



2000-2008
First 5 Alameda County
Program Summaries



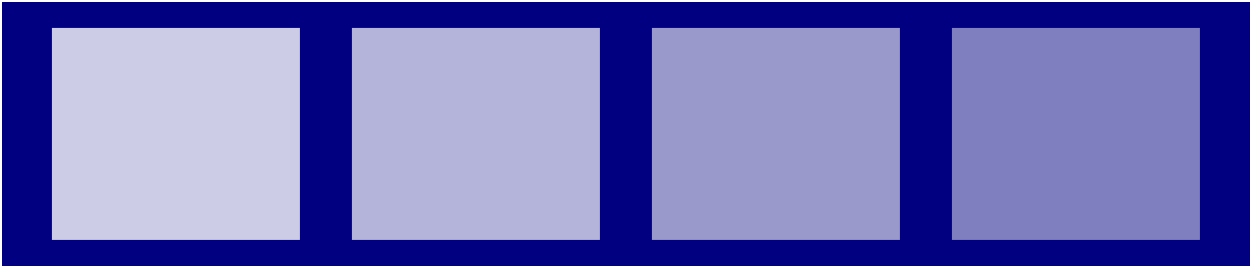


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Appendix A: Goals & Outcomes90



program name:

time period:

ecc goals:

Family Support Services
Postpartum Home Visiting

2000-Present

goals 1 goals 2 goals 3 goals 4

brief program history

The Postpartum Home Visiting (PPHV) program began as a home-based support for families with newborns to promote a healthy beginning for mothers and infants focusing on social and emotional well-being. It was envisioned as a “universal” voluntary home visiting model, serving families regardless of socio-economic status, medical or social risks, language capacities and first time parenting status. The program utilized Public Health Nurses in part to address medical issues that may complicate the postpartum period 48-72 hours post discharge. The professional nursing model also served to shore up the support of the pediatric community whereby nurses can provide feedback directly to medical providers through the duration of home visits. The Alameda County Public Health Nurse (ACPHN) Community Health Teams and the City of Berkeley (COB) Public Health Nurses formed the core service providers to conduct home visits throughout the county. Alameda Family Services (AFS) formed a small complementary community-based support for families in the City of Alameda that received nursing home visits. A Specialty Provider Team housed in F5AC consulted with the nursing staff, and visited families with the nurse, on issues related to lactation support, mental health and substance use issues and early childhood development, with the goal of co-managing families that required additional support while building nursing staff capacity.

Hospital Outreach Coordinators staffed by F5AC enrolled families at the hospitals and referred them to ACPHN or COB, as appropriate. As the program progressed, it became clear that the universal approach referred many more new families than the agencies could support. The program model changed starting in FY2004-05 by reducing the number of referrals to ACPHN and targeting higher risk families. As a result, the stressor profiles of families increased in risk, requiring a greater intensity in services.

Current literature on promising practices documented that high quality home visiting programs “...requires a high frequency and intensity of visits, quality staff training and supervision, and close monitoring of consistency between program design and implementation” (*Home Visiting: Strengthening Families by Promoting Parenting Success*, Policy Brief No. 23, Family Strengthening Policy Center). Based on F5AC experience, higher risk families require that home visitors hold a family for a longer term (up to 1 year), while offering with greater frequency a coordinated menu of specialty services, and outreaching to families as early as possible, including prenatally. Through a collaborative process in 2007-08, a new program model was finalized which requires a multi-disciplinary team case management approach to home visitation. The new model retains the need for a public health nurse (PHN) to address medical issues near the time of discharge, emphasizes a team approach to meet the needs of high risk families and recommends a system of support for and reflective supervision of team members. As such, F5AC released a Request for Proposals in 2008 for partners with the capacity to fulfill the core requirements and implement the new home visiting model by Fall of 2008.

BRIEF CURRENT PROGRAM DESCRIPTION

Hospitals Outreach Coordinators (HOCs) enroll families from hospitals that served the greatest number of Medi-Cal recipients: Alta Bates-Summit and Highland. Home visits occur within one week of hospital discharge to address medical issues related to lactation, weight gain, jaundice and to provide anticipatory guidance. Public Health Nurses (PHN) can visit the families for up to 3 times, with the option of an additional 10 home visits as needed. In addition to providing anticipatory guidance to new parents, PHNs should be integrating screening for maternal depression and identification of potential child development issues.

ECC Specialty Provider Team (SPT) members assist PHNs through support and consultation. Families are referred jointly to PHNs and the SPT. The SPT provides direct services for breastfeeding / lactation concerns, depression, grief, substance use, domestic violence and child development.

2006-07 PROGRAM COSTS: \$1,750,469

Includes Postpartum Home Visiting contracts with Alameda County and City of Berkeley Public Health Nursing and Alameda Family Services

Funding Sources: First 5 Alameda County, MAA

PROGRAM DOSAGE:

Variable: visit 48 – 72 hours post discharge, up to 3 visits. 10 additional visits as necessary. SPT supports for case consultation, joint visitation, building PHN staff capacity and direct services.

PROGRAM REACH

(Numbers & Population Served):

Since inception: 12,726 clients served

FY 2006-07:

1,247 clients seen

Demographics: 54% Hispanic, 16% African American / Black, 12% Asian, 9% White, 5% Multi-race, 3% Other

Mother's primary language: 54% English, 37% Spanish, 5% Cantonese, 1% Vietnamese; remaining 3% Punjabi, Farsi-Dari, Korean, Mandarin, Thai, Urdu,

Other Region: 53% Oakland, 11% Berkeley, 10% Alameda, 10% Hayward, 9% San Leandro

2006-07 Annual Report

Outcome 1B. Children are free from abuse and neglect

- 1% of children have open Child Protective Services cases at time of referral
- 2% of children are placed in foster care during the report period
- 2% of children have a CPS case opened during the report period

Outcome 1C. Enhanced economic self-sufficiency of families

- 79% of children have no health insurance, or whose health insurance is Medi-Cal or Healthy Families by program
- 2% of children have no health insurance by program
- 0% of children are in foster care at time of referral
- 8% of families are receiving CalWORKs or CalLEARN assistance
- 71% of families have at least one caretaker who is employed or on leave

Outcome 2E. Increased school readiness

- 93% of families report reading, storytelling or singing three or more times per week to their children

Outcome 3A. Increased support for breastfeeding mothers

- 90% of women were breastfeeding at the first home visit
- (COB Only) Of those who breastfeed, 84% breastfeed for 6 months to 1 year

Outcome 3B. Children are healthy, well nourished and receive preventive and on-going health and dental care from a primary provider

- 98% of children with health insurance
- 99% of children have an identified primary pediatric provider
- 98% of children have appropriate number of well child visits per age
- 98% of children are up-to-date on immunizations for age
- 0% of children hospitalized or who made ER visits for asthma
- 1% of children hospitalized or who made ER visits for preventable ACS* diagnoses (other than asthma)
- 2% of children exposed to secondhand smoke
- 2% of parenting women and teens who smoke

Average number of visits received by Postpartum program clients

Alameda County Public Health Nurse (ACPHN), City of Berkeley (COB) and Alameda Family Services (AFS) served 1,247 families for an average of 2 postpartum home visits

Number and percent of families receiving more than 3 visits

8% (97) families requiring an additional intervention received an average of 5 per family

Percent seen within 48-72 hours

Approximately 20% of families enrolled by HOCs never receive a home visit:
(21.6% ACPHN, 4.5% COB)

16.4% seen within 48-72 hours of assignment to nursing team (15.3% ACPHN, 28.9% COB)

Percent who experience problems breastfeeding

58% experience problems breastfeeding

Agencies used F5AC funds to draw down TCM funds for services provided to families with Medi-Cal

ACPHN, COB, AFS use ECChange which allowed for:

- Client based tracking
- Sharing of cases between multiple service providers and SPT
- Reduction of duplicated services by identifying agencies involved with clients
- Implementation of best practices
- Facilitation of communication between PHNs and Pediatric providers

Collaboration with Teen service agencies: Front end medical support followed by Teen services through outreach services

Improved skill set of PHNs by offering multiple and frequent trainings on lactation, mental health, domestic violence, substance use, early childhood mental health, and best practice tools.

Community-wide “normalization” of newborn home visits

Acceptance and expectation of services by obstetric and pediatric community

Coordination of home visiting efforts at hospitals to better serve patients by the Hospital Outreach manager.

Involvement in Baby Friendly planning as well as lactation support services and training at Highland to influence improved maternal child services.

POTENTIAL FOR SUSTAINABILITY OR LONG-TERM HOME:

Program contractor must be willing to embrace and build the capacity to offer long term case management, configuring services to include SPT services.

The new program model still relies heavily on F5AC involvement in training and technical assistance.

Will there be a culturally competent workforce to hold this program in the long-term? Service providers must demonstrate the capacity to provide services in the families’ primary language and effectively utilize the competencies of paraprofessional Family Advocates.

Long-term Funding commitments for preventive services are not identified. The future of TCM remains questionable.

The Public Health Nursing workforce recently experienced shortages in recruiting qualified candidates and problems and keeping existing nurses. Furthermore, Alameda County PHN and COB have not articulated a commitment to maintain a stable nursing workforce.

The Postpartum Home Visiting program (PPHV) is one of the few Family Support Services programs that was conceived as a prevention support model. Even though recent enrollments targeted higher-risk families, the populations served still reflect a high degree of diversity. 47% of the families served spoke 20 different languages other than English; approximately 37% of mothers spoke solely Spanish.

A difficult lesson learned during the first 7 years of the program was that with approximately 20,000 births in the county each year, the PPHV program can only serve a small percentage of families, leading to the targeting of higher risk families. HOCs and nurses directly referred 318 mothers experiencing mental health issues and 245 mothers with breastfeeding problems to F5AC SPT. HOCs also played another valuable role by continuing Medi-Cal coverage through the completion of 1,242 Newborn Referral forms in order to automatically enroll infants in health insurance.

Over time, it became apparent that ACPHN could not successfully meet the model's requirements. ACPHN infrastructure and low prioritization of prevention-focused services contributed to nurses responding slowly after new mothers are discharged (~8 days); closing cases after minimal visits; unsuccessfully coordinating acute cases with SPT; and bypassing the required "dedicated model" whereby 40+ nurses served F5AC clients only during a small percentage of their time. However, F5AC did encounter some success instituting the home visiting model with COB. COB nurses showed promise in their ability to engage families promptly post discharge and for an extended period of time, even outreaching to prenatal clinics for follow-up postpartum. With longer follow-ups, COB families received intense breastfeeding and lactation support and approximately half were screened for maternal depression.

Past telephone surveys of families that received home visits reveal that the services are highly valued, even for non-first time mothers. Different families desired varied types and levels of support, some stating having sufficient visits while others requested more visits and much later postpartum. Of note, were high levels of satisfaction among mothers whose primary language is not English, but who received services via interpreters.

Training, reflective supervision and supporting a multidisciplinary team of providers requires a significant commitment in time and effort, and are backbones to a well-functioning home visitation program. The new program design will leverage the multi-disciplinary, dedicated team model to enhance capacity building and reflective supervision opportunities. The pilot phase will serve to monitor how successful the new program design is, beginning a new phase of program monitoring and evaluation of impact on families.

STAFF REVIEW

INCLUDING RECOMMENDATIONS FOR CHANGE

Staff comments and recommendations were included in presentation of postpartum home visiting during the December 2007 Commission Meeting and the recently released RFP for Prenatal/Postpartum Home Visiting Services.

program name:

time period:

ecc goals:

Family Support Services
Another Road to Safety (ARS)

Oct 2002-Present

goals 1 goals 2 goals 3 goals 4

brief program history

A CWLA report in 1998 articulated the need for Alameda County to intervene on behalf of families reported to the Child Abuse Hotline, but who never receive follow-up services. Another Road to Safety (ARS) program began as a pilot program designed as an alternative response to tertiary child welfare services provided by Social Services' Child Protective Services. With a Title IV-E waiver, Family Advocates comprised primarily of paraprofessionals and mental health clinical supervisors based at community-based organizations provide family-centered intensive case management to families who would otherwise not meet Social Services' criteria for immediate investigation, "No Intervention Needed, Close File" (NINCF). The program targets families residing in high-risk neighborhoods with the highest historical recorded hotline hits: East Oakland and South Hayward with an expansion to West Oakland in 2005.

BRIEF CURRENT PROGRAM DESCRIPTION

Families referred who meet specific Social Services (SSA) referral criteria are contacted by the CHO. An initial assessment for risk of abuse or neglect (using the Structured Decision Making tool, SDM) is conducted by the CBO staff to determine if a family would be better served through community resources if risk is low, retained for services, or returned to SSA for immediate follow-up, if risk is very high. Families retained by CBOs receive weekly home visits for 9 months and up to 1 year if necessary. Families who refuse CBO support services or unable to be located are returned to SSA for follow-up.

During the home visits, Family Advocates provide anticipatory guidance to families, model developmentally appropriate activities for parents/primary caregivers of the children, connect families to resources such as medical insurance, food assistance, income supports, residency / license documentation and health care providers, and address mental health and substance use issues with primary caretakers when necessary.

2006-07 PROGRAM COSTS: \$1,168,489

Funding Sources:

First 5 Alameda County, State SR grant, Title 4-E

PROGRAM DOSAGE:

Weekly home visits, up to 9 months with an extension available to 1 year

PROGRAM REACH

(Numbers & Population Served):

ARS has targeted 3 specific communities where previous call rates to the Child Abuse hotline were the highest. Entry into the system is only through calls coming into the CPS hotline and referrals to CBOs must have a 0 to 5 year old or pregnant woman in the household and live in the targeted zip codes. This substantially limits program reach.

In 2006-07:

East Oakland: Family Support Services of the Bay Area served 46 families

South Hayward: La Familia Counseling Services served 72 families

West Oakland: Prescott Joseph served 38 families

Demographics: 62% Hispanic, 25% African American / Black, 5% White, 4% Multi-Race, 2% Asian, 2% Other

Family Support Services (Another Road to Safety)

2006-07 Annual Report

Outcome 1A Enhanced parenting and stronger families

- 43% of primary caretakers screened for depression
- 25% screened positive for depression

Outcome 1C. Enhanced economic self-sufficiency of families

- 71% of children have no health insurance, or whose health insurance is Medi-Cal or Healthy Families by program
- 1% of children have no health insurance by program
- 41% of families are receiving CalWORKs or CalLEARN assistance
- 7% of teen families are CalLEARN recipients
- 8% of pregnant/parenting teens remain in school or graduated from high school
- 58% of families have at least one caretaker who is employed or on leave

Outcome 2A. Improved child social, developmental and emotional well-being

- 26% of children screened for developmental concerns who scored “of concern”

Outcome 2E . Increased school readiness

- 93% of families report reading, storytelling or singing three or more times per week to their children

Outcome 3B. Children are healthy, well nourished and receive preventive and on-going health and dental care from a primary provider

- 99% of children with health insurance
- 97% of children have an identified primary pediatric provider
- 98% of children have appropriate number of well child visits per age
- 98% of children are up-to-date on immunizations for age
- 69% of children one year and older received an annual dental exam
- 0% of children hospitalized or who made ER visits for asthma
- 1% of children hospitalized or who made ER visits for preventable ACS* diagnoses (other than asthma)
- 8% of children exposed to secondhand smoke
- 15% of parenting women and teens who smoke

Number of referrals made to CBOs by SSA**Since inception through FY 2006-07**

- SSA referred 1,207 families to CBOs

Amount of effort Family Advocates spend to engage families 2006-07**Family Advocates (FA) spent**

- 20 days finding families, getting consents to conduct a risk assessment and to determine whether ARS services were appropriate for each family.
- 18 days and 3 contact attempts before the FA successfully made a face-to-face contact with families referred by SSA.

Number of families assessed with SDM and results 2006-07

- 529 families were successfully screened with SDM by CBO
- Of 529 families assessed with SDM since inception
 - ◆ 18% Low Risk
 - ◆ 44% Moderate Risk
 - ◆ 27% High Risk
 - ◆ 11% Very High Risk

Percent of families referred, retained or returned to SSA 2006-07

- 41% retained for services, 1% referred to other community resources, 58% returned to SSA for follow-up

Percent of families returned to SSA by reason 2006-07

- 33.4% Family Refused
- 25.8% Lost to Follow-up
- 21.5% Other
- 8.9% Moved Out of Area
- 8.7% Receiving Services from Another Program
- 1.7% CPS Opened Case

Number of repeat CPS referrals per ARS family (if CWSCMS data available) - recidivism

Recidivism: from 2005 analysis 4 out of 79 families who participated in ARS had substantiated calls to CPS at 6 months after the CBO's last visit. Comparisons with State and National data prove difficult as other alternative response programs target families at different points of entry into the child welfare system and data is not readily available through CWSCMS, the main child welfare database.

- Ongoing transition of ARS to SSA is an example of a project piloted by First 5 that is transitioning to the community.
- Using CBO family advocates to provide services traditionally reserved for SSA staff presented a significant shift in SSA operations.
- Linkage of Lawrence Hall of Science (UC Berkeley) community grantee provided a different dimension of intervention services outside of home, emphasizing parent child interactions through play and learning. This opportunity also allowed Family Advocates to observe the family as a unit and their interpersonal socialization outside of the home.
- Having CBO staff train with (establish relationship and ‘credibility’) SSA staff in using the SDM (one of few, if any, CW programs in CA to do so).
- Implementation of the “Basic Needs Fund” to allow each program site to meet the specific needs of their families without having to use general funds or the personal resources of the home visitors (which sometimes happens) ... provides another engagement tool and helps respond to the economic self-sufficiency issue for some families

POTENTIAL FOR SUSTAINABILITY OR LONG-TERM HOME:

ARS provides a source for family support for families that SSA would never have engaged.

Management of ARS under SSA brings up issues regarding:

- Hiring (civil service system) efficiently and meeting the requirements of Specialty Provider services
- Shifts in funding priorities at the State and County levels
- Continued narrow point of entry of very high risk families using the Child Abuse hotline
- Prioritization of NINCF families
- Support for and understanding the culture of CBOs providing direct services

CBOs are also serving families with older children, requiring expertise and continued training on issues separate from the 0-5 population.

Since the transfer of oversight and funding of ARS to SSA, the continuation and scale of F5AC’s investment commitments remain unclear; in 2007-08 alone, F5AC contributed approximately:

- \$200,000 to serve 0-5 population
- \$200,000 SPT support; potentially outsourcing SPT functions to Children’s Hospital
- \$50,000 ECChange database maintenance and support that CBOs and SSA use for ARS data tracking and case management documentation

Improving services to families who are at risk of abuse or neglect is a stated interest in the Child Welfare community. The need for services remains high. Yet, ARS is only able to serve a very small percentage of families referred to CPS. Available data from the first 3 years of ARS show that 13% (3,018 out of 22,504) of all NINCF calls originated from East Oakland and South Hayward. Only 558 of these families involved a child 0-5 or a pregnant woman in the home. About 40% of these qualifying families were returned to SSA because they could not be found, refused ARS services, or required immediate CPS attention.

By the time a call is made to CPS, a family is already deemed 'at risk'. In this operating environment, engaging families for services requires extensive follow-up and results in less than a third of the families agreeing to intensive case management.

With intensive family support services, children consistently retained health supports, families get connected to necessary resources and developmental concerns are identified early. Over 25% of mothers screened for depression score positively for depression. 26% of the children screened "of concern" in at least one developmental domain. 19% of referrals FA made for families were for food and shelter/housing, another 16% included referrals for employment and financial assistance.

ARS services fall on the tertiary end of the preventive care continuum. CBO partners and F5AC have advocated capturing families through points of referrals other than through the child abuse hotline.

The partnership between SSA, F5AC, CBOs proved intense, with advantages and challenges. Each partner brought different operational, program and staff cultures, requiring a high level of effort to maintain a strong and supportive partnership. It is unclear whether SSA will be able to provide the "holding environment" necessary to support this intense work with at risk families.

Despite providing technical assistance, funding and supporting the SSA data system infrastructure and multiple requests, we have been unable to obtain SSA data that would facilitate the calculation of recidivism rates – the key outcome of measuring the success of this program.

The Child Welfare community is interested in Alameda County's alternative response model. In addition to pursuing recidivism data, a study funded by CalSWEC and conducted by the School of Social Work, UC Berkeley, will attempt to identify longer term impact of ARS services on families. This research team will also investigate another critical data point: the fate of families who were referred to the CBO's but never received services.

Program already scheduled to fully transition to SSA by June 30, 2009 (e.g., consultation contract w/ CHO (4/1/08-6/30/09) = transition of SPT services). Other issues to think about but have no impact on: potential “model drift” due to higher risk families and longer term of engagement (most, if not all, families receive 9 months of services); how to address needs of older children; new concept to bundles services beginning with FY 2008-09. Implications for who providers may be and how to support them: data collection/analysis/reporting needs, etc.

For FY 2008-09, it is important to determine with SSA (1) the ability to transition other FSS providers to that system (i.e., teen services, Special Start) and (2) the level of partnership desired beyond June 30, 2009, and if our strategic plan will support that.

program name:

time period:

ecc goals:

Family Support Services
Special Start IFS

2000-Present

goals 1 goals 2 goals 3 goals 4

brief program history

Each year, approximately 1,000 births to mothers who live in Alameda County are discharged from the Neonatal Intensive Care Unit (NICU). The Special Start program was established as a collaboration with Alameda County Public Health Department and Children’s Hospital and Research Center at Oakland (CHRCO) to provide intensive family support services to this medically-fragile infant population and their families who often experience high social/emotional risks. Some of these children experience long term medical and developmental conditions, or initially require intensive follow-up during his/her first years of life. The Special Start Programs jointly serve 600-700 families per year.

BRIEF CURRENT PROGRAM DESCRIPTION

Through a weekly disposition process that reviews NICU cases, a case manager is assigned to follow families identified to receive services while the infant is still in the NICU. Once discharged from NICU, infants and families receive intensive support services at home from a multi-disciplinary team of Public Health Nurses, Family Advocates (CHOWs: paraprofessional public health staff), mental health and substance use specialists and child development specialists through age three years, if necessary.

During the home visits, Special Start staff provide anticipatory guidance to families, assess the child for medical and developmental needs, facilitate medical appointments, model developmentally appropriate activities for parents/primary caregivers of the children, connect families to resources such as medical insurance, food assistance, income supports, residency / license documentation and health care providers, and address mental health and substance use issues with primary caretakers when necessary. Due to a high concentration of medical and developmental issues, Special Start home visitors frequently communicate issues between the families and their primary medical providers.

2006-07 PROGRAM COSTS: \$3,270,738

FUNDING SOURCES:

First 5 Alameda County, TCM

PROGRAM DOSAGE:

Variable: Weekly, monthly home visits up to the child’s 2nd birthday; based on clinical judgment, can monitor child through 3rd birthday

PROGRAM REACH

(Numbers & Population Served):

From FY2001-02 to FY 2006-07:

1,961 children served (unduplicated)

FY2006-07:

639 children served

Demographics: 40% Hispanic, 28% African American / Black, 11% Asian, 10% White, 6% Multi-race, 4% Other

Mother’s primary language:

65% English, 30% Spanish, ~6% Vietnamese, Tagalog, Arabic, Cantonese, Farsi-Dari, Punjabi, Kamir

Region: 48% Oakland, 18% Hayward, 10% San Leandro (remaining are spread out over the county)

Family Support Services (Special Start)

2006-07 Annual Report

Outcome 1A. Enhanced parenting and stronger families

- 83% of primary caretakers were screened for depression
- 26% screened positive for depression

Outcome 1B. Children are free from abuse and neglect

- 6% of children are in foster care at time of referral
- 11% of children have open Child Protective Services cases at time of referral
- 6% of children are placed in foster care during the report period
- 10% of children have a CPS case opened during the report period

Outcome 1C. Enhanced economic self-sufficiency of families

- 77% of children have no health insurance, or whose health insurance is Medi-Cal or Healthy Families by program
- 0% of children have no health insurance by program
- 19% of families are receiving CalWORKs or CalLEARN assistance
- 27% of teen families are CalLEARN recipients
- 42% of pregnant/parenting teens remain in school or graduated from high school
- 77% of families have at least one caretaker who is employed or on leave

Outcome 2A. Improved child social, developmental and emotional well-being

- 99% of all one-year olds screened for developmental concerns
- 66% of children screened for developmental concerns who scored “of concern”

Outcome 2E. Increased school readiness

- 93% of families report reading, storytelling or singing three or more times per week to their children

Outcome 3A. Increased support for breastfeeding mothers

- 58% of women were breastfeeding at the first home visit
- Of those who breastfeed, 41% breastfeed for 6 months to 1 year

Outcome 3B. Children are healthy, well nourished and receive preventive and on-going health and dental care from a primary provider

- 100% of children with health insurance
- 100% of children have an identified primary pediatric provider
- 99% of children have appropriate number of well child visits per age
- 99% of children are up-to-date on immunizations for age
- 29% of children one year and older received an annual dental exam
- 1% of children hospitalized or who made ER visits for asthma
- 13% of children hospitalized or who made ER visits for preventable ACS* diagnoses (other than asthma)
- 8% of children exposed to secondhand smoke
- 8% of parenting women and teens who smoke

Number of Special Start clients who received IFSS

639 children served

Range in number of visits received by Special Start clients

Clients received 1 to 58 visits

Percent of encounter time spent on economic self-sufficiency issues, e.g. housing, staying in school, child care, employment, ESL, etc.

15% of community referrals were for basic needs, health insurance, financial assistance

Number of children referred for developmental services by type of service

14% of community referrals were for child development at Regional Center or Head Start

Number of children with special needs receiving ECC services by type of program

58% of Special Start children have a documented special need

44% <1500g (very low birth weight), 34% 1500-2499g (low birth weight), 22% > 2500g (high social stressors / developmental risk)

Percent of encounter time spent on providing or supporting medical issues, e.g., appointments, medications, etc.

30% of community referrals made by case managers related to medical issues or for a primary care physician

Special Start has had many compelling stories reflecting impact of the program in the annual reports.

SYSTEMS CHANGE IMPACT

Special Start showcases targeted intensive support using a multi-disciplinary team approach

Attempt to create a public-private partnership to build awareness and capacity

Attempt to 'make a case' for sharing program costs and oversight with SSA

POTENTIAL FOR SUSTAINABILITY OR LONG-TERM HOME:

Services to families limited up to (or through?) age 3. Other services in the county are limited to Regional Center and School District services, both of which have capacity and organizational issues.

Special Start services do not fit squarely within any known funding source. Funding for intensive family support programs for medically-fragile infants relies heavily on block grants administered at the State level. Title V funding was recently reduced substantially and continues to be vulnerable to swings in the State budget.

The federal Deficit Reduction Act of 2005 also puts programs relying on reimbursements for providing services to Medi-Cal eligible populations on a tenuous track, e.g., agencies that currently rely on First 5 funds to draw down matching TCM dollars.

Special Start provides critical and high cost support to families who experience multiple risks and stressors. The program also provides one of the few long-term case management interventions available in the county. Special Start is only able to serve a small proportion of all NICU births in the county (~388 new children enrolled each year since FY 2003-04).

Special Start staff possess a constellation of skills that are responsive to the families' needs. In addition to the diverse medical and developmental needs of the children served, families also come from a wide range of linguistic, literacy, cultural and socio-economic backgrounds. Both Special Start agencies maintain a high level of professional integrity, are committed to their clients and strive to provide culturally sensitive, relationship-based services and embrace FSS tenets. CHRCO conducts complementary parent support groups for Spanish-speaking families.

The program is fundamentally a tertiary support program. Families targeted for services are generally at high risk, medically and socially, and experience a higher incidence of developmental, behavioral, mental health and substance use problems.

Additionally, many families are in a precarious position financially, experience instability in housing, feel isolated in the community or are unable to navigate community support systems due to language and cultural barriers. Home visitors spend a large proportion of their time helping families navigate available resources in the community to address the wide range of issues affecting the families.

Many families connected to external community resources are limited by:

- Application and assessment requirements for external services at the Regional Center / School Districts
- Services not available until the child turns 3 years of age
- Availability of services provided in appropriate language of family
- Maintenance / documentation requirements for continuation of Medi-Cal coverage
- Numerous medical providers and specialists serving multiple medical complications

Special Start is a vital community service with no identifiable funding source if the F5AC funds go away. While there is data to show the positive impact of the intervention both for the child and family, research demonstrates that NICU infants are at high risk for abuse and neglect. A proportion of the NICU infants are already known to SSA and another proportion are referred to SSA/Children and Family services. We have not yet found a way to obtain a commitment from SSA to help shoulder the enormous expense related to administering this program. Ultimately, this is a program to which we must remain committed until there is a secure funding source or the public will mandate the provision of these services.

Factors to consider:

- Impact on length of engagement for monolingual Spanish-speaking families
- Link to FRC and other advocacy groups (political)
- Infant mortality rate in Alameda County at time of implementation (pre-ECC) and expansion (additional funds allowed more children to be seen, “saved”)
- Early, and current, role of HCSA/other public and private entities that have a vested interest in the outcome of these children and families?
- Annette’s PP caseload, pilot program that has proven beneficial to both CHO and PHD

program name:

time period:

ecc goals:

Family Support Services
Teen IFS Program

2000-Present

goals 1 goals 2 goals 3 goals 4

brief program history

The number of births to teen mothers living in Alameda County steadily decreased since 1990, but has stabilized now around 31 per 1,000 females ages 15-19. Birth records show 1,394 births to females < 20 years old in 2006, 1% of whom were less than 15 years of age. (Alameda County Public Health Department of Vital Statistics) Each year, Tiburcio Vasquez Health Center (TVHC) and Brighter Beginnings (formerly The Perinatal Council) serve close to 700 teen parents. These two agencies originally served pregnant teens through AFLP and CAL Learn funding with a primary focus on the teen mother. The First 5 Teen intensive family support program was designed to enhance their capacity by placing the focus of support on the child in addition to supporting the teen parents facing various stressors.

BRIEF CURRENT PROGRAM DESCRIPTION

Brighter Beginnings and TVHC staff the teen programs with paraprofessional family advocates who are managed by at least one licensed clinical supervisor. Family Advocates serve both children of teen parents as well as pregnant teens. During the home visits, family advocates provide anticipatory guidance to families, screen for developmental concerns, model developmentally appropriate activities for parents/primary caregivers of the children, support teens to stay in school or graduate, connect families to resources such as medical insurance, food assistance, income supports, residency / license documentation and health care providers, and screen for and address mental health and substance use issues with primary caretakers when necessary.

2006-07 PROGRAM COSTS: \$1,136,081

Funding Source:

First 5 Alameda County

PROGRAM DOSAGE:

Variable: Weekly, monthly home visits up to the child's 3rd birthday or until teen parent ages out

PROGRAM REACH

(Numbers & Population Served):

From FY2001-02 through FY 2006-07: 2,567 pregnant teens and children of teens served (unduplicated)

FY2006-07:

691 clients served

Demographics: 72% Hispanic, 19% African American / Black, 2% Asian, 1% White, 2% Multi-race, 3% Other

Mother's primary language:

71% English, 29% Spanish,

Region: 41% Oakland, 29% Hayward, 8% Fremont, 8% Union City

Outcome 1A. Enhanced parenting and stronger families

- 58% of primary caretakers screened for depression
- 22% screened positive for depression

Outcome 1B. Children are free from abuse and neglect

- 3% of children are in foster care at time of referral
- 2% of children have open Child Protective Services cases at time of referral
- 2% of children are placed in foster care during the report period
- 4% of children have a CPS case opened during the report period

Outcome 1C. Enhanced economic self-sufficiency of families

- 88% of children have no health insurance, or whose health insurance is Medi-Cal or Healthy Families by program
- 1% of children have no health insurance by program
- 26% of families are receiving CalWORKs or CalLEARN assistance
- 19% of teen families are CalLEARN recipients
- 58% of pregnant/parenting teens remain in school or graduated from high school
- 61% of families have at least one caretaker who is employed or on leave

Outcome 2A. Improved child social, developmental and emotional well-being

- 50% of all one-year olds screened for developmental concerns
- 14% of children screened for developmental concerns who scored “of concern”

Outcome 2B. Increased access to resources for children and families with special needs

- 3% of children receiving Teen IFS services have a documented special need

Outcome 2E. Increased school readiness

- 90% of families report reading, storytelling or singing three or more times per week to their children

Outcome 3A. Increased support for breastfeeding mothers

- 46% of women were breastfeeding at the first home visit
- Of those who breastfeed, 34% breastfeed for 6 months to 1 year

Outcome 3B. Children are healthy, well nourished and receive preventive and on-going health and dental care from a primary provider

- 99% of children with health insurance
- 89% of children have an identified primary pediatric provider
- 98% of children have appropriate number of well child visits per age
- 97% of children are up-to-date on immunizations for age
- 24% of children one year and older received an annual dental exam
- 3% of children hospitalized or who made ER visits for asthma
- 0% of children hospitalized or who made ER visits for preventable ACS* diagnoses (other than asthma)
- 6% of children exposed to secondhand smoke
- 6% of parenting women and teens who smoke

FY2006-07 Annual Report

Number of children of teen parents who received IFSS, by age (<15, <20)

- 691 families served, receiving
- 6% of teen parents were less than 15 years old

Range in number of visits received by Teen program clients

- Received 1 to 34 visits

Percent of encounter time spent on economic self-sufficiency issues, e.g. housing, staying in school, child care, employment, ESL, etc.

- 11% of community referrals were for child development at school districts or Head Start
- 17% of community referrals were for health insurance, 10% financial assistance and education/vocation, 10% for basic needs (housing, food, transportation, emergency services and shelter), 10% for child care (R&R, daycare, Early Head Start)

SYSTEMS CHANGE IMPACT

Teen agencies began to staff Mental Health providers and Child Development specialists to support the needs of teen parents, using EPSDT as a funding source. Mental health services now available on site due to EPSDT coordination efforts.

Curriculum, Growing Great Kids, was adopted to focus teen support on the child, developmental milestones and parent child relationships.

Improved relationship with ACPHD Special Start in developing protocol for joint visits and “warm handoff”

Child Find (have been able to identify other children in the home who may not have come to our, or any other provider’s, attention)

Impact on high school graduation rate (how to attribute our impact on this, however, is difficult)

POTENTIAL FOR SUSTAINABILITY OR LONG-TERM HOME:

Teen programs rely heavily on state funds. Categorical funding streams include AFLP, CalLEARN. Title V funding was recently reduced substantially and continues to be vulnerable to swings in the State budget.

The federal Deficit Reduction Act of 2005 also puts programs relying on reimbursements for providing services to Medi-Cal eligible populations on a tenuous track:

- Required documentation and re-application for Medi-Cal
- Reliance on First 5 funds to draw down matching TCM dollars
- EPSDT funding for mental health, health & dental screening and assessments, immunizations of families with Medi-Cal.

Both agencies have been recipients of multiple community grants initiative awards for various wrap-around services (e.g., parenting partnerships, developmental playgroups)

TVHC is also a F5AC contractor for Healthy Steps at their clinic.

The two funded agencies provide services for a large proportion of teen parents in the county. The family advocates provide a “safe” place to support teens anonymously, without judgment, and away from school and family pressures. Advocates serve as a receptive ear to parenting questions. Advocates also offer sources for information on community resources, teach teens important life skills such as making appointments, talking to doctors, arranging for child care, etc. Advocates report finding themselves defending and educating other community providers on behalf of teen parents.

Initially, the teen agencies resisted changing their model of service to meet ECC standards and incorporate the FSS tenets. Through dedicated technical assistance and program oversight, the agencies eventually embraced the model. The agencies moved toward focusing the teen parenting support on the child, encouraging breastfeeding, building the agencies’ capacities to provide child development screening and guidance and promoting social-emotional well-being as an integrated part of family support.

Teen agencies serve a variety of age groups, each with very distinct needs. Of note, 6% of the teens receiving services were less than 15 years of age. Many of the very young mothers still live with her parents, and are recipients of extraordinary scrutiny from middle-school peers. Community resources are also unfamiliar with the needs of very young parents. A small percentage of older teens work with their family advocates to complete GED requirements, submit job applications and apply for college. Few teens served also participate in CalLEARN / AFLP due to documentation of residency requirements or difficulty re-integrating into CalLEARN campus postpartum.

The availability / accessibility of child care for teen parents attempting to complete academic requirements remains a critical need yet a constant challenge. Housing stability also presents a problem due to the high cost of rent, especially for teen parents who no longer live with their parents; shelter options are not available if teen has a child with the exception of a small number of transitional housing accepting non-foster care youths. Many teens cannot afford to purchase car seats, diapers, food, prompting agencies to maintain a “pantry” of supplies to fulfill basic needs. Dental services, even with Medi-Cal, are relatively costly.

Despite the obvious stressors, graduation rates (~53% average over 4 years) among the teen parents in the program show promise, compared to the 40% national graduation rate among teen parents (National Campaign to Prevent Teen Pregnancy Report, 1997). Health indicators show that the infants remain well-connected to medical and health insurance resources. Data is not available to monitor the effects of parenting education and empowerment; however, proxies suggest that most parents are reading / telling stories / singing to their children and that secondhand smoke exposure declined over the last 2 years.

Staff turnover creates challenges for the agencies to maintain a well-trained and consistent staff.

Need to integrate this program into Social Services Agency (SSA) system. Under the Title IV-E waiver, SSA is providing expanded ARS services to the teen population in general. There is a proportion of the population that is known to SSA prior to enrollment and also a cohort who are referred to SSA. The need to look at the prevention end of the population and evaluating how the pregnant teen population can be integrated into the SSA service system is worth exploring. This program has already experienced a substantial decrease in F5AC funding and, due to other fiscal leveraging strategies put into place and has done well; not sure if further cuts are warranted—given positive outcomes and target population and possible impact on financial viability (e.g., leveraging ability, dependable cash flow, etc.). Current budget crisis at federal and state levels also makes these programs vulnerable. We would have to feel somewhat assured that a funds at same or higher level would be substituted prior to cutting our funding.

program name:

time period:

ecc goals:

Family Support Services
Specialty Provider Team

Inception-Present

goals 1 goals 2 goals 3 goals 4

brief program history

The Specialty Provider Team (SPT) consists of F5AC staff who are formally trained in the areas of Lactation/Breastfeeding, Child Development and Mental Health. SPT services grew from the need to respond to multi-faceted family needs quickly, flexibly, and using best / promising practices to promote healthy attachment and bonding between parent and child and the social-emotional health of young children and families. The initial concept of building an in-house F5AC SPT team, with the intent of embedding specialty provider services into Family Support Service contractor agencies and convening bi-monthly multidisciplinary team meetings, proved to be unrealistic. As a result, the SPT assumed responsibility of addressing the mental health and lactation needs of families directly while working on relationship-building with and providing consultation to FSS contractors. The SPT supported:

- The institutionalization of best practices and the Family Support Services Tenets in the provider community
- Raising the competencies of the workforce in the community
- Embedding multi-disciplinary staff into agency workforce.

The team's relationship with program contractors expanded to include providing trainings (up to 50 a year), consultation, and developing subject-specific intensive case-study training "pods." Over time, the reliance on SPT direct services increased as community agencies struggled to maintain their own staff of multi-disciplinary teams. The SPT responsibilities also evolved to provide technical assistance across F5AC programs outside of family support services, as well as to staff the Healthy Steps program.

BRIEF CURRENT PROGRAM DESCRIPTION

In addition to directly serving families at home and in the hospitals, SPT assists in coordinating the support for families by communicating with other contracted providers known to the case. They also coordinate care by ensuring that families are linked to appropriate services in the community. To support provider capacities countywide, the SPT provides a broad range of technical supports to the community and to F5AC staff. The SPT currently provides technical support through:

1. **Multi-disciplinary team meetings** - SPT specialists participate in case reviews to raise the skill level of Contractor family advocates and supervisors.
2. **Joint visits** - specialists make a joint home visit with a PHN/family advocate to provide consultation including additional family observation/screening and on improving home visitor/family relationship skills.
3. **Monthly Clinical Meetings (Pods)** that combine case study and clinical skill building. Each pod focuses on specific subject matter, e.g., lactation, mental health, substance use.
4. **Case coordination** with other home visitors to share information about families receiving SPT direct services to discuss progress, evaluate stressors, etc.
5. **Consultation to providers** (PHNs, family advocates, supervisors) regarding provider concerns about families they serve as well as directing providers to community resources such as obstetricians and EPSDT providers for follow-up interventions. Consultations also serve as opportunities to provide reflective supervision to help home visitors manage their encounters with grief, domestic violence, and other difficult situations.
6. **Intensive training** to agencies, on topics such as: Home Visiting 101, Lactation Basics and Parent/Child Relationship Building Skills.
7. **Cross-agency technical support** to assist F5AC programs such as Community Grants, Early Childhood Education, Training Connections, Quality Improvement Initiative, Partners In Collaboration.
8. **Community Engagement** providing consultation to community groups not directly affiliated with F5AC program such as: helping Project Pride (residential drug treatment program for pregnant women) set up lactation support groups for families struggling with substance use.

2006-07 PROGRAM COSTS: \$639,963
(excludes Healthy Steps)

Funding Sources: First 5 Alameda County, State School Readiness grant

PROGRAM DOSAGE:

Variable depending on the need of families and capacity building methods with community providers

PROGRAM REACH

(Numbers & Population Served):

277 HOC and 41 PHN mothers of newborns referred for mental health

Clients referred for SPT direct services: 245 Lactation, 304 Mental Health / Substance use, 10 Child Development

181 Brief Lactation / Breastfeeding Intervention contacts at Highland

Providers received 89 consultations, 82 multidisciplinary team meetings, 15 Technical Assistance sessions, 49 trainings on special topics

SPT helped 59 families by coordinating their care through contacts with community resources, medical providers, etc.

Family Support Services (Specialty Provider Team)

2006-07 Annual Report

Note: SPT contributes to ECC Outcomes by providing support and training to contracted agencies, Summer Pre-K, Grants and QII. See Program Outcomes.

Outcome 1A. Enhanced parenting and stronger families

Outcome 1B. Children are free from abuse and neglect

Outcome 2A. Improved child social, developmental and emotional well-being

Outcome 2B. Increased access to resources for children and families with special needs

Outcome 2E. Increased school readiness

Outcome 3A. Increased support for breastfeeding mothers

Outcome 3B. Children are healthy, well nourished and receive preventive and on-going health and dental care from a primary provider

FY2006-07 Annual Report

Number of postpartum mothers referred by Hospital Outreach Coordinators (HOCs) for SPT services

318 mental health referrals to SPT. Examples of reason for referral include: 142 for Depression, 14 for Depression & Domestic Violence (DV), 11 for Depression and Substance Use, 33 Substance Use, 25 DV, 22 History of Fetal Demise, 11 Teen Moms with mental health needs, 10 History of Sexual Trauma, 9 Grief, 8 Substance Use and DV, 8 Isolation/Immigration, 5 Child Medical Condition, 5 Attachment Concerns, 4 Adoption Issues, 1 Child Development Concerns for Sibling of Baby, 3 Death of FOB, 3 Developmental Delay of MOB

Number of parents receiving individual consultation for mental health and lactation and child development

- 270 cases were assigned to SPT mental health specialists
- Referred families received 330 face to face encounters and 648 telephone calls.

Number of SPT services to providers including consultation, trainings, direct services, attendance at MDT meetings and participating in joint home visit

SPT provided consultation support to three Another Road to Safety (ARS) programs. A MH specialist and a CD specialist attended bi-monthly multi-disciplinary team (MDT) meetings at each ARS community site and provided clinical consultation, mini trainings and technical support. The SPT Administrator provided bi-monthly one-on-one consultation to each of the ARS clinical Supervisors. SPT provided ongoing trainings on alcohol and drug abuse in addition to individual and group consultations for ARS family advocates.

Number of trainings provided to Contractors and community providers regarding child development

- SPT Child Development specialists provided joint home visits to augment the family advocate's ASQ screening tool skills.
- 14 trainings this year covered using ASQ, ASQ-SE, DECA, PIPE, Child Development trainings on Gross Motor, Language and Communication, Special Education System – Resources and how to Refer, Early Childhood Mental Health, ASQ and ASQ-SE labs.
- SPT provided 89 consultations for providers (not client specific), attended 82 MDT meetings, provided 15 sessions of Technical Assistance and 49 trainings

Number of postpartum mothers who received hospital-based lactation support

Lactation Specialists served 176 new mothers at Highland Hospital immediately after giving birth.

Number of postpartum mothers who received home-based lactation support

245 breastfeeding mothers received support at home through 914 phone consultations and home visits.

By engaging with the community, the SPT helped build support groups at Project Pride and Madres, assisted Highland Hospital in systemically changing lactation support practices for new moms, and encouraged the widespread utilization of validated screening tools for maternal depression, substance use and early identification of developmental concerns.

Other system changes include:

- Countywide use of early screening tools
- Increased provider capacity building around lactation, mental health, child development
- Greater case coordination among community partners

POTENTIAL FOR SUSTAINABILITY OR LONG-TERM HOME:

MAA claiming allows F5AC to leverage Medicaid dollars for SPT direct services and Hospital Outreach Coordinator case coordination activities

MDT services / skills are not priorities in community agencies, especially during a budget crisis. The required skills translate to greater hiring expenses and a perceived limited range in skill set compared to generalist family advocates or nurses. Some partners may not need MDTs full-time, creating another barrier to recruitment and sustainable staffing.

Initial efforts to instill workforce changes in the community to support multi-disciplinary practices evolved into a heavier focus on broad-based training of non-specialist providers (PHNs, family advocates, program supervisors) in the community. The SPT serves as a resource for teaching providers best practices such as using appropriate tools for assessments and screens, and acts as a networking agent by getting providers to communicate with each other and to tap into other available community resources.

The SPT is often the first responder to families enrolled for home visits. SPT MH Coordinator provides linkage and further communication between Hospital Outreach Coordinators (HOCs) and home visiting partners to ensure a smooth transition and safety net for depressed new mothers. HOCs were also trained by SPT to address basic breastfeeding issues in order to support new mothers immediately postpartum. Lactation specialists directly served the greatest number of clients through phone calls and home visits.

SPT advises providers on effective prevention strategies that impact the quality of interventions. The demand for quality multi-disciplinary team (MDT) interventions is high. In 2006-07:

- Maternal depression is prevalent among 25% of mothers receiving intensive family support services.
- 318 Mental health issues referred by Hospital Outreach Coordinators and Public Health Nurses of postpartum mothers
- Approximately half of all new mothers experience breastfeeding or lactation problems.
- Over 1,300 Child Development screens conducted by F5AC partners using the ASQ (SE), DECA
- Children served at Summer Pre-K, PIC, QII are referred to F5AC Child Development Specialists should additional screens be required.
- F5AC Community Grants Initiative piloted the Parenting Partnerships 2007-09 to ensure community agencies conducting intensive parenting programs use promising practices

SPT staff each exhibits a talent and commitment to engage with the community, establishing a rapport with medical and non-medical providers and hospital and public administrators. Mental health, lactation / breastfeeding, substance use and child development support services in the community exist, though are often decentralized, usually isolated by subject matter and vary in the spectrum and intensity of services provided. SPT often relies on personal interactions and networks to discover community resources in order to refer families and providers to appropriate resources.

Maintaining a “roving” team of specialists requires a champion in the community. Furthermore, building community capacity requires intensive training and re-training.

Providing direct service keeps the Specialty Provider Team as well as FSS management grounded in the reality of family needs. We are able to observe trends in Alameda County and are aware of clinical training needs. The SPT has first hand knowledge about the stressors and challenges to providing direct family support specialty services.

The SPT module in ECChange has grounded the clinical work by providing a tool for documentation and for organizing our clinical experience leading to thoughtful protocols and guidelines overall. It has provided cross-checks in our thinking to hopefully result in meaningful outcome data.

The SPT is comprised of bi-cultural, bi-lingual staff that have been trained at the bachelor and master level. This cultural and professional is an integral part of the very same community to whom we offer services. We strive to maintain an awareness of cultural humility as it is manifested not only in our work with clients, but also in-house among our staff.

FSS might consider providing a monthly community MDT now that the community is better connected and grounded in FSS tenets and screening tools. The idea of the roving MDT may reach its maturity by the end of the next iteration of the PPHV program.

Reflective Supervision is one of the FSS tenets. FSS should consider providing a training series for contractor program managers and supervisors to review reflective supervision as it applies to administration, ECChange, agency protocols, as well as, home visiting within the parameters of the particular staff's role and scope of work. Becoming an agency grounded in reflective practices will further facilitate systems change.

There are no in home breastfeeding/lactation services available for low income/MediCal Families in Alameda County. Resources are extremely scarce for postpartum mothers experiencing complex breastfeeding issues,. Community breastfeeding resources are limited by geographical location and offer basic interventions. Private consultation services are available for costly a fee and are usually office based.

Further, there are no mental health services available for Emergency MediCal families. SPT is truly a safety net for undocumented and monolingual families.

program name:

time period:

ecc goals:

Family Support Services
Pediatric Support Programs

End of 2004-05-
Present

goals 1 goals 2 goals 3 goals 4

brief program history

Developmental Screening and Support

F5AC invested significant efforts to support systems of early identification of children with developmental delays (“Child Find”) at pediatric sites and through training of pediatric providers. These efforts support best practice models of promoting developmentally oriented pediatrics. In 2003, F5AC began a pilot Healthy Steps program to support child development at two pediatric sites. Healthy Steps placed Child Development Specialists at pediatric clinics to screen children whose pediatric providers suspect developmental delay, to provide case management, link children and families to appropriate resources, and to share basic parent education information with families. In 2004, another model originally funded by the Commonwealth Foundation ABCD Initiative was designed to support pediatric providers to screen all 18-month old children using a standardized screening tool (the Ages and Stages Questionnaire) during well child visits at three private practices. If a developmental concern was identified, the provider offered information and resources to the family, monitored and re-screened the child months later, or decided to refer the family to appropriate services for a complete developmental assessment.

Reach Out and Read

F5AC connected pediatric sites to the National Reach Out and Read program. This literacy program supported pediatricians to discuss the importance of reading with families and provided books to children at each of their well child visits beginning at 6 months old until age 5.

Pediatric Trainings

Quarterly trainings were offered to pediatric providers on developmentally oriented pediatrics.

HEALTHY STEPS

Child Development Specialists (CDS) from ECC Specialty Provider Team and contracted community organization offer parent education and support, developmental screenings and referrals to community resources for parents at four pediatric clinics. Pediatric providers or parents refer families directly to the CDS if they suspect a child has developmental concerns. CDS conduct an ASQ and or ASQ-SE to determine if follow-up assessment services or additional developmental services are needed. CDS will also assist families, as needed, in navigating referral systems such as the Regional Center and School District services and other community resources.

ABCD

The ABCD Program is implemented at four pediatric practices. The ECC Pediatric Strategies Associate and a contracted community agency visit each site monthly to provide incentive bags to participating families; collect completed ASQ score sheets; and provide technical assistance and support to the sites. Consultation to the site includes assistance with completing ASQ screeners, information on referral pathways, discussion of office flow and general program development support.

Reach Out and Read (ROR)

There are 21 active Reach Out and Read sites. The Pediatric Strategies Associate provides basic technical support to sites to complete required reports and information to the national office. In conjunction with the ROR pediatric champion, we host quarterly networking meetings for all participating sites in the county.

Pediatric Trainings

Trainings are held quarterly on various topics related to child development and the pediatric practice and offer an opportunity for networking. Topics included: Autism, Maternal Depression, Bilingual Language Acquisition, ADHD, and Understanding Sleep Disorders. Continuing Education Units are provided.

2006-07 PROGRAM COSTS: \$889,557

Includes Healthy Steps and Pediatric Support Programs

Funding Sources: First 5 Alameda County, State School Readiness grant

PROGRAM DOSAGE: VARIABLE: Based on available ECChange data from May 2005 through June 2007

Healthy Steps CDS averaged 3.3 contacts (phone or face-to-face) per child. Some children received up to 22 contacts.

~81 days from first to last contact with families who received case management

PROGRAM REACH

(Numbers & Population Served):

Number of children screened through Healthy Steps: (Duplicated)

2003-04: 90 children

2004-05: 230 children;

2005-06: 231 children;

2006-07: 232 children

Brief interventions in 2006-07: 82

Distribution

2006-07 Enrolled at:

Tiburcio Vasquez: 51 children

Silva Clinic: 146 children

East Oakland Pediatrics: 26 children

Asian Health Services: 93 children

2007-08: expansion to Highland;

Discontinued at East Oakland Pediatrics.

48% live in Hayward, 26% in Oakland,

7% in San Leandro

Primarily monolingual non-English or English Learner families served: 21%

English, 50% Spanish, 25% Cantonese/ Chinese

ABCD served families with private and Medi-Cal insurances at Kiwi Pediatrics (2 sites), Bay Area Pediatrics and Oakland Behavioral Pediatrics.

14 pediatric sites received training and information on medical home, 12 agencies received trainings on medical home and referral pathways, reaching 430 providers.

Family Support Services (Pediatric Support Programs)

2006-07 Annual Report

Outcome 2A. Improved child social, developmental and emotional well-being

In 2006-07, 60% of Healthy Steps children screened scored "of concern" in at least one developmental domain

- 65% of children referred to school districts completed or were in the process of completing referral
- 43% completed or were in process of completing their referral to the Regional Center.

A survey of a small sample of Healthy Steps families in summer 2007 indicates that less than half received all the services specified in their child's respective IEP or IFSP even with active case management. This is, in part, due to a lack of bilingual providers at the referral agencies and a long wait time for appointments at both the Regional Center and School Districts.

Increased parental knowledge of typical and atypical child development and of related community resources for children under 5 and their families

Early identification of developmental and behavioral concerns and linkages with follow-up supports

Increased pediatric settings' focus on child development, knowledge of typical and atypical child development and awareness of community resources for children under 5 and their families.

PROGRAM RESULTS:

Healthy Steps

In 2006-07, 60% of Healthy Steps children screened by the CDS scored "of concern" in at least one developmental domain. 65% of children referred to school districts completed or were in the process of completing referral. 43% completed or were in process of completing their referral to the Regional Center. A survey of these families in summer 2007 indicates that less than half of them received all the services specified in their child's respective IEP or IFSP

ABCD Project

2005-06: 28% of children screened by pediatric providers scored "of concern" in at least one domain in the ASQ. Of those who scored "of concern":

- 32 of 59 received some intervention from their primary care provider
- 19 were referred to Regional Center, Children's Hospital Speech and Language Center, Children's Hospital Child Development Center or Early Childhood Mental Health; 10 of the 19 actually received treatment from the external source

Reach Out and Read (ROR)

Reach Out and Read engaged 23 pediatric sites by offering support in completing ROR applications and ordering books. As a result, over 35,000 books were distributed at pediatric sites in 2006-07.

Quarterly Pediatric Trainings

- 44 participants, 22 practices attended "The Well Child Visit", highlighting legislative and policy issues affecting young children and referral pathways
- 36 participants, 24 practices attended "Evaluating and Treating ADHD", focusing on the process for evaluating and treating ADHD
- 24 participants, 14 practices attended "Understanding Sleep Disorders", increasing understanding of pediatric sleep disorders and treatment options and strategies to help parents
- 23 participants, 14 practices attended "Addressing Parents' Concerns around Discipline Issues", with topics centered on assisting parents in the context of the well child visit and understanding socio-cultural factors

Participating providers in pediatric support programs demonstrate increased awareness of the importance of child development issues, the benefits of identifying developmental concerns and making appropriate referrals early.

Participating providers learned to implement a standardized developmental screen in their practices to identify children with special needs.

Participating pediatric clinics changed the culture of their practices to include child development as integral to pediatric services

Healthy Steps increased number of children screened in higher risk neighborhoods (School Readiness / Low API).

Healthy Steps and ABCD raised awareness around the need for a Children's Screening ,Assessment , Referral and Treatment (SART) Initiative.

POTENTIAL FOR SUSTAINABILITY OR LONG-TERM HOME:

Some potential exists to institutionalize pediatric support strategies through the national ABCD Initiative.

American Academy of Pediatrics has recommended standardized developmental screening at a specified periodicity for all children 0-5 which has increased provider's interest.

SART can play an integral role in pursuing policies and fiscal incentives in sustaining best practices and developing / funding services for children who do not qualify for Regional Center or School District services.

A sustainable strategy must include buy-in and sufficient reimbursement for services provided to families. Policy work should focus on getting approval to bill Medi-Cal for the 96110 billing code.

Healthy Steps sites currently bill for developmental screening for Alameda Alliance patients. Although this is nominal amount, it partially funds the Reach Out and Read program.

Sustainability and expansion of Healthy Steps is difficult due the cost and recruitment issues of providing a child development specialist in every pediatric practice.

Family Support Services (Pediatric Support Programs)

Pediatric providers serve an important role in the county's larger system of early identification, referral and treatment for developmental concerns identified in the early childhood period. Pediatric Support Strategies made significant strides in enhancing the standards of practice in screening and referring. Linkages with Regional Center and the School District were more challenging due to capacity issues and ability to serve families whose primary language is other than English language capacity.

Healthy Steps is a nationally recognized practice-based intervention that has demonstrated the potential to enhance the quality of care for families of young children and to improve selected parenting practices (JAMA, December 17, 2003 -- Vol 290, No. 23). A controlled study showed that families who participated in the program had greater odds of children receiving timely well-child visits and sustained services, of parents receiving more anticipatory guidance and using less severe discipline, and greater odds of mothers at risk of depression discussing sadness with someone at the practice. The ABCD project is another national program that attempts to enhance child development practices by promoting standardized developmental screening at pediatric sites. Both programs juxtaposed different strategies in promoting "child find" in the pediatric sites, though highlighting varying competencies in each model.

Both strategies demonstrated success in delivering brief parenting supports and developmental guidance provided on site at the provider office; Healthy Steps CDS offered a limited number of home visits as well. Families are generally appreciative of the case management support provided by the Healthy Steps CDS. Parents of children who required follow-up assessments or services at the Regional Center expressed satisfaction and appreciation for the CDS' support in navigating services in the community, in completing necessary forms and for providing guidance on supporting their child's development. Despite the CDS intervention, some parents still struggled to obtain all the services their child required. Anecdotal responses from the most recent phone survey suggested the lack of capacity at the Regional Center/ School Districts; some parents indicated that they could not successfully complete the necessary application forms or the request for a school evaluation; another stated that their child no longer needed services.

Similarly, only half of the children screened and referred at the ABCD sites received services from external resources. ABCD providers noted, however, that screens "engaged parents in thinking about their child's development and gave [parents] a language for discussing developmental concerns with the pediatric provider." As a result of the project, providers requested that:

- Supports such as form letters be available that would make the referral process to School Districts or Regional center more efficient.
- Intervention pathways for children with different intervention needs be clearly defined to assist in external referrals
- Continued training be available to support the implementation of standardized screening

The Healthy Steps program screened many children from English Language Learner families and provided intense follow-up strategies to assist families in navigating the complex referral system. Through the early screening activities, F5AC is gaining a better sense of the overall demand for services to promote early childhood mental health.

Books and parenting materials supplied through pediatric offices gave parents a powerful reason and motivation to begin literacy (and bonding) activities at an early age.

Although one of the goals of Pediatric Support Strategies is changing the culture of pediatric practices to address more holistic parenting needs, this remains difficult to measure. Outreach to pediatric sites did fulfill providers' desire for additional information on screening and referral guidelines and resources for families based on consistent orders for updated information in Medical Home Project binders and CD-ROMs.

Pediatric Support Programs are part of a “child find” focus of early identification, early intervention and treatment when appropriate. FSS is looking at the two strategies Healthy Steps and ABCD in conjunction with the Medical Home Project and attempting to move providers to an integrated approach for pediatric sites to be responsible for the actual developmental screening (per AAP guidelines). Additional supports can be offered to pediatric practices/clinics that implement developmental screening at a wellness appointment. If the Strategic Planning process incorporates SART planning recommendations, we would like to see the Pediatric Support Programs merged into the Alameda County SART. This may be the only way to sustain the Pediatric Support Programs.

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| program name: Family Support Services Early Childhood Mental Health | time period: 2000-2009 | ecc goals: <input type="checkbox"/> goals 1 <input type="checkbox"/> goals 2 <input type="checkbox"/> goals 3 <input checked="" type="checkbox"/> goals 4 |
|---|---------------------------|--|

brief program history

The Harris Early Childhood Mental Health Training Program (Harris Training Program) began in 2000 as part of the Infant, Preschool and Family Mental Health Initiative sponsored by the California State Department of Mental Health and funded by the State First 5. In 2003, the program received grants from the Irving Harris Foundation and ECC. Alameda County Behavioral Health Care Services (BHCS) and ECC collaborated in the development and sponsorship of the program since the beginning. The training program is directed by the Early Childhood Mental Health Program of Children’s Hospital and Research Center at Oakland. The original goals of the program were to bring together new and experienced mental health practitioners in an applied, post-graduate setting, to learn the emerging specialty of early childhood mental health.

In 2006-07, First 5 established a committee to build a coordinated referral system mental health providers who serve the 0-5 population and can claim reimbursement through EPSDT. Thirteen agencies met monthly to coordinate EPSDT services. ECC also took a leadership role in the ECMH Development Workgroup. The workgroup developed recommendations for Prop 63 funds for infant and early childhood mental health prevention strategies.

A third important strategy is the Mental Health Consultation to Child Care which is summarized in the Grants Partnership Programs.

BRIEF CURRENT PROGRAM DESCRIPTION

ECC and the Harris Foundation continue to fund the program and BHCS continues to provide staffing resources. In 2007, the program was redesigned to include ECE professionals, in part, because the mental health partnership program was being phased out and because of the growing need for training in early childhood mental health by providers interested in mental health consultation to ECE settings. The Harris Training Program combines interactive, didactic instruction with clinical process instruction. It is a 2-year program with a weekly 3-hour core seminar on early childhood mental health theory, assessment and intervention. The seminar emphasizes infant and early childhood mental health services that are culturally relevant to diverse populations. Trainees receive weekly individual and group supervision by practicing early childhood mental health clinicians. Trainees use a competency – based instrument to reflect on their skill development with their supervisor and the impact of the program on the trainees' agencies is also assessed via a brief interview. Priority and reduced fees are given to Alameda County residents that are practicing in the community. The amount of participation time is reduced in the second year of the program when greater emphasis is placed on case conference reviews. CEUs are available for a range of professionals who wish to acquire them.

First 5 continues to support the EPSDT coordination committee and the Prop 63 Workgroup.

Mental Health Partnership Grants have been converted to formal contracts to continue these services. See Partnership Grants summary, page 50, for more information.

2006-07 PROGRAM COSTS: \$75,000

Includes the ECMH plus the \$75,000 Harris training contract with CHO

Funding Sources:

First 5 Alameda County

PROGRAM DOSAGE:

2-3 year program. First year seminar occurs weekly for 3 hours plus another 2 hours/month of individual and group supervision. In the second and third years, trainees attend individual and group supervision and occasional large group training (2-3 times/year)

PROGRAM REACH

(Numbers & Population Served):

2000 – 2007 124 mental health and public health professionals have been trained

From July – Dec 2007 there were 19 agencies represented by 25 trainees in the first year of the 2-yr program. At the same time there were 13 agencies represented by 15 trainees in the 2nd year of the 2-yr program.

Race/ethnicity and language spoken of 38 trainees:

2 African American

6- Latino

7- Asian, and Asian Pacific-Islander

26 – White

1 – Native American

Languages Spoken:

English, Spanish, French, Vietnamese, Hebrew, ASL, Portuguese, Tagalog, Arabic

Professional License or degree:

5 – LCSW

6 – MFT or MFTI

2 – PT

1 – RAS

3 – Psy.D; Ph.D

10 – MA, MS, MSW

10 – ECE professional, ECMH consultant, case manager, operations manager, child welfare worker, family support

ARTICULATED PROGRAM OUTCOMES

Increased capacity and skills of mental health and early childhood providers to meet the early childhood mental health needs in Alameda County

- 2000-2007 Over 124 mental and public health professionals have participated in the training
- Eight community training sessions were attended by 317 (duplicated) providers. Topics included the Importance of Immigration History in Work with Young Children and Families and the Development of Self Regulation in Infants and Young Children.
- In 2006-07, directors were interviewed about the impact of the training on their agency. Directors noted such things as improved observation skills, interviewing skills, empathy and perspective-taking skills of trainees. Trainees have increased awareness about the value of reflective practice and supervision, understanding different cultures and the quality of EPSDT documentation has improved.

Increased number of high risk, underserved children and families who receive early childhood mental health services

- In 2003-04, approximately 390 (unduplicated) children were impacted by trainees that participated in the Harris Training Program
- In 2006-07, 550 new children received EPSDT funded services for a total of 43,271 service hours.

SYSTEMS CHANGE IMPACT

The Harris Training Program, along with other ECMH Initiatives, such as Prop 63, SART and the Early Childhood Mental Health Policy Collaborative increase the county capacity to serve the early childhood mental health needs of the 0-5 population and are important strategies to increase county-wide service coordination and collaboration for ECMH services.

POTENTIAL FOR SUSTAINABILITY OR LONG-TERM HOME:

The Harris Training program is currently facilitated by Children's Hospital and BHCS and supported by First 5. There is interest in training in this field. Continuation of the program will depend on external funding and the ability to secure Prop 63 funds.

The Harris Training Program has been well received by mental health and other public health providers who have participated in the program. It is an important systems change strategy to build community provider capacity for early childhood mental health service referrals. The program has increased the number of agencies and individuals able to provide early childhood mental health services. . A focus group conducted in 2006 with clinicians who participated in the Harris Training and the Mental Health Partnership showed that participants appreciated the networking opportunity and support they received for their work by participating in both. Recommendations from the focus group included more information on techniques of programmatic consultation to preschools, more intensive training in the county with the possibility of peer consultation, explore working in family child care, more information on working within systems such as the public school system, and more county infrastructure development around early childhood mental health. In 2008, First 5 conducted 3 focus groups with ECE professionals who participated in the training for the first time. Results from this pilot will be forthcoming. Preliminary results suggest that integrating training of ECE with ECMH professionals has been challenging.

STAFF REVIEW

INCLUDING RECOMMENDATIONS FOR CHANGE

First 5 Alameda County engaged in an intentional focus on Early Childhood Mental Health since its inception. It was understood that if we asked our partners to do developmental and behavioral health screening, ECC would need to build capacity within the community to assist families with young children who may be having social and emotional difficulties. The intent was to strengthen the treatment community to be able to serve an ethnically diverse early childhood population. The Harris ECMH Training Seminar is only being sustained by The Harris Foundation and First 5. In 2008-2009 CHO will get 25,000 less than the previous year and First 5 Alameda County funding will end 6/2009. It would be helpful to consider all of the strategies that focus on ECMH within First 5. Some of the strategies build capacity within different provider communities (mental health clinicians, community mental health clinics, early care and education). The ECMH training program is part of the developmental continuum from social and emotional wellness through early childhood mental health treatment. This strategy spans the organization in multiple ways.

program name:

time period:

ecc goals:

Community Grants Initiative
(Non-Partnership)

2000-2009

goals 1 goals 2 goals 3 goals 4

brief program history

In 2000, ECC launched the Community Grants Initiative (CGI) to: seed innovative programs; respond flexibly to emerging community needs; provide “wrap-around” support to existing ECC services; and increase provider capacity to serve children 0 to 5 and their families. In contrast to ECC’s contracted services provided by a select number of agencies with prescribed scopes of work and reporting requirements, the CGI was envisioned to provide less structured funding opportunities to seed new ideas and allow access to ECC funding for a broader array of agencies. Parenting education and support, an important program focus area that was not directly included in ECC contracted services, was identified as a priority area for CGI funding.

Beginning in the second year of the CGI and continuing until the present, the CGI has placed a large emphasis on building grantee capacity for accountability and the tracking of outcomes. The CGI has provided grantee trainings and technical assistance on developing accountability plans, using qualitative and quantitative approaches to collecting and analyzing data, communicating successes, etc.

Most CGI grant awards have been for 2 years, for approximately \$75,000 per year. Agencies can re-apply with each new grant cycle, and a few agencies have been funded each cycle (BANANAS, Family Resource Network, and Family Support Services of the Bay Area). A majority of the grants have been made to enhance parenting and build stronger families. Consistent with the CGI’s intent of addressing emerging community needs and supporting innovative approaches, the CGI also has funded school readiness, mental health, health, special needs, and systems change efforts. Grant awards have been used to support grant program staff doing direct service with families and a variety of other strategies, such as: facility improvements, curricula development, production of a children’s music CD, equipment purchases (e.g. ultrasound machine and computers), staff training, etc. The Grant RFP process has been competitive with between 90 to over 100 agencies submitting applications each grants cycle. The number of grants awarded each year has varied from a high of 57 in 2001-02 to a low of 34 in 2003-05, with a total of 391 annual grants awarded from 2000-09. The selection of grantees has included staff review, a community review panel and final approval by the Commission.

The first 3 years of the CGI had only one category of grant funding with multiple priorities. In 2003-04, a second category of funding, “Partnership grants,” was introduced in response to concerns about whether grantees were using best practices. Partnership grants are designed to increase the use of best practices and to build expertise and leadership by bringing together a small number of agencies providing similar services for additional training and support (see separate program summary for Partnership Grants).

Community Grants Initiative (Non-Partnership)

BRIEF CURRENT PROGRAM DESCRIPTION

Since launching the CGI, there has been a pull between the desire to offer a flexible and relatively unstructured funding opportunity and the desire to focus funding in order to demonstrate outcomes, increase the use of best practices, and create systems change. The current configuration of grant categories attempts to balance these sometimes competing objectives.

The current CGI portfolio includes 46 grantees funded in 3 categories: Partnership, Targeted, and Community Support grants.

Community Support – was established as a smaller grant award to increase the ability of the CGI to fund community agencies throughout the county and to encourage agencies to creatively address unmet needs, to explore innovative approaches, and to expand their focus to the 0-5 population. This category has fewer training and accountability requirements.

14 agencies are currently funded (all for the first time) and many have not had a strong programmatic focus on families with children 0-5 in the past. They offer a broad array of services across the county and some are engaged in systems change.

Targeted – is ECC’s “traditional” grants model. Applicants’ proposed programs must fit into identified targeted focus areas that fit with identified needs articulated in our needs assessment and the strategic plan. Targeted grantees have more training and accountability requirements than the Community Support grants, but fewer than for the Partnership grants. Targeted grantees (as well as Community Support grantees) have select opportunities to meet together in small “clusters” focused on similar services and/or outcomes.

26 agencies are currently funded to address the following priorities: opportunities for parent child interaction, enhancing social emotional development, increasing support for families with special needs, increased support for families that are pregnant, post partum or have a young infant, creating systems change, and services for other specific “at risk” populations

Partnership – is the most intensive grant category for both grantees and ECC staff. Partnership grants afford the greatest opportunity for encouraging best practices, creating systems change, demonstrating outcomes and creating new leaders in the community..

6 agencies are currently funded for parenting support and education. (See Partnership Grantee program summary) In previous years Partnership Grants were awarded for Mental Health Consultation to Childcare, School Readiness and Parent Child Developmental Playgroups.

In addition to the changes described above, the 07-09 grant cycle has simplified and automated all reporting and tracking requirements in ECC Online. At the same time, there is greater focus on tracking ECC outcomes and including a few key measures of impact in grantee accountability plans. There also is more focus on supporting service quality and increasing program capacity through additional site visits and technical assistance provided by ECC support staff and external consultants.

The current grants cycle has been extended by 6 months in order to align the funding priorities for the next grants cycle with the 2009-2013 Strategic Plan.

2006-07 PROGRAM COSTS: \$2,149,855
(includes Community Grants Initiative-Non Partnership)

Funding sources: First 5 Alameda County, State School Readiness grant, MAA

PROGRAM DOSAGE: Variable. For drop-in programs, the dosage may be very low. At the other end of the continuum are programs that provide services (e.g., mental health, case management) on a regular basis for a year or more to select clients.

PROGRAM REACH

(Numbers & Population Served):

From 2000-09, 109 different agencies have been funded. 15% of the agencies were public agencies (e.g., county or city agencies, school districts); 85% were community based 501(c)3 organizations.

A large number of children, parents, and providers have been served (e.g., 41,967 duplicated clients served in 2006-07). The number of clients served by any one program varies from about 20 on the low end to an estimated 4,000 or more in the case of Childhood Matters radio program. The CGI has served a highly diverse population including families from a wide range of cultural, linguistic, and economic backgrounds; families with special needs; and high risk families. In 2006-07, out of 10,053 clients for whom we have race/ethnicity data, 27% were Hispanic/Latino, 27% were Black/African American, 19% were Asian, and 19% were White. Out of 9,007 clients for whom we have data, 65% reported English was their primary language, 23% Spanish, and 5% Cantonese.

Grantees identify which ECC Outcomes their funded services support. The CGI has worked steadily with the grantees to encourage their use of ECC indicators and common measures to produce consistent and reliable quantitative results. In 2005-06, a number of grantees were able to provide quantitative results and ECC began systematically aggregating ECC indicator data collected across the grantees. Also in 2005-06, ECC began requiring a subset of grantees to use the ECC Client Survey and several other grantees voluntarily administered the survey to their clients. In 2007-09, all Partnership and Targeted grantees will use the Client Survey as appropriate.

ECC OUTCOME INDICATOR RESULTS: 2006-07 (INCLUDES PARTNERSHIP GRANTEE DATA)

Outcome 1A. Enhanced Parenting and Stronger Families

- 14 out of 28 agencies provided parenting education or support groups
- 88% (n=280) of parents reported they used what they learned
- 56% (n=280) reported that the program had a large (“a lot of”) impact on their family

Note: While the number of parents responding to the survey increased from the previous year, it is still small compared to the total number of parents attending parenting education/support programs (approximately 1,600 in 2006-07). For several years, grantees have provided anecdotal evidence suggesting strong impacts on individual families, but until recently, the CGI has not had much information regarding the quality of the parenting services provided by grantees. In order to promote and better understand of best practices for parenting education and support, ECC implemented the parenting partnership in the current cycle.

Outcome 2A. Improved child social, developmental and emotional well-being

- 19% (n=255) of primary caretakers screened for depression screened positively
- 43% (n=268) of children screened for developmental delays scored “of concern.” Note: More developmental screenings were conducted through the CGI than through any other ECC program except for Special Start.
- 144 parents and 147 children received mental health services; a total of 1,014 therapy sessions were provided in English, Spanish, or Hindi

Outcome 2B. Increased access to resources for children and families with special needs

- Close to 3,000 referrals were made for children and families with special needs
- 74 families were accompanied to IFSP or IEP meetings

Outcome 2E. Increased school readiness

- 79% (n=237) of families reported reading, storytelling or singing to their children at least one time per week. 3,214 children’s books in 4 languages were distributed.

Outcome 3A. Increased support for breastfeeding mothers

- 133 mothers attended breastfeeding workshops
- 106 mothers were breastfeeding 2-3 weeks after delivery
- 53 mothers borrowed breast pumps

Outcome 3B. Children are healthy, well nourished and receive preventive and on-going health and dental care from a primary provider

- 91% (n=310) of children have an identified primary pediatric provider
- 89% (n=345) of children with immunizations up-to-date for age
- 4% (n=319) of children do not have health insurance

As with all other ECC programs, grantees define a set of program outcomes specific to their funded programs. In each funding cycle the outcomes selected by grantees are driven by funding priorities described in the request for proposals. While the grants program suggests that the grantee collect information on common outcome indicators, common measures are only required for partnership grants. Consequently the universe of indicators on which grantees collect data, is large and varied, and therefore, difficult to summarize. The advantage to this variety is that programs are encouraged to think about outcomes or desired results that are specific to their unique program model and that are achievable. Through accountability trainings and individual technical assistance, the CGI has provided considerable support to grantees regarding the collection of qualitative and quantitative data. CGI grantees have reported a wealth of qualitative data; some of the data indicate there have been impressive results for individual families.

- Most of the grantees have achieved what they had projected and a few exceeded their goals. Only a handful of grants have been de-funded or came close to being de-funded due to serious budgetary/ programmatic deficiencies.
- The CGI has increased access to services for children 0-5 and their families, increased accountability and the tracking of outcomes, enhanced provider capacity, enhanced networking and the sharing of resources between grantees, and contributed to systems change. In addition, grantees have succeeded in leveraging funding.

Increased Access to Community Resources & Enhanced Parenting Support

From inception, over half of community grants awarded has been for parenting support or education. Access to parenting support and other community resources has increased substantially; especially for certain populations (e.g., low-income and high risk families, families speaking various languages). For example, the CGI has funded several parent-child activities (e.g., dance, art, swimming, play groups, kinder gym, etc.) for select populations. Seven former grantees that addressed unmet community needs and that demonstrated success in working with families now have contracts with First 5 to provide services (Asthma Start, Dental Health Foundation/Alameda County Office of Dental Health, Childhood Matters, and 4 agencies providing mental health consultation to early care and education).

Increased Support for New and Innovative Approaches

The CGI has funded a number of new and innovative approaches, including a group model of postpartum medical care for mothers and babies (Centering Parenting), play groups for the siblings of children with special needs, art instruction and support for early childhood educators, police officer training regarding the needs of young children exposed to domestic violence, language interpretation and support during labor and delivery, parent-child dance classes for parents being reunified with their children, parent-child music and art classes for grandparents raising young children, and parent-child kinder gym/nutrition classes for children at risk of childhood obesity.

Enhanced Support for Efforts Addressing Unmet Needs in the Community

Several of the grants funded through the CGI have addressed unmet needs in the community. One example is the funding of a new pediatric audiology suite that has led to a reduction in the lengthy wait time in the county for audiology screening.

Enhanced Provider Capacity to Serve Children 0-5, to Use Best Practices, to Track Outcomes, and to Serve Diverse Families*

Increased Networking, Collaboration, and Sharing of Resources among Community Agencies*

*See sections on Systems Change and Program Reach.

The CGI has greatly improved accountability and the tracking of outcomes among grantees, as indicated by grantee reports and ECC surveys of grantees, as well as an external evaluation of ECC impact on service systems in Alameda County and elsewhere (*Changing Systems: Assessing the Impact of Every Child Counts*, 2003, p. 8).

The CGI also has increased provider capacity to serve the 0-5 population and to use best practices (especially among Partnership grantees). Examples include the following.

- A number of agencies enhanced their focus on young children; a number of grantees now conduct ASQ screenings
- The CGI helped to fund the creation of a “little art studio” at MOCHA for children under 5 that had 3,710 visits from Alameda County children in 2006-07
- The CGI has funded the development of new curricula, including an art curriculum for training teachers at licensed child care sites that was subsequently used for a Merritt College preschool lab practicum

At CHO, Asthma Start has changed the practice of hospital-based physicians who now write orders for asthma education prior to discharge

In addition, the CGI has greatly increased networking and the sharing of resources among agencies in the county. Although networking and resource sharing have not been tracked systematically, grantee reports and surveys of grantees provide several examples. For example, Seneca Center’s Building Blocks program, Family Support Services of the Bay Area, BANANAS, Children’s Fairyland, and Women’s Daytime Drop-In Center have arranged with Luna Kids Dance and/or MOCHA to offer services at their sites. The Lawrence Hall of Science now provides parent-child math and science classes for Alameda Family Literacy’s Even Start families in addition to the South Hayward ARS Program.

One challenge to creating and maintaining systems change is staff turnover in grantee agencies. Another challenge is that the reach of any individual grant typically is very limited.

Because the CGI is the linkage point between a relatively large number of CBO’s and First 5 Alameda County, it increases awareness of and access to our training programs such as the Specialty Topic Seminars. Staff of CGI partners are frequent attendees. This results in a general support of professional development for the 0-5 human services workforce.

Diffusion of developmental screening into community based venues. Currently 14 community grantees who are not child care centers or pediatric practices are conducting developmental screening using the ASQ. This creates a model and precedent for community-based screening that can increase the pathways into early intervention system wide.

POTENTIAL FOR SUSTAINABILITY OR LONG-TERM HOME:

In general, we do not have much data regarding the sustainability of the programs we have funded through the CGI. We have required grantees to undergo an assessment of their potential for leveraging funds, and we know that grantees have been able to leverage a considerable amount of funding (\$3,574,112 in 2006-07). Some past grantees have been able to continue their programs without funding from ECC. For example, the Alta Bates Compassionate Touch program used its grant to train several of their providers who are now able to provide services without ECC funding. It is likely that many of the CGI grantees could not provide their services without ECC support.

The CGI provides access to First 5 funding for a broad array of community agencies and with the introduction of Community Support grants, the access has increased.

Although the number of clients served by any one grantee may be small, the CGI, overall

- Reaches a large number of clients and supports a number of ECC goals and outcomes
- Has greatly increased access to parenting education/support and other services for children 0-5 and their families, especially for certain populations (e.g., low-income families, high risk families, families with special needs, etc.)
- Has enhanced provider capacity
- Has increased grantee accountability and the tracking of ECC outcomes, in part through the introduction of online reporting
- Has fostered networking and the sharing of resources between agencies in the community
- Has supported innovative approaches
- Has enabled grantees to leverage a large amount of funding relative to the amount of funding allocated to the CGI
- Has created opportunities for agencies that have not traditionally had a focus on the needs of children ages 0 – 5 to build the requisite staff capacity to provide developmentally appropriate services

Challenges include:

- Tension between providing a flexible and relatively unstructured funding opportunity and demonstrating outcomes and fostering systems change
- Ascertaining the quality of services provided by grantees
- Managing and supporting a diverse group of grantees in a continually changing service environment

The Community Grants Initiative staff is eager to take advantage of the strategic planning process to help us set a clearly defined course over the term of the next strategic plan. The staff of the CGI hope that the strategic planning process will create further clarity about the role and desired results of the CGI in the context of our organizations' shared strategic goals. We have identified a number of questions for consideration as we move into strategic planning. We hope that answers to these questions will emerge through the planning process.

- What are the desired strategic results of the Community Grants Initiative? Do we expect anything to be different as a result of this initiative? If we don't have an articulated response to that question, what process do we need to go through to develop one?
- Are there gaps in the agency's support of the Strategic Plan outcomes i.e., areas not fully addressed through FSS and ECE contracts? In other words, assuming that CGI funds can be re-tasked with more agility than the large contracts, and that all funding serves the priorities of the strategic plan, are there any specific outcomes or goal areas (i.e. community based treatment services for SART) that are not well supported by current funding?
- Should we continue with our funding strategies of Community Support, Targeted and Partnership Grants? Are there other strategies, such as social capital/neighborhood based, direct to parent, or results-oriented collaborative networks that we should consider?
- How do we adjust our grant making strategy to support our funded partners relative to broader environmental issues such as the state budget crisis, the local impact of the housing market collapse, changing immigration policy etc.?

The elements that we see as existing strengths include:

- A partnership model that has allowed a small number of community based agencies to "go deep" and create shared standards of best or promising practices and increase their professional capacity for leadership in meaningful ways. We recommend that the partnership model be retained in some form.
- A stance as a funder that emphasizes partnership and capacity building. In response to our concerns around quality, we have enhanced our ability to provide training and technical assistance and would like to continue to develop a robust and responsive training and technical assistance component for our non-partnership partners.
- The ability to allocate at least some percentage of funds to innovative or community identified needs that cannot necessarily be fit neatly into our preconceived funding priorities or results areas. If we choose to use the grants program to support a very focused set of services (e.g. SART) we need to be aware of the opportunity cost inherent in not supporting more flexible innovation.
- The small community support grants are new, but appear promising. We do seem to have created inroads into agencies who have not previously considered the needs of children 0-5 years of age.

program name:

time period:

ecc goals:

**Community Grants Initiative
(Partnership)**

2003-2009

goals 1 goals 2 goals 3 goals 4

brief program history

In 2003-05, the Community Grants Initiative piloted a new category of grants called, “Partnership Grants.” “Partnership” refers to a grantmaking strategy in which the grantee and First 5 become partners in an effort to learn more about a particular sector of early childhood practice.

Partnership Grants were developed to address concerns about a lack of consistency in using best practice approaches among grantees providing similar kinds of services. By bringing together a small number of agencies providing similar services for ongoing training and peer support, Partnership Grants were designed to: foster a common language and approach based on the use of best practices; track common measures; improve service integration; and build provider expertise and leadership. Partnership grants have received awards of between \$75,000 and \$80,000 per year. Although the Partnership Grants have required considerable time and commitment from both ECC staff and grantees, the results have been promising and the model has been continued, with some changes and refinements, with each grants cycle.

In 2003-05, nine agencies received Partnership Grants.

- 4 “**school readiness**” Partnership Grants were funded to serve children in license-exempt care or at home with a parent/primary caregiver.
- 5 “**mental health**” Partnership Grants were funded to provide mental health consultation services to early care and education settings. A “lead” agency, through a contract with ECC, co-facilitated partnership trainings for the mental health “cohort” and provided mental health consultation services to select ECE sites

In 2005-07, seven agencies received Partnership Grants. In contrast to the previous grant cycle, service delivery models were more prescribed in order to facilitate the use of best practices, track common measures, and build a “partnership.”

- 4 “**mental health**” Partnership Grants were funded. Additional emphasis was placed on standardizing service delivery, and requirements were added for previously funded grantees.
- 3 “**parent-child developmental play group**” Partnership Grants were funded. Grantees offered weekly parent-child playgroups for children identified with communication and social-emotional concerns who did not qualify for regional center or school district early intervention services. A lead agency co-facilitated trainings for the grantee cohort and provided technical assistance and consultation at grantee sites.

In 2005-06, “Partners in Collaboration” (PIC) was piloted. PIC was a 12-month cross-disciplinary training program that grew out of the mental health partnership.

- 4 ECE mentor teachers were paired with 4 mental health consultants to provide joint mental health consultation services

Community Grants Initiative (Partnership)

BRIEF CURRENT PROGRAM DESCRIPTION

For 2007-09, a “Parenting” Partnership is being piloted. Since the inception of the Community Grants Initiative in 2000, a majority of the grants funded have been for parenting education and support. Historically, these programs have used a variety of approaches and curricula. While past “parenting” grantees have provided anecdotal evidence suggesting strong impacts on individual families, the CGI has not had much information on the quality of parenting services provided by grantees. The intent of the partnership is to promote and better understand the use of best practices for parenting education and support.

6 “parenting” Partnership Grants have been funded to provide parenting services that combine parenting education/support and parent-child interaction components. A “lead” agency is helping to facilitate the partnership trainings and is providing individual technical assistance to the grantees.

2006-07 PROGRAM COSTS: \$750,206

Includes Parent Child Developmental Playgroup Partnership Grantees: Asian Community Mental Health Services, Chabot Community College Children’s Center, and Kerry’s Kids and lead agency, CHO PLUS Mental Health Consultation to Child Care Partnership Grantees: Jewish Family and Children’s Services, Parental Stress/ Family Paths, The Link to Children, and Kidango and lead agency BHCS

Funding Sources: First 5 Alameda County, State School Readiness grant

PROGRAM DOSAGE:

Variable, although many of the partnership programs have provided weekly services (e.g., playgroups, school readiness activities, parenting groups).

PROGRAM REACH

(Numbers & Population Served):

From 2003-09, 16 agencies have been funded. 19% were public agencies (city, school district, college); 81% were community based 501(c)3 organizations.

In 2006-07, 314 ECE providers and 1,435 children were served through the “mental health” partnership.

“Parent-child developmental playgroups,” served 62 children and 73 parents

2006-07 ANNUAL REPORT

Outcome 1A. Enhanced Parenting and Stronger Families

- Parenting Partnership: 2007-2008 Pre and post results from the Parental Stress Scale will be available in July 2008
- Process evaluation underway

Outcome 2A. Improved child social, developmental and emotional well-being

School Readiness Partnership: 2004-05

- 49% (n=78) of children screened with the Desired Results Developmental Profile scored “of concern” and were referred for further assessment or services

Partners in Collaboration: 2005-06

- The mental health and early childhood specialist dyad visits to ECE classrooms provided an integrated model of consultation that led to improved classroom outcomes. In 2006-07, in 3 of 4 classrooms participating in the PIC program, the percentage of children with behavioral concerns decreased. DECA results indicated that an average of 46% of children showed behavioral concerns at the beginning of the program compared to an average of only 6% of children 6-7 months later.

Mental Health Partnership: 2006-07

- 19% (n=62) of children screened for developmental delays scored “of concern” and were referred for further assessment or services
- In keeping with best practices, one of the goals of the partnership was to promote greater use of classroom-based consultation vs. child-specific consultation. Over the four years of the “mental health” partnership, classroom-based consultation increased from 38% to 68% of the consultation provided.
- Teachers have incorporated more techniques based on attachment theory to help children when they are having behavioral difficulties. 51% of teachers receiving consultation felt it changed the way they think about children’s emotional development and 72% said it changed the way they thought about children’s social development.

Outcome 2B. Increased access to resources for children and families with special needs

- Parent-Child Developmental Playgroups: 2006-07
- 75% (n=60) of children screened for developmental delays on the ASQ scored “of concern” and were referred for further assessment or services
- 65% of children in the playgroups screened “of concern” in the area of communication skills

Outcome 2E. Increased school readiness

- School Readiness Partnership: 2004-05
- 110 children were read to or told stories by family members at least once a week
- 78 families had library cards
- 72 families visited the library at least once a month

ECC has articulated program outcomes for the Partnership Grants as a whole. These are:

- Greater consistency in approach; use of a common terminology and common measures
- Increased use of best practices
- Increased service integration
- Increased provider expertise and leadership

ECC also has articulated outcomes for each specific partnership. After the grantees are selected, each partnership collectively identifies its own set of common measures, which all grantees in the partnership are required to collect.

School Readiness Partnership Outcomes

- Increased use of neighborhood based services
- Enhanced focus on children’s social emotional development
- Increased school readiness

The “school readiness” partnership enhanced provider capacity regarding knowledge of children’s social/emotional development, the use of developmentally appropriate practices, and the use of common measures and tools (e.g., the Desired Results Developmental Profile). Some of the grantees were able to provide services at conveniently located, neighborhood-based sites (e.g., elementary schools), which resulted in good family participation and which contributed to children’s school readiness by connecting families to their local school. One challenge experienced by the partnership was that the agencies did not establish a strong cohesiveness as a group. This was due partly to disparate service delivery models. Also, one of the 4 grantees was de-funded because of serious financial and programmatic deficiencies.

Mental Health Partnership & PIC Outcomes

- Expansion and enhanced sustainability of mental health consultation services in the county
- Increase in the capacity of mental health professionals to offer consultation services in early care and education settings
- Increase in classroom-based consultation as a first strategy, with the use of “pull-out” child-specific services reserved for later as needed
- Increased coordination and integration of mental health and ECE services

The “mental health” partnership, which was implemented over a period of 4 years, experienced several successes. One significant achievement was the increase in the use of classroom-based consultation. Other accomplishments included increased service integration and increased sustainability of direct services through the use of EPSDT funding. In 2007-09, four former partnership grantees became ECC contractors.

The PIC program, which expanded upon the “mental health” partnership, also experienced positive results. An external evaluation of the PIC program conducted by La France Associates found that the “PIC project was uniformly considered a success by MTs [Mentor Teachers], MHCs [Mental Health Consultants], classroom teachers and ECC staff.” (p. 3, Executive Summary, *Evaluation of Partners in Collaboration*, see www.firstsecc.org/reports/reports_docs.htm). Mentor Teachers, Mental Health Consultants, and classroom teachers all experienced a change in knowledge and attitudes, and children’s classroom behaviors improved. The PIC program is currently being integrated into the Enhanced Mentor and the QII programs.

Parent-Child Developmental Playgroup Partnership Outcomes

- Increased access to services (specifically, parent-child developmental playgroups) for children at risk of developmental delay but not meeting eligibility requirements to receive services through the regional center or school district
- Increased support for the parent-child relationship
- Increased school readiness
- Increased integration between playgroup agencies and early intervention providers: agencies ended the partnership with an increased capacity to identify developmental concern and refer to regional center and school districts)

The “parent-child developmental playgroup” partnership established the feasibility and utility of using community-based, parent-child developmental playgroups to serve children with developmental concerns who are not eligible for regional center or school district services. Provider capacity was enhanced considerably regarding knowledge of typical and atypical child development, the ability to build and sustain relationships with parents from diverse backgrounds, and the ability to facilitate developmental activities for parents and children together. Grantee staff observed notable changes in parents’ and children’s behavior stemming from program interventions. Two challenges for the partnership were the varied skill levels/backgrounds of the staff facilitating the playgroups, and initially slow enrollment in the playgroups. In addition, one of the 3 grantees was unable to fully implement the playgroups due to a lack of agency infrastructure.

Parenting Partnership Outcomes (still in first year – no results available)

- Increased use of best practices

Adoption of a program design that includes parent education, parent/family support, and parent-child interaction components

Because the partnerships bring together a cohort of agencies that work together over time, the partnerships, on the whole, have achieved stronger results in the area of systems change than non-Partnership Grants. In fact, most, if not all, of the major accomplishments of the partnerships have contributed to “systems change,” including the adoption of standards of practice, increased use of best practices across a cohort of agencies, and increased ability to demonstrate outcomes. Agencies who were mental health partners took a leadership role in advocating for including mental health consultation to child care as a strategy to be supported by Proposition 63 early intervention funds. Following the lead of First 5 Alameda County, the City of Oakland has included both mental health consultation to child care and parent child play groups as foci of their funding efforts – which has substantially increased community access to these services in Oakland.

POTENTIAL FOR SUSTAINABILITY OR LONG-TERM HOME:

Mental health consultation services are currently being funded through contracts with ECC. EPSDT funding is helping to support direct mental health services to children work, but not consultation to child care.

PIC is being integrated into the Enhanced Mentor and QII programs.

One of the “parent-child developmental play group” grantees now has a strong focus on building and sustaining relationships with parents and is training early care and education staff to facilitate parent-child playgroups. This work is continuing without ECC funding - the lead agency in the parent-child developmental play group has secured funding to provide similar groups in South County.

The Partnership Grants are a relatively small component of the overall CGI, in terms of the number of grants awarded and clients served. And yet, thus far they have achieved promising results and afforded the greatest opportunity for encouraging best practices, fostering systems change, and creating a network of providers and leaders in the community.

Like the CGI in general, the partnerships have been effective in terms of increasing access to services for the 0-5 population, increasing accountability, enhancing provider capacity, and enhancing networking and the sharing of resources between grantees. In addition, because of the intensive nature of the partnerships, further accomplishments have been achieved, especially by the mental health partnership and the PIC program. The Partnerships have promoted standards of practice and the adoption of a common language among providers, have increased the use of best practices across a cohort of agencies, and have increased the ability to demonstrate outcomes. To a lesser degree, the partnerships have enhanced service integration and have increased provider leadership.

The combination of cohort trainings and peer networking/support has contributed to Partnership success. Grantees have rated the trainings highly, and have found the opportunity to share information and experiences with fellow grantees especially valuable. At the same time, there have been occasions when attendance at mandatory partnership meetings lagged; in response, the CGI altered the schedule and/or topics of trainings to better meet the needs of grantee agencies.

The CGI has found that it is easier to develop cohort trainings, to facilitate peer sharing and support, and to identify common measures and demonstrate outcomes across agencies when the agencies in the partnership share similar service delivery models. As a consequence, the CGI has increasingly required the adoption of specific service delivery components (based on best practices). A potential drawback of prescribing service models is that fewer agencies may decide to apply for the partnership and/or fewer agencies may be able to prepare a competitive grant proposal.

One challenge for the Partnership Grants has been the relatively small applicant pool. Ten agencies applied in 2003-05 for up to 10 grants, 9 agencies applied in 2005-07 for up to 10 grants, and 15 agencies applied in 2007-09 for up to 10 grants. One of the lessons learned through the partnership program is that if only 3-4 agencies participate, and one agency later leaves the partnership or is unable to fully participate, the effectiveness of the partnership can be seriously compromised.

Our grantees tell us that they often feel isolated and that the pace of their professional lives does not allow the space and time to slow down and think about their work. These are not conditions that support practice change and quality improvement. The partnership model is the laboratory where we test our belief that practice change requires not only information, but the opportunity to integrate and reflect in the context of supportive relationships. It is the place in the CGI where improving the quality of grantee practice is explicitly and intensively addressed through the development of learning communities or partnership “cohorts”. This grantmaking approach has deliberately enhanced both knowledge transfer (through training and consultation) and created space and time for reflection and integration and peer support.

These enhancements to the traditional grantmaking model are expensive. Both grantees and First 5 have invested heavily in the training, technical assistance, and peer support components of these grants. The return on that investment is the opportunity to go deeper and experience shared reflective practice. Both grantees and First 5 have learned many lessons from each partnership, both about the process of organizational change and about the particular content focus of the partnership.

The mental health consultation and parent child developmental playgroup partnerships are examples where the partnership focused on a field of practice that was new or emerging in Alameda County. By exploring these new fields of practice with a small group of grantees, First 5 was able to not only build capacity in the community to offer the service but also learn together with grantees about the standards of practice and how to best support implementation.

One of the opportunities of the partnership approach has been to learn about the role of a funder as a capacity building partner not just a monitor. There have been many lessons learned including:

- It takes a lot of time for everyone in a partnership to understand roles and expectations. This has been true for the grantees, the lead agencies, and First 5. A great deal of effort is spent in the first 6 months of the partnerships clarifying, developing, and understanding the roles of all parties and how they work together. This seems to be a necessary first step before the work of quality improvement can begin.
- It is very difficult for the staff of community based agencies to make regular time for activities that take them away from the day to day demands of direct service and agency management. The responsibility of the funder in this relationship is to make sure that this time, which is a precious commodity, is used well and in ways that are relevant to the participants. It can be a challenge to make this happen for both the direct service practitioners and administrators – as they have different needs.
- Facilitators of the partnerships must be skilled in not only the specific content area (early childhood mental health, early intervention, parent education etc.) but also skilled in meeting individuals and agencies where they are. The consultant role requires strong skills in observation, the ability to make strategic decisions about when to and when not to comment or intervene, and the ability to take multiple perspectives.
- The work of the partnerships is not achieved quickly. At the end of two year grant cycles it seems as though the work is just beginning. Two years is a minimum term – there is some consensus among F5 staff who have led partnerships that three years feels about right.
- Using the partnership experience to improve quality practice requires that participating agencies meet a “readiness” threshold. Agencies without sufficient infrastructure (qualified staff, supervision structures, organizational commitment to both the service and the process) are unable to make good use of the learning.

The staff of the Community Grants Initiative support retaining the partnership approach in some form. While time and effort-intensive, it seems to offer a unique opportunity for agencies to reflect on their practice and institutionalize practice change. It also allows First 5 to acquire a depth of understanding about particular service models that is not available through the monitoring of traditional grants.

program name:

time period:

ecc goals:

Early Care & Education
(Professional Development)

2000-2009

goals 1 goals 2 goals 3 goals 4

brief program history

PHASE 1: The Corps was created to begin to address the low wages, limited career development opportunities and high turnover of Early Care and Education (ECE) providers. ECC launched the Corps in May 2000 as a systems change initiative designed to build a network of ECE providers and to advance professional development through both formal and informal educational opportunities. In 2001, with a 1:4 First 5 CA State matching CARES grant, ECC invested \$4.2 million in program stipends. Corps primary objectives were retention and continued education of Corps members. In the first years of the program, providers received stipends for their education, attended seminars and engaged in a variety of professional development opportunities. From 2000 – 2005, stipends were provided for entry level students seeking college units as well as more experienced and educated providers engaged in professional development. The Corps funded educational support programs at four Community Colleges as well as informal training and technical assistance (refer to ECE Professional Development Program Summary for more information). A focus of the Corps in the early years was to train providers on the use of the Environmental Rating Scales as a way of building awareness of and engagement in discussions about classroom quality.

Phase 2: ECC conducted an intensive review of the first four years of the Corps by convening community input and workgroup sessions comprised of administrators, teachers and providers from a range of programs and backgrounds to address the limitations of the Corps. Although retention increased over the four years (primarily the higher level stipend recipients), new memberships declined. In addition, there was a lack of intentionality in student course selection and concerns about declining revenue and sustainability. The Corps was redesigned to address the continuum of ECE provider educational needs, from informal, community-based training, the attainment of the AA degree, to the attainment of a BA or graduate degree. The redesign addressed declining enrollment and continued retention by assisting students having difficulty meeting professional development goals and general educational requirements at the community colleges. The community colleges now place greater emphasis on student advising and support to attain the AA degree. Greater outreach to enroll family child care providers and greater emphasis on bilingual recruitment and retention of English-language learners was included in the redesign. Stipends were discontinued for providers at the higher levels of the Child Development Matrix to encourage enrollment at lower levels. Three 4-year colleges now have pilot programs for students wishing to attain BA and MA degrees in early care and education. The Resource and Referral agencies offer training for the community, including Family, Friend and Neighbor providers. The Corps also supports community-based training through the Training Coalition.

BRIEF CURRENT PROGRAM DESCRIPTION

PHASE 2 The overall goal of the Corps is to increase student awareness of and participation in professional development and educational opportunities and to encourage retention. The Corps also encourages a diverse workforce to meet the demographic needs of the community and to encourage participation of family child care providers. The Corps provides formal educational opportunities through the AA degree program, the higher education initiative and the BA/MA scholarship fund. Systems are also in place to support English-language learners at the community college level. The Corps AA program is now able to evaluate the impact of the program by tracking the completion of general education requirements and the achievement of the AA degree.

Informal training includes the Training Coalition, a pilot program launched in 2007–08, to enhance the ECE training capacity of seven community-based agencies, build a system of Alameda County agency leadership to provide high quality training of ECE professionals and increase the number and quality of informal (non unit-bearing) training opportunities for ECE providers. A formal evaluation of the pilot is underway and is showing promising results.

2006-07 PROGRAM COSTS: \$1,286,366
ECE Professional Development:
Formal, Informal training (BA/MA,
Training Coalition

FUNDING SOURCES: First 5
Alameda County, State School
Readiness grant, CARES

PROGRAM DOSAGE: Variable

PROGRAM REACH
(Numbers & Population Served):
From 2000 – 2005, six rounds of
stipends were distributed totaling
over \$22 million for over 4,000
providers.

ECC Outcome 2C: Increased professional development and retention of Early Care and Education (ECE) providers

Phase 1 Corps Program 2000 to 2005:

Retention was greater for Corps members at higher levels of the Child Development Permit Matrix.

Proportion of Child Development Corps (Corps) members returning from previous years, by year:

2001: 59% (n=1835) 2002: 70% (n=2036) 2003: 75% (n=1997) 2004: 89% (n=1674)

2001-2005 Seminars and Environmental Rating Scale trainings

5,244 (duplicated) Corps members attended seminars in English, Chinese, Vietnamese and Spanish

2,308 (duplicated) members were trained to use the environmental rating scales in English, Spanish, Cantonese, Mandarin

1,703 (duplicated) members conducted self-assessment using environmental rating scales

2001–02, three Resource and Referral Agencies (R&Rs) conducted a total of 32 trainings for 302 providers in the community

2001–02 three new off-campus introductory courses were offered to 75 new ECE students in low-income neighborhoods.

2003-04 two community colleges offered a three-unit course “Socio-Emotional Foundations for Early learning”

Phase 2 Corps AA Program (2005-to date)

586 members enrolled and active (78% center-based providers)

Increased awareness and participation of a diverse student population in the Child Development Corps

2002 – 03 outreach focused on increasing the number of family child care providers by lowering the minimum number of units required to qualify for the Corps from 12-6 and by translating Corps brochure to reach English-language learners

2002-03 4 workshops were held to assist returning Corps members with the application and 34 enrollment specialists provided application assistance in languages other than English

2003-04 Corps staff outreached to more than 800 students and providers at the Merritt College Child Care Fair and Our Focus: The Child Conference at Chabot College

2005–06 more first time Corps applicants were Asian (32%) and Hispanic (25%) compared to previous years

Per cent of family child care providers participating in the Corps increased from 10% in phase 1 to 17% in phase 2

Increased number of units attained by need (ESL, GE, and ECE)

After the first year of Corps AA implementation, 43% of total units completed were General Education; 38% were ECE; and 19% were Basic Skills

Increased number of Corps Achievement Stipends awarded for AA degree completion/equivalency or transfer to BA program 2006-07

3% (18 of 586) currently enrolled students received an achievement stipend, which represents attaining an AA degree or equivalent

Over 2/3 of all Corps AA members had 24 ECE units or more upon entry (60 units are required for the AA degree or for transfer into a BA degree program)

40 students enrolled in the BA/MA programs at UC Berkeley, Mills College and CSU/East Bay

Documented advancement in the Child Development Permit Matrix

In the four years prior to the Corps (1996-2000) the Child Development Training Consortium (CDTC) processed 675 permits from Alameda County. From 2000-2004, with support from Career Advocates at the R&Rs, the CDTC processed 2,671 permits. Alameda County now has the highest number of Child Development Permit holders in the state.

2006-07 97 Child Development Permit Workshops were provided in English, Spanish and Chinese

Increased county-wide capacity to provide comprehensive training for the child care community

2006–07 seven agencies participated in Training Coalition Project; 357 providers have been trained as of April 2008

All Corps members have been trained to use the Environmental Rating scales that provide a venue for discussions about ECE quality

Development of a networked professional development system, including both informal and formal educational opportunities

Initially the Corps created a significant spike in the number of students enrolled in the ECE programs at the community colleges

The increased number of ECE providers earning lower division college units helped promote a county-wide interest in developing BA and MA programs. This interest was further accelerated by Prop 82 which would have funded preschool for all 4-year olds and by an interest in promoting leadership opportunities in the field.

Colleges increased capacity and awareness of addressing the needs of students to promote success

Colleges increased focus on social emotional development

POTENTIAL FOR SUSTAINABILITY OR LONG-TERM HOME:

No identified source of funding without ECC

Continuation of the state match is unclear

Long term sustainability will be strongly influenced by an ECE for All Initiative.

Corps AA programs would be strongly influenced by better articulation and interaction among community colleges and four-year institutions

BA and MA program success would also be supported by ECE for All Initiatives

Training Coalition is promising in terms of increasing informal training opportunities for ECE providers throughout the county. However, a sustained county-wide system of training is unlikely without funding from universal preschool

Colleges ability and willingness to continue support systems to promote student success

Early Care and Education (Professional Development)

The Corps program was initiated to increase awareness of and participation in professional development opportunities, to provide networking opportunities and to increase provider awareness of quality in early care and education. Although, in the first four years of the program, the numbers of returning Corps members increased, we know little of the reasons providers stayed and why there was ultimately a decrease in the numbers of newly enrolled members. There was higher retention of members at the higher levels of the Child Development Matrix than at the lower levels. Increased enrollment of a diverse population of providers, who reflect the demographics of the children in the county, is an important objective of the Corps redesign.

One measure of the success of a professional development initiative is whether the program had an impact on the quality of care provided to children in their care. While we now have the ability to know whether students achieve the AA degree or the equivalent, we have no clear data of the impact of the Corps on classroom quality or changes in practice of Corps member classrooms and for the children enrolled in these programs (Kreader, Ferguson & Lawrence, August 2005). There is also no consensus from national leaders or researchers about whether advanced education leads to greater quality. For example, using an experimental study design, one researcher showed that teacher training, paired with on-site coaching leads to changes in classroom practices and greater changes in classroom quality than training alone (Susan Neuman, 2008). Data collected specifically in Alameda County between 2001 and 2003, showed that both licensed center-based and family child care providers who were Corps members received higher ratings of environmental quality and reported more time reading and interacting with children than their non-Corps member peers. Recent analyses and summaries of research show a complex relationship between measures of teacher education and classroom practice (Bogard, Traylor & Takanishi, 2007). One major problem is that wide variation in teacher education and credentialing programs makes it difficult to relate degrees or credential to ECE classroom quality (Early et. al., 2007). Furthermore, how children experience the classroom (the quality of the interaction between teachers and students) is more predictive of children's learning and development than teacher credentials (Kelley & Camilli, 2007). Attempting to measure impact and understand the complex relationship between education and quality will continue to be a challenge for the Corps AA program evaluation.

1. Kreader JL, Ferguson D, Lawrence S, (August 2005). Impact of Training and Education for Caregivers of Infants and Toddlers, Research to Policy Connections No. 3. National Center for Children in Poverty.
2. Neuman, S. (2008). Enhancing Professional Development: Project Great Start Professional Development Institute. Presentation from www.personal.umich.edu/sbneuman/presentations.html.
3. Whitebook M, Phillips D, Bellm D, Almarez M and Yong Jo J. (2004). Two Years in Early Care and Education: A Community Portrait of Quality and Workforce Stability (Executive Summary). Center for the Study of Child Care Employment, University of California at Berkeley. www.iir.berkeley.edu/cscce.
4. Bogard K, Traylor F, Takanisi R. (2007). Teacher Education and PK Outcomes: Are We Asking the Right Questions. Foundation for Child Development. www.fcd-us.org.
5. Early, D, Maxwell KL, Bender RH. et.al (2007). Teachers' Education, Classroom Quality, and Young Children's Academic Skills: Results from Seven Studies of Preschool Programs. *Child Development*, March/April 2007 (78); 558-80.
6. Kelley P., and Camilli G. (2007). The Impact of Teacher Education on Outcomes in Center-Based Early Childhood Education Programs: A Meta-analysis. National Institute for Early Education Research (NIEER).

The Corps AA Degree Program is one strategy to assist early childhood teachers and providers to develop the skills and knowledge needed to create and maintain quality early care and education. One goal within this strategy is to link providers to a larger education system and prepare providers for ECE systems that require college degrees. Increasingly, across the nation, legislation and policies are expanding access to child care and preschool and requiring that providers in those programs hold bachelor degrees and, in some cases, early childhood teaching credentials. Head Start already requires 50% of its teachers to hold a BA degree. In California, multiple legislative initiatives have been introduced over the last several years aimed at creating higher ECE teacher standards and creating a rating system that will reward programs with staff who have degrees.

After completing the first year of the Corps AA Degree Program it is clear to staff that ECE students need a tremendous amount of support and guidance to navigate the educational system. As we continue to support efforts to increase degree attainment, it is imperative that our programs are accessible and appropriate for non-traditional college students. English Language Learners (ELL) in particular experience many barriers that make earning even an AA Degree very challenging. For example, an entry level working provider with limited English skills may need eight to ten years to complete the necessary courses for their AA Degree.

The state match received from First 5 California provided vital additional funding during the first phase of the Child Development Corps. The Corps AA Degree Program is much smaller and the need for state support is no longer critical to funding the program. Participating in the state match requires a significant amount of staff time in collecting information, reporting and financial oversight. In addition, the state requires ECC to gather a significant amount of data from participants and have them sign an evaluation release form that is often overwhelming to Corps members. Staff recommends that ECC considers not re-applying for the state match. This would free- up staff time and allow ECC to pilot several strategies that are not allowed under the current state match guidelines including:

- Aligning Corps employment and eligibility requirements with the community college semester system
- Adjusting the Harms/Clifford training and self-assessment requirements
- Eliminating duplication of Corps professional development plans with the California Commission on Teacher Credentialing Professional Growth system
- Shortening the application form by removing unnecessary state match questions and the state evaluation release form

In an effort to increase the quality of care and education provided to children by the existing workforce, the Corps programs are designed for the existing ECE workforce. This of course should remain a key goal of the Corps; however, efforts to recruit and educate the future workforce should be taken into consideration, particularly considering that we currently face an aging workforce. Because of the requirements for the CARES match, we are restricted from using funds to support education and professional development programs that serve people who are not currently working in ECE.

program name:

time period:

ecc goals:

Professional Development Supports
(Professional Development Coordinators,
Career Advocates, Training Coordinators
Inclusion Coordinators and Professional
Growth Advisors)

2000-2009

goals 1 goals 2 goals 3 goals 4

brief program history & current program

ECC launched the Child Development Corps in May 2000 as a systems change initiative designed to build a network of ECE providers and to advance professional development through both formal and informal educational opportunities. Corps primary objectives were retention and continued education of Corps members. Professional Development Supports were established to support and create points of entry into the professional development system for providers in the community as well as those accessing formal educational opportunities. The long range goals are to build an integrated ECE Professional Development support network and infrastructure. Monthly contractor meetings have been put in place to encourage networking among professionals and systems to provide seamless, comprehensive support. Professional development supports have included Professional Development Coordinators (PDCs) at the community colleges; Career Advocates (CAs), Training Coordinators (TCs), Inclusion Coordinators (ICs) at the Resource & Referral agencies (R&Rs); and Professional Growth Advisors (PGAs) in the community.

Professional Development Coordinators (PDCs): In Phase I of the Corps program, First 5 funded a PDC at each of the four community colleges that offer ECE degrees to conduct outreach, enroll and provide support to Corps members taking college-level courses and additional support for English-language learners. The PDC at each college worked on systems-level changes, including coordination and implementation of campus programs to eliminate barriers to student progress faced by non-traditional students. Non-traditional students include: being older than 24 years; being an English-language learner; having family responsibilities and working full-time. System PDCs participate in strategies to enhance articulation toward four-year college degrees through cross-campus collaboration and also coordinate and participate in a variety of local, regional and statewide conferences on ECE professional development.

The role of the PDCs was strengthened in the new Corps AA program by adding a PDC at each college to focus primarily on providing student support. PDCs conduct outreach for the Corps AA program in the community (including family child care associations, child care centers, college classes, community events, provider support groups and newsletters) in English and other languages; assist providers in completing the Child Development Permit application; process and approve Corps applications (replacing 30+ Corps Enrollment Specialists), advise students on developing a professional development plan, including ESL and general education requirements and connect students with campus resources.

PDCs at Chabot College administer the Spanish cohort for English-learners. The Emerging Teacher Program at Merritt College, administered by a community college counselor provides additional support to English – language learners. PDCs collaborate with Career Advocates at the R&Rs to establish a seamless, county-wide system of professional development.

Career Advocates (CAs) In Phase I of the Corps Program, CAs at the three local R&Rs conducted outreach and enrollment of Corps members and provided resources and advice for entry level and experienced ECE professionals. CAs coordinated support groups, provider recognition events and training on how to use the Environmental Rating Scales. CAs were responsible for recruitment and training of Professional Growth Advisors (PGAs) who are community-based ECE providers who assist their peers with professional development needs related to the Child Development Permit system.

(continued to the next page...)

brief program history & current program

(continued from previous page)

With the implementation of the Corps AA program in Phase II, enrollment is now conducted exclusively by the PDCs. Providers in the community who wish to receive one-on-one professional development advice in the community can continue to meet with CAs at the R&Rs. CAs also assist providers in finding a PGA, offer career planning, address questions about the Child Development Permit, link providers with ECC programs and evaluate and process foreign transcripts for providers seeking a child development permit or college enrollment.

Professional Growth Advisors (PGAs): To be eligible for a stipend in Phase I of the Corps, members had to obtain a Child Development Permit. Permits are renewed every five years and require written documentation and signed approval from a PGA as evidence of completion of a professional growth plan. PGAs, established by the State (but without funding, training or standards) in the community assist providers to obtain and maintain their Child Development Permits. PGA training was initially conducted by the CAs at the R&Rs.

An advanced PGA training program was conducted by First 5 in 2006-08 and focused on building leadership capacity and strengthening the advising system.

Training Coordinators These positions were developed as part of the Phase II Corps to improve the infrastructure of the informal training system in the county and to assist both center-based and family child care providers in meeting their training needs. Training Coordinators (TCs) coordinate non-unit bearing training offered to the ECE community; implement new trainings and trainings in languages other than English; maintain a county-wide training list by location, cultural and linguistic considerations; and coordinate training on the Environmental Rating Scales for Corps members. The Training Coordinators also work closely with the ECC-funded Trainer Enhancement and Training Coalition Projects to support and enhance training opportunities for community-based providers.

Inclusion Coordinators (ICs): Inclusion Coordinators at the R&Rs were initially funded by the state. As state funds decreased, First 5 augmented the funding. Inclusion coordinators address the barriers to inclusion for parents of children with special needs; address provider inclusion concerns; coordinate a variety of support groups and trainings and maintain county-wide resources on inclusion. State funding is no longer available for these positions.

2006-07 PROGRAM COSTS: \$1,882,448

(includes Professional Growth Advisor Project, R&R Career Advocates, R&R Inclusion Coordinators, R&R Training Coordinator, Trainer Enhancement Project, Community College Contracts and) – excludes stipend awards)

FUNDING SOURCES: First 5 Alameda County, State School Readiness grant, First 5 State CARES matching grant

PROGRAM DOSAGE: Variable

In Phase 2, PDCs are required to see every Corps member at least once/year

Other support services dosage varies by provider demand and outreach

PROGRAM REACH

(Numbers & Population Served):

Phase 1 Corps 2000-2006

- 5,880 Corps members were enrolled

2001-07

- Over 200 students participated in English-language learner cohorts

2006 to present

- Over 600 Corps members enrolled by PDCs
- 111 PGAs trained by ECC
- 273 of FFN providers trained on basic child development and health and safety
- 535 providers and 507 families advised by inclusion coordinators

Outcome 2B: Increased access to resources for children and families with special needs:

From 2006 – 07, 535 ECE providers received technical assistance and referrals from ICs on developing inclusive child care programs and 507 families received assistance in locating, obtaining and maintaining inclusive child care services. Services are primarily provided in English (89%). 7% of calls are from Spanish-speaking providers and/or parents and 4% are from Mandarin speaking providers and/or parents.

Outcome 2C: Increased professional development and retention of ECE providers:**Proportion of Child Development Corps (Corps) members returning from previous years, by year (Phase 1 Corps Program)**

2001: 59.2% (1087 of 1835)

2002: 70.0% (1364 of 2036)

2003: 75.2% (1502 of 1997)

2004: 89.2% (1493 of 1674)

From 2000 to 2005, retention was greater for Corps members at higher levels of the Child Development Permit Matrix.

Proportion of Corps members who complete AA degrees:

18 of 586 (3%) currently enrolled students have received an achievement stipend, representing either the achievement of the AA degree or the equivalent.

Increased professional development and retention of ECE providers through career planning and support services for ECE students to obtain the AA degree

- 2001-06 PDCs provided career advising for over 3,200 Early Childhood education students at 4 community colleges
- 2001-06 CAs provided career advising for an average of 900 providers/year in the community
- 2001-06 280 PGAs were trained to support ECE providers around Child Development Permits
- 2006-07 PDCs completed 851 educational plans and conducted 10 Child Development Permit Workshops for 161 providers
- 2006-07 111 PGAs received advanced training in leadership skills

Increased support for ECE students who are English language learners

- 2001-07 350 students participated in the Chabot College Spanish Cohort.
- The Merritt College Emerging Teacher Program cohort began with 25 English language learners; second cohort began the following year. 68% of students who were surveyed from the cohort said they planned to continue their education toward the Bachelors Degree.
- 2006-07 CAs evaluated over 200 foreign transcripts and facilitated support groups for 212.
- 2006-07 Las Positas College PDCs worked collaboratively with faculty and staff to offer a targeted group of “at risk” students (those with disabilities) additional support through a cohort.

Improved articulation among four-year educational institutions and community colleges

- 2001-06 Community colleges expanded and diversified credit-bearing course offerings on the social-emotional development of children, children with special needs and a cross-disciplinary course on business practices.
- 2005-07 Systems PDCs are participating in the Curriculum Alignment Project (CAP) to articulate 8 ECE courses from the community colleges to the CSU system, making transfer seamless. Agreement has already been reached with the 4 community colleges to enable transfer of 4 core ECE courses among institutions.

Enhanced training opportunities and training support for ECE providers in the county

2001-06

- CAs conducted 56 trainings for 536 participants, including 36 trainings offered in English, Spanish, Cantonese and Mandarin on how to use the Environmental Rating Scales.
- CAs conducted 6 professional growth trainings for PGAs in multiple languages
- Courses were provided for 75 ECE students in low-income neighborhoods.

2006-07

- TCs implemented workshops for 398 providers on the social-emotional foundations of development and cultural and linguistic diversity in child rearing
- 2006 Trainer Enhancement Project trained 26 ECE trainers to enhance their ability to provide quality, culturally sensitive training

System PDCs work at the systems level to enhance collaboration between college campuses and other Alameda County agencies and have succeeded in establishing MOUs among the 4 community colleges to insure that the 4 core ECE classes are transferable among the 4 community colleges, thus allowing students to move more easily between campuses. Systems PDCs also develop linked courses and study skills models, professional development opportunities for adjunct faculty and links to student support programs, including assessment and counseling.

In 2006, the PDCs implemented the Child Development Permit Verification of Completion Program (VOC) to streamline the approval time for permit applications. Since establishing the VOC program the time from application to approval was reduced from 8-10 months to 2 months.

Training Coordinators work to create an integrated system of community-based training by tracking various training opportunities in their regions and participating in the Training Coalition.

The combined work of the R&Rs and the Systems PDCs should lead to a more integrated system of training and education in the county.

Inclusion coordinators have the potential to increase access to appropriate child care services for children with special needs and increase provider capacity to serve these children.

POTENTIAL FOR SUSTAINABILITY OR LONG-TERM HOME:

No identified source of funding without ECC for PDCs, PGAs, Training Coordinator or the Inclusion Coordinators (no longer state funding)

R&R revenues from the state appear to be declining and the R&Rs have come to rely more on ECC support for their programs. Much of the Corps enrollment and support is provided by the PDCs at the community colleges and is funded, in part, by the state First 5 CARES matching grant, which may or may not continue. ECC has not decided whether it is cost-effective to continue to apply for the CARES funds.

It is unlikely that the R&Rs will receive significant funding from a universal preschool initiative; R&Rs may need to consider alternative sources to fund family child care, Family Friend and Neighbor programs and the Inclusion Coordinators.

Supports are necessary to attract and retain students and to build a coherent system of training and educational opportunities. Impact and tracking data on Corps AA support and student achievement have not been available until the full implementation of the ECC Online Corps database in 2007. ECC will implement a longitudinal survey of Corps members to evaluate members' experience as they progress through the program and to measure members' perceptions of competence and confidence in their professional achievements.

We will be able to examine system-level impact at the colleges by documented county-wide college articulation and through interviews with local leaders who can inform us about systems level changes. Unfortunately, the contract for the PDC at Merritt College was terminated due to inability to meet contractual requirements and systems dysfunction. A PDC is now housed at Bananas to enroll Merritt students in the Corps AA program.

There has been no systematic measurement of on how many providers PGAs serve, or their impact on providers maintaining or moving along on the child development permit process. To assess effectiveness of the ECC PGA training, pre and post training professional development plans from a sample of providers PGAs advise will be evaluated in 2008.

The R&Rs provide an important and valuable resource for providers and parents who do not choose to access the community college formal educational system. It has been challenging to measure the impact of the various community-based training and supports provided by R&Rs through First 5 funding. In addition, one R&R has been reluctant to collect and report required quantitative data. R&R narrative reports have informed accountability and annual reporting requirements.

There appears to be significant overlap in the roles and activities of the various support programs (e.g., advising is conducted by CAs and PDCs; R&Rs provide training as do PDCs, Mentors and the Training Coalition.) This overlap poses tracking and evaluation challenges. It is uncertain that so many similar and overlapping support programs are truly efficient in serving providers and parents. In addition, professional support outcomes on provider retentions, increased education, application of training topics and effects on children and families are not available.

In 2008, the Training Coordinators will be conducting a survey of providers who attend training at the R&Rs to evaluate how well provider training needs have been met and whether providers are using what they learned.

With increased funding of the Inclusion Coordinators, First 5 has been able to institute a tracking system that allows closer monitoring of their activities and impact. In 2006-07, inclusion coordinators reported serving primarily English speaking parents and providers. Considering the diversity of the county, there is a potentially large underserved population who do not access these services. Outreach and future inclusion services should be both culturally and linguistically relevant.

Program Strengths:

The Professional Development Support positions have created a strong network of support and communication among the community colleges and Resource and Referral agencies in Alameda County. These support positions have been instrumental in supporting a variety of ECE programs.

The early care and education system is very challenging to navigate. Community-based support positions assist ECE providers in navigating this system. These positions also provide valuable feedback to ECC on the implementation of programs and have been critical in providing information for key programmatic decisions.

Staff would like to stress the importance of continuing to invest in increasing the capacity of trainers as part of our larger efforts to strengthen informal training in the county. Trainers currently receive little to no support or training around how to be effective trainers. Trainers play an important role in the professional development of ECE providers and therefore have the potential to positively impact the quality of care for children.

Program Challenges

Managing all of our ECE contracts and support positions can be very time consuming for staff. Maintaining positive working relationships among contractors and agencies is an on-going issue. There are also times when ECC has to engage in philosophical discussions with contractors on how to best support the ECE workforce.

ECC requires a significant amount of data collection and reporting from all of our contractors. This can be very challenging to monitor and maintain.

Turnover among the community support positions is an on-going challenge. These positions are very specialized and when there is turnover ECC staff must spend a significant amount of time orienting and training new support personnel.

Long-Term Sustainability

ECC currently receives financial support from First 5 California to fund all of our support positions through the CARES and School Readiness matching programs. However, it is unknown whether or not the state will continue these matching programs.

The Resource and Referral agencies are working with the state to include the Inclusion Coordinator positions into their state allocation. This would create funding support for these positions.

It has become evident that each of the colleges is greatly impacted by the budget reductions they have received from the state. Classes that do not meet enrollment levels are canceled and at some colleges, no ECE courses are offered in summer semester. Absorbing the Professional Development Coordinators (PDCs) positions into the community college budget is an unlikely and unrealistic expectation given the financial climate. The PDCs have come to be seen as part of the institution, but like almost all support programs on campus, including EOPS, Puente, and TRIO they rely on funding from other funding sources, mostly federal and state grants. The PDC positions should be seen as part of ECC's long-term funding efforts, while at the same time, it would be valuable to include a component in the System PDC scope of work to seek/leverage additional funds. The Spanish Cohort at Chabot College and the Emergent Teacher Project at Merritt work with a specialized population and there are viable state and federal grants that could support these positions financially.

The current budget crisis in California has had a significant impact on resource and referral agencies. In addition to general cuts to their budget, the money they receive for child care subsidies is consistently reduced. Adding to this is the financial strain R&Rs must endure while waiting for the state budget to be signed. It is highly unlikely that the Resource and Referral agencies will reach a point where they have the capacity to financially support the Career Advocate and Training Coordinator positions. These positions should be seen as part of ECC's long-term funding efforts, while at the same time, it would be valuable to include a component in their scope of work to seek/leverage additional funds.

ECC may want to explore developing a lead agency model to coordinate our support positions. This would reduce the amount of staff time needed to monitor these programs.

program name:

time period:

ecc goals:

**Early Care & Education
Quality Enhancement Programs**

2001-08 with program
modifications in 2006 (QII)
all other programs 2001-08

goals 1 goals 2 goals 3 goals 4

brief program history

QEP programs have focused on improving quality child care, through professional guidance and supports to ECE providers including: Quality Improvement Program (QII), the Enhanced Mentor Program (EMP), the Child Care Fund (now known as Quality and Facility Grants) and the Family Child Care Fair.

QII: In 2001, ECC launched the QII program to improve ECE quality. Initially, QII consultants assessed program needs using Environmental Rating Scales (ERS), identified goals and developed individualized, long range plans for implementing changes. Based on evaluation results from the first 3 years of the program, the QII program was modified. The modified 6-8 month program includes assessments, written plans and technical assistance to implement change.

Quality and Facility Grants: This program was developed in 2001 to train ECE providers in business management and financing, to increase child care slots through grants and loans for facility development and to initiate the Quality Improvement Grant program

EMP: In 2001, the EMP partnered with the California Mentor Program to increase recruitment of experienced ECE providers to provide support and additional services to Mentor programs at Alameda County's four community colleges; to offer practicum experience for ECE students, either at the Mentor or student's site; and to provide technical assistance and support to other providers with the goal to improve program quality. In the first few years, mentors received training on the environmental rating scales and the California Child Development Permit. In 2005, a new focus on improving mentoring skills included on-camera presentation coaching and training on effective communication, critical thinking skills and developing action plans. In 2006-07 mentors were offered the opportunity to receive additional training on how to engage teachers in reflective conversations about their practice by participating in a pilot program called "Exploring Reflective Conversations."

Family Child Care Fair: Since 2001, The Child Care Fair has provided a one day annual event to honor family child care providers with an ECE workshop and vouchers to purchase books and child development materials for their programs. In recent years, workshops have been provided in multiple languages.

BRIEF CURRENT PROGRAM DESCRIPTION

QII: Family child care and center-based programs are eligible to apply to participate in this 8 month, intensive, individualized quality improvement program. Targeted sites are located in low API neighborhoods and target programs serving children with special needs. A trained consultant provides on-site, relationship-based technical assistance after jointly completing an environmental assessment with the program provider. Action plans are collaboratively developed based on assessment results and provider-identified needs. Participating sites are eligible to apply for a quality improvement grant administered by the Low Income Investment Fund (LIIF).

Quality and Facility Grants: Both grants are administered by the Low Income Investment Fund (LIIF). QII grantees who have participated in the 8 month QII program are eligible to apply for a Quality Grant (up to \$ 5,000 for Family Child Care and \$10,000 for centers). Quality grants are used to make improvements based on the individual site plans. Facility Grants of up to \$50,000 are available to support pre-development, construction and other facilities and equipment costs for the start-up of a new program, expansion of an existing program or preservation of a program that is at risk of losing existing slots.

EMP: The Enhanced Mentor Program (EMP) continues to partner with the CA Mentor Program and engages community-based mentors to conduct recruitment and outreach activities to attract a more diverse workforce and provide short term one-on-one mentoring to providers. The EMP promotes a cross-disciplinary approach to caring for children and their families. Mentoring topics include: curriculum design and implementation, making changes to the outdoor environment, administration, program management, how to cultivate leadership skills, providing TA to QII grantees and Corps members.

Family Child Care Fair: The Fair continues to offer Family Child Care Providers a one day workshop in English, Spanish and Chinese and vouchers worth \$250 to purchase materials. Selected vendors are on site with a wide selection of books, toys, and outdoor equipment. Workshop topics in the past two years were children's social and emotional development and infant-toddler care.

2006-07 PROGRAM COSTS: \$825,312

(includes EM Community Training, EM Professional Development, QII, Quality Counts Grants, QI Grants, Quality Counts Leadership and Business Support, Family Child Care Fair and PIC)

Funding Source: First 5 Alameda County, State School Readiness grant

PROGRAM DOSAGE:

Up to \$50,000. May apply more than once.

EMP variable depending on provider request

Child Care Fair: one day including workshop and \$250 in vouchers

PROGRAM REACH

(Numbers & Population Served):

QII

2001 – 2006: Over 100 QII classrooms or programs serving at least 3,800 children

QII prioritizes site recruitment to reach children at higher risk including, School Readiness (low API) neighborhoods, sites with the likelihood of impacting children and families with special needs, sites with low-income families and sites with infants and toddlers.

In 2004-05, 28 of 29 QII sites served low-income children.

Quality and Facility Grants

Can fund up to 30 Quality Grants and 30 Facility Grants per year

EMP

100 mentors (duplicated) have been recruited since 2001 to provide at least 92 trainings and 1:1 mentoring for 1,320 providers (duplicated)

Family Child Care Fair: Targets 200 Family Child Care providers each year.

2006: 178 family child care providers attended

2007: 188 family child care providers attended

QII

Outcome 2B Increased access to resources for children and families with special needs

2005 - 06: 106 children with special needs attended 27 classrooms or programs receiving QII services.

2006 - 07: 49 children with special needs attended programs that received facility improvement grants; two specifically to increase access for children and families with special needs

Outcome 2D Increased access to high quality early care and education

100% of QII settings (both center-based and family child care) showed improved environmental assessments (2006-07)

100% of QII participants applied for and received Quality Improvement Grants

Proportion of ECE settings receiving QII consultation that have improved teacher/child/parent interactions outcomes: results not available yet. Since Environmental Rating Scales are not very sensitive to behavioral changes, we began using a teacher/child interaction evaluation tool (CLASS) in center-based programs

Note: Relationship-based consultation models, combined with intensive, early childhood technical assistance and the active participation of the provider leads to positive changes with long-term effects on quality (University of North Carolina, Quince research project, 2006).

EMP

The number of mentors increased from 16 in 2000 to 34 in 2007.

Quality and Facility Grants

Number of grants awarded 2006-07

| Impact of LIIF Facility and Quality Grants on Children | Facility Grants awarded for site improvements, expansion, equipment, preservation of slots | Quality Grants awarded to QII Participants |
|--|--|--|
| Number of Grants | 16 | 19 |
| Number of children with special needs | 49 | 14 |
| Number of children from low income families | 597 | 114 |
| Number of children with a home language other than English | 303 | 200 |

QII

Results from a 2004 impact evaluation of the first 3 years of QII by La France Associates

QII providers were satisfied with training, long-range planning, training in child development, technical assistance received and with the grant award.

Improvement in Environmental Rating Scales in areas identified in improvement or action plans

Environmental ratings of 41 classrooms or programs showed:

- 25% of centers improved at least 1-point (on 7-point scale) in space & furnishings
- 60% of family child care programs improved at least 1-point (on 7-point scale) in space & furnishings

In 2003, QII participated in the national QUINCE longitudinal research project, which was administered by the University of North Carolina and UCLA. UNC/UCLA research provided preliminary data (in 2007) on changes in the environmental ratings for the research sites in 2004-05.

The center- based providers overall had a modest improvement in ECERs scores. Family child care sites appeared to have a significant improvement in their FDCRS scores.

Results of a 2005 ECC survey of providers who participated in either the UNC/UCLA Quince research project or QII programs between 2004-05 (13 of 29 sites were Quince sites) to identify differences between programs and inform program planning.

Providers wanted to conduct their own environmental assessments and work collaboratively with their consultant. Space and furnishings received the most attention from consultants and led to the greatest improvements.

Facility Grants 2006-07

Increased access to high quality early care and education

| | |
|-------------------------------------|---|
| Playground safety | 8 |
| Increasing disabled access | 2 |
| Health and Safety Improvements | 9 |
| Construction of new facility | 3 |
| Renovation and deferred maintenance | 8 |
| Completion of licensing process | 1 |

Family Child Care Fair

Increased provider awareness and intention to support children and families

2006 – 2007 188 Family Child Care providers attended and each received \$250 in vouchers to purchase child appropriate materials for their programs.

A survey of providers 2 months after the infant-toddler care workshop reported that as a result of attending the workshop, providers do things differently, e.g., try to understand children’s development and needs; try to bond individually with child; use different toys and activities and try to make food more fun; pay more attention to what child does; increase amount of independent play time

EMP

2006 -2007: 14 mentors provided 1:1 support for 18 providers

Recruitment of bilingual mentors continues to be challenging. Note: Mentor program was understaffed in 2006-07. Tracking systems and impact studies not available.

Increased knowledge of social-emotional consultation

The Partners in Collaboration project, a collaboration between the EMP program and Mental Health Partnership Grants, provided cross-discipline training and practicum to ECE Consultants and ECMH Consultants. (see Partnership Grants program summary)

Increased reflective practice skills of mentors

Two day training series on reflective practices were held for 12 mentors; another six participated in a 6 month hands-on training

QII has improved the quality of participating child care sites in Alameda County.

QII has engaged providers in discussions about quality throughout the county and increased provider awareness of local professional development opportunities.

There is increased awareness and use of the environmental rating scales and other validated tools.

Mentors participate in Partners In Collaboration (PIC) and Training Enhancement Program (TEP) which expands both the training and consultation services available to providers countywide.

Family Child Care Fair targets FCC providers training and educational opportunities in this hard-to-reach group.

The LIIF contract supports the work of a program officer who works closely with the Local Planning Council and LINCC, the county-wide facilities planning group.

POTENTIAL FOR SUSTAINABILITY OR LONG-TERM HOME:

The possibility of "Preschool for All" and a California statewide quality rating system would increase the likelihood of sustainability of the QII similar to other state programs, e.g. North Carolina.

Continued partnership with LIIF and documentation of impact may help with sustainability efforts.

Increased integration of the various quality enhancement programs and with other First 5 professional development and family support programs (such as mental health consultation and PIC) may serve to strengthen the services provided for families and providers.

The results of ECC-supported and the UNC/UCLA evaluations as well as other published studies show that a relationship-based model that "meets the provider where the provider is" and that uses on-site consultation or coaching is most successful (Project CREATE, UNC). QII has had both quantifiable and qualitative positive results on the quality of child care in Alameda County in some of our most at-risk communities. The QII program reach is small in terms of the number of programs we can serve (based on intensity of the intervention), but those that do participate are able to make significant changes.

Compared to observable environmental changes it is more challenging to document changes in children's development and teacher-child interactions. However, the results of our evaluation and that of other programs show that training and consultation on these topics are critical for quality improvement efforts (Pianta, et. al., 2004). Future QII evaluation plans include continued interviews with providers about the program, documenting parental perceptions of changes and possibly using the CLASS, along with the Environmental Rating Scales, to assess teacher-child interactions.

Challenges to the program include, reliability of the rating systems, their appropriateness in various cultural and linguistic settings and the compatibility of ratings with program consultation activities. QII has recently hired three, full-time consultants (one is bilingual) and with continued reliability checks and training on the rating scales, quality assurance and program consistency should improve.

The Enhanced Mentor Program policies and acceptance of new mentors is determined by the CA Mentor Program, which impacts the effectiveness of First 5 efforts. Recruitment of new bilingual mentors has been challenging. The program has not had a systematic method of tracking or evaluating the impact of the programs and the number of sites served has been low. Efforts to implement more effective outreach and evaluation have been "on hold" until the vacant manager position is filled. In the past two years, trainings to improve the quality of mentoring and to strengthen the program have been instituted.

With greater integration of the PIC program (family support services), the Enhanced Mentor and QII programs, it will be possible to create a more comprehensive consultation service for ECE programs. This comprehensive program includes not only environmental assessment and consultation but mental health consultation as well. This would provide a more well-rounded intervention for the ECE programs that are served.

QII

Objective data indicate that the QII is effective at reaching its goals and providers report a high degree of satisfaction with the program's services. We are only able to serve a third of the sites who submit applications. Consideration should be given to expanding the QII to include more comprehensive services (e.g. business skills training, social-emotional health issues, etc.) to serve more sites.

A major challenge continues to be recruitment of bi-lingual staff with experience providing consultation and who work in the ECE field.

FACILITY GRANTS

This program has been very successful in repairing and improving child care facilities. Demand for this program exceeds supply of funds. Investments in improved facilities could potentially be better sustained if grantees also received business training on how to fundraise and plan for future capital improvements.

FCC Fair

The FCC Fair continues to be a highly popular event, with almost twice as many applicants as can be accommodated. Data shows that the majority of Fair attendees have not participated in other F5AC funded programs, including the Child Development Corps. Anecdotal reports indicate that Fair attendees show increased interest in participating in F5AC programs and other professional development programs throughout the county.

EMP

This program has significant potential to be a valuable resource to the ECE community. However, the program lacks a coordinated, focused outreach effort, which is evident in the number of providers who have not heard of it, despite its existence for the past seven years. In addition, the evaluation system in place has not been effective in gathering data. The manager position that would address these issues has been vacant for two years, but will be filled soon.

program name:

time period:

ecc goals:

School Readiness

2001 to present

goals 1 goals 2 goals 3 goals 4

brief program history

School Readiness Strategies incorporate several approaches to prepare children, families, Early Care and Education / Kindergarten teachers and schools for children’s entry into Kindergarten. Strategies focus on services for children and families in targeted neighborhoods with low performing schools (API: 1-3) with some approaches reaching countywide. The School Readiness Strategies portfolio focuses on familiarizing school administrators, Kindergarten and ECE teachers on effective transition strategies, assisting families in getting children physically, socially, emotionally and cognitively ready for the Kindergarten, and institutionalizing promising transition practices at elementary schools and ECE programs. The Summer Pre-K (SPK) program is the signature strategy, offering a short-term pre-kindergarten summer program for children without preschool or licensed child care experiences to prepare for Kindergarten entry. An early study of the SPK using the High Scope Child Observation Tool demonstrated that the short term intervention produced positive results.

Successful transition of children into Kindergarten also depends on “ready” schools. The School Readiness team developed key relationships with school staff and district administrators to ensure that schools expand their outreach to families and ECE providers. Contracts were established to encourage districts to offer comprehensive transition activities and resources to families year round. In addition, the School Readiness team facilitates forums that offer knowledge exchanges between ECE and K providers/teachers/administrators about streamlined transition services and activities for all families, coordinated approaches to school readiness reflecting developmentally and culturally/linguistically appropriate practices in ECE and Kindergarten settings and quality literacy curriculum and classroom environments. The team also offers technical assistance and support to F5AC staff and partners on issues relating to school readiness and promising literacy enhancement practices.

BRIEF CURRENT PROGRAM DESCRIPTION

- SPK offers children a 5-6 week half-day Pre-K program that familiarizes children to their future school and classroom environment and helps link parents to health, dental and child development supports in preparation for Kindergarten. Each classroom is co-taught by a Kindergarten and ECE teacher, with at least one of which is bilingual. During the program, F5AC staff work with teachers in assessing their classroom environment to instill developmentally appropriate practices. Parents attend workshops held as part of the SPK program.
- School districts offer year-round school activities to families and preschool age children entering Kindergarten in the Fall.
- The K/ECE Collaborative provides a forum for school-based administrators, teachers, ECE providers and other family support professionals serving families in 5 school districts to network, develop common transition approaches and collaborations and further understanding of the links between ECE and Kindergarten.
- The Early Childhood Literacy Network convenes professionals across multiple disciplines serving young children and families to provide information, resources and support to share best practices in early childhood and family literacy programming.
- Broad-based outreach to families includes the distribution of books and countywide Kindergarten Registration Information Sheets translated into 5 languages.
- Outreach strategy to the faith-based communities, Leading Ladies, was launched in 2007 to implement and provide resources for church and community based school readiness activities

2006-07 PROGRAM COSTS: \$737,333

(includes ECE Kindergarten Collaboration, Kindergarten Registration, Literacy Enhancement, School Based Programs/Parent Education and Summer Pre-K)

Funding Sources: First 5 Alameda County, State School Readiness grant

PROGRAM DOSAGE: Variable. SPK held part-day for 5 to 6 weeks in the summer for children who have not attended licensed preschool or child care

Year round activities vary by district

PROGRAM REACH (SEE CHART TO LEFT) (Numbers & Population Served):

In Summer 2006, 323 children attended SPK: 67% spoke Spanish at home, 28% English, 1% Tagalog, 1% Cantonese, and remaining spoke Korean, Hindi, Pashto, Punjabi, Russian or Vietnamese.

Schools offered 48 parent workshops in conjunction with SPK activities for children

Parents of new Kindergarteners attended 21 orientation sessions / workshops, five in Spanish-only and 16 were simultaneously translated by bilingual interpreter.

364 children, 242 adult family members and 73 ECE and K staff have participated in transition to K activities held by the school districts

50 participants from 25 community agencies attended Literacy Network meetings

PROGRAM REACH (Numbers & Population Served):

| Year | # of School Districts | # of Classrooms |
|-----------|-----------------------|-----------------|
| 2001-2004 | 2 | 6-8 |
| 2005 | 3 | 12 |
| 2006 | 7 (15 schools) | 19 |
| 2007 | 6 (16 schools) | 21 |

School Readiness

2006-07 Annual Report

Outcome 2A. Improved child social, developmental and emotional well-being

14 of 18 children identified for developmental screens were screened as a result of participation in SPK.

17 received services from F5AC Child Development Specialist. 6 were referred for additional services upon further assessment. 2 speech, 3 overall, 1 parent-child work

Outcome 2E Increased school readiness

Proportion of children attending SPK who have good attendance records in K,1 & 2*

Proportion of children attending SPK who successfully move on to first and second grade*

- School data not yet available

Outcome 3B Children are healthy, well nourished and receive preventive and on-going health and dental care from a primary provider

99% of children attending SPK were up to date on immunizations

83% of children attending SPK had health insurance

79% of children attending SPK received an annual dental exam

Number of children attending SPK by school

323 children attended SPK in 2006

Description and number of parent workshops offered at SPK

48 parent workshops were held to discuss topics covering Transition to Kindergarten/School Readiness, Dental and Medical Health, Literacy, Nutrition, Social/Integrated Services, Child Abuse Prevention, Parent Leadership/Rights and Responsibilities, Positive Discipline/Understanding Temperaments, Computer Training, and Handwriting.

Number of children attending Summer Pre-K Programs who have or need IEPs***Number of children attending Summer Pre-K Programs who are in process of receiving district services*****Proportion of parents who have written letter to district requesting developmental services*****Description and number of schools participating in Year Round school activities to assist children and parents in kindergarten transition**

364 children, 242 adult family members and 73 ECE and K staff have participated

Description and number of orientation sessions for parents of entering Kindergartners

21 orientation sessions offered

Number of schools with procedures that facilitate continuity between early care and education programs and elementary schools as described by NEGP "ready schools"

27 schools have formalized procedures

Number of children who participate in school-linked transition practices that meet NEGP criteria**Description and number of trainings and participants in the K/ECE Collaborative**

Each participating district held K/ECE Collaborative events to discuss common goals and activities to support children and families as they transition to kindergarten. Topics included enhanced services, streamlined registration, smooth transition procedures, curriculum and assessment and the development of more family-friendly and developmentally appropriate services in both ECE and Kindergarten environments. Participants primarily represent ECE/Kindergarten staff; however, multidisciplinary participants are beginning to participate.

Number of Kindergarten Registration Information Sheets distributed and by language

4,800 information sheets in English, 2,200 in Spanish, 400 in Vietnamese, 350 in Farsi and 800 in Chinese were distributed at early childhood conferences, meetings and workshops, resource and referral agencies, public health centers, pediatric offices, children's centers, Head Start programs, WIC programs, and counseling agencies.

Description of book distribution efforts and Literacy Network activities

F5AC family support contractors distributed 4,360 books to families. Additionally, Reach Out and Read circulated >35,000 books through pediatric sites and a Family Child Care Fair distributed over 1,200 books to licensed family child care providers.

The Early Literacy Network held quarterly gatherings attended by professionals from multiple disciplines to discuss best practices in early childhood and family literacy, and funding sources and policies that affect literacy services.

First 5 AC provided matching funds for Oakland School District to hire a 1 FTE Transition Coordinator.; A new Transition Team was created at one school within OUSD; 1 additional school district hired a part-time Transition Coordinator; 2 additional school districts hired part-time Summer Pre-K coordinators.

San Lorenzo Unified School District has used district funds, including Title 1, to supplement the SPK program and add additional classrooms. Pleasanton Unified in partnership with the City of Pleasanton is funding the SPK program serving 40 low-income children and/or English Language Learners. Chabot College is implementing a SPK like model this summer for the first time. Our goal has been for each school district to provide/support a SPK in every low API school for which they can use Title 1 funds. (Title 1 funds are based on income levels of children.)

Collaboration meetings provided valuable opportunities for Pre-K and K teachers and administrator to network and discuss the most pressing issues in K-transition.

F5AC School Readiness Manager assessed each of the 19 SPK classrooms using the Assessment of Practices in Early Education Classrooms (APEEC) guidelines. 11 out of 19 teachers reported that in reading the results of the APEEC they changed or enhanced their classroom environment and/or practices.

27 schools now have formalized procedures that facilitate continuity between ECE programs and elementary schools. Examples include:

- All schools in San Lorenzo USD, for the first time, offered a Kindergarten Orientation for parents prior to school starting. In addition, all Kindergarten students were screened prior to K entry to ensure appropriate placement and curriculum.
- Livermore Valley Joint USD expanded the Latino Family Literacy program to 2 additional schools
- One district reported a more streamlined Kindergarten registration process including more complete enrollment packets from parents

POTENTIAL FOR SUSTAINABILITY OR LONG-TERM HOME:

At this time, State First 5 is undecided whether to continue the 1:1 matching dollars for School Readiness Initiatives. Funding is secured through 2010. Since much of F5AC programs (in addition to School Readiness Strategies) draw down funding through this matching initiative, the potential loss of School Readiness Initiative dollars pose a significant challenge.

Maintaining quality SR programs is highly dependent on the health of the school district and school administrators.

School Districts may be willing to sustain programs, as demonstrated with Oakland's Transition Coordinator. Can Transition Coordination be institutionalized?

Kindergarten Transition plans are required of Program Improvement Schools. Can we leverage this requirement to further our work re: K Transition?

School Readiness, in practice, is infused throughout all of F5AC programs. The specific strategies highlighted here target the needs immediately leading up to a child's entry into Kindergarten. School Readiness staff provides training and technical assistance to a variety of community members and school partners. Recipients of training and TA included several community grantees and community partners such as Children's Fairyland, MOCHA, San Leandro Even Start, South County Head Start and the United Way. The SR team also offers technical assistance and expertise to all programs at F5AC.

Many School Readiness strategies reflect a high degree of systems change, resulting in budding examples of long-term sustainability. A key to affecting school district changes is to design activities in partnership with local school districts to develop district-specific strategies (this does not make sense –not clear what you are saying). Through the Early Literacy Network and the K/ECE Collaborative, teachers and providers participate as 'experts'.

District results include:

- Spanish speaking families in Livermore whose children did not participate in preschool learned ways to help their children prepare for Kindergarten during the summer months
- In Oakland USD, a Transition Team was developed at MLK, Jr. Elementary School including several community partners
- Parents in Livermore now receive a school readiness brochure created by the K/ECE Collaborative which gives parents ideas on how to prepare their children for K at home.
- Parents and children visit K classrooms ahead of entering Kindergarten. Some Kindergarten teachers have spoken at parent meetings held at partner preschools regarding school readiness.
- Through the K/ECE Conference, Kindergarten and ECE teachers and providers alike received valuable information regarding the value of play and developmentally appropriate practice in the classroom environment.
- Parents in Pleasanton now receive a bilingual "Getting Ready for Kindergarten" brochure at Kindergarten registration and through local preschools.

The Leading Ladies Initiative provides training and support for women leaders in the faith based community to outreach to families around school readiness and child development. How many??

The SPK continues to expand to more classrooms, with schools continuing the program without F5AC funding. The success of SPK went beyond preparing children for school. Parents and teachers reflected on changes in the children, the classroom and within themselves.

Parent focus group of 2005 SPK:

- "I just felt more confident.... I was a little worried about how she was going to do at school..."
- "[My child] was kind of isolated.... He didn't speak to the others, and now he's really friendly."
- "[My son] was excited because he learned how to spell his name, and [exposure to] his teachers really was a very good experience for him. And when the teacher say[s], "You did it," he was like, oh, my God, I did it. He was so excited."

Teacher Narrative Reports 2005 SPK:

- "The staff worked as a team to improve our environment constantly. We moved things around (such as the sign-in sheet) in order to create better flow to the classroom. As the students produced artwork, we posted them on bulletin boards so they could take pride in their work. We also took photos so students can see themselves reflected. As the weeks passed, we also involved more family members as volunteers in order to build capacity in the families, but also so they too felt ownership of the classroom."
- "Many of the students needs were met by having in class a bilingual aide. She was able to comfort those who needed comforting and intervene in an appropriate matter when conflicts arose between the children. "

2006 SPK Teacher Survey:

- "We thoroughly enjoyed our experience as teachers during the SPK. We had an ideal team, one of us is a preschool teacher and one of us is a Kindergarten teacher. Both of us have a broad background in ECE and we used the knowledge that we have about how child develop to deliver appropriate curriculum that met needs of the children in all their developmental areas. "

F5AC hired Applied Survey Research to evaluate the readiness of children who participated in SPK or were touched by other F5AC programs in targeted schools in low API neighborhoods. The evaluation will begin in Fall 2008.

The School Readiness Team makes the following recommendations for change:

Expand targeted SR programs (SPK, Year Round and K/ECE Collaborative) to serve all school districts with low-API schools adding 3 districts: Newark, Mountain House and San Leandro USD's.

Provide funding for a Transition Coordinator at each low-API district

Expand Leading Ladies program to include entire faith-based community, not exclusively African American churches.

Expand Early Literacy Enhancement project to include partnership grantees (non-literacy based programs) as well as family support contractors

Develop infrastructure to manage all agency literacy programs under School Readiness

Change Kindergarten Registration Information Flyer to give more general information and be combined with "Getting for Kindergarten" type information for countywide distribution

Develop plan to transition management of K/ECE Collaborative meetings in each district to funded Transition Coordinators

Provide year round Child Development support to Year Round and Summer Pre-K programs (currently in planning stages for FY20 08-09 through 2009-10)

program name:

time period:

ecc goals:

Health Access
Alameda Alliance for Health

2005-2008

goals 1 goals 2 goals 3 goals 4

brief history & current program description

Alameda County is fortunate to have a fairly high rate of children who have health insurance. A 2005 California Health Interview Survey reported that 98% of children 0-5 in Alameda County are insured. Health insurance for children 0-5 living in households under 300% of the federal poverty level (FPL) is available from a combination of Medi-Cal, Healthy Families, the Access for Infants and Mothers program and the county Healthy Kids program (Alameda Alliance for Health). However, data for undocumented children and families is difficult to obtain.

First 5 CA launched the Health Access for All Children Initiative to expand coverage for uninsured California children. F5AC was approved for this matching grant and contracted with the Alameda Alliance for Health to provide low cost health insurance for children 0-5 in Alameda County (Healthy Kids).

Healthy Kids includes children whose families earn up to 300 percent of the FPL (or \$58,050 for a family of four). Healthy Kids coverage is available to all children, regardless of immigration status. Benefits are similar to the benefits provided under the Healthy Families Program and include health, vision and dental services as detailed in the Alliance Family Care Evidence of Coverage.

PROGRAM COSTS: \$218,750/year as part of 4 to 1 state match.

PROGRAM DOSAGE: 130 children 0-5 per month

PROGRAM REACH (Numbers & Population Served):

2006-07: 1,678 children were enrolled

- 1,370 Hispanic/Latino
- 112 Korean
- 95 White
- 42 Vietnamese
- 27 African American
- 21 Chinese
- 61 Other/unknown

ARTICULATED PROGRAM OUTCOMES, MEASURES AND RESULTS

2006-07: 1,678 children were enrolled. 77% Spanish speaking; 7% English; 4% Korean and 12% other languages

ECC OUTCOME INDICATORS & RESULTS (IF NO MEASURABLE RESULTS, CITE RELEVANT LITERATURE REFERENCE):

2006-07 Annual Report

Proportion of children who do not have health insurance by program:

2% Postpartum Home Visits; 0% Special Start; 1% Teen Services; 1% ARS; 4% Grants

SYSTEMS CHANGE IMPACT: Unknown. Enrollment in health Insurance is only one factor contributing to health access. If outreach and access to this insurance continues to be problematic, systems change potential will remain low.

POTENTIAL FOR SUSTAINABILITY OR LONG-TERM HOME: The Alameda Alliance has just announced the closure of Health's Healthy Kids Program effective September 30, 2008. First 5 CA matching funds for the Healthy Kids program sunset in December 2008. It is yet to be determined if First 5 CA funds will be available after this time.

COMMENTS AND ANALYSIS STATEMENT (INCLUDING QUESTIONS TO CONSIDER):

Enrollment as been at capacity. Family Support Service (FSS) contractors report difficulty obtaining referral and enrollment assistance. The program is not well publicized or supported. Although insurance coverage is high in the county, actual access to health care services is unknown. Barriers exist for non-English speaking families and new immigrants. It is uncertain whether First 5 CA will continue to support this program although there is considerable political pressure to continue and expand it as the state budget crisis continues.

| | | |
|---|---|--|
| program name: Healthy Kids Healthy Teeth (HKHT) | time period: Community Grantee 2002-2005; Contractor 2005-2008 | ecc goals: <input type="checkbox"/> goals 1 <input type="checkbox"/> goals 2 <input checked="" type="checkbox"/> goals 3 <input type="checkbox"/> goals 4 |
|---|---|--|

brief history & current program description

Dental disease is the most common chronic disease of childhood. 40% of Alameda County children 2-4 years have never been to a dentist (CA Health Interview Survey, 2001) and 46% of kindergartners at low-income schools had untreated decay. (Oral Health Needs assessment, February 2006)

HKHT is a partnership between Alameda County Public Health Office of Dental Health and the Dental Health Foundation that addresses three major concerns:

1. the relatively low level of access to dental care for children aged 0-5 particularly at-risk children
2. the disproportionately high rate of dental caries for at-risk children aged 0-5
3. lack of knowledge about prevention of early childhood caries among the general public and specifically among many parents, caregivers, childcare providers and other related professionals and paraprofessionals

F5AC Funding supports a Community Health Worker (CHOW) who provides outreach and case management to at-risk families for dental decay primarily in Oakland, Hayward and San Lorenzo/San Leandro. They also take referrals from agencies, early childhood programs, medical offices and other sources, to enroll children in HKHT and facilitate dental appointment and linkages with other health and social services. Additionally, workshops and trainings are provided to early childhood providers, WIC, First 5 Family Support contractors, Summer Pre-K Programs and staff in appropriate languages and distribute educational materials in Spanish and English.

PROGRAM COSTS: \$75,000 per year

PROGRAM DOSAGE: varies

PROGRAM REACH (Numbers & Population Served):

2002-2005 1,253 children enrolled
2006-07: 289 children enrolled

ARTICULATED PROGRAM OUTCOMES, MEASURES AND RESULTS::

Of 368 referred to HKHT, 173 had a dental visit or were scheduled for one
289 Children were enrolled in HKHT for case management
83 children were referred for other health or social services
52 parents attended workshops on dental health

Contracts: Healthy Kids Healthy Teeth

ECC OUTCOME INDICATORS & RESULTS (IF NO MEASURABLE RESULTS, CITE RELEVANT LITERATURE REFERENCE):

2006-07 Annual Report

Proportion of children 1 year and older who received an annual dental exam

Results from programs collecting data range between 29% (Special Start) to 79% (Summer Pre-K Program - school requirement is for children to have a dental exam in May of their kindergarten year). Only 60% of HKHT enrolled children had a dental exam.

SYSTEMS CHANGE IMPACT:

The intention of HKHT was to provide training and education at both the parent and provider level to increase the number of children who receive dental care and parental and provider knowledge about oral health prevention strategies. Infrastructure challenges at HKHT have resulted in small numbers being served and fewer educational opportunities. Despite initiatives to train pediatricians and other providers to screen for caries and apply fluoride treatments, the lack of reimbursement options limits the viability of this strategy. Until the number of dentists serving young children increases in the county, the ability to impact these poor health outcomes will be challenging.

POTENTIAL FOR SUSTAINABILITY OR LONG-TERM HOME:

The Office of Dental Health, ACPHD, has organized age-related interventions designed to address both the primary and secondary prevention of dental caries. These include Healthy Kids, Healthy Teeth, Early Childhood Caries Initiative for 0-5 year old Medi-Cal enrollees, the California Children's Dental Disease Prevention Program which provides sealants and dental education in a school-based setting, the Healthy Smiles Children's Dental Treatment Program for children who require dental care and have no insurance, and Dental Health Referral Services for people of all ages who need dental referrals and information.

The Alameda County WIC Program has embarked on a four year pilot project in collaboration with the Dental Health Foundation and the Alameda County Office of Dental Health to provide Well Child Dental Visits in WIC offices to children aged 9 to 15 months of age. Services will begin in July 2008 at the Hayward office. This project is now partially funded by F5AC and it is hoped that the pilot will demonstrate ways to develop sustainable screening for these very young children.

COMMENTS AND ANALYSIS STATEMENT (INCLUDING QUESTIONS TO CONSIDER):

Limited resources and infrastructure challenges of HKHT impacted the program's ability to offer services and meet referral demand. Family Support Service (FSS) contractors and grantees have indicated frustration with making referrals to HKHT because response time is so long or is non-existent. FSS contractors and grantees track whether children one year and older have had a dental visit in the past year and reflect that families experience the most difficulty obtaining annual dental exams with or without dental insurance or MediCal. An approach that is more focused on prevention through education of parents and providers may be more effective in addressing this need.

Appendix A: goals & outcomes

Goal 1: Support optimal parenting, social and emotional health & economic self-sufficiency of families

OUTCOMES

- Enhanced parenting and stronger families
- Children are free from abuse and neglect
- Enhanced economic self-sufficiency of families

Goal 2: Improve the development, behavioral health & school readiness of children 0 to 5 years

OUTCOMES

- Improved child social, developmental and emotional well-being
- Increased access to resources for children and families with special needs
- Increased professional development and retention of ECE providers
- Increased access to high quality early care and education
- Increased school readiness

Goal 3: Improve the overall health of young children

OUTCOMES

- Increased support for breastfeeding mothers
- Children are healthy, well nourished and receive preventive and on-going health and dental care from a primary provider

Goal 4: Create an integrated, coordinated system of care that maximizes existing resources & minimizes duplication of services

OUTCOMES

- Increased sharing of resources and ability to leverage blended funding
- A common set of results, indicators and performance measures across participating ECC agencies
- Increased county-wide training opportunities to promote best practices, increase provider capacity and assure quality services for families and children 0-5 years
- Increased access to and utilization of ECC programs and services for all families with children 0 to 5 years in diverse communities of Alameda County
- Increased county-wide service coordination and collaboration identified by system-wide initiatives such as: ECMH, child development, Schools' Capacity
- Increased opportunities for early care and education students to earn AA and advanced degrees to promote a diverse professional workforce