Best Practices Report
Planning Efforts for Countywide Coordinated Systems of Screening, Assessment, Referral and Treatment of Young Children

Prepared for First 5 Alameda County
Steering Committee for the
Assessment System Planning Process

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I. Introduction

Purpose of Planning Process

Across the nation, counties recognize the need to develop coordinated and seamless systems of screening, assessment and treating the health and social service needs of their residents, particularly pregnant women and young children aged 0-5 years. Broward County in Florida, a large ethnically diverse county that has rural, suburban and urban areas, reports:

> *Children's services are delivered through fragmented, unconnected agencies rather than through a coordinated delivery system from prevention and early intervention through aftercare thus creating gaps in assistance, inadequate or non-existent transitioning between providers, and or duplicate, overlapping services.*[1]

Alameda County faces a similar problem. In response, the county is in the process of planning a county-wide system of screening, assessing, referring and treating young children to ensure they receive the health and social service care they require. In preparation for the planning process, we assessed planning efforts underway in other California State counties that have already created similar, county-wide programs. . The assessment showed that each county had identified a similar need, implemented a county-wide planning process to obtain consensus on the design of a new system of care, and are in the process of, or have, implemented the proposed system.

Key Informants

Part of our research included interviewing individuals who led the planning processes or who were responsible for supervising the new care systems. The following people were interviewed:

1. Julie Kurtz,
   Director of Mental Health Services
   Kidango, Inc.
   4533 Mattos Drive
   Fremont, CA 94536

2. Vivian Gettys,
   FASD Project Manager
   Capital Area Human Services District
   4615 Government Street, Building 2
   Baton Rouge, LA 70806

[1] Children's Services Council of Broward County. *Problem Statements with Goals & Objectives*, 2003, p.1.

3. Anne Molgaard
   Executive Director
   First 5 Mendocino County
   166 Gobbi Street
   Ukiah, CA 95482

4. Jill Smialek, Program Officer
   & Marie Barni, Program Manager
   Invest In Children
   Office of Early Childhood, Cuyahoga County
   310 W. Lakeside Avenue, Suite 565
   Cleveland, OH 44113

5. Cindy Faulkner, Program Specialist
   & Amy Cousineau, Desert Area SART
   First 5 San Bernardino
   330 North D Street, Suite 500
   San Bernardino, CA 92415-0442

6. Laurie Misaki, R.N.
   Perinatal Services Coordinator
   Breastfeeding Promotion Coordinator
   Maternal, Child and Adolescent Health
   Fresno County Community Health Department
   1221 Fulton Mall
   Fresno, CA. 93721

Research Questions

The following questions were asked during the interview:

1. Please give me an overview of your system for screening, assessing and treating young children at risk of behavioral or developmental delays.

2. What was your planning process like to get you to this system?

3. What are some of the lessons learned in your planning process that we should be aware of?

4. What would you identify as the successes/strengths of your system?

5. What would you identify as the challenges or ongoing areas for refinement in your system?

6. If you could do anything in your planning and design process over, what would it be?

Methodology

This report summarizes the models and approaches used by other counties that have successfully completed the planning process for a new county-wide system of care. Included are the methods used to resolve similar tasks and problems found in the Alameda County project. Telephone interviews, follow-up conversations, and planning process documents were reviewed as part of the data collection process. Citations are in the appendix.

II Program Models

Of the six regions included in this report, four programs were in California, and were associated with First Five Agencies, and two were in other states. Summaries of each planning process and program are below.

The California-based programs included:

- San Bernardino County Screening, Treatment, Assessment, Referral and Treatment: (START System)
- Santa Clara County Early Screening and Assessment Team: (KidConnections)
- Fresno County Screening, Decision-Making, Assessment, Referral, and Treatment Model of Care: (SMART MOC)
- Mendocino County Special Needs Project: (WISH & WEAVE)

The two out-of-state programs were:

- Baton Rouge, Louisiana, Capital Area Human Services District (CAHSD): Fetal Alcohol Spectrum Disorders (FASD) System of Care
- Cuyahoga County, Ohio, Office of Early Childhood: Early Childhood Initiative (ECI)

San Bernardino County START System

Guiding Vision

> *Children and their families, especially young children ages 0-6, will be screened, assessed and referred for treatment through a universal collaborative and standardized process that strengthens and builds on existing programs in the community. Our goal is to improve the mental and social functioning of children as measured by school readiness and the achievement of appropriate developmental milestones.*[2]

Program Overview

The San Bernardino Countywide Screening, Treatment, Assessment, Referral and Treatment (START) system is a multi-disciplinary collaborative for women and children[3]. The size of the county, along with the lack of financial resources and institutional capacity, was a critical factor in determining the nature of the San

[2] "Current Evidence Based and Emerging, Screening, Assessment and Treatment Practices for the Mental and Neurodevelopmental Health of At-Risk Children ages 0-5." Report prepared by the Best Practices Committee in San Bernardino County for First 5 San Bernardino County, August 2006.

3 Initially, the program was a Screening, Assessment, Referral and Treatment (SART) system. Later, federal funding received from the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) grant, required an additional level of treatment and the program was reconceived as the START System.

Bernardino START system. Because San Bernardino County is the largest county in the United States – there are nine states that are smaller than it – the planning committee acknowledged that one service center was not sufficient to meet the needs of the entire county. In addition, the lack of high quality social service institutions in the county available to host the program led to the decision to develop and implement the START incrementally.

The original SART initiative was financially supported by the Children's Fund, a 501(c)(3) fundraising arm of the Children's Network, and the San Bernardino County First 5 commission. It focused on providing services, at a single location, to children in the County's Child Welfare System. The geographic and programmatic scope has since broadened to include the eventual development of three assessment centers, two in the urbanized, western part of the county, and one in the vast, eastern desert, and plans to provide services to all children in the county aged 0-5.

The financial support of the First 5 Commission included the year-long planning process that resulted in the opening of the first SART Assessment Center in Apple Valley. Finding additional funding sources has been a critical component of the ongoing planning efforts. EPSDT funds are not intended to sustain an assessment center – it can only sustain a treatment center for children who are MediCal eligible. Further, the EPSDT diagnostic guidelines only recognize diagnostic tools that were developed for adults.

The Assessment Center is run by the Desert/Mountain SELPA and is funded by the San Bernardino County Mental Health Department. Before selecting the Desert Education SELPA, the County Mental Health department agreed to contract with them to provide onsite screening, assessment, and treatment services, with screening and case management performed by public health nurses.

The second center was opened in the city of San Bernardino, in October 2006, and is run by a partnership between Cal State San Bernardino, Loma Linda University, and the University of Redlands. The vision for this center is to provide a training ground for students and professionals, who work with these special needs populations, so that they will create a cadre of skilled professionals for San Bernardino County.

Planning Processes

Planning processes used by several other county programs helped influence the development of the San Bernardino START system and the system itself developed in stages in San Bernardino County, starting first on the perinatal side and then building to serve children 0-5 under the auspices of the First 5.

Dr. Ira Chasnoff and Dr. Bruce Smith, from the San Bernardino County Public Health Department, helped establish the Perinatal SART program in an effort to meet the needs of children with Fetal Alcohol Syndrome (FAS) or Fetal Drug Exposure (FDE) and to prevent such conditions. At a leadership training institute, county stakeholders began discussions about blending funds and services for this population of children. Clarity and agreement on the scope of the program lead to the creation of mission and vision

statements for the Perinatal SART system. The perinatal planning process that ensued took one year to complete

Santa Clara KidConnections

Mission

We will collaborate with our partners to develop a shared, strengths-based and culturally sensitive understanding of a child's development and behavior and translate such understanding into responsive action.

Planning Processes
In Santa Clara County, the FIRST 5 Screening and Assessment Referral and Treatment planning team was developed by the Inclusion Collaborative, a county-wide effort to include children with development delays and special education needs in regular pre-schools. The planning team goal was to design a developmental screening and assessment process for children aged 0-5 that would address unmet developmental screening and assessment needs in high-risk populations. The program would also take into account the multiple, system barriers impacting the effective and timely delivery of services by creating an integrated approach to screening and assessment for categorical service eligibility that could be utilized across multiple systems. The program aims to serve all children in Santa Clara County aged 0-5, with priority given to children aged 3 and 4 who live near the pilot sites, and those who do not otherwise qualify for existing resources in the community.

The planning process was led by a group of 15 individuals from all levels of the following agencies:

- Numerous non-profit service providers;
- Regional Center;
- Santa Clara County Office of Education,
- M.D. Center for Learning Achievement;
- Numerous School Districts;
- Santa Clara County Mental Health Department;
- SELPAs;
- Mental Health/Homestart HOPE Services; and,
- Head Start/Early Start.

The multi-agency planning group was funded by First 5 and Santa Clara County Mental Health. Over the course of 13 months, focus groups were held to determine the existing services available and the needs of the county. Utilizing information obtained from the focus groups and analysis of the best practices of other such systems, they designed a total system of care. Once the design was complete, consultants with experience on similar initiatives were included to help refine the system.

The final plan recommends a two-level screening and assessment process. Level 1 Screening and Assessment involves a screening team of mental health and early intervention professionals. Level 2 Screening and Assessment encompasses a wider range of people from all services children might require. Both processes focus on the actual needs of a child rather than the financial constraints that may bound service delivery mechanisms.

KidConnections, the operators of the SART system, is a collaborative partnership of the following community agencies:

- Children's Health Council;
- Santa Clara Department of Mental Health;
- Kidango;
- KidScope Assessment Center for Developmental & Behavioral Health;
- Parents Helping Parents;
- Santa Clara County Office of Education; and,
- VIA Services.

Fresno County SMART MOC

Core Values

- *Community-wide access and cultural competence*
- *Early Intervention*
- *Easy Access*
- *Simplicity*
- *Financial Sustainability*
- *Not dependent on individuals*
- *Begin with the needs of the children and families*

Program Overview
In Fresno County, the SMART Model of Care (SMART MOC) results from the collaboration between several county agencies across multiple disciplines. SMART MOC targets multi-system, multi-problem children aged 0-5 who are unable to succeed in preschool, day care, or kindergarten settings. The goal of the program is to function as an integrated system of health and behavioral care that will identify children ages 0-5 years that are at risk for medical, emotional, developmental or learning problems, and move them into a system of care before they begin to fail in school or enter the juvenile justice system. The children targeted by the program are those with attachment/bonding issues, serious emotional disturbance, or who exhibit risk factors, such as multiple office referrals (sent to child care program director's office), crisis contact, frequent absences, disruptive behaviors and/or co-occurring disorders.[4] Most children, and their families, served are labeled "at-risk" or are court dependents through the Child Welfare System.

[4] Fresno County MHSA Three-Year Program & Expenditure Plan. Community Services And Supports FY 2005-06, 2006-07, & 2007-08.

The five core functions of the Fresno SMART system are Screening, Decision-Making, Assessment, Referral, and Treatment. The screening, decision-making, and treatment functions are performed by community agencies. Assessments are conducted at the Assessment Center, which is located in the City of Fresno. The center is run by the non-profit organization Exceptional Parents Unlimited (EPU). The Model of Care Partner Oversight Committee (MOC POC) meets monthly to coordinate the operations of the multiple service providers and is responsible for overseeing the program.[5]

The SMART MOC is public-private partnership that draws on the experience of parents of high-risk children and the expertise of staff working in the following partner agencies:

- Fresno County Department of Children and Family Services;
- Fresno County Department of Employment and Temporary Assistance;
- First 5 Fresno County;
- Exceptional Parents Unlimited, Inc;
- Fresno Unified School District;
- Fresno County Office of Education;
- Clovis Unified School District;
- Central Valley Regional Center;
- Court-Appointed Special Advocates;
- Fresno Metro Ministry;
- Fresno County Juvenile and Dependency Courts;
- University of California San Francisco-Fresno Medical Education, Department of Pediatrics; and,
- Fresno County Mental Health Board.

Planning Processes

The Fresno County SMART MOC emerged from the work of the Perinatal Substance Abuse Committee. During planning for the County's Perinatal SART system, the committee became aware that a similar system was needed for children 0-5 years with at-risk histories. Once the Perinatal SART model was implemented, the committee formed a Child Study Group to investigate the needs of at-risk children aged 0-5.

Widespread support in Fresno County for the development of a Child Study Center arose from two key events. In February 2002, Dr. Ira Chasnoff, who had been involved in the planning for the Perinatal SART program, conducted a retreat, funded by a Healthy Start grant, for members of the Child Study Group. Around the same time, he also addressed local judges, attorneys, and staff members of the Juvenile Drug Dependency Court about the link between fetal exposure to drugs and alcohol, the response of early-childhood care systems, and the later involvement of these children in the court system.

In response to county-wide support for an initiative to address these concerns, First 5 Fresno provided funding for a one-year planning grant in late 2002. Together, the Child Study Center and First 5 Fresno engaged in a planning process that conducted interviews and town hall meetings, in both English and Spanish, with 60 service-delivery specialists

[5] Lauie Misaki Interview, January 18, 2007.

and 400 community members, including parents of affected children., The scope and nature of the need emerged from the data. The resulting plan, *Putting the Pieces Together: Ensuring Access to Early Intervention for High-Risk Children Birth through Five in Fresno County*, was completed in April 2004.

Three months later, First 5 Fresno selected Exceptional Parents Unlimited (EPU), a local non-profit agency, to lead the Model of Care's Children's Center. In addition, First 5 awarded grants for center funding to Fresno County Maternal, Child and Adolescent Health (MCAH) to partially staff positions at the Assessment Center. The EPU Children's Center opened in February 2005. The center assesses and treats children screened and referred by other community partners. The Model of Care Partners Oversight Committee (MOCPOC), which is comprised of participating partner agencies,[6] oversees, directs and monitors implementation of this system.

Current funding is provided through multiple partners, including:

- Fresno County Department of Children and Family Services
- Fresno County Maternal Child and Adolescent Health
- Fresno Unified School District
- Central Valley Regional Center
- First 5 Fresno County

Mendocino County WISH & WEAVE

Willits WISH Practical Vision

In the year 2008, we have competent happy staff, stable program funding, quality inclusive child care, local resources that support families, empowered families, seamless services for all children and families, community commitment to on-going screening, all children ready for school, community awareness about substance use and early brain development.

Round Valley WEAVE Practical Vision

In the year 2008, our support system is widely used and responsive; Our system effectively reaches out to/and serves families with young children; We are utilizing and cultivating local expertise; Families support the nutritional needs, of mind body and spirit; We embrace and reflect Round Valley Family values; Children with special needs are served by competent and confident staff; Parents feel comfortable with Special Needs Service System; Families seek out Early Intervention and Screening Support; High quality, effective programs lead us to ongoing funding.

[6]Fresno County Department of Community Health. *Healthy Start Impact Report,* pp: 50-51.

Program Overview
In Mendocino County, screening, assessment, referral, and treatment of children aged 0-5 takes place in the towns of Willits (WISH) and Round Valley (WEAVE). The restricted scope of the care system to only two locations is due to the limited social services infrastructure and funds available in the rural county.

Screeners in both programs, hired by First 5, work with Head Start, local pediatricians, the Family Resource Center in each town, and family child care centers to screen children and educate the community on services provided by the program. After an initial screening, children needing additional assessments are sent to the appropriate city Child Study Team (CST). Each CST is comprised of partner agencies and Family Resource Center staff. Children requiring treatment are then referred to the appropriate agency.

Currently, First 5 Mendocino has achieved almost universal screening in Willits and Round Valley, but there are no plans to expand services to the rest of the county.

Planning Processes
The planning process for the seamless integration of screening, assessment, referral and treatment into one system began in 2003. Lack of funding caused the initial process to falter. Planning was revived in 2004 when the Mendocino County First 5 Commission was selected by the State to become one of 10 Special Needs Demonstration Program sites.

Through the grant, Sonoma State University was hired to do technical assistance and recommended First5 Mendocino start a new planning process. Early in the planning process, insufficient funding caused concern that children who were assessed, which was covered by funding, would be caught in a backlog waiting for follow-up services that did not have funding. The demand for services was lower than previously anticipated, however, and the concern was unfounded. Conscious efforts were made to include parents throughout the planning process and to obtain buy-in from partner agency leaders. This second planning process took 4 months and included the following partners:

- First 5 Mendocino County;
- Mendocino County Office of Education;
- Early Start;
- Regional Center;
- Head Start;
- State preschools;
- SELPAs;
- First 5 School Readiness Program; and,
- Local pediatricians, public health nurses, and parents.

One key planning decision made by Mendocino County was to allow assessment providers to use the tools already familiar to them, which increased the range of

assessment tools used and circumvented the need for additional employee training. This decision allowed a greater range of partners to assist in the screening process.

One interesting evaluation dilemma was resolved through ongoing dialogue and resulted in an agreement of mutually beneficial information exchange. Treatment agencies serving the children do not necessarily have funding from First 5. This led to initial data collection problems for the First 5 funded evaluation because of confidentiality concerns amongst treatment agencies. By sharing their own data and findings with the non-First 5 funded agencies, and promising to open up future funding opportunities during subsequent funding cycles, First 5 was able to successfully bridge the information sharing gap across agencies.

Baton Rouge, Louisiana, FASD System of Care

Mission

The mission of the Capital Area Human Services District is to enhance the availability of support services leading to a satisfying and productive life for persons living with developmental disabilities, addictions, and mental illness.

Vision

The health care and social services community of East Baton Rouge Parish is united and committed to ensuring a healthy and safe environment for families by providing coordinated prevention and intervention services addressing substance use, domestic violence, and depression throughout pregnancy, birth, and early childhood.

Goals

The goals of Capital Area Human Services District have been to provide more services for the tax dollars invested, take the services where people in need live, make services available at convenient times, and implement a preventive early intervention approach.

Program Overview

In Baton Rouge, Louisiana, the Capital Area Human Services District (CAHSD) is a publicly funded program that provides mental health services, substance abuse services, and developmental disability services for the Baton Rouge region. The CAHSD operates a county-wide screening, assessment, referral and treatment (SART) system for children aged 0-6 with Fetal Alcohol Spectrum Disorders (FASD). Like in other counties, the Baton Rouge SART grew out of a Perinatal SART program that aimed to reduce incidences of FASD. The SART is funded, in part, by a SAMHSA FASD intervention grant.

The perinatal screening component of the Fetal Alcohol Spectrum Disorder (FASD) System of Care utilizes the 4-Ps Plus tool, licensed from Dr. Ira Chasnoff, in an "upstream screening approach" with pregnant women in outpatient, prenatal clinics. To ensure the 4-Ps Plus tool was a good fit, it was initially piloted at a test site. Currently, thirty practitioners and partners from three local hospitals (Charity Hospital, Women's Hospital, and Baton Rouge General) use the 4-Ps Plus tool to perform screenings. All participants in the Women Infants and Children Program (WIC), a federal food program for Medicaid-eligible women and children, also receive the screenings.

If screening is positive, an intervention group provides resources and referrals to other necessary resources. The intervention group is composed of social workers and licensed counselors. They work with the light to moderate substance users in the clinics but for the heavy users they refer to outpatient gender specific treatment programs for substance abuse. This is run through CAHSD. For positive domestic violent screens they refer to a local battered women's program. For smoking cessation programs they also have resources that they refer to.

The Children's SART, for children 0-6, builds upon the existing partnerships established during the implementation of the perintal FASD System. Screenings continue to assess the need for children's services interventions based upon risk factors presented by the parents (typically the mothers) using the 4-Ps Plus protocol.

Planning Processes

Planning for the SART began in 2002, when the CAHSD received a SAMHSA Center for Substance Abuse prevention (CSAP) grant to raise awareness of the harmful effects of substance abuse during pregnancy. To increase the visibility and success of the program, CAHSD built a partnership of 70 agencies within the seven-county Baton Rouge area which helped promote and build the program. The program's success led to receipt of the Northrop Grumman grant in November 2004. The five-year grant provided for eight months of planning and the acquisition of a full-time grant coordinator responsible for planning and implementation of the grant program.

As in many of the California SARTs, Dr. Chasnsoff, was involved in planning the CAHSD FASD SART. The 12-member, high-level planning team attended a three-day Leadership Institute training in Chicago with Dr. Chasnoff. As a result of the training, the team prepared a draft plan framework for the new care system. The ensuing planning process included monthly team meetings, the formation of subcommittees responsible for logistics and implementation, and clarification of the system's scope and service delivery approach.

During the eight-month planning process, the planning team did a formal needs assessment, which consisted of focus groups held with providers, OB physicians, and other stakeholders, to reveal the issues, needs and barriers that existed. The needs assessment findings helped determine the composition of the strategic planning process and the formation of 12-person teams responsible for each partner agency's decision-making.

Cuyahoga County Early Childhood Initiative

Mission

Invest in Children is a communitywide, public private partnership whose mission is to mobilize resources and energy to assure the well being of all young children in Cuyahoga County, provide supportive services to parents and persons who care for these children and build awareness, momentum, and advocacy in the community around children and family issues.

Vision

All children in Cuyahoga County will reach their full potential, nurtured by families sensitive to their needs and supported by a community committed to their success.

Program Overview
Perhaps the most ambitious and well-run planning process, and most successful and encompassing implementation plan, was in Cuyahoga County, Ohio. The Early Childhood Initiative (ECI) was launched in July 1999, with the following four goal areas: Effective Parents and Families; Safe and Healthy Children; Children Prepared for School; and Community Committed to Children.

The Early Childhood Initiative serves children 0-6. The service strategies and indicators for each goal are as follows:

Goal 1. Effective Parents and Families

1. Home visiting
2. Service coordination/case management
3. Mental health screening and services

How we'll know we're succeeding:

- *Child abuse and neglect rates will decline.*
- *Parents will read to their children every day.*

Goal 2. Safe and Healthy Children

4. Health insurance enrollment
5. "Medical homes"
6. Prevention of lead exposure

How we'll know we're succeeding:

- *Mothers will give birth to healthy babies.*
- *Children will have health insurance.*
- *Babies will receive recommended check-ups, on time.*
- *Lead exposure levels will fall.*

Goal 3. Children Prepared for School

7. High-quality early care and education system for children from birth through age five

How we'll know we're succeeding:

- *Child care homes and centers will provide high-quality care.*
- *Children will score well on kindergarten entry tests.*

Goal 4. A Community Committed to Children

8. Community mobilization and advocacy
9. Cuyahoga County and the ECI as a center of excellence
10. Communications campaign

How we'll know we're succeeding:

- *The public will know that the first five years are the most important for children.*
- *Public and private investment in early childhood programs will continue and increase as projected.*

From the beginning, the first two focus areas received a majority of available funding. Funding is concentrated amongst five interrelated program efforts:

1. *Welcome Home*, which provides one-time, home visits by a nurse to all first-time or teen mothers and their newborns;
2. Intensive home visits, through *Early Start*, with families whose children, up to age 3, were identified as facing developmental challenges due to family and environmental characteristics;
3. Expansion and quality improvement of certified home-based child care;
4. Training of child care providers to serve children with special needs;
5. Outreach and expansion of government-subsidized health insurance coverage for children of low-income families through enrollment in Healthy Start and other Medicaid programs.[7]

Planning Processes

The development of ECI was trigged in the late 1990s when active, local philanthropic community members urged Cuyahoga County's three-member Board of County Commissioners to invest more in early childhood programs. Community members were influenced to take action by several events, including new research published on early brain development and the mass need for good, affordable health care created by welfare reform that required low-income parents to work. The community initiative was led by the Cleveland Foundation, and included the Mt. Sinai Health Care Foundation and the TRW Foundation.

County Commissioners responded by introducing planning for the Invest in Childhood (IIC) initiative in 1998. The one-year long IIC planning process began with broad-based community visioning that engaged multiple community service organizations and 26

[7] Cuyahoga County Early Childhood Initiative Evaluation: Phase I Final Report, pp: 1-2.

local foundations. Local foundations urged the Board of County Commissioners to pledge the first three years of funding for the Early Childhood Initiative (ECI) and agreed, in return, to donate their own funds to the program. The same year funds were committed to ECI, 1999, the program was able to offer services.

The Deputy County administrator in charge of the planning process took the lead in recruiting public and private agencies already providing services to children to join the initiative. Collectively, they brainstormed ways to work together more efficiently, what infrastructure was needed to prevent service delivery gaps, and how to build a system that would leverage funding to ensure adequate access to resources.

From the beginning, the planning process was divided into two committees. The service providers on the innovations committee examined data on existing programs and what needed to be done differently to improve the quality of care. The policy committee reviewed the recommendations of the innovations committee and considered how best to incorporate the new philosophy into existing County operations. This also required finding ways to make prevention, rather than intervention, a County priority and where program resources would be acquired.

Throughout the planning process, and into the implementation phase, there existed a great deal of disagreement over how to achieve the desired results. Although most of the disagreements were not resolved until well into the implementation phase, participants remained clear about their ultimate goal to help children enter school ready to learn. Ultimately, this shared commitment to a common goal was the factor which led to the success of the planning process.

In 2003, after 3 years of implementation, ECI underwent a second strategic planning process. The purpose of the process was to assess the strengths and weaknesses of the program, identify continuing gaps in service, and to determine where services should be expanded. It incorporated evaluations of the first years of service as a way to improve on the quality, not just the quantity, of services provided. In addition, service recipients and service providers, including line staff and directors, provided feedback on the strategic planning process.

A major component of the second strategic planning process involved strengthening relationships with the foundations supporting the program, of which, twenty-one recommitted and contributed funds. In response, the Board of County Commissioners tripled their resource commitment and secured the involvement of the business and faith communities in the oversight committee. The oversight committee has become a working committee, rather than just a formal body. A third planning process is now underway to identify the need for universal pre-kindergarten services.

Between 1999 and 2005, Invest in Children's budget was $90 million, with $18 million provided by local philanthropies and the remaining $82 million contributed by Federal, State and County sources.[8] The county estimated that 75% of the families with children

[8] "Invest in Children: A Storybook of Success." Financial Report, p.16.

under 6 received services during those years and 96% of children under 6 now have some form of health insurance. In addition, at-risk children were identified at an earlier age. Ongoing evaluations of the programs, demographic analyses, and needs assessments are conducted by the Center on Urban Poverty and Community Development of the Mandel School of Applied Social Science at Case Western Reserve University and via subcontracts with the University of North Carolina.

III Major Issues of the Planning and Implementation Processes

All six planning processes investigated differed in length, amount of forethought given to selection of participating agencies, strength of funding, and approach to implementation. In addition, each varied in level of local government support.

The planning processes also shared aspects. Each grappled with common structural, political, and financial issues in their planning and implementation. Analyzing the planning processes, as a whole, including relevant issues and solutions, will provide a solid foundation from which the planning process in Alameda County can be built.

The Planning Processes

All planning processes had the following issues in common:

- Non-linear due to differing agendas and funding sources of each agency involved;
- Integration and harmonization of fragmented services;
- Acquisition of additional funds to complete implementation;
- Increased county service delivery capacity;
- Implementation costs exceeding expenditures of existing programmatic parts; and,
- Deliberate action taken to increase awareness of community need and purpose of planning process.

Given the time consuming nature of conducting comprehensive planning, many counties that had already conducted similar planning processes hired full-time coordinators. Each considered expert, neutral facilitation of the process, and accountability systems designed to ensure action and commitment of participants, as critical during the planning process. Specific accountability suggestions included the following:

- Specific time-line established that includes task assignments and regular meetings; and,
- Continuous feedback to participants throughout the process.

The following planning recommendations are synthesized from the comments and stories reported by the eight key informants interviewed.

- Advantages of a well-thought out and well-run planning process include creation of a system suited to local need, wider credibility and support, and ease of implementation. A good planning process is iterative, in that each stage requires a return to former stages for guidance. For example, the system scope must be determined before implementation and decision on the scope should determine composition of the strategic planning process.

- Experts who are knowledgeable about the operations of partner agencies, contract guidelines, rules and regulations, and service provision should be actively

involved in obtaining MOUs, or RFPs, from participating county agencies and non-profit providers.

- The more stakeholders successfully engaged in the process, the greater the systems change.

- Too many participants involved may inhibit maneuverability in the planning process. Critical partners deemed necessary to the process are:

    - The School Districts;
    - Regional Centers;
    - Parents; and,
    - Decision-makers from participating public and private agencies.

Funding

The infrastructure needs of lead agencies should be given careful consideration during the planning process to ensure successful implementation of the program. One infrastructure need is funding for services that will be provided. The following recommendations were made regarding funding:

- Include insurance providers in planning process to help determine billing protocol for physicians;
- Understand restrictions and requirements of funding streams, how to blend them, and capitalize on federal matching dollars;
- Avoid funding health care specialists exclusively with MediCal to prevent excluding sub-groups of non-MediCal eligible clients;
- Apply First 5 funding to programs not covered by other sources and pursue federal matching, rather than county matching funds; and,
- Partner with providers who already bill for services they provide.

To ease service-delivery negotiations, committees and structures should be fully staffed and operational first. Piloting the system at select sites before the program officially begins can be one way of assessing readiness for service-delivery negotiations.

Evaluation

- Early and frequent evaluation of all of services will help build a successful system.
- Capable evaluators should be involved from the early stages of the planning process.
- Partner agencies should be informed, in advance, of evaluation questions, what information should be provided in their answers, and how the information will be used.
- Helping providers understand the purpose of evaluations is to improve service delivery will reduce potential fear or resistance.

The more care and planning put into designing evaluations, the less time researchers will have to spend seeking additional data. The continual education of service providers in the importance of data collection and sharing will also help minimize gaps in data gathering. Specific suggestions about the evaluation process include:

- Keep evaluation needs in mind when preparing materials or components of the program. For example, including foster children in research studies requires consent forms be written with consideration given to who can provide consent; and,
- Build evaluation forms around information sharing restrictions.

Implementation

Solid planning does not guarantee effective implementation. Implementation should be guided and managed by capable and effective individuals and plans. In the counties investigated, the same committees responsible for planning were retained to oversee implementation.

The implementation plan should be designed to adapt to new opportunities, unforeseen events, and potential road blocks. This includes adjusting the plan, as necessary, when it makes sense, rather than strictly adhering to what is written. Implementing the plan in phases, with realistic time-line goals, would allow agencies time to build capacity, hire new staff, conduct additional training, and form relationships with new partners. Specific relationship-building advice includes:

- Consider budgetary deadlines of partner agencies in developing plan;
- Establish specific strategy subcommittees devoted to the strategic plan;
- Balance quantity and quality;
- Understand limitations of state and federal policies, how to navigate them, and when to get wavers; and,
- Maintain inclusion and relationships with stakeholders.

Just as with the planning process, evaluation and data collection are critical to the implementation phase. The importance of data collection in improving service delivery should be stressed to all service providers. Demonstrating the positive effects of data collection to providers might increase motivation levels to participate. Suggestions for data collection were:

- Control data base and ensure the data input system is ready when services start; and,
- Train, or retrain, providers on data system changes.

When providing care to children, the following recommendations were made:

- Adopt flexible screening tools that broaden the pool of partners by allowing them to use tools they are already familiar with;
- Enable screeners to also do interventions to minimize time delays , ensure no one is neglected, and more children are reached; and,
- Take into account possible steps between positive screening and full assessment.

IV Lessons Learned

This was a painful process.[9]

Knowledge of the difficult lessons learned by the six counties investigated in this research will help guide Alameda County in its own process. This report was compiled in an effort to minimize road blocks and impediments to an Alameda County-wide screening, assessment and service system for children 0-5. The following points summarize the main lessons learned in this research:

- Powerful, committed, multi-agency leadership is important;
- Create a strong name and publicize efforts;
- Incorporate all stakeholders early in the initiative;
- Deliberately craft the planning and implementation processes, lending the same thoroughness to implementation as to planning; and
- Understand that planning processes have limitations.

The county with the greatest success in planning and implementing a system of care had broad and powerful support; county leaders from the highest levels, and from all sectors, not just early childhood or health, supported the initiative. Strong, committed multi-agency leadership was present in all six counties. Individuals willing to champion the initiative were critical in getting others involved. For example, doctors were able to encourage other doctors to participate. In addition, champions were able to raise awareness and build the necessary political will for implementing institutional changes.

A good, descriptive name that is well-publicized was considered important to the success of system of care initiatives. Additionally, specific attempts should be made to find funding for publicity and marketing efforts.

Key community partners who have special knowledge and expertise in all of the proposed services areas should be involved early in the planning process. These individuals will assist in critical decision-making relevant to the operations of their agencies, in addition to the quality of service delivery. Involving key community partners from the beginning ensures their program needs are also met.

Consideration for the membership of participating groups (e.g., leadership, stakeholders, etc), and how the work was divided among them, appeared to directly impact the degree of controversy or acceptance surrounding the implementation process. The more forethought and deliberateness put into the planning at the beginning, the less controversy and greater the acceptance there was at the end.

[9] Julie Kurtz. Santa Clara County.

In the planning process, the possibility for including too many stakeholders, rather than enough, exists. Undecided and un-agreed upon issues will arise that should be worked out over time, even into the implementation phase.

Ultimately, the system of care is designed to benefit children and their families. Planning processes should maintain their focus on the goal of serving children and resist accommodating the agendas of partner agencies.

V Appendix

A. References
B. System Flow Charts and Organizational Descriptions
C. Evidence Based Best Practices

Appendix A. References

Documents Consulted.

San Bernardino County

Lakes, K. D. (Ed.). *(August 2006). Current evidence-based and emerging screening, assessment, and treatment practices for the mental and neurodevelopmental health of at-risk children ages zero to five.* San Bernardino, California: First 5 San Bernardino.

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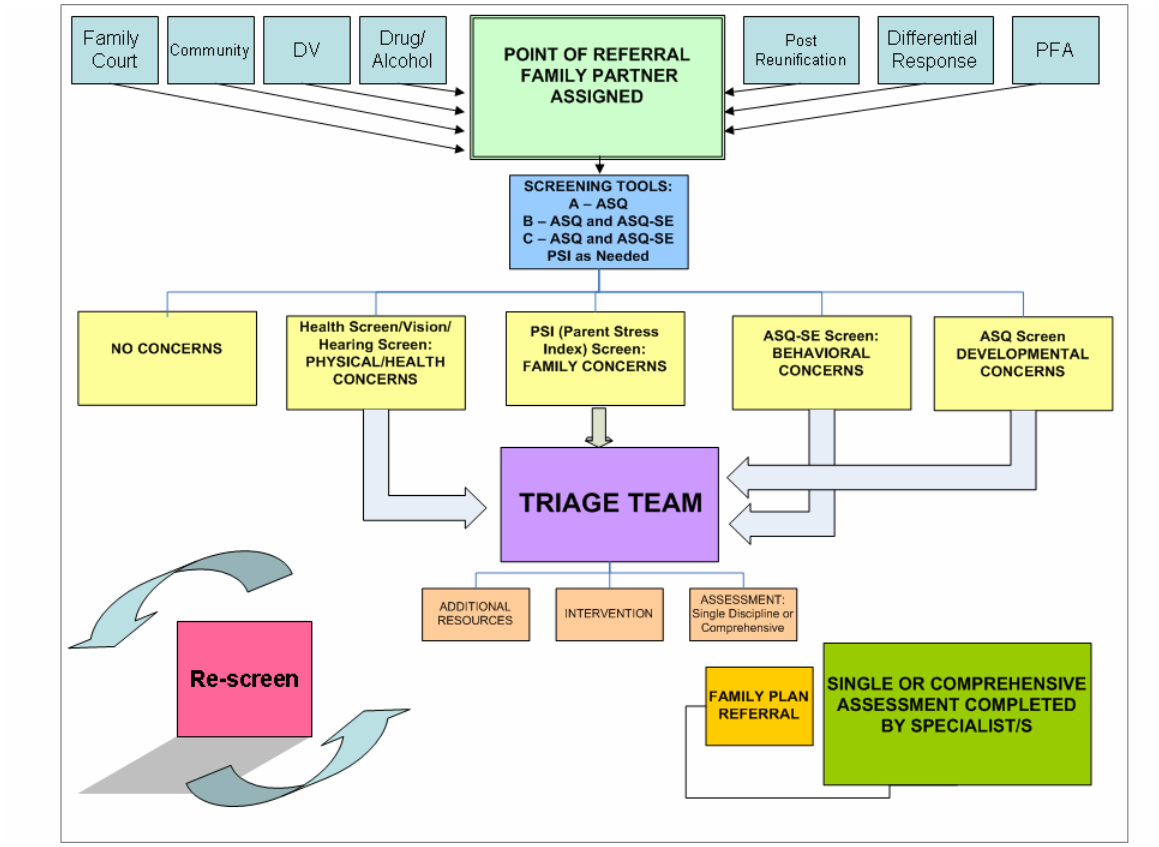
Evaluation: Phase II Final Report. Cuyahoga County Early Childhood Initiative May 2005. Submitted by Mandel School of Applied Social Sciences Case Western Reserve University with Chapin Hall Center for Children University of Chicago and with consultants from Frank Porter Graham Child Development Institute University of North Carolina at Chapel Hill Principal Investigator: Claudia Coulton, Ph.D.

Appendix B. Systems Flow Charts and Organizational Descriptions

San Bernardino

Pending

Santa Clara County Flow Chart of Services



Definitions of Flow Chart:

1. Point of Referral – Referrals come from Family Court, Community, Domestic Violence, Drug and Alcohol, Post Reunification/Social Services, Differential Response and/or the Preschool for All (PFA). The first call may go to a call center, 1-800 referral line.
2. Family Partner (FP) – Once the first call comes to the centralized referral number, families will be assigned a Family Partner to help them navigate and advocate. A Family Partner is assigned at the point of referral. The FP conducts a screening of families using the ASQ, ASQ-SE, Health Screen and Vision/Hearing Screen. To consider: (Part of the health screen should be to make sure that the child has a Primary Care Physician (PCP) and has been seen periodically. For the screening process to trigger referrals of all the kids to their PCP will only create confusion among the physicians as to what they are suppose to do because inappropriate expenditures of time and limited resources, and might trigger duplicated referrals to CLA, CHC or other resources to what the AT will be doing. The time for referral to the PCP is a part of the Family Plan so physicians know what is happening to their patient, what medical concerns have been raised through the assessment process, and can help determine what further needed medical work-up

or treatment might warrant referral to CLA or elsewhere.) The FP may identify 1 or more "red flag/s" that warrant a referral to the Triage Team to consider further assessment, interventions or referral. Those children without ASQ or ASQ-SE "red flags" will be considered for future re-screening.

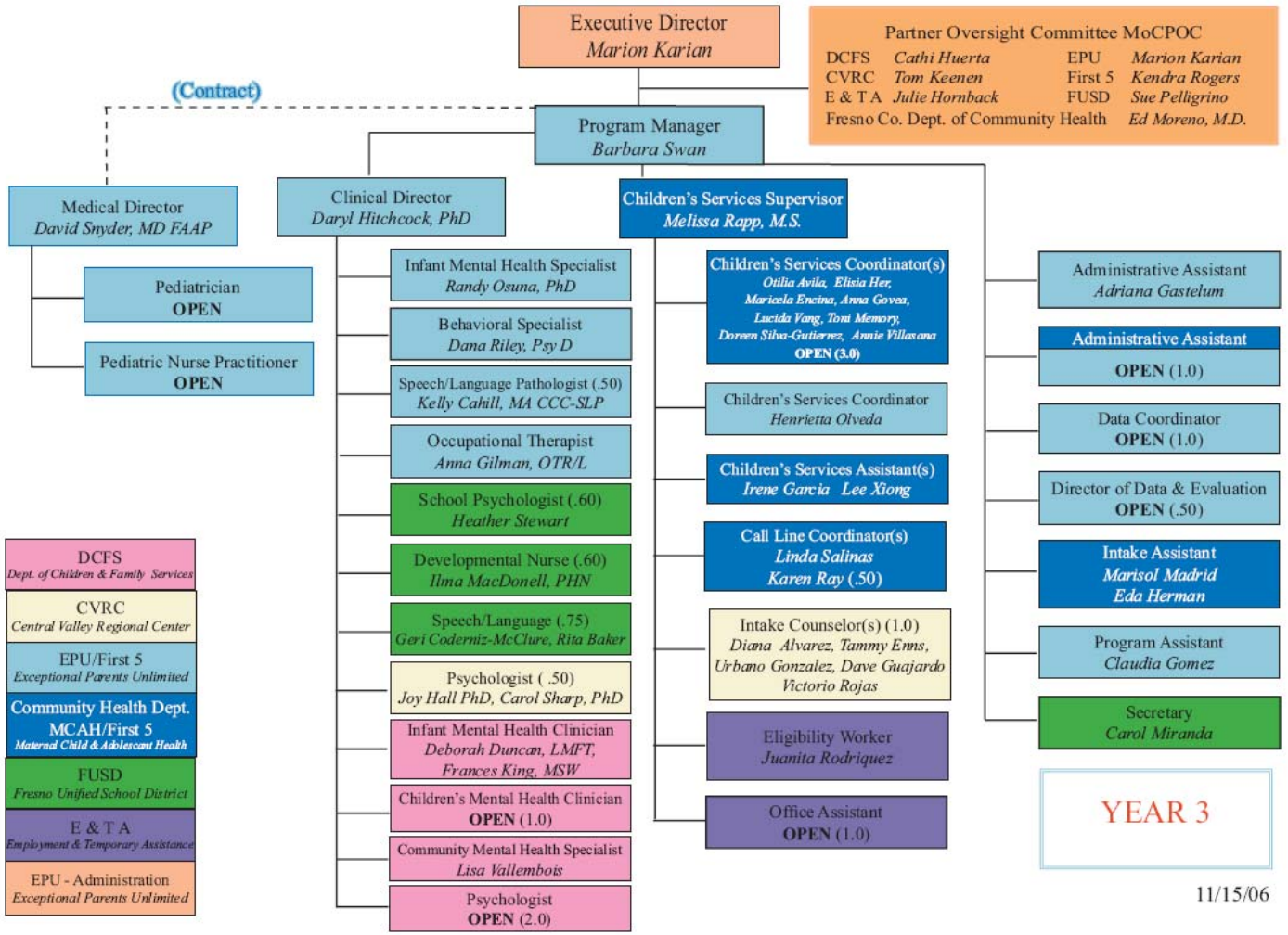
3. Screening Tools- Screening tools used in Component C would be the Vision/Hearing and Health Screens, ASQ and ASQ-SE and an optional tool of the PSI and would be given to all children enrolled in PFA or referred to the FP. Screening tools in Component B would be the ASQ and ASQ-SE and screening tools for Component A would be the ASQ, given only to children who are referred because of concerns communicated from parents, relatives, care-providers, or other professionals. The Family Partner refers any child with red flags to the Triage Team to interpret scores, to determine further screening, assessment, intervention and referral needs. The ASQ (Ages and Stages Questionnaire) is recommended to be used to screen children 0-5 years old and identify "red flags" or concerns. Some referrals to the Triage Team may indicate using further screening tools as indicated below:
    a. PSI (Parent Stress Index)
    b. ASQ – SE (Ages and Stages Questionnaire – Social Emotional)
    c. Health Screen
    d. Vision/Hearing Screen
    e. Assess child within other ecologies

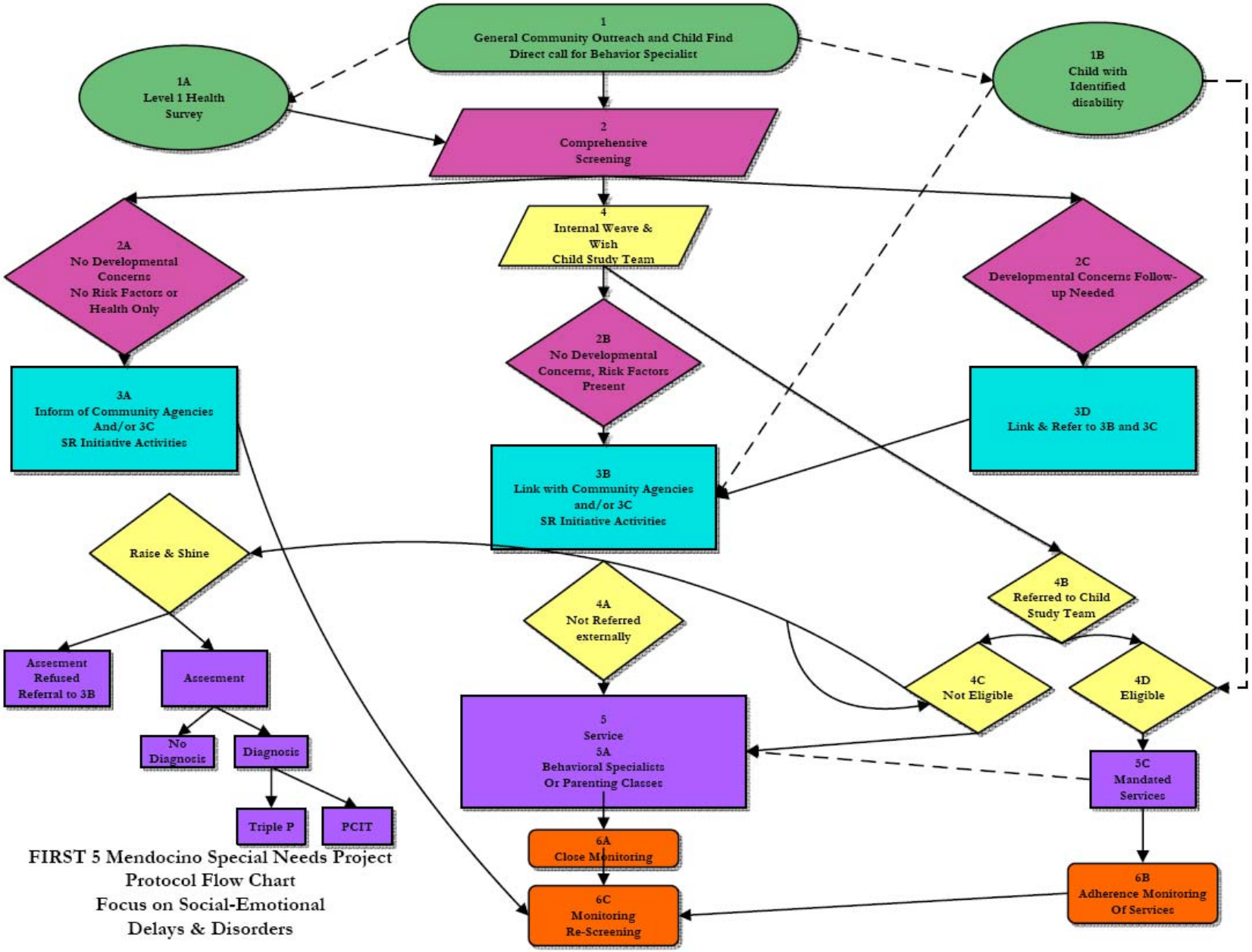
For the purposes of Santa Clara First Five, screening infants and young children for development, social-emotional, physical/health and mental health concerns early can help identify risk, determine the need for further assessment and/or connect the family and child/ren to resources for help. Further assessment would be either a single or comprehensive assessment by specialist/s in the area/s identified as having concern.

4. Red Flags – A child may score "of concern" in one developmental domain or several domains. Once it has been determined that a child has one or more "red flags", the FP will work with the family to refer to the Triage Team.

5. Triage Team – The Triage Team consists always of the family and Family Partner. In general it would include an Infant Mental Health specialist (trained in relationship-based practice) and a Child Development Specialist. (This specialist could be from the preschool community or School District or a Public Health Nurse with developmental expertise.) This phase of the process would be a low key, supportive "conversation" with family members in order to flesh out a clearer interpretation of screening instruments. Other specialists would only be asked to consult at this stage if red flags suggested a need. These might include: Early Childhood Education Specialist, MH Specialist, Early Start/Developmental Specialist, Psychologist, Developmental Pediatrician, Audiologist, Occupational Therapist and/or Medical Specialist. The service providers already involved in the child's life would be invited to participate in the Triage Team.

ASSESSMENT CENTER FOR CHILDREN STAFFING CHART




1
General Community Outreach and Child Find
Direct call for Behavior Specialist
1A
Level 1 Health
Survey
1B
Child with
Identified
disability
2
Comprehensive
Screening
2A
No Developmental
Concerns
No Risk Factors or
Health Only
4
Internal Weave &
Wish
Child Study Team
2C
Developmental Concerns Follow-
up Needed
2B
No Developmental
Concerns, Risk Factors
Present
3A
Inform of Community Agencies
And/or 3C
SR Initiative Activities
3D
Link & Refer to 3B and 3C
3B
Link with Community Agencies
and/or 3C
SR Initiative Activities
Raise & Shine
4A
Not Referred
externally
4B
Referred to Child
Study Team
Assesment
Refused
Referral to 3B
Assesment
4C
Not Eligible
4D
Eligible
No
Diagnosis
Diagnosis
5
Service
5A
Behavioral Specialists
Or Parenting Classes
5C
Mandated
Services
Triple P
PCIT
6A
Close Monitoring
6B
Adherence Monitoring
Of Services
6C
Monitoring
Re-Screening
FIRST 5 Mendocino Special Needs Project
Protocol Flow Chart
Focus on Social-Emotional
Delays & Disorders

Willits WISH Practical Vision

In the year 2008, what do we want to see in place in regard to the system

that provides services for children with disabilities and their families?

Competent Happy Staff	Stable Program Funding	Quality Inclusive Child Care	Local Resources that Support Families	Empowered Families	Seamless Services for all Children and Families	Community Commitment to on-going Screening	All Children ready for school	Community Awareness about Substance Use and Early Brain Development
• Happy staff • More training about screening for teachers	• Sustainable funding • There is plenty of money to continue these efforts • Programs continue into the future	• More quality child care for 0-5 • Children with disabilities served in natural settings • Child care providers and parents know how to support staff and children with behavioral issues • Expand Early Head Start to serve all eligible children	• Local resources • All children 0-5 receiving quality health care • Transportation for 0-5 programs (e.g., Early Head Start, Early Start) • Play Park • Transportation for medical appointments • Children 0-5 with all health needs met • More high school classes about child development	• Warm line • No isolation • Families feel respected and heard • Families know whom to contact for help • Parents have access to parenting information • Family support services • Capture moving families • Home visiting workers support parenting • Self-referral for assessment	• Efficient referrals and collaboration • Cooperation among agencies • Money well spent • Services are seamless for families • Seamless service to children and their parents • Strengthen Family Connections • Services provided to all families and children who need them	• Community acceptance for screening • Community commitment to screening and intervention • Developmental Screening for all children 0-5 • All family child care homes can access screening • Repeat screens from 0-5 • Assessment desired and repeated • High visibility of the project • Community support	• Children start school ready to learn • API scores go through the roof • Children benefit greatly • No child falling through cracks • Develop services for at risk/slow children • Serve children that are slow but not devel-opmentally delayed	• Addressing the effect of AOD on birth and parenting • Prevention of drug-exposed babies

In the year 2008, we have competent happy staff, stable program funding, quality inclusive child care, local resources that support families, empowered families, seamless services for all children and families, community commitment to on-going screening, all children ready for school, community awareness about substance use and early brain development.

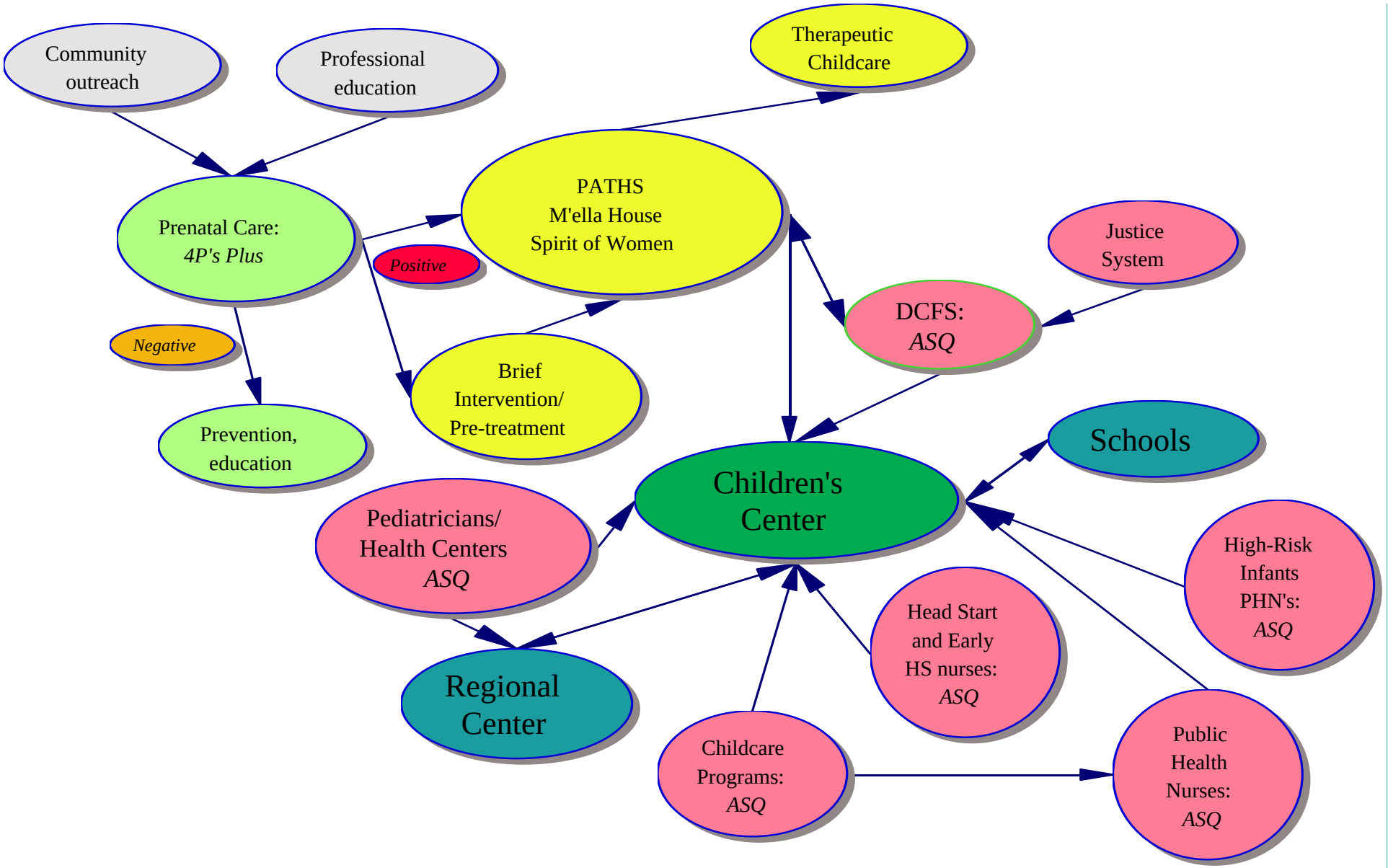
Round Valley WEAVE Practical Vision

In the year 2008, what do we want to see in place in regard to the system that provides services for children with special needs birth to five and their families?

Our support system is widely used and responsive	Our system effectively reaches out to/and serves families with young children	We are utilizing and cultivating local expertise	Families support the nutritional needs, of mind body and spirit	We embrace and reflect Round Valley family values	Children with special needs are served by competent and confident staff	Parents feel comfortable with special needs service system	High quality, effective programs lead us to ongoing funding	Families seek out early intervention, screening, and support
• Services include behavioral health and physical health interventions • Support services for children with mild issues • Support for children before they fail • Coordinated network of support services • Counseling /play therapy for children 0-5 with special needs and their families • Parent-Child playgroups for children in Early Start • Strong partnership with	• All 0-5 children in Covelo have been screened • More referrals to Early Start • All of our children referred for services receive them	• Community members trained as specialists • Services provided by local people • Children stay in and receive all services needed in Round Valley • Round Valley employs local screeners and behavioral specialists • Resources and support are local	• Identification and use of foods effective for mind, body and spirit • Nutritional information and practice • Physical evaluations • Families understand about nutrition	• Including all of the family • Native American cultural Values • Music and arts • To build a stronger native community • Screenings are culturally appropriate	• Increase/ provide training for teachers in special needs • High quality child care for all	• Comfort with the educational systems • Parent leadership in programs and planning • Active parent support group for special needs • Parents with children with special needs feel confident and supported • People know whom to talk to for help • Stronger relationship with specialists • Involvement of all	• Super leveraging sustainability • An effective progress monitoring system • High quality model Head Start • Kindergarten teachers embrace the special needs project	• Families feel safe to refer children • The whole community understands and embraces early screening • More child development high school classes • Parents seek out screening for young children

AOD and mental health providers						community segments		

In the year 2008, our support system is widely used and responsive; Our system effectively reaches out to/and serves families with young children; We are utilizing and cultivating local expertise; Families support the nutritional needs, of mind body and spirit; We embrace and reflect Round Valley Family values; Children with special needs are served by competent and confident staff; Parents feel comfortable with Special Needs Service System; Families seek out Early Intervention and Screening Support; High quality, effective programs lead us to ongoing funding;


Community outreach
Professional education
Therapeutic Childcare
Prenatal Care: *4P's Plus*
Positive
PATHS
M'ella House
Spirit of Women
Justice System
Negative
DCFS: *ASQ*
Brief Intervention/ Pre-treatment
Prevention, education
Schools
Children's Center
Pediatricians/ Health Centers *ASQ*
High-Risk Infants PHN's: *ASQ*
Head Start and Early HS nurses: *ASQ*
Regional Center
Childcare Programs: *ASQ*
Public Health Nurses: *ASQ*

Baton Rouge: Children's Center Organizational Chart

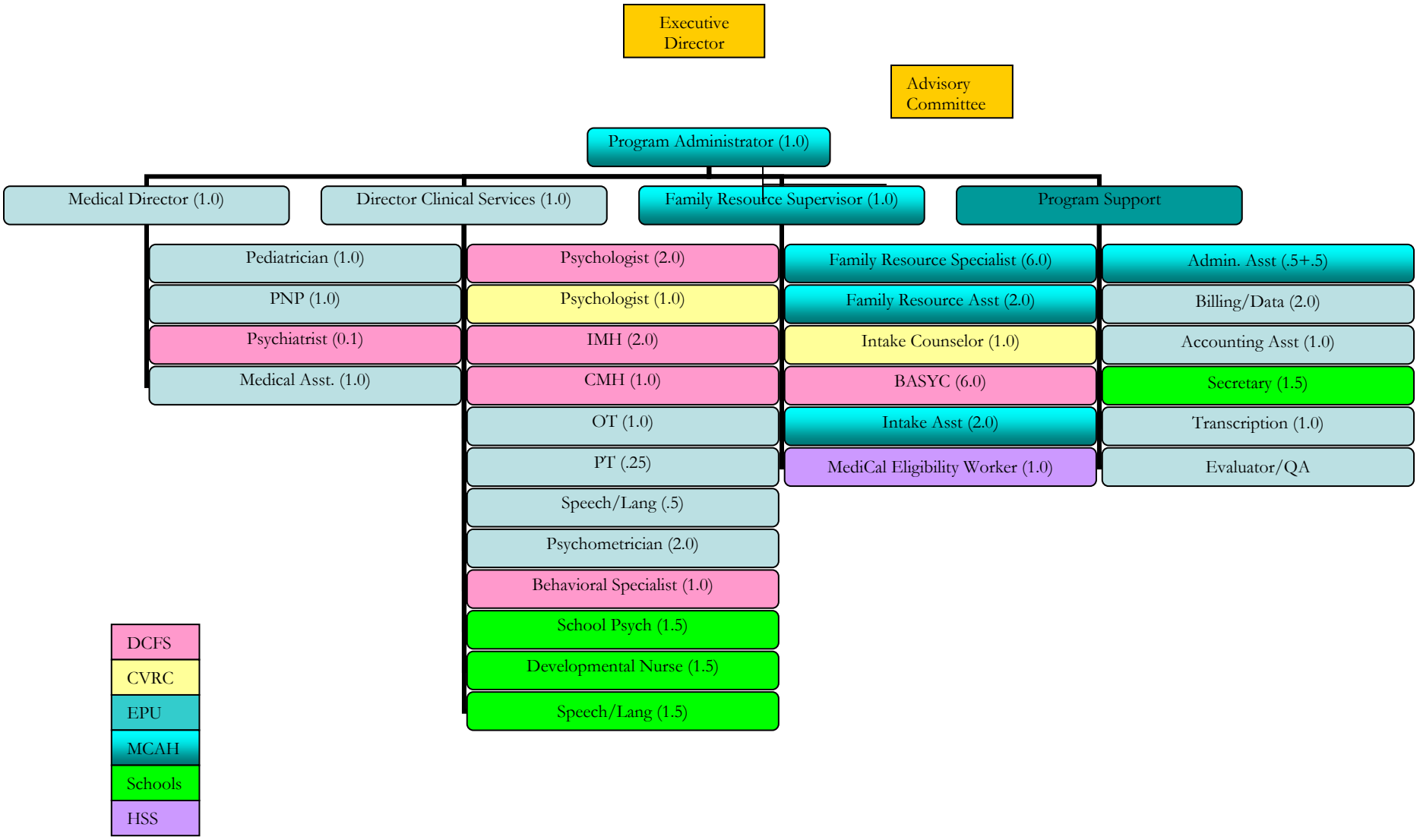
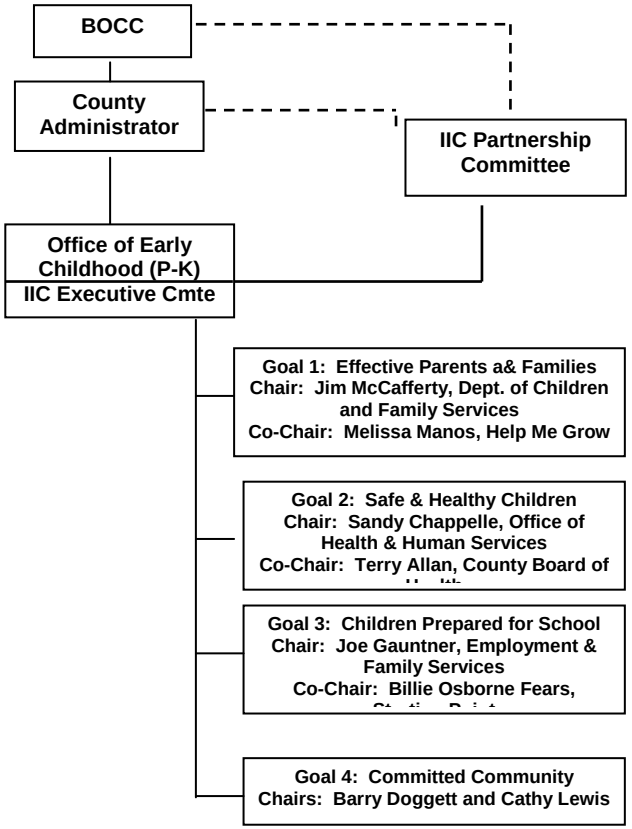


Table of Organization



Goal #3 Committee: Children Prepared for School

CHARTER

Vision

All children in Cuyahoga County will reach their full potential, nurtured by families sensitive to their needs and supported by a community committed to their success.

Goal #3 Statement

Children have access to high-quality early care and education settings that will prepare them for school.

Targeted Population

Children birth to Kindergarten in Cuyahoga County.

Goal #3 Strategies

The overall charge of the Goal #3 Committee is to carryout the recommendations identified in the Invest in Children Strategic Plan. These include:

1- FAMILY CHILD CARE HOMES PROFESSIONAL DEVELOPMENT AND ACCREDITATION- Increase support, training, and TA to family child care homes.

OUTCOMES- # family child care homes participating in Care for Kids; Family Day Care Rating Scale (FDCRS) scores; # homes pursuing National Association of Family Child Care (NAFCC) accreditation; # providers completing CDA; Teacher Education And Compensation Helps (T.E.A.C.H.) participation

2- CENTER PROFESSIONAL DEVELOPMENT AND ACCREDITATION- Increase the number of child care settings participating in quality improvement initiatives, pursuing national accreditation, and child care providers participating in Child Development Associate (CDA) credential training, T.E.A.C.H., and other professional development opportunities.

OUTCOMES- # centers at Getting Ready (GR), Step 1, 2, 3; # staff completing CDA; # staff participating in T.E.A.C.H.; ECERS-R scores; # centers receiving TA and pursuing National Association for the Education of Young Children (NAEYC) accreditation

3- SPECIAL NEEDS CHILD CARE – Provide technical assistance and training to child care providers in order to increase the number of child care slots available to children with special needs.

OUTCOMES- # of children with special needs served; # TA visits and pre-service training opportunities offered to providers; # of special needs children maintained in their child care setting for at least six months

4- CHILD CARE CAPACITY AND EXPANSION – Increase the number of high-quality early care and education settings, where needed, in the county.

OUTCOMES- # of certified family child care homes; # of centers and capacity of existing centers; # of accredited centers and homes; # of centers rated Step 2 or better.

5- UNIVERSAL PRE-KINDERGARTEN- Plan and implement a voluntary high-quality universal pre-kindergarten program.

OUTCOMES- TBD

Background Information of Service Strategies

Overview of the Early Care and Education System

In Cuyahoga County, there are a variety of programs and services that contribute to children's early care and education experiences. Children birth through kindergarten are served through many different programs in a number of settings. Early learning services are provided in a multitude of settings including family child care homes, child care centers, faith-based settings, public schools, community schools, county boards of mental retardation and developmental disabilities, community action agencies, and organizations with other purposes such as a lab school or local mental health agency. Not all of these services are focused exclusively on learning and they reflect considerable diversity in type, quality and delivery of services.

Family Child Care Home Regional System

The Family Child Care Home (FCCH) Regional System, known as ***Care for Kids***, was created in response to the increased demand for child care slots as more parents entered the labor force. In addition to increasing the capacity of care available through family child care homes, resources are provided to focus on the quality of family child care, which is defined as supporting an optimal learning environment for all children. Thus the Family Child Care Home Regional System's primary goals are to: 1) increase access to care; and 2) improve the quality of care provided.

Through the quality enhancement component of ***Care for Kids***, the Family Day Care Rating Scale (FDCRS) is administered to determine the level of quality in the family child care home. Family child care home providers then receive in-home technical assistance and consultation, opportunities to participate in training sessions and workshops, as well as materials and resources, based

on their individual needs. In addition, a Family Child Care Home Accreditation consultation and support program has been implemented, with the goal of increasing the number of homes meeting national standards.

Family Child Care home providers will have access to established services and supports, such as T.E.A.C.H. and specialized early literacy training, to enable their participation in professional development opportunities.

Professional Development and Accreditation

The ***Early Care and Education Professional Development System,*** enhances services to child care providers, and focuses on both teachers and administrators. Early care and education professionals are provided training, technical assistance, and continuing education that follow a professional development career lattice for participants.

Components of the Early Care and Education Professional Development System include:

- Teacher Education and Compensation Helps (T.E.A.C.H.) Scholarships for college coursework.
- Participation as a pilot program in the State of Ohio's Step-Up to Quality Program, a tiered rating system for child care centers with the overall goal of enhancing quality and providing parents with an easy-to-use tool to assist them in selecting quality early childhood programs.
- Resources and technical assistance for child care centers to apply for National Association for the Education of Young Children (NAEYC) Accreditation.
- Child Care Center Directors Credentialing Program.
- Child Development Associate (CDA) credentialing program

Special Needs Child Care

Special Needs refers to children with a range of physical, medical, cognitive and behavioral needs. In some instances these children have behavioral issues exacerbated by one or a combination of other special needs. Parents often have difficulty finding individuals or centers to provide care for their child with special needs. Similarly, providers face a variety of challenges in caring for these children, often not having the resources, services, and/or necessary equipment.

Special Needs Child Care (SNCC) program to assist parents and child care programs in providing care for children with special needs, including severe behavioral problems. The goals of the SNCC program are to: 1) increase the number of providers who can provide care for children with special needs; and 2) increase access to special needs child care. The philosophy behind the SNCC system is to provide child care centers with the resources, knowledge, support and child care alternatives so that children with special needs have access to stable.

Through the SNCC program, providers - both child care centers and family child care homes - can receive technical assistance, training, and special equipment. The program has available a rapid response team that will dispatch trained instructors - the same day - to assist in caring for a child. The program also provides options and resources for parents seeking care for their children with special needs.

Child Care Capacity and Expansion

The purpose of the Early Care & Education Center Capacity Expansion Program is to increase the supply of quality child care through start-up or expansion of early care and education programs in neighborhoods where care is needed to meet the needs of OWF and low income working families.

The Child Care Capacity and Expansion program provides technical assistance, workshops, and training for existing and potential child care center or Type A Home providers. In addition the program provides mini start-up and expansion grants to providers which may be used for staffing salaries; inventory and equipment; computers; and minor remodeling and upgrading of facilities to assure that providers meet state and local child care standards including applicable health and safety requirements.

Universal Pre-Kindergarten

The third goal of Invest In Children, Prepare Children for School, focuses on the development and implementation of a comprehensive, high-quality early care and education system in Cuyahoga County. One identified long-term objective for this goal area is the pursuit of a Universal Pre-Kindergarten (UPK) program that would meet the needs of children, ages 3-5, in the County.

A planning process has been outlined and is underway for the development of the UPK model. A countywide taskforce made up of local experts from the field of early care and education has been convened and charged with model development of the UPK program. The taskforce is focusing on access to UPK settings; standards for quality early learning including professional development; comprehensive services including linkages with related systems and family involvement; and measures for accountability. A Policy Advisory Committee has been convened to oversee the UPK model development and is responsible for recommending a governance structure and finance plan.

Committee Member Roles & Responsibilities

1. Represent IIC on behalf of your organization and act as an ambassador, sharing and promoting the work of IIC.
2. Bring agency concerns and perspectives to the table, and take a goal-level view on behalf of the county.
3. Promote the group's recommendations within your agency and across the county.
4. Commit to carrying out the work related to Goal 3 and assisting in identifying and addressing challenging issues.
5. Attend and productively participate in goal meetings and subcommittees.

6. Review, refine, and validate Work Plans and/or products adequately and assertively representing the needs of their respective agencies.
7. Provide subject matter expertise on behalf of your agency and the families and communities that your agency serves.
8. Perform the analysis necessary to investigate a topic thoroughly.
9. Recommend appropriate action on topics, based on well-researched and thoughtful analysis.
10. Be open to all viewpoints across the county and focus on the county-wide enterprise value.

Committee Chair Responsibilities

1. Update the Executive Committee periodically, as requested by the Chairperson, on active initiatives and progress-to-date.
2. Create goal committee agendas, meeting minutes, and monthly progress reports to the Executive Committee in conjunction with OEC staff.
3. Keep the Work Plans updated on a bi-monthly basis.
4. Resolve issues or bring them to the Executive Committee for further discussion and decision.
5. Provide issues or questions to the Executive Committee five (5) business days prior to the next meeting.

Goal 3 Strategy Sub-Committee Roles & Responsibilities

1. Gather and assess pre-existing and/or complementary work plans, supporting documentation, literature reviews, etc. related to the strategy.
2. Develop a detailed work plan for each recommendation, inclusive of appropriate strategies, activities/milestones, deliverables, timeframes for assessing progress, responsible parties/entities, task completion dates, and a clear description for measuring progress (i.e. outcomes and performance indicators).
3. Monitor progress of strategies; Recommending the validation and/or calibration of outcomes and performance indicators to the Goal 3 Committee.
4. Recommend and utilize available data, reports, resources, etc. to inform strategies and outcomes.
5. Research and develop service delivery models or adaptations to pre-existing service delivery models that are responsive to specific populations (i.e. families of a certain cultural background, children in specific age groups, children served in specific settings, etc.).
6. Assist in the dissemination of information on the status of the goal and/or specific recommendations and obtaining feedback on this status to and from multiple stakeholders.
7. Adhere to mutually agreed upon timeframes related to work plans, meetings, communication, and other strategy-related functions.
8. Commit to a regular meeting schedule.
9. Make recommendations to the Goal 3 Committee.

Goal 3 Strategy Sub-Committee Chair and Co-Chair Responsibilities

10. Create strategy sub-committee agendas, meeting minutes, and progress reports in conjunction with OEC staff.
11. Facilitate the development of work plans; Update work plans as needed.
12. Provide regular updates to the Goal 3 Committee on strategy progress, barriers, issues, etc.
13. Assist in identifying and gathering supporting materials (literature reviews, Best Practice, etc) related to the strategy.
14. Represent the strategy sub-committee on the Goal 3 Committee.

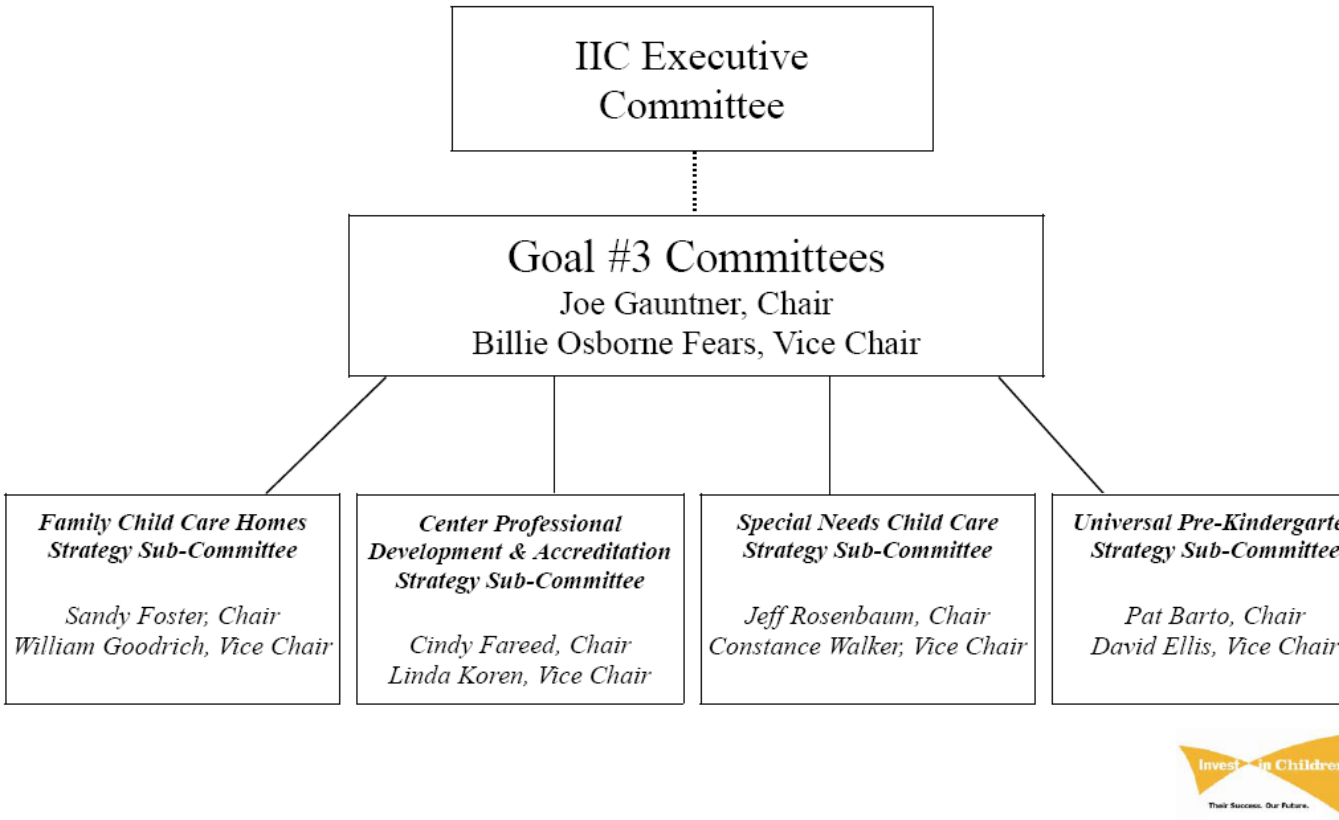
Boundaries of the Goal 3 Committee and Strategy Sub-Committees

1. Do not set rates or payment structures related to the provision of or contracting of services.
2. Do not negotiate contractual matters with lead agencies, sub-contractors or provider agencies.
3. Do not discuss personnel issues.

Characteristics of Committee Membership

1. Ability to navigate systems
2. Content expert within a system
3. Ability to move/seek decisions within a system
4. Cross-system knowledge and experience

Invest in Children
Goal 3 Committee
Children Prepared for School



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Appendix C. Evidence Based Practices

The following sections are excerpts from the summaries of existing, evidence-based practices. Each excerpt is prefaced with a citation listing the author's name and the publication reference. These excerpts are provided for informational purposes only. They provide an overview of different evidence-based practices used across the Country. The purpose of the overview is to illustrate either mechanisms to change service delivery systems or to implement a unique model of addressing the needs of young children with special needs or at risk of social/emotional and developmental delays.

System of Care Model

Adopted from: Pires, Sheila, "Building Systems of Care: A Primer." National Technical Assistance Center for Children's Mental Health, Center for Child Health and Mental Health Policy, and Georgetown University Child Development Center, 2002.

A system of care incorporates a broad array of services and supports that is organized into a coordinated network, integrates care planning and management across multiple levels, is culturally and linguistically competent, and builds meaningful partnerships with families and youth at service delivery and policy levels.

Increasingly, these values are being applied in all system of care building, that is, regardless of whether the focus is on only children with *serious* disorders, those who also are at risk for serious disorders, or on a total eligible population (for example, all Medicaid-eligible children, within which there will be children with serious disorders and those at risk). Indeed, one of the challenges in large scale reforms focused on total eligible populations of children—for example, large scale Medicaid managed care reforms—is incorporating and operationalizing system of care values and principles that were developed initially for populations of children with serious disorders, but which are equally applicable to systems of care for all children.

The definition of a system of care for children with emotional disorders was first published in 1986, "A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families."

The core values of the system of care philosophy specify that services should be community based, child-centered and family-focused, and culturally and linguistically competent. The guiding principles specify that services should be:

- Comprehensive, incorporating a broad array of services and supports;
- Individualized;
- Provided in the least restrictive, appropriate setting;
- Coordinated both at the system and service delivery levels;
- Involve families and youth as full partners; and,

- Emphasize early identification and intervention.

Principles of Family Support Practice

1. Staff and families work together in relationships based on equality and respect.
2. Staff enhances families' capacity to support the growth and development of all family members—adults, youth, and children.
3. Families are resources to their own members, to other families, to programs, and to communities.
4. Programs affirm and strengthen families' cultural, racial, and linguistic identities and enhance their ability to function in a multicultural society.
5. Programs are embedded in their communities and contribute to the community building.
6. Programs advocate with families for services and systems that are fair, responsive, and accountable to the families served.
7. Practitioners work with families to mobilize formal and informal resources to support family development.
8. Programs are flexible and continually responsive to emerging family and community issues.
9. Principles of family support are modeled in all program activities, including planning, governance, and administration.

System of care initiatives essentially are addressing entrenched systems' problems having to do with patterns of utilization, costs, administrative inefficiencies, and poor outcomes. The following table highlights the shifts that systems of care are trying to achieve as *systems reform* efforts.

FROM	**TO**
Fragmented service delivery	Coordinated service delivery
Categorical programs/funding	Multidisciplinary teams and blended resources
Limited service availability	Comprehensive service array
Reactive, crisis-oriented approach	Focus on prevention/early intervention
Focus on "deep end," restrictive settings	Least restrictive settings
Children out-of-home	Children within families
Centralized authority	Community-based ownership
Creation of "dependency"	Creation of "self-help" and active participation
Child-only focus	Family as focus
Needs/deficits assessments	Strengths-based assessments
Families as "problems"	Families as "partners" and therapeutic allies
Cultural blindness	Cultural competence
Highly professionalized	Coordination with informal and natural supports

Child and family must "fit" services	Individualized/wraparound approach
Input-focused accountability	Outcome/results-oriented accountability
Funding tied to programs	Funding tied to populations

Public Health Model: Promotion, Prevention, and Intervention

Adopted from: Lise Fox and Barbara Smith, "Policy Brief: Promoting Social Emotional and Behavioral Outcomes of Young Children Served Under IDEA." Center for Evidence Based Practice: Young Children with Challenging Behavior, January 2007.

OSEP requires states to demonstrate that children served by IDEA are benefiting from those services. In doing so, OSEP established a system of accountability and monitoring related to prescribed areas of child outcomes. For young children, birth through five, served under Part C and B/619 of IDEA, those child outcomes include:

- Positive social-emotional skills, including social relationships;
- Acquisition and use of knowledge and skills, including early language/ communication, and early literacy for preschool; and,
- Use of appropriate behavior to meet needs.

Specifically, states are required to report the percent of infants and toddlers with IFSPs and preschool children with IEPs who demonstrate improvements in those three areas. Thus, two out of three child outcomes to which states are accountable for child progress are related to social, emotional and behavioral development.

Universal Promotion

- Provide families with information on how to develop nurturing relationships with their infant and toddler;
- Provide information to families on practices that may be used to promote their child's healthy social-emotional development;
- Provide screening and referral services for mothers who may have maternal depression;
- Design quality early education and care environments that prevent problem behavior and promote pro-social learning; and,
- Provide mental health or behavioral consultation to early childhood and care programs.

Prevention Strategies

- Appropriately screen and identify children who need individualized and focused strategies to promote social development;
- Provide families with infant mental health services, home visitation, or clinical consultation to support families while they implement strategies that teach targeted social and emotional skills; and,

- Ensure that early care and education providers develop intentional strategies to teach critical social and emotional skills to individual children at-risk of poor social development and challenging behavior.

Treatment Strategies

- The use of Positive Behavior Support, a team based process that results in an assessment based, comprehensive behavior support plan designed to be implemented by the child's natural caregivers in home and early care and education environments;
- Specialized and intensive treatment that addresses parent/child dyad concerns due to neglect, abuse, and trauma; and,
- Multidisciplinary, or trans-disciplinary, teaming among professionals to ensure that families receive access to comprehensive services and supports.

Systems Change

- Engage in collaborative system planning;
- Develop a collaborative personnel development system for all personnel involved with young children; and,
- Engage in on-going collection of evaluation data to measure impact, sustain the systems and approach, as well as build support to ensure that children's social and emotional development continues to be a priority.

Example of Models

- Learn the Signs, Act Early – A CDC national campaign from the national center on birth defects and disabilities.

Child Care Model: Multi-Disciplinary Child Care Consultation

Adopted From: Jennifer McGrady, Heath Holt, Wexler & Farnam, LLP, "Creating a Statewide System of Multi-Disciplinary Consultation for Early Care and Education in Connecticut." Child Health and Development Institute of Connecticut, April 2005.

Child care consultation refers to professional guidance or services delivered on-site at a child care program. The goal of the consultation is to improve child care services (i.e., program level consultation) and/or to address the individual needs of a child and her family (i.e., child specific consultation). The consultation can target one or more disciplines such as health, special education, mental health, early education, and nutrition.

Program-level consultation builds the capacity of child care staff by increasing their skills and knowledge to provide high-quality care. Highly trained child care consultants model effective teaching techniques, explain how to reorganize the classroom's physical space to promote learning, reinforce health and safety practices, and help teachers

understand how to create stronger relationships with families. Child care staff receive real-time feedback as they apply their new knowledge and skills in the child care setting. As needed, program-level consultation can focus on a center's administrative practices to help programs develop the capacity to sustain changes.

Child-specific consultation refers to a situation in which a child and her family require specific services that extend beyond the knowledge, skills, and/or experiences of the child care staff. During child-specific consultation, consultant services typically include screenings and/or assessments, direct services or interventions, and/or referrals for more intensive support services. Consultants can help families access services, support greater integration of services, and reduce duplication among different service providers.

*System Goals***.** The overall purposes of the multi-disciplinary consultation system are to enhance the quality of early care and education and to improve children's developmental outcomes. The specific goals for the consultation system should include:

1. Enhance teachers' ability to provide high-quality care by strengthening their expertise and improving their own health and mental health.
2. Help staff bring best practices to children and families.
3. Provide access to resources that help programs offer high-quality early care and education.
4. Ensure that all children's individual health, mental health, and learning needs are supported.
5. Support the early identification of children's special health, mental health, and learning needs.
6. Promote healthy child and family development.

Examples of Models

- Head Start and Early Head Start;
- US Army Child Development System;
- Day Care Plus (Cuyahoga County, Ohio); and,
- Early Childhood Consultation Partnership (Connecticut).

Program Design

- Include a full range of disciplines in the consultation system, with a focus on health, mental health, and education;
- Provide both program-level and child-specific consultation;
- Offer consultation supports to the full spectrum of early care and education settings; and,
- Make consultation available to all programs, regardless of the population they serve;

Quality Assurance

- Establish consistent qualifications for consultants;
- Clarify consultants' roles and responsibilities;
- Provide training, resources, and networking opportunities for consultants;
- Promote training and information to help directors make best use of consultation; and,
- Incorporate a strong evaluation component;

Delivery Structure/Process

- Develop a structure for statewide oversight;
- Create a regional service delivery system with clear entry points;
- Develop multi-disciplinary teams within each region;
- Deliver consultation based on a program's individual needs; and,
- Stimulate public and entrepreneurial funding mechanisms to expand and sustain the system.

Overall Lessons Learned

- Consultants must appreciate and understand early childhood development and early care and education settings;
- Relationships are key; and,
- Consultation should be ongoing.

Case Study: Day Care Plus (Cuyahoga County, Ohio)

Day Care Plus is a mental health consultation initiative available to all child care centers and licensed family child care homes in Cuyahoga County, which encompasses the City of Cleveland. Day Care Plus was initiated in January 1997 as a collaborative project of the Cuyahoga County Community Mental Health Board, Starting Point for Child Care and Early Education (the local child resource and referral agency), and Positive Education Program, a community-based agency that provides mental health services to children and youth.

Day Care Plus's mission is to maintain young children with challenging behaviors in their existing child care settings. The initiative has three goals: 1) improve the social, behavioral and emotional functioning of at-risk children in child care; 2) increase the competencies of parents and caregivers of at-risk children in child care; and, 3) increase the competencies of child care staff.

Day Care Plus offers two types of consultation services: 1) the Intensive Program, which provides ongoing consultation for a limited number of centers; and, 2) the Response Team, which provides periodic, time-limited assistance to a larger number of programs based on specific requests for help.

The Intensive Program lasts for one year and programs are invited to participate. Any child care center or licensed family child care home can request help from the Response Team. Response Team members work with sites on average for two months, but the length of time can vary depending on how long it takes to resolve the specific problem. Sites that are invited to participate in the Intensive program must sign an initial agreement to participate. Child care staff then work with their assigned consultant to develop a plan of action for the center.

Day Care Plus services for intensive sites include:

- Ongoing on-site technical assistance for directors and staff, generally one scheduled day each week, focused on: individual child study and intervention, center/family communication, developmentally appropriate activities and materials, and staff/management communication and relations;
- Providing or linking centers with resources, such as a coordinated arts program, art therapy, hearing screenings and health referrals, programs for families, financial support for centers to acquire materials, and additional staff; and,
- Training and professional development, such as centralized Saturday staff training activities, center-based evening training activities for families and staff, promoting enrollment in formal coursework toward a degree, mentoring CDA candidates, and taking child care providers to the annual state conference on early childhood.

Programs access the Day Care Plus Response Team services by calling and asking for help. It is free for any program in the county[10].

Day Care Plus uses a pool of dollars for additional wrap-around services, such as a short-term one on-one aide to work with a child, or to make environmental changes (like buying a fence) to improve the program's ability to address a child's needs. In addition, Day Care Plus staff provide training for parents and providers. Day Care Plus provides training and implementation support for developmentally appropriate programming for classrooms, including a music and motion program designed to help reduce children's stress and through the Storytelling series, which helps staff learn creative ways to increase literacy in child care settings and for the children to experience fun ways to explore literacy.

Day Care Plus employs consultants who have multi-systems experience or multiple credentials. The Program Director indicated that when a consultant has only one area of expertise, he or she is not as effective in the field because providers tend to present multiple issues during an on-site visit. For example, Day Care Plus looks for individuals with a mental health background and an early childhood background so that they have

[10] There are 620 center-based programs in the county; in 2003, Day Care Plus provided consultation services in 93 of them. Day Care Plus has chosen to work with fewer centers through the Intensive Program over time in order to free up more resources for the Response Team. Day Care Plus is funded by the county budget.

respect for the early care and education setting and understand the difficulties of the job. Day Care Plus requires that consultants have a Master's degree plus teaching certificate in special education, or social work license, or be a licensed professional clinical counselor.

According to Ann Bowdish, the Early Childhood Project Director, several factors contribute to and influence the effectiveness of the consultation approach:

- The director's openness about center needs and willingness to respond or reciprocate;
- The degree of agreement between the consultant and director about what needs exist and how they should be addressed;
- The degree of communication and agreement between the director and her staff; and,
- The director's and staff's comfort with, and confidence in, the consultant personally, which is critical and depends in part on the "goodness of fit."

The county's overall early childhood initiative, now called Investment in Children, is funded for the next five years at close to $20 million/year. Of that sum, $1 million is earmarked for an outcomes study, which will be conducted by Chapin Hall and Case Western Reserve. The study, while examining outcomes of the initiative, will not be an experimental design. To date, the project only has descriptive and qualitative research.

Pediatric Clinical Model

Adopted from: Neal Halfon, Moira Inkelas, Melinda Abrams, and Gregory Stevens, "Quality of Preventative Health Care for Young Children, Strategies for Improvement." Commonwealth Fund, May 2005.

The term *developmental services* refers to preventive pediatric services focused on optimizing healthy development. These services are distinct from other, more traditional preventive services, such as immunizations and lead screening, because of their potential contribution to early learning, healthy development, and school readiness.

Developmental services include:

- **Assessment** to identify developmental risks and problems. This includes reviewing parental concerns, which may lead to periodic structured evaluation (often referred to as developmental screening) and diagnostic assessment, if warranted;
- **Education** for parents on child development and ways of promoting learning and growth. This is also called anticipatory guidance or health supervision;
- **Intervention** for developmental concerns, either within the pediatric practice or by specialists or community programs; and,
- **Coordination** of intervention and treatment services, including referral and follow-up.

Recommendations call for standardized methods for identifying children at risk of developmental delays, easy access to services for children with problems, coordinated case management, and ongoing measurement to produce information to facilitate quality improvement.

Implement Routine Use of Standardized Developmental Assessment Tools

Improving early detection requires interventions at the clinician, community, and state level. In particular, it is critical to use standardized, validated tools to improve the identification of young children at risk of delay

Measure and Compare Quality of Developmental Services

Measuring performance can help clinicians, parents, payers, and policymakers monitor progress and make adjustments to their practice.

Create Public–Private Quality Improvement Partnerships

Create community partnerships of pediatric clinicians collaboratively engaging in quality improvement activities under the guidance of experts. For example, in the Vermont Children's Health Improvement Program (VCHIP), all pediatric practices in the state engage in evidence-based, measurement-driven, quality improvement projects on topics ranging from asthma to preventive services.

Provide Adequate Reimbursement for Developmental Services

At least one-half of the pediatricians surveyed by the AAP cite inadequate visit time, inadequate reimbursement, and a shortage of non-physician staff as major barriers to delivering developmental services.

Raise Parents' Expectations

Increase parents' demand for developmental services. Parents should receive educational materials prior to well child care visits to help prepare them and to provide tips on how to broach child development topics with providers. The combination of written and verbal guidance is often most effective at changing parents' behavior. Written brochures and videos can provide details not addressed during the office visit and can reinforce messages.

Examples of Models

- Developmental Screening and Surveillance of Infants and Young Children, American Academy of Pediatrics, Committee on Children with Disabilities; and,
- Bright Systems, Kaiser Permanente (Adapted from Bright Futures Model).