomes and final disposition of cases). A separate set of performance measures was also developed to assess utilization of the ASQ Monitoring Program. As required, Help Me Grow files annual RBA reports to the legislature as part of its budgeting process.

Sustainability

Because Help Me Grow is dependent on state funding, it is essential that the program and its supporters be able to demonstrate its value to Connecticut's children and families. To date, this has been done through the RBA process and through the vocal support of program advocates — and in particular, pediatrician advocates — to local and state policymakers. It is anticipated that state support for Help Me Grow will continue, although changing budget environments at the state level may influence long-term growth and sustainability.

Outcomes

- *How much did Help Me Grow Do?* Nearly 2,750 calls were made to Help Me Grow in 2006-2007, a 16% increase over the previous year. Of these calls, the majority were made by parents and guardians (63%), followed by pediatricians (17%). The remaining 26% was equally distributed between social service agencies, child care providers, relatives and friends, and the Department of Children and Families.

- *How well is Help Me Grow doing?* Help Me Grow made over 3,100 referrals to existing community-based services, supports and programs in 2006-2007, a 60% increase since mid-year 2006. The top five program referrals included: Preschool Special Education, the ASQ Monitoring Program, the CDI (i.e., basic needs), disability-related services, and parent education.

- *Is anyone better off as a result of utilizing Help Me Grow?* Eighty-six percent of families referred to Help Me Grow in 2006-2007 were connected to services and/or support, up from 81% in 2005-2006. An additional 7.5% of families were awaiting pending services and/or supports, a slight decrease over the previous year.

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OPPORTUNITY KNOCKS (Middletown, CT)

ORIGIN OF THE INITIATIVE

The convergence of two collaborative efforts laid the groundwork for Opportunity Knocks (OK), a Middletown, Connecticut initiative focused on healthy development in young children.

- At the state level, in early 2003, four Connecticut foundations — the Connecticut Health Foundation, the Children's Fund of Connecticut, the Greater New Haven Community Foundation, and William Caspar Graustein Memorial Fund — joined together as a Funders' Collaborative to support a new *Early Health and Learning Initiative* with the goal of improving the health of Connecticut children from birth through eight years old. To further enhance impact, the Funders' Collaborative targeted its RFP to 50 high-need Connecticut communities already receiving grants through the Graustein Memorial Fund's *Discovery Initiative*, which focuses on enhancing early childhood education (ECE); building stronger ties between ECE and elementary education; and improving students' social, emotional and academic performance. Under the new initiative, the Discovery communities were invited to apply for a planning grant to develop a community initiative that would integrate a health agenda into early childhood programs, including access to health services and education, for young children and their families. In writing their proposals, Communities were asked to: (1) target systemic approaches; (2) address health as broadly defined, to include physical, oral, cognitive and social-emotional health; and (3) address racial and ethnic disparities as well as cultural and ethnic priorities and concerns.

- At the local level, the initiative owes its origins to three community leaders — Cliff O'Callahan, Pediatric Faculty of the Family Practice Residency Program at Middlesex Hospital; Christine Fahey, Middletown School Readiness Coordinator; and Dona Hoff, then Supervisor of the Family Advocacy Program at Middlesex Hospital — who found themselves serving together on several area advisory committees focused on the needs of young children and their families. As the same issues were raised across various advisory committee meetings, the three recognized that it made more sense to address these needs collaboratively and across sectors. The Funder's Collaborative RFP provided the opportunity that O'Callahan, Fahey and Hoff needed to collaboratively address the health and developmental needs of young children in Middletown. Together they submitted a proposal to obtain a planning grant for Opportunity Knocks. They also enlisted Middlesex United Way as an initial "funding match" partner, a collaboration that has continued through the life of the initiative.

INITIATIVE OVERVIEW

Early Development

In July 2003, Middletown's "Opportunity Knocks" proposal was one of three community-based proposals receiving a one-year planning grant under the *Early Health and Learning Initiative*. Within a few months of receiving the initial planning grant, the principals involved in preparing the proposal hired a part-time program planner, who guided the development of the initial strategic plan. In September 2004, following successful completion of a promising strategic plan, Opportunity Knocks was awarded a three-year implementation grant for $100,000 per year, with the requirement that the initiative obtain a $25,000 local match. The original program planner became the Program Planner for the initiative, and continues to serve in this capacity today.

In its planning proposal, Opportunity Knocks chose to focus on three broad health areas: oral health, physical activity-nutrition, and social-emotional health (later expanded to include behavioral health). Initially OK identified cultural sensitivity and barrier reduction as a separate focus area, but eventually these were integrated into activities related to the three health focus areas.

From the start, planning for OK has been a cross-disciplinary, collaborative effort that has included representatives from the local hospital, the School Readiness program, mental health, the United Way and parents, among others. This working collaborative approached each health focus area by systematically: (1) assessing community needs, (2) identifying pertinent research/evidence on which to base interventions, (3) identifying proven or promising intervention strategies/programs, and (4) planning and implementing a multi-disciplinary set of interventions based on findings.

In addition, from the beginning the collaborative has built its programs on three basic tenets, which have remained in place for the four years that Opportunity Knocks has been in existence:

- Intervention in early life periods, when there is greater receptiveness to change and when the impact on developmental trajectories is the greatest.

- Development of a multidisciplinary model of consultation and education to help providers modify their behavior in the arenas of screening, teaching and early intervention, with the underlying assumption that these changes will lead parents to modify their behavior, as well.

- Systems change.

Today, strategic planning for OK is undertaken collaboratively with Middletown's School Readiness Council (SRC) and is guided by a cross-collaborative Steering Committee, which includes the OK Steering Committee and one additional representative from the SRC.

Strategic Plan

The current OK strategic plan includes the following components:

- ***Mission.*** To improve the health of the children and families we serve.

- ***Vision.*** Children enter kindergarten physically and emotionally healthy and ready to succeed.

- ***Community System Goal.*** To strengthen the links between health services and early care and education.

- ***Community System Objectives***

    - Craft a sustainable multidisciplinary consultation and referral system that helps early care educators and health providers promote more effective practices in the areas of pediatric oral health, nutrition and obesity, and social and emotional health.

    - Increase access to care in these same areas for children birth through five and their families.

- ***Long Term Goals for Healthy Development***

  - ***Nutrition/Physical Activity - Obesity Prevention.*** Better nutrition and higher levels of physical activity both at home and in preschools; improved access to obesity management care and nutrition counseling.

  - ***Oral Health.*** Better dental health as a result of better dental hygiene; lower prevalence of dental disease; improved access to routine dental care and treatment.

  - ***Social and Emotional Health.*** No child is expelled or suspended from his or her preschool as a strategy for managing children with challenging behavior; fewer children with behavioral health problems; improved access to behavioral health care.

- ***Outcomes and Indicators.*** The Opportunity Knocks Outcome Logic Model, 2007-2008 delineates "shorter term" and "longer term" outcomes and indicators. Outcomes are organized around three broad sets of program activities: (1) Access to care: Consultation and Services; (2) Training and Education; and (3) Quality: Indicators fall into two categories — (1) Child and Individual and (2) Systems.

Shorter Term Outcomes and Indicators	
Outcomes	**Indicators**
Access to Care: Consultation and Services. (1) A system of SE, OH and nutrition consultation and service is in place for health and education providers. (2) Improved access to SE, OH and nutrition services for children. (3)Decreased preschool expulsions and shortened days. (4) Decreased active tooth decay for preschool children. ***Training and Education.*** (1) A system is in place to enhance training and education in SE, OH and nutrition, to promote more effective health care practices for children. (2) Increased Provider/community knowledge. ***Quality Management.*** (1) Data-driven decision making occurs regularly. (2) Maintained parent representation. (3)Increased representation of under-represented groups.	***Child and Individual Indicators.*** (1) Increase the # and % of children in preschool programs receiving dental care. (2) Decrease in the # and % of children who are expelled from preschool or put on reduced-day schedules due to behavioral problems. (3) Increase in the # of parents and members of under-represented groups recruited. ***System Indicators.*** (1) # of dental hygiene and restorative services. (2) # of SE consultations for preschool teachers. (3) #of SE consultations to children and families. (4) # of nutrition consultations and policies developed. (5) # of trainings in each focus area. (6) # of documented decisions based on process evaluation and consultant logs. (7) Gains in pre-post test scores of knowledge. (8) Evaluation/satisfaction questionnaires of trainings.

Longer Term Outcomes and Indicators	
Outcomes	**Indicators**
Access to Care: Consultation and Services. (1) Increased, comprehensive, and coordinated health care access is available to children. (2) Increased community capacity to work collaboratively resulting in improved access to health care for children. ***Training and Education.*** (1) Routine and systematic training of providers in selected curricula and assessments. (2) Increased provider and community knowledge to promote more effective health care practice for children. ***Quality Management.*** Increased community capacity for a replicable CQI system.	***Child and Individual Indicators.*** (1)Utilization of service delivery by children and families evidenced by consultant logs. ***System Indicators*** (1) Expansion of service delivery models throughout Middlesex County evidenced by attendance forms, consultant logs, and verbal and written reports. (2) Increase in the number of health and education providers working collaboratively to increase access to health care evidenced by meeting minutes and logs. (3) Number and frequency of trainings in each focus area. (4) Gains in knowledge from pre- to post-intervention test scores. (5)Reports of expansion of process evaluation .

Target Population

The target population for Opportunity Knocks is children 0-5 living in the town of Middletown, Connecticut. While the primary focus is on children through age five, the initiative uses an age cut-off of seven years, to assure all children are reached prior to starting school. Opportunity Knocks also targets all providers serving Middletown's young children.

The extent to which OK focuses on universal need versus vulnerable populations varies by component, for example: The behavioral/developmental screening and healthy living components of OK are targeted to all Middletown children through age seven. The mental health component focuses on low-income children (i.e., Medicaid and non-insured); and OK's oral health services (through the Miles of Smiles program) focus on low income, uninsured children.

The initiative has also identified an "impact population" of approximately 1,500 children enrolled in the city's nine state and federally subsidized preschool programs, and three community programs, which together serve the majority of low-income and ethnically diverse families in the area.

While the initial target population resides in the town of Middletown, the initiative has started to extend its oral health and behavioral components county-wide and is expanding statewide with its obesity prevention learning collaborative.

Platforms for Implementation

Primary platforms for implementation include: health care practices (e.g., primary care pediatric practices, dental care practices, community health centers); early care and education settings (e.g., School Readiness, Head Start, and other center-based early care and education providers); and other community service providers (e.g., Middlesex Hospital and its Family Advocacy Program, WIC supplemental food program, Visiting Nurses Association, and Department of Children and Families).

Program Overview

Opportunity Knocks seeks to optimize the health and development of young children in Middlesex, Connecticut through program efforts focused on three aspects of health:

- Nutrition-physical activity/obesity prevention (note this is at times referred to as the "wellness" component).
- Oral health.
- Social-emotional/ behavioral health.

Interwoven with the focus on health is a focus on cultural sensitivity and the elimination of barriers to care.

OK uses a "basic building blocks" approach — that is, a consistent set of strategies across settings and services — to address each health focus area. These include:

- Simple, consistent, cross-sector health promotion messaging (for children, parents, and providers).
- Early screening and identification of health issues.
- Training, education and consultation support for ECE and pediatric healthcare providers.
- Improved access to existing services/care.
- New gap-filling services.
- Efforts to improve financing and reimbursement policies to better serve young children.

By using the same "building block" strategies focused on a core set of service systems, Opportunity Knocks achieves systems integration and systems change. At the same time, specific activities and messages are tailored to best address each health topic.

Anchor Programming

There are three sets of anchor programs within Opportunity Knocks, one for each health focus area. While broad strategies are the same across health topics, specific program activities are built around the community needs assessment and the research/evidence base related to each topic. Key program activities for each of the health focus areas are as follows:

- ***Oral Health Program.*** The Opportunity Knocks oral health program is called the *Middlesex County Miles of Smiles Mobile Dental Program*. Based in part on a model developed in Southeastern Connecticut, the Miles of Smiles program is managed by the Middletown Community Health Center (CHC), with oversight jointly provided by the CHC and Opportunity Knocks. Key program activities include:

  - *Free, on-site dental hygienist screening, cleaning and education for children at early care and education centers, schools, and WIC offices (pregnant women included at WIC sites).* This was accomplished through the creation and funding of a roving dental hygienist position.

  - *Dental care referral and linkage services for children, including assistance with finding a dentist and making a dental appointment.*

  - *Assistance with accessing dental insurance for children through HUSKY, the state's healthcare program for uninsured children and youth*. (HUSKY A is Medicaid; HUSKY B is SCHIP.)

  - *Training and education for pediatricians and family practice physicians in the community.* These efforts promote: (1) screening for dental caries at well-child visits; and (2) oral health education/ anticipatory guidance at well-child visits (this component focuses on simple, consistent messages such as when to start brushing and when to establish a dental home).

- *Training and education for dental practices to promote the establishment of a dental home for all children by age 1 year.*

- *Ongoing efforts address access to care.* This includes promoting participation of private dentists in Medicaid programs, and working on reimbursement through Federally Qualified Health Center (FQHC) subcontracting.

- ***Social-Emotional Health Program.*** OK activities build on a proven national curriculum for prevention, a state supported early childhood mental health resource, and a quality improvement approach within pediatric primary care that promotes universal screening for emotional-behavioral health at well-child visits. These activities are coordinated across service sectors and settings, so that care and support are integrated for children and families. Key programs/activities include:

  - *Education and training for pediatric residents, local pediatricians, and family practice physicians to promote universal developmental screening at well-child visits, with referral to community services as needed.* The training sessions promote the use of two screening tools in particular: Parents' Evaluation of Developmental Status (PEDS) and the Modified Checklist for Autism in Toddlers (M-CHAT). In addition, the pediatric residency training promotes screenings for maternal depression and family violence, as needed.

  - *Use of the Second Step curriculum in all School Readiness, Community Renewal Team Head Start, and Early Head Start Centers, and non-subsidized center-based community programs in Middletown. Second Step* is a social-emotional health curriculum for children that promotes respectful peer interactions and is a pre-cursor to related curricula used in elementary schools. Early childhood educators in these targeted centers are trained in the use of *Second Step*. In addition, centers have the option of including a parent education component when implementing *Second Step.*

  - *Monthly rounds and center-, classroom- and child-specific consultation for early care educators.* These services are implemented in partnership with the state-funded *Early Childhood Consultation Partnership (ECCP)*, an integrated, cross-sector partnership focused on early childhood mental health. (ECCP Funding comes primarily from the Department of Children and Families, the state's child protection agency.) Middletown's ECE providers also utilize a behavioral health consultant from the *Area Cooperative Education Services (ACES)* — the Regional Educational Service Center for the twenty-five school districts in south central Connecticut. Through direct observation and using various screening tools, the consultant observes children and the classroom, advises teachers, offers staff development, and refers families to community agencies when necessary.

  - *Home-based parent education and support implemented in partnership with Middlesex Hospital's Family Advocacy Program*. These services reinforce classroom management approaches and promote consistency for the child from home to classroom. The services also go beyond the capacity of preschool staff to address parent-child-family stress and risk factors.

  - *Training and coaching for ECE providers in the Bingham Prosocial Development Curricula for Early Childhood.* The Bingham is an evidence-based program designed to encourage positive social skills in preschool and kindergarten children. The curriculum examines the roles of administrators, coaches, teachers/facilitators and parents in helping children learn

kindness, respect, empathy and self-control. The curriculum is introduced to early childhood educators in a series of hands-on learning sessions provided free of charge to Connecticut communities by the Child and Family Agency of Southeastern Connecticut. After this introductory experience, educators work with coaches in their classroom to develop their abilities to elicit and nurture positive behaviors from their students. These learning sessions provide the basic training necessary to coach and effectively implement the curriculum. To date, the Bingham has been successfully implemented in early care and education programs in Southeastern Connecticut.

- ***Nutrition-Physical Activity/Obesity Prevention (Wellness).*** Key programs and activities include:

  - *Working with all targeted ECE centers to increase physical activity to at least one hour per day for full-day classrooms, consistent with national standards.*

  - *Training for all targeted ECE centers in the use of the Captain 5 A Day curriculum, which promotes healthful eating.* This curriculum is supported by the Connecticut Departments of Public Health and Social Services and the United States Department of Agriculture.

  - *Contracting with a public health nutrition consultant who works with ECE/preschool centers to establish center-based, culturally sensitive policies and practices that optimize nutrition and physical activity for children at the centers.*

  - *Contracting with a public health nutrition consultant who provides training, education and assistance for ECE/preschool staff, family resource centers, pediatricians, other healthcare staff, and families.* These activities include a train-the-trainer program to give community service providers the tools to support families in developing healthy eating and physical activity patterns; direct parent education on request; and collaboration with health care settings to establish a childhood obesity prevention and treatment system that includes direct consultation to families via the public health nutrition consultant.

  - *Developing and testing an early childhood adaptation of the Fit for Kids obesity prevention/intervention program, which was originally developed by Maine's Keep Me. Healthy Initiative.* The adapted version uses the pediatric medical home as a primary setting for promoting healthy eating and physical activity, screening for obesity (including tracking BMI at well child visits), and linking children and families to obesity consultation and case management provided by a care manager/nutritionist. OK has worked with all five pediatric primary care practices in Middletown, reaching about 11 pediatricians and 19 family doctors with office-based training that is based on the chronic care model. The *Fit for Kids* pilot also includes an active role for ECE providers, who participate in care management, support child and family behavior change, and can directly refer children for consultation.

  - *Collaboration with the Ethel Donoghue Center for Translating Research into Practice and Policy (TRIPP Center) at the University of Connecticut Health Center, to evaluate the Nutrition/Physical Activity components of Opportunity Knocks.* The TRIPP Center serves the people of Connecticut through research and evaluation. Its mission is to facilitate practice-oriented translational research of practical benefit to the University and the region.

Staffing, Administration, and Governance

Staffing and Administration: Opportunity Knocks has one employee, a half-time Program Planner who works out of Middletown Hospital's Family Advocacy Program. Other professionals providing services

through OK receive stipends or fees for their work. These include, among others: a roving dental hygienist who works in early childhood education settings and in WIC clinics; a parent educator working through the Family Advocacy Program, who provides consultation to families of children with behavioral issues; a nutritionist who consults with ECE settings and parents; and a physician involved in leadership and training for primary healthcare practices. Parents who attend OK coalition meetings are also paid a stipend.

Governance: From the beginning, OK has functioned as a collaborative partnership of service providers, parents, community organizations, public agencies and other community stakeholders. The partnership includes: Middlesex United Way (Community Partner), Middlesex Hospital Family Practice Group and Family Advocacy Program (Health Partner), and Middletown Discovery Initiative/School Readiness Council (Collaborative Partner). Representatives from these partners, along with two parent representatives, form the seven-member steering committee that guides the initiative.

Financing and Allocation of Funds

Financing. Primary funding of $100,000 per year is provided by the Funders' Collaborative, which consists of four Connecticut-based foundations: the Children's Fund of Connecticut, the Connecticut Health Foundation, the Graustein Memorial Fund and the Community Foundation of Greater New Haven. In addition, several community partners contribute a total of $25,000 for the annual match required by the Funders Collaborative. These include: the Middletown Office of the Mayor, Middlesex United Way, Middlesex Hospital, School Readiness/ Quality Enhancement Fund, and School Readiness Programs,. Middlesex Hospital is the lead fiscal agent for Opportunity Knocks. The initiative also receives additional funding for specific projects or program activities: for example, the Child Health and Development Institute supports the Fit for Kids pilot, and the City of Middletown Board of Health supports direct services such as the dental hygienist working at the local Community Health Center. The Connecticut Health and Educational Facilities Authority, McKesson Foundation, Hartford Courant Foundation, and private donations have also contributed towards specific components of the initiative.

Allocation of Funds. Allocation of funds includes approximately 30% for the Program Planner; 63% for consultant stipends and fees for direct services to children/families or training/support for providers.

Data, Evaluation and Accountability

As noted above under "Strategic Plan," the Opportunity Knocks collaborative has established a clear set of outcomes and related, measurable outcome indicators that focus on children and families, as well as on systems change.

In addition, the Funders' Collaborative has engaged The Consultation Center in New Haven, Connecticut to conduct annual process evaluations of the community projects receiving funding under the Early Health and Learning Initiative. These evaluations focus on three sets of results: (1) enhanced collaboration capacity and community outreach; (2) increased integration of health and early care; and (3) sustainability.

Sustainability

With the grant from the Funders' Collaborative coming near an end, Opportunity Knocks is currently in the process of applying for additional funds to cover the work of its Program Planner, as well as various programs and activities. Local and state non-profit organizations are currently funding or contributing funds to some of the OK program activities. One route to explore is whether the local hospital might fund the program planner position as a community benefit focusing on linkage and integration across community services and systems of care.

Selected Outcomes
The following selected outcomes are taken from the Opportunity Knocks Process Evaluation Report for Implementation Year 3:

- *Availability of health education or health services over time.* Findings from key informant interviews indicate an increase in the level of health education services available at participating early care settings and home visiting services, and increased access to dental care in the Middletown community. Over the four project years, 1,071 health providers, early care providers, and parents received training in at least on target area (nutrition, oral health, social emotional wellness, and multicultural education).

- *Decreased number of expulsions and reduced schedules for children in preschool programs.* Middletown evidenced a significant reduction in the number of reduced days, suspensions and expulsions from Initiative Year 1 (IY1) to I Y2; and then experienced an increase in expulsions and reduced schedules in IY3. This is not a direct comparison over time since some of the programs have closed and others have joined the data collection efforts in subsequent years. It should be noted that all of the behavioral problems recorded in IY3 were from one program and involved three children. It appears that the first strategy for this early care site was to reduce the school day and work with the families to help the children remain in the preschool setting.

- *Number of full day preschool classrooms engaging children in 60 minutes of physical activity per day.* Of the 25 classrooms that provided physical activity data for IY3, all classrooms charted at least one hour of daily physical activity (and most charted and reported more than one hour).

- *Increased number of children in preschools receiving dental care.* Approximately 521 children were seen by the *Miles of Smiles* dental program over a two-year implementation period.

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REGION A PARTNERSHIP FOR CHILDREN (WESTERN NORTH CAROLINA)

ORIGIN OF THE INITIATIVE

In 1993, under the leadership of then-Governor Jim Hunt, the North Carolina legislature approved a new statewide initiative to ensure that every child in the state begins school healthy and prepared to succeed. Known as "Smart Start," this initiative was based on the belief that every child can benefit from, and should have access to, high-quality early childhood education and developmental services. Smart Start held that the economic future and well-being of North Carolina depended on such access. It also claimed that the while parents have the primary duty to raise young preschool children, the State can assist and aid parents in this effort.

At the time of its creation, Smart Start received an initial appropriation of $20 million to be administered at the local level by non-profit organizations called "Local Partnerships." The establishing legislation also created a new 501(c)(3) organization, the North Carolina Partnership for Children (NCPC), to provide oversight and technical assistance to the Local Partnerships, as well as a new division of the North Carolina Department of Human Resources, the Division of Child Development (DCD), to institute a statewide Smart Start process.

Smart Start sought to ensure that local communities had maximum flexibility and discretion in developing their own Smart Start plans. Depending on local needs, Local Partnerships were permitted to fund child care services (e.g., start-up funding for child care providers, child care resource and referral services, and technical assistance and training for child care providers) and/or family- and child-centered services, including early childhood education and child development services (e.g., service enhancements, needs and resource assessments, and home-centered care). They also were permitted to fund development programs for child care and family- and child-centered services staff, as well as activities to ensure that infants and young children receive needed health, immunization and related services.

Smart Start also provided counties with a number of valuable planning and evaluation tools. For example, DCD, in cooperation with NCPC, was instructed to develop and fund a needs and resources assessment for each county. Similarly, DCD was charged with developing and implementing a performance-based evaluation system to assess Smart Start statewide.

Smart Start was launched in 1993 with 12 "pioneer" partnerships selected jointly by DCD and NCPC. Currently, 78 Local Partnerships covering all 100 North Carolina counties participate in the program.

State Strategic Plan

As initially crafted, Smart Start deferred much of the strategic planning responsibilities to the Local Partnerships. However, following an audit by Coopers and Lybrand in 1997, the North Carolina General Assembly passed a number of changes to the establishing legislation in order to improve program oversight and operations. Most significantly, NCPC was given administrative control of Smart Start, including approval authority for Local Partnership plans and budgets, funding allocations, and bidding procedures. NCPC was charged with overseeing the development and implementation of the Local Partnerships as they were selected for funding. It also was charged with establishing a fiscal accountability plan and a centralized accounting and contract management system.

Also important was a new match requirement that was placed on NCPC and all Local Partnerships. This requirement demands a 20% match (10% cash and 10% in-kind) for each fiscal year. Should NCPC or the Partnerships fail to meet this match by mid-year, their state appropriation the following year may be reduced on a dollar-for-dollar basis.

Finally, a number of important changes were made to the funding allocations for the Local Partnerships. Specifically:

- NCPC was instructed to develop a formula for allocating direct services funds to the Local Partnerships.
- Of the funds appropriated by the State to the Local Partnerships, 75% is to be designated for direct services at the local level, including an expanded array of child care services, family- and child- centered services, and other appropriate activities and services;
- Of the 75% designated for direct services, no less than 30% is to be used to expand child care subsidies. At NCPC's discretion, this amount could be raised to no less than 50%;
- An additional 40% of local Smart Start funding must be designated for activities related to early care and education with the remaining 30% of local Smart Start dollars available to address the specific health and family support needs of young children.
- Administrative costs for the Local Partnerships is capped at no more than 8%.

In response to the legislative mandates, NCPC established a 30-40-30 funding allocation formula for direct services by the Local Partnerships: 30% for child care subsidies (as required by the 1997 reform package); 40% for other child care related services; and 30% for health and family support activities. NCPC also developed and issued core service guidelines, and instituted a requirement that all Local Partnership plans include measurable outcomes.

State Financing

Since the initial appropriation of $20 million for Smart Start in 1993, state funding for the initiative has grown exponentially. In 2007-08, Smart Start received an annual appropriation of $205.5 million.

INITIATIVE OVERVIEW

Early Development

Just as the state was issuing its first request for proposals under the Smart Start program, the Region A Child and Youth Planning Council (Council) was completing a two-year study of child and family needs across seven far-western counties — Clay, Cherokee, Graham, Haywood, Jackson, Macon and Swain — and the Cherokee Indian Reservation. Established in 1978, the Council served as an advisory body to the Southwestern North Carolina Planning and Economic Development Commission, a county-supported coalition that helps member counties (and the cities therein) develop regional funding plans and obtain state and federal monies. In its advisory role, the Council was charged with coordinating regional communication and planning for child and youth services, assessing the needs of children and youth, and making recommendations for the implementation of identified needs.

The Council's 1993 needs assessment found that children in the region were increasingly falling victim to a range of societal ills, including poverty, infant mortality, illiteracy, and domestic and community violence. It noted that the region's families faced a fragmented network of human services and duplicated intervention efforts. It recommended that the region develop a detailed strategy with clear priorities having the support of business and political leaders, as well as child-serving agencies and organizations.

Based on the findings and recommendations of the 1993 assessment, the Council strongly supported the development and submission of a regional Smart Start proposal. Although there initially was some resistance from individual counties that had considered applying separately for Smart Start funds, the regional approach ultimately prevailed. Following review by the state, Region A was selected to serve as one of the "pioneer" partnerships and the Region A Partnership for Children (Region A Partnership) was formed.

Current Strategic Plan
Building on more than fifteen years of regional collaboration, the Region A Partnership operates under the following framework:

- ***Vision***. Witness the miracle: a nurturing community, a loving family, a smiling child.

- ***Mission***. To improve the quality of life for young children and families in western North Carolina by encouraging advocacy and collaboration and funding services that focus on prevention and early intervention.

- ***Goals***. That in Region A:

    - All children from prenatal to five years of age will have access to high quality, affordable early care and education that addresses their individual needs.

    - All children from prenatal to five years of age and their families will have access to a coordinated system of family-centered resource services that will strengthen families, increase mental health resources, and streamline the process of accessing services.

    - All children from prenatal to five years of age will have access to preventive health care and treatment to ensure that they are healthy when they enter school.

    - There is regional and local collaboration among public, private, and non-profit sector partners to build and maintain a comprehensive and integrated system of services for young children and their families.

Platforms for Implementation
The Region A Partnership offers coordinated, comprehensive services and support through a range of delivery platforms. For example: Family Resource Centers offer a centralized location for screenings, referrals and services; training, education, screening and assessment programs are available in early care and child care settings, as well as pediatric and other primary care practices settings; training for child care and family day care providers is available at a regional facility; and, information about all programs is made available to, and from, all partners in order to ensure maximum familiarity and utilization of Smart Start resources.

Target Population
The target population for the Region A Partnership is young children aged prenatal to five years (approximately 11,000 children) and their families living in the region's seven counties and on the Cherokee Indian Reservation. Program services and supports are made available on a universal basis to this population; however, most of the families served are low-income. In addition, specialized services are made available to children with special needs such as identified behavioral or emotional challenges, autism spectrum or severe communications/sensory disorders, and special needs resulting from premature birth and other health concerns.

Program Overview
The Region A Partnership supports a variety of community- and practice- based programs, as well as programs based in child care and family day care settings, that are designed to support young children aged 0-5 years and their families. These programs include efforts to fill service gaps; improve the quality of child care, early care and education, and health care services; increase the use of validated screening

and assessment tools; establish service referral networks; and coordinate care for children with identified needs.

Anchor Programming
Consistent with the funding allocations and service guidelines produced by NCPC, the Region A Partnership offers programming in three areas: Early Care and Education, Family Support, and Health. Work across these areas is integrated at the staff and initiative levels. Specific initiatives within these areas include:

- **Early Care and Education**

  - *Early Care Subsidies.* Using Smart Start dollars, the Region A Partnership supplements North Carolina's child care voucher program by providing eligible families with additional subsidies. (Under the state voucher program, eligible families may be required to pay up to 10% of monthly costs.) The Region A Partnership also makes subsidies available to eligible families on the state program waiting list.

  - *Quality Improvement.* As part of its commitment to improve the quality of early care and education, the Region A Partnership supports a number of education, training and incentive programs for child care providers. These include the Region A Training Center, which provides regional training and technical assistance to providers in child care centers, family childcare homes and public pre-K programs; the Southwestern Child Development Commission Resource and Referral unit, which provides technical assistance and on-site training to child care centers and homes; the Quality Infant/Toddler Bonus program, which provides per child bonuses to child care facilities that score four or five stars under the North Carolina licensing system; and the WAGE$ project, which provides early care providers with salary supplements tied to their enrollment in continuing education with at least six months of employment in the same childcare program.

  - *Community Early Learning Groups.* In order to provide children aged 0-5 years not currently enrolled in childcare with the opportunity to engage in structured activities designed to help them learn in all areas of development, the Region A Partnership supports community-based early learning groups. Children participating in these groups receive health screenings, among other benefits. Parents of the children also receive information about children's health and safety, and community resources.

- **Family Support**

  - *Family Resource Centers.* Located across seven counties and on the Cherokee Indian Reservation, the Region A Partnership's Family Resource Centers offer a range of services including parenting education, crisis intervention, early literacy and respite care. The centers also serve a care coordination role by acting as a clearinghouse for referrals from (and to) program partners — such as primary care providers, child care provider and others — who have identified children and families in need of additional assessment or more specialized services or support.

  - *Assistance for Children with Special Needs.* The Region A Partnership supports four programs targeting children with special needs, including:

- *Child's Garden,* through which early childhood interventionists provide technical assistance to child care providers and families in the home or child care setting. Therapists also provide referrals and service coordination for the children

- *Communications Disorder Specialist (CDS) Services*, through which a multidisciplinary team of specialists, working in collaboration with the state's Children's Developmental Service Agency, provides evaluation and intervention services to children with autism spectrum or severe communications/sensory disorders. Services include support, consultation and training, as well in-home interventions.

- *Infant Massage*, through which a licensed Infant/Toddler massage therapist provides individualized training to parents and child care providers of children with special needs resulting from premature birth or other health concerns. In addition, working with caregivers and other developmental specialists, the therapist develops individualized treatment plans for the children. The therapist also offers workshops on the benefits and techniques of infant/toddler massage to families, providers, and other professional caregivers.

- *Family Support Network (FSN),* through which one-to-one matching and support is provided for parents and caregivers of children with special needs. The FSN coordinator provides training and workshops about a variety of issues such as accessing services, communicating with professionals, transitioning to pre-school and kindergarten, participation in Individual Educational Planning (IEP) and self-care for caregivers. The FSN coordinator also facilitates support groups for children with siblings with special needs, to engage them in supportive, fun and educational activities enabling them to cope with the particular stressors encountered in their daily lives.

- *Parents as Teachers.* Following the national Parents as Teachers (PAT) model, the Region A Partnership supports individualized, strength-based, in-home education for parents of young children aged 0-5 years in six counties.

- *Literacy*. The Region A Partnership supports literacy outeach programs that includes mobile library programs in four counties including the Cherokee Indian Reservation, bringing children's books and materials to child care homes and centers. During these visits, librarians train the providers in creating story telling and early literacy activities.

- **Health**

  - *Screenings.* The Region A Partnership has been closely involved with a number of programs to improve screening, assessment and referral rates for young children. This includes promoting the use of the Ages and Stages Questionnaire (ASQ) and the ASQ-Social Emotional (ASQ-SE) screening tools in over 50 primary care and pediatric practices around the region through office-based and off-site education and training; working with the local health departments to arrange and conduct vision screening; and partnering with various state agencies to pilot a redesign of a comprehensive health assessment given to all children upon kindergarten entry.

  - *Child Care Health Consultants.* In addition to enlisting the support and participation of health care providers, the Region A Partnership brings health to the child care and early education communities through on-site consultation services for providers in child care centers, family day care homes and preschools.

- *Health Education.* The Region A Partnership supports a range of health education programs, including education sessions on car seat safety and infant/toddler massage. These sessions are available at community sites and in child care and family care settings.

- *Dental Services.* With support from the Region A Partnership, dental screenings are conducted in child care settings across the region. Children identified as being in need of dental care receive referrals to and direct services from various county and private dental offices. Services range from the application of fluoride varnish to comprehensive dental treatment.

Administration and Staffing

The Region A Partnership currently has 12 employees, including senior management, program specialists and support staff. Its operating budget in 2007-2008 is $6.2 million. It is governed by a 39-member Board of Directors.

Financing and Allocation of Funds

In FY 2006-2007, slightly more than one-half of the Region A Partnership's funding comes from the state government through the Smart Start program. An additional 27% comes from the North Carolina *More at Four* pre-school program, and 12% comes from private sources and in-kind contributions. (Smart Start requires a match of at least 10% from participating partnerships.) Consistent with the funding formula established by NCPC, the largest expenditures for the Region A Partnership are the Early Care and Education programs, including the child care subsidies. Other resources and expenditures of the Region A Partnership in FY 2006-2007 include:

Region A Partnership for Children: Resources (FY2006-2007)	
North Carolina Smart Start	51% ($3,221,730)
Other State Grants	27% ($1,691,852)
Private Gifts and Grants	12% ($ 765,826)
Federal Grants	5% ($ 324,635)
In-Kind Contributions	3% ($ 210,867)
Volunteer Hours	1% ($ 49,611)

Region A Partnership for Children: Expenditures (FY2006-2007)	
Early Care and Education	60% ($3,864,822)
Subsidized Child Care	16% ($1,008,275)
Administration	8% ($ 496,613)
Family Support Services	7% ($ 469,578)
In-Kind and Volunteer Hours	4% ($ 260,478)
Health Initiatives	3% ($ 172,330)
Evaluation and Project Mgmt	2% ($ 159,653)

Data, Evaluation and Accountability

NCPC guidelines require that all local Smart Start partnerships include as part of their plan measurable outcomes. For the Region A Partnership, these outcomes (discussed below) are tracked through a quarterly reporting process whereby contracted partners provide client and outcome information to Region A, which analyzes and consolidates the information before reporting to NCPC. In addition to its routine data assessments, Region A uses a contract evaluator for special projects, for instance, when it seeks to capture longitudinal data or more specific information about its programs.

Sustainability
The Region A Partnership is largely dependent on the Smart Start funds it receives from the state and the associated match dollars. Although state funding for Smart Start increased dramatically over the first seven to eight years of the program, it has subsequently plateaued and recently declined compared to previous allocations. In 2007-08, for example, Smart Start received an annual appropriation of $205.5 million, down from a high of $231 million in 1999-2000.

Recognizing the need to pursue options beyond its Smart Start dollars, the Region A Partnership actively seeks funding from alternative sources, including federal grants and private foundations. It also serves as a co-applicant for community-based programs throughout the region as a way to increase overall community capacity.

Outcomes
In FY 2006-2007, with the help of Smart Start, the following outcomes were documented in Region A:

- 352 children received oral health examinations or treatment interventions
- 97 children with special needs received therapy or interventions
- 875 parents participated in home visits to increase parenting skills
- 878 parents participated in activities to increase literacy at home
- 547 parents received one on one consultation, counseling or crisis intervention services
- 1,021 parents received a referral to community resources
- 1,028 parents received help in finding child care services
- 80 childcare facilities participated in activities designed to raise their star ratings and
- 2,352 teaching staff attended workshops or training
- 354 Child care providers participated in the WAGE$ Bonus program

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WESTSIDE INFANT-FAMILY NETWORK (LOS ANGELES, CA)

ORIGIN OF THE INITIATIVE

The Westside Infant-Family Network (WIN) is an early childhood mental health initiative collaboratively developed with the help of six pre-existing agencies in the Westside area of Los Angeles. The development of WIN was facilitated by The Atlas Family Foundation (TAFF), a Los Angeles-based private philanthropy focusing on early childhood development and mental health for children, prenatal through age three**.** The development of WIN is a natural off-shoot of TAFF philosophy and practice: The foundation views grant-making as a long-term investment in change. It selects grantees with a philosophy that closely matches its own, works with them as partners, and goes beyond funding to provide technical assistance and other support for their work. One form of such support is fostering collaboration among grantees.

The actual origin of WIN was serendipitous: In Fall 2003, TAFF invited several of the six grantee organizations to a meeting to discuss the possibility of opening a West Coast branch of Zero to Three, a national organization focused on early childhood development. In the course of the discussion, grantees raised a shared and growing concern about mental health issues among their youngest clients and their parents, As described in *Insight*, a publication of Grantmakers for Children, Youth and Families*:* "The agencies feared the lack of available mental health care services would have a devastating effect on the children's development and on their future success in school, work, and social endeavors. The lack of public funding available for infant mental health services and dyadic parent-child therapy also frustrated the agencies. The system simply was not set up to meet this very real need."

TAFF recognized this shared concern as an opportunity for fostering interagency, cross-grantee collaboration with the goal of better serving young children. The foundation offered assistance in the form of funding for a consultant to work with the six agencies and develop a shared, community response to early childhood mental health needs among families living in the Westside area of Los Angeles. The result of the collaborative problem solving was the launching of WIN.

INITIATIVE OVERVIEW

Early Development

Working with the facilitator funded by TAFF, the six agencies — Mar Vista Family Center, the Infant and Family Support Program, Saint Joseph Center, Venice Family Clinic, Westside Children's Center, and Westside Family Health Center — conceived and designed WIN. Initial planning started in 2003. The Executive Director came on board in November 2005. The Director's first charge was to work with the agencies to develop the program component of WIN and hire initial staff. WIN launched the first set of services in July 2006, two and a half years after the initial discussions and planning activities.

Mid-Course Restructuring

As originally conceived, all six collaborating agencies were to engage at the same level in the partnership. In January 2008, after 18 months of implementation, the collaborative redefined its structure so that it now has three Primary Partners (also known as Level 1 Agencies) and three Associate Partners (Level 2 and 3 Agencies). Primary Partners are engaged in all WIN services and capacity building opportunities. Associate Partners attend WIN trainings and can refer clients to be case managed by one of the Primary Partners or by WIN. Since they do not provide WIN case management directly to clients, they do not receive capacity building grants from WIN. (See "Key Program Components" below for further details).

This approach allows flexibility for agencies to engage at a level they can manage, enhances cost-effectiveness of WIN services, and helps assure a high standard of case management and cross-agency care to WIN clients. As of January 2008, Westside Children's Center; Saint Joseph Center, and Venice Family Clinic are Primary Partner Agencies; and Westside Family Health Center , Mar Vista Family Center, and the Infant and Family Support Program are Associate Partner Agencies.

Strategic Goals and Outcomes

WIN engaged in a new strategic planning process from January through Summer 2008. While WIN has not had a written strategic plan to date, its program development has been guided by an over-arching goal and four sub-goals. In addition, WIN has developed four goal areas, each linked to measurable outcomes, with defined targets:

- ***Overarching Goal.*** To improve outcomes for children 0-3 in high risk family environments, by helping to improve the mental health of the primary caretaker and concrete social and economic stability of the family.

- ***Sub-Goals***
  WIN seeks to:

  - Increase the capacity of parents with children 0-3 to be responsive parents.

  - Increase agency staff capacity to identify and integrate clinical issues into their case management work.

  - Increase use of available resources by agency staff to meet the basic material needs (food, shelter, income) of clients.

  - Enhance coordination, communication and continuity of approach among participating agencies.

- ***Goal Areas.*** WIN's four goal areas focus on: (1) children, (2) families, (3) agency staff, and (4) agencies.

- ***Measurable Outcomes and Targets.*** As outlined in the chart below, measurable outcomes and targets link to the four goal areas.

Goal Area	Measurable Outcome	Target
Children	1. Improve developmental outcomes as screened by Ages and Stages Questionnaire administered upon referral, as indicated throughout WIN involvement, and upon exiting the program. 2. Demonstrate increased behaviors associated with secure attachment as observed and reported by therapists after six month case review.	1. 70% of children 0-3 will show improvement in identified areas of concern after 1 year of tier 2 services.* 2. 70% of children will show an increase in attachment behaviors after 1 year of Tier 2 services.*
Families	1. Parents receiving tier 2 services* will experience a reduction in symptoms as screened by the Parent Stress index (PSI). 2. Families will be successfully linked to services in the community as tracked through the case management needs assessment and case notes from each agency. Identified needs that remain unmet will be tracked to determine what barriers prevented amelioration.	1. 70% of parents will show improvement after a 6 month re-screen. 2. 60% of needs will be addressed by 4th case review.
Agency Staff	1. Direct service staff at each agency will be better able to identify, refer and provide services for families as indicated through surveys and demonstrated knowledge on scenario tests. 2. Clinical staff at each agency (where present) will observe an improved capacity of non-clinical staff to identify, refer and support "WIN eligible" families as measured via interview.	1. 75% of staff will both demonstrate and report increased knowledge and competency. 2. 90% of clinical staff will report improvements.
Agencies	1. Will demonstrate improved capacity to serve the mental health needs of WIN-eligible families – as measured against baseline tracking of families demonstrating need during the 3 month ramp up period before new services are available.	1. Case managers for 80% of families referred to WIN will receive consultation on meeting the mental health needs of the family; 40% of WIN families will receive enhanced mental health services.

* For a description of tiered services, see "Key Program Components" below.

Target Population

WIN serves "at-risk" young children (0-3) and their families living in West Los Angeles communities. Eligibility for client services is agency-driven; that is, to be eligible for WIN services, children and families must be clients of one of the collaborating agencies. While each agency has its own eligibility requirements, all of them target services to low-income, predominantly immigrant Latino families. All six of the WIN partner agencies serve families in communities within Los Angeles County's West Service Planning Area (SPA 5): West Los Angeles, Inglewood, Culver City, Santa Monica, Mar Vista, and Venice.

Program Overview

The WIN collaborative partnership is focused on improving mental health and related developmental outcomes for young children. WIN programming combines three key components:

- A tiered service delivery system focused on addressing current and potential mental health issues among young children and their families in order to promote healthy child development.

- Community agency training and capacity building.

- Community service system linkage, integration and capacity building.

While WIN specifically focuses on mental health issues, its scope is much broader than traditional mental health diagnosis and treatment: From the clients' perspective, the initiative provides a nested set of services designed to address current and potential family mental health issues and to promote healthy child development, all provided within the context of a familiar community agency or the client's home. The initiative takes a "family systems" approach to strengthen family stability, which includes meeting the families' material needs (for food, shelter, healthcare, etc.) as well as improving the capacity of parents to be responsive caretakers. For the partner agencies, the initiative expands capacity to identify and address mental health and developmental needs in-house, to link children and families to additional appropriate clinical and other services, and to collaboratively identify and address community-wide needs. From the community service system perspective, the initiative provides a means of networking across service providers to improve care for children and families, it offers new gap-filling services, and it provides a forum for integrated planning and service delivery across a common community population.

Key Program Components

- ***Tiered Services for Children and Families***
  WIN uses a three-tiered framework for delivering services to children and families:

  - *Tier 1 – Services to address basic needs.* All children and families referred to WIN by collaborating partner agencies receive case-managed, networked services to meet basic needs. Case management is provided by the Primary Partner Agencies and, as needed, by WIN. The networked services are provided by one or more of the collaborating agencies and include: public health insurance enrollment, medical care, housing and food assistance, baby supply assistance, child care, employment training, emergency funds, transportation assistance, foster/adoption services, play groups for young children, teen and after school programs, and more. For about 15% of the families, addressing these and similar underlying stressors reduces the need for more intensive mental health intervention. For these families, WIN provides Tier 1 services only.

  - *Tier 2 – In-home therapy.* About 85% of WIN families need more than the basic services provided in Tier 1. For these families, WIN's licensed clinical social workers, clinical psychologists and marriage and family therapists provide in-home, joint parent-child (i.e., dyadic) therapy focused on strengthening the parent-child relationship by fostering early attachment. Most of the WIN therapists have over ten years of experience. In addition, six of the seven therapists are multicultural and/or bi-lingual.

  - *Tier 3 – Psychiatric care and medication.* For families requiring interventions in addition to Tier 1 and 2 services, WIN provides linkage to psychiatric care and medication services. These Tier 3 services are currently provided through the Venice Family Clinic and other local clinics.

- ***Capacity Building, Training and Support for Partner Agencies***
  WIN uses several strategies to help partner agencies identify and manage mental health and related developmental issues for children and their families:

  - ***Case management capacity building grants for agencies.*** For agencies that agree to use WIN standards of care, the initiative provides annual grants of approximately $50,000 per agency toward employing on-site, dedicated case managers for WIN families. Agency case

managers coordinate Tier-1 cross-agency services and also function as the families' advocate, particularly when families need to access services from agencies beyond the WIN partnership. The agency case managers are the nexus of connection between the family and WIN: They provide initial screening and make sure the families' basic needs are met before referring to Tier 2 services. If the family is referred for in-home therapy, the agency case manager brings the therapist to the family home, providing a "warm hand-off" that helps to jump-start the therapeutic process. The case manager stays in contact with the child/family, continues to stay abreast of therapeutic developments, and manages other service connections for the family.

- *Training and support for agency staff.* WIN provides weekly clinical supervision for its therapists; weekly case reviews that include in-house case managers and WIN therapists; and a dedicated time for agency case managers to meet and discuss common issues as well as promising strategies. In addition, WIN provides training for agency doctors, clinicians, case managers, and other agency staff. This interdisciplinary, cross-agency training is provided through a series of formal sessions totaling 40+ hours each year. Starting with site visits to all the agencies so that all providers know the other agencies and what they have to offer, the training sessions have also covered the use of diagnostic screening tools such as the Ages and Stages Questionnaire (ASQ) and ASQ-SE (Social-Emotional), developmental milestones, infant mental health and trauma, interaction guidance, and more. Staff are also trained to assess parental stress; insurance and medical home status; and other family needs such as housing, food assistance, and job training. The goal is not to refer to WIN, but instead, for each agency to get better at identifying and providing an early response to issues. In addition to training, the WIN Clinical Coordinator is available for site visits to help agencies problem solve.

- *An electronic, online client data system.* Each partner agency that refers to WIN uses the secure, HIPPA-compliant, online WIN data system to track and refer clients. The system facilitates timely referral, linkage, and information sharing by allowing the partner agencies to login, update records and make referrals online. When one agency enters a progress note, it triggers an email to the partner agencies that serve the family, informing them that a case note was entered for the client. Agencies are required to update case files on the data base within 72 hours of action related to the client family.

- ***Community Service System Linkage, Integration and Capacity Building***.
From a community systems perspective, WIN contributes several new components that fill service gaps while also linking and integrating care within the Westside community.

  - *New, shared clinical services.* WIN adds a new set of mental health services and providers to Westside agencies and the communities they serve, including: a Clinical Coordinator, who works closely with agency case managers helping them develop skills to effectively assess needs and link families to appropriate services; seven licensed therapists who provide in-home, parent-child dyadic therapy; psychiatric and medication therapy provided through the Venice Family Clinic; and a unifying clinical model for dyadic therapy that is unique and replicable. Developed by Connie Lillas, the model is based on a neuro-relational framework and uses the heuristic: Head, Hand, Heart. WIN is collecting data on specified outcome measures to assess its impact.

  - *A network-wide data system.* As noted above, the shared WIN data system allows partner agencies to communicate with each other in order to refer and track the families they serve in common. As such, it provides an effective and efficient means for agencies to co-manage

clients without requiring co-location. Currently, the Primary Partners are the main users of the data system; however, it is also available to Associate Partners. From a community systems perspective, it builds a virtual service system across independent agencies, without requiring them to give up their unique identity, characteristics, or services. This is particularly important since all the partner agencies have long-standing reputations in the community, with the newest having served for 15 years and the oldest for 37.

- *A forum for collaborative, inter-agency planning and program implementation.* Beyond any new services and supports, WIN offers the infrastructure for collaborative, inter-agency planning and program implementation, squarely focused on the needs of a shared client population. It provides the opportunity for true system integration without losing sight of the underlying purpose for integration: to improve the lives of young children and their families.

Staffing, Administration, and Governance

- ***Staffing***.WIN employs a small staff consisting of four therapists and four core positions: the Director, Clinical Coordinator, Clinical Information Systems Manager, and Program Assistant. A case manager is soon to be hired. The core team works with the Program Committee (comprised of lead social service staff from each agency) to develop and implement cross-agency infrastructure and training. WIN's clinical team — which provides in-home therapy — currently includes seven licensed clinicians. In addition, WIN contracts with the Venice Family Clinic to access psychiatric care for clients, as needed.

- ***Governance.*** Reflecting its collaborative nature, WIN is governed by an Executive Committee comprised of the Executive Director or the E.D.-designate from each of the six partner agencies. The Executive Committee meets monthly. In addition, the Program Committee, comprised of social service/clinical leads from each agency, works with core WIN staff to develop cross-agency trainings as well as infrastructure for cross-agency referral, linkage, and service. This committee also meets monthly.

Financing and Allocation of Funds

- ***Financing.*** WIN is currently funded by foundations and private donors. The Atlas Family Foundation was instrumental in launching the initiative, providing planning and start-up funds. TAFF continues to provide financial support during the current four-year, pilot phase (2006-2010). TAFF also extends its support for WIN through leveraging funds from other private foundations, both regional and national. WIN currently receives funding from 14 foundations including, among others, the Annenberg Foundation and the Robert Wood Johnson Foundation Local Initiative Funding Partners.

  WIN's collaborative structure adds complexity to the initiative's financing. The WIN Executive Director raises funds for WIN services (including cross-agency, collaborative activities and infrastructure), while making it clear to foundations that requests for network funding are in addition to agency-specific funding requests. One additional, unusual aspect of the initiative's funding picture is that WIN is not currently an independent non-profit agency. Instead, one the collaborating agencies, Westside Children's Center (WCC), serves as a fiscal agent, with WIN writing its proposals under WCC's 501(c)(3) status.

- ***Allocation of Funds.*** WIN's total annual budget in FY 2008 is approximately $888,000. Currently, about 43% ($379,000) is allocated to therapists; 23% ($200,000) is directed to capacity-building grants for case managers in Primary Partner Agencies; 3% ($25,000) goes to

maintenance of the data base; and the remaining 32% ($284,000) goes to core staff, training and other program activities.

Data, Evaluation and Accountability

WIN's unique, shared client data system is described above, as are the initiative's measurable outcomes and targets. With regard to evaluation, WIN has engaged the National Health Foundation to conduct an external evaluation of the initiative's outcomes and impacts during its pilot phase (2005-2007). WIN is currently evaluating the use of standardized screening tools (ASQ and ASQ-SE) to assess progress for WIN children. It also assesses mental health outcomes for parents, competency of agency staff, service outcomes, and the effect of the collaborative as a whole. The measurable outcomes and targets described above under "Strategic Goals and Outcomes" provide the framework for this evaluation. WIN also contracted with a second consulting group, Urban Resources, to conduct an evaluation specifically focused on expenditures for the agency capacity-building component (completed in 2007). Both evaluations have informed WIN's continuing planning efforts.

Sustainability

Although WIN is still in the pilot stages, its Executive Committee and lead staff have already begun to think about sustainability and replication. Front and center in their thinking is the idea that WIN can serve as a model for cost-effective use of resources for mental health and family support services. In addition, it can serve as a model for community collaboration and agency networking around any set of direct services. More specifically, WIN provides a model that combines collaboration across existing community-based services, with shared use of new and enhanced, gap-filling services.

In addition to continuing to receive private foundation support, WIN leaders see the need to draw down public funding to sustain their service model. Ultimately, they hope to advocate for public financing and service system changes based on successful WIN outcomes. WIN may, indeed, benefit from California's current and recent state systems change initiatives such as California Proposition 10/California First 5, which allocates tobacco tax funds to establish an early childhood initiative in every county in the state; and California Proposition 63, which provides new funding for mental health services, via a tax on personal incomes greater than $1million. In addition, WIN principals hope to use their model to advocate for Medicaid/EPSDT financing for dyadic therapy and for treatment of mental health issues while they are still at the sub-clinical stage.

One issue WIN must address in the near future is whether it should expand beyond the current six partner agencies, and if so, how large it should become. WIN will need to carefully consider how expansion might affect sustainability and potential replication of the collaborative model, as well as how it might impact funding opportunities in the long-run.

Selected Outcomes

Evaluation data from WIN's first year of implementation indicate the initiative has met or exceeded most of its target outcomes. Selected outcomes from FY2006-2007 (as noted in WIN's 12-month report to the Carol and Roberta Deutsch Foundation) include the following:

- Of WIN children who exhibited areas of developmental concern during their initial ASQ screening, 83% showed improvement in those same areas of concern after receiving Tier 2 services. Similarly, 83% of children exhibiting developmental delays via their initial ASQ-SE screening also showed improvement.(Target: 70%)

- Of parents that received both an initial and follow-up PSI [Parent Stress Index] screen, 69% showed an improvement in identified stress levels. (Target: 70%)

- As tracked through each client's case review plan, most linkages to needed resources were completed. 80% of referrals were successfully linked. (Target: 60%)

- Case managers for 100% of WIN families [100%] received consultation on their cases. Each new family's case was brought to case review within 90 days of the initial referral. (Target: 80%)

- Of WIN families referred to WIN by partner agencies, 51% received enhanced mental health services. (Target: 40%)

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WIN Website: www.winla.org/about_staff.asp. Downloaded 1/2/2008.

APPENDIX B

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Children's Futures, Inc.
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First Five Ventura County
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Help Me Grow/ChildServ
- Joanna Bogin, Project Manager, HMG Replication Project, Connecticut Children's Medical Center
- Paul Dworkin, Physician-in-Chief, Connecticut Children's Medical Center

Opportunity Knocks
- Susan Macary, Program Planner
- Cliff O'Callahan, Faculty, Middlesex Hospital Family Practice Residency Program

Region A Partnership for Children
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- Emma Miller, Early Learning Specialist

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- Ana Friendly, Executive Committee Chair
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APPENDIX D

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Phoenix Park Hotel, Washington, DC – April 6-7, 2008

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